MORE THAN WEIGHING BABIES

Quality and competence in the specialist practice of child and family health nursing

By

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CONTENTS

ABSTRACT

Growth and development in infants and children lay the foundations for productive life trajectories into adulthood. Child and Family Health Nurses (CFHNs) in Australia are the primary workforce tasked with supporting families to promote optimal growth and development in infants and children from birth to five years. CFHNs' work is distinctive because it is conducted in homes and community settings, is relational and is in the preventative health and early intervention domain. Many standards, frameworks, policies and guidelines govern the practice of CFHNs across Australia. There is no available empirical evidence of a transferable process of defining quality and competence in the practice of CFHNs compared to other nursing and midwifery roles. This study aimed to identify the elements of competence in the specialist practice of child and family health nursing to ensure quality care for children and families.

Focused ethnography, as the qualitative research methodology and a constructivist-interpretivist lens were used to explore the perspectives of CFHNs in health jurisdictions across all states and territories in Australia. Data were collected through online in-depth semi-structured interviews with sixty CFHNs, complemented by eighty-four organisational documents related to child and family health nursing practice.

The findings across settings suggest that there are challenges and inconsistencies in how CFHNs' practice is identified and measured, where the focus is on service provision rather than a qualified and competent workforce. Current assessment of quality and competence relies on health organisations having task-focused skills assessments for initial employment of qualified CFHNs or a transition to practice programme for postgraduate students. It was found that opportunities to assess quality and competence in the ongoing practice of CFHNs presently exist. The approaches have individual merit, but their full benefit is not realised because these approaches are currently applied inconsistently or only in part across jurisdictions or settings. It is recommended for future practice that the use of reflective practice through clinical supervision, practice consultancies and peer or performance reviews be applied as an integrated approach in all settings, to enable the quality and competence of child and family health nursing practice to be comprehensively identified and measured.

The findings also suggest that transition to practice programmes offer valuable platforms for supporting inexperienced practitioners and cultivating a skilled workforce deeply rooted in providing early intervention and preventive care for children and families. A further recommendation for practice, therefore, is to establish the progressive implementation of transition to practice programmes across Australia for nurses who wish to qualify as CFHNs.

It is suggested that future research focuses on both recommendations for practice, that is, on an integrated approach to reflective practice and the extension of transition to practice programmes. Research focusing on the implementation and operation of these recommendations could evaluate their relevance and efficacy in providing a qualified and competent child and family health nursing workforce to care for children and their families.

This thesis contributes new knowledge to understanding the complexity involved in establishing quality and competence in the specialist practice of child and family health nursing. To promote optimal growth and development in infants and children from birth to five years, families rely on CFHNs who can provide quality and competent care.

DECLARATION

I certify that this thesis:

1. does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university

2. and the research within will not be submitted for any other future degree or diploma without the permission of Flinders University; and

3. to the best of my knowledge and belief, does not contain any material previously published or written by another person except where due reference is made in the text.

Louise Wightman

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LIST OF PRESENTATIONS

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CHAPTER ONE: INTRODUCTION

This research explores the specialist practice of child and family health nursing and how quality and competence are identified and measured from the perspectives of child and family health nurses (CFHNs) employed across eight Australian health jurisdictions. Child and family health nurses are the primary workforce tasked with supporting families to promote optimal growth and development in infants and children from birth to five years (Australian Health Ministers' Advisory Council, 2011). Australia offers a universal child and family health service to all families with infants and children in this age range (Australian Health Ministers' Advisory Council, 2011). How this service is delivered varies in each health jurisdiction. Child and family health nursing education programmes also differed across Australia, with no universal standards for prerequisite qualifications, course length, clinical exposure or award title (Kruske & Grant, 2012).

Background

The importance of the early years

The importance of nurturing in the early years has been well documented by leading health organisations and researchers. These years are critical because they lay the foundations for the lifelong trajectory of health, learning, behaviours and relationships (Centers for Disease Control and Prevention, 2019b). Caring for infants and children in the early years is essential because their growth, development, health and well-being depend on being raised in a nurturing environment (World Health Organization et al., 2018). Infants and children depend on adults from the beginning in utero through the early years as they develop physical, cognitive, social and emotional life skills towards caring for themselves independently (World Health Organization et al., 2018). For example, access to appropriate nutrition for infants and children has been shown to contribute substantially to good health in adulthood (Campbell et al., 2014). A recent analysis of the use of World Health Organization's (WHO) growth standards highlighted the need for a more accurate assessment of rapidly changing growth in infancy and the need to address undernutrition that begins in pregnancy leads to the increasing prevalence of overweight infants and children (de Onis, 2017). Thus, evidence supports the argument that the quality of nurturing that infants and children receive determines in large part the extent to which they fulfil their potential across a range of areas as they grow.

There is mounting recognition of the complexity of family needs. This complexity is reflected in the work of CFHNs, who increasingly support families experiencing trauma, mental health problems

and substance abuse issues that impact on their parenting capacity (Rossiter et al., 2017). Advances in research have promoted a growing focus on the importance of early intervention to prevent adverse childhood experiences negatively affecting adult life. It is often inferred that outcomes for infants and children will be poor if they are exposed to adverse childhood experiences with their parents/carers and the environment in which they live (Shonkoff et al., 2012). Undoubtedly, the nature and frequency of events such as experiencing violence, abuse or neglect, growing up in a household with substance misuse or mental health problems, are adverse events that can shape children's responses to trauma (Centers for Disease Control and Prevention, 2019b). Toxic stress can have enduring consequences on brain architecture, resulting in challenges related to the acquisition of social-emotional, cognitive, and language abilities (Shonkoff et al., 2012). Additionally, individuals may exhibit heightened reactivity to minor adverse events, which can subsequently contribute to unfavourable health and educational outcomes throughout childhood (Shonkoff et al., 2012). Understanding how adverse childhood experiences impact on the growth and development of infants and children can guide policy and practice for workers who deliver care to support families to address these issues. This understanding also has the potential for those workers who provide care to families experiencing these issues, to have a positive influence on the life trajectory for infants and children in those settings.

The accumulation of adverse childhood experiences beginning from conception and continuing throughout the perinatal period and early years can disrupt attachment, brain development and early learning (Black et al., 2017). When children who are exposed to adverse childhood experiences become adults and parents, the cycle of damage can continue as these distressed parents are unlikely to provide a supportive and stable relationship that offers protection from toxic stress (Shonkoff et al., 2012). Adverse experiences in the perinatal period are more strongly related to children's difficulties in their current functioning than adverse experiences that occur during other periods in their childhood (Hambrick et al., 2019). To address these situations, it is imperative to provide support to parents who are experiencing distress or who are under significant stress. This support is crucial for the well-being and development of infants and children. Parenting stress can be caused by economic hardship, relationship breakdown, mental illness and substance abuse, creating an unstable environment for infants and children (Crouch et al., 2019). Unpredictable or hostile parenting can become a source of distress for infants and children and disrupt the forming of positive maternal-child relationships, which may buffer against adverse experiences (Condon et al., 2019).

These adverse experiences can impact on infants' or children's informal learning that begins in the home, in early childhood care and continues into formal education in school (McKelvey et al., 2018). Socioeconomic disadvantage in infancy directly affects academic skills in middle childhood, possibly resulting from difficulties that parents experience in providing a stimulating and sensitive home environment in early childhood (O'Connor et al., 2019). Lipscomb et al. (2019) found that access to early care education aimed at assisting children from low-income families experiencing adversity was challenging when work for parents was inflexible and unpredictable. When the process of acquiring knowledge is disrupted or impeded as a result of learning difficulties, it can give rise to maladaptive behaviours during middle childhood and subsequent stages of development, ultimately affecting one's employment prospects in adulthood (Black et al., 2017; McKelvey et al., 2018). Children exposed to cumulative adverse childhood experiences of which parental anxiety and depression were the most prevalent, were more likely to exhibit higher degrees of maladaptive behaviours and be given corresponding behavioural diagnoses (Hunt et al., 2017). It is important to acknowledge that the initial stages of infancy and childhood are characterised by substantial developmental progress but that developmental deficit and heightened vulnerability occur when infants and children encounter adverse circumstances.

When infants and children face increasingly adverse experiences in their lives, the potential for poor outcomes related to future health and well-being dramatically intensifies. Socioeconomic disadvantage and poor health significantly influence children's cognitive achievement, with the disparities becoming more pronounced between the ages of three and nine years. These gaps in cognitive achievement, however, tend to stabilise during middle childhood and adolescence (Lee & Jackson, 2017). The cost of inaction means that more money needs to be spent on crisis interventions such as child protection, chronic and mental health services, youth justice systems and increasing social security payments. Early intervention has the potential to help prevent problems and issues escalating to the point of becoming too challenging to resolve, meaning that infants and children are more likely to grow into productive adults, with reduced pressure on government budgets (Teager et al., 2019). This work is now very much in scope for CFHNs. While service models of care that focus on early intervention exists, little is known about how CFHNs enact care in this space.

Global directions for policies and frameworks related to child and family health

Global frameworks related to child and family health highlight the importance of caring for infants and children and how family life can impact on the growth and development of children. These

key international documents support the development of child and family health care policies, which underpin child and family health nursing practice in Australia. The United Nations' Sustainable Development Goals (SDGs) of 2015 are a call to action for all countries to work in a global partnership for prosperity for all nations. Three goals particularly align with child and family health: SDG 3, 'Ensure healthy lives and promote well-being for all at all ages'; SDG 5, 'Achieve gender equality and empower all women and girls'; and SDG 16, which pertains to 'Peace, justice and strong institutions'. These goals focus on promoting the health and development of all children, ending preventable maternal, newborn and child deaths and ending all forms of violence against children (United Nations, 2015). To achieve these goals globally, families need nationwide, timely access to services that provide accessible, sustainable and skilled assistance to support parents to optimise health outcomes (UNICEF, 2016; United Nations, 2019). The World Health Organization (WHO) encourages the focus on children to shift from survival alone to one where children thrive in an environment that can transform their health and human potential and where families and carers provide nurturing care (World Health Organization et al., 2018).

The Nurturing Care Framework (World Health Organization et al., 2018) supports a whole of society approach for children from conception to three years. The components of nurturing care include "good health, adequate nutrition, responsive caregiving, safety and security and opportunities for early learning" (World Health Organization et al., 2018, p. 12). Children need to be surrounded by caregivers who have their capabilities enhanced by supportive services and empowered communities underpinned by government policies (Richter et al., 2017). The Nurturing Care framework considers how a pregnant woman's health and well-being influence the unborn infant's trajectory and how parenting and family relationships can have an impact on the growth and development of children in the early years. The most powerful impact on child development comes from the immediate home and care setting which, influences the nature and extent of care that children receive (Britto et al., 2017). It can be challenging for parents and carers to provide nurturing care when experiencing poverty, struggling for survival or surrounded by conflict. WHO (2020) refers to the most intensive and frequently occurring sources of stress that children may suffer in their early years of life as adverse childhood experiences. These experiences include psychological, physical, or sexual abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18. Examples include violence against mothers, living with household members who are substance abusers, mentally ill or suicidal, and those who have experienced imprisonment (Centers for Disease Control and Prevention, 2019a). The accumulation of adverse childhood experiences disrupts neurodevelopment, attachment and

early learning, and this burden leads to poor personal and social consequences in adulthood (World Health Organization, 2020).

Australian context

The work of health professionals caring for infants and children in Australia is guided by several national frameworks. The Healthy, Safe and Thriving: National Framework for Child and Youth Health (Australian Health Ministers' Advisory Council, 2015a) advocates for health professionals to work in partnership with parents to provide the best possible conditions for children and young people to thrive. The National Framework for Universal Child and Family Services (Australian Health Ministers' Advisory Council, 2011) and the National Framework for Child and Family Health Services – Secondary and Tertiary Services (Australian Health Ministers' Advisory Council, 2015b) guide a whole of population approach to child and family health care. Universal services work from a primary health care focus, providing early identification and intervention and referral to secondary and tertiary services for all children and families with identified increasingly complex needs (Australian Health Ministers' Advisory Council, 2011, 2015b). The National Action Plan for the Health of Children and Young People 2020-2030 (Australian Government Department of Health, 2019) focuses on improving equity across populations, empowering parents to maximise health development, tackling health and risky behaviours, addressing chronic conditions and prioritising preventative health measures, and strengthening the child and family care workforce.

An integrated approach to early childhood development is required if nurturing care is to become embedded in child and family primary health care (World Health Organization, 2020). Australia has a national commitment to focus on the importance of growth and development in the first 1,000 days of a child's life (Australian Government Department of Health, 2019; Moore et al., 2017). Australia is a high-income country comprising six states and two territories with an approximate population of 26 million. It includes over six and a half million family groups, including 1,463,817 children aged birth to four years (Australian Bureau of Statistics, 2018). The largest populations live in the major capital cities of each state and territory; therefore, most services for infants and children are located within these cities.

Health policies and frameworks may differ across Australia because the states and territories and their jurisdictions are individually responsible for their own policies and frameworks. For example, in Queensland and Victoria, the focus has been on the first 1,000 days of life when addressing the health and well-being of Aboriginal and Torres Strait Islander infants and children (Monson-Wilbraham & Arabena, 2018). New South Wales (NSW) has extended this growth and

development lens to include the first 2,000 days of early childhood. It is believed that the first 2,000 days can have a significant impact on children's life courses and is an opportunity to reduce risk factors and increase resilience for the child and the family (NSW Health, 2019).

Health professionals and the care of children

Primary health care providers such as general practitioners (GPs), CFHNs, community nurses, and, in some countries, paediatricians, are the health professionals who provide well-child health care. Children in the USA receive care from family physicians or paediatricians depending on their access to health insurance, and the focus on preventive health care is limited (Phillips et al., 2006). Children's access to well-child care is reported to be linked to parents' discernment regarding the necessity to access services proactively and the level of trust that parents have for health professionals (Bellettiere et al., 2017). International research suggests that supporting parents who care for infants and children will support the growth and development of infants and children (Britto et al., 2017).

A review of child health care in Europe and the paediatric workforce found inconsistencies in how paediatric care systems operated. Some systems favoured paediatricians and psychologists as lead professionals over general medical practitioners, family doctors or nurse practitioners to deliver complex child health care (Ehrich et al., 2016). In the Netherlands, free public preventative health care focuses on monitoring growth and development in children from birth to five years and providing information to parents who have concerns about their children (Siderius et al., 2016). This care is delivered primarily by nurses in the community who make referrals to general medical practitioners, physiotherapists and speech therapists for additional assessment before paediatricians provide specialist services (Siderius et al., 2016). Denmark has a similar system, with public health nurses and general medical practitioners offering scheduled preventative health checks for children from birth to five years. These health professionals are seen as the gatekeepers to secondary health care services in hospitals where most paediatricians work (Mathiesen et al., 2016).

The UK has free child health care that focuses on birth to five years through a universal programme monitoring growth and development and supporting parenting. This programme is delivered by health visitors, who are nurses or midwives with specialist training in supporting families and children, in partnership with general medical practitioners (Wolfe et al., 2016). Most child health problems are managed by general medical practitioners, who will then refer to specialist community paediatricians for more complex care (Wolfe et al., 2016). In contrast,

according to Staines et al. (2016), the Republic of Ireland has a mix of public and private health care services that cater for children from birth to five years. These authors also noted that general medical practitioners are the leading providers within these services, while the main foci of public health nurses working in supportive roles within these primary health care teams are screening, surveillance and health promotion. As with Denmark, general medical practitioners in the Republic of Ireland are the referral point for all access to secondary specialist services, such as paediatricians and allied health professionals (Staines et al., 2016). The health and wellbeing outcomes for children in the UK and the Republic of Ireland remain very low compared to other comparable European countries; this is because of inequitable access to primary health services and inconsistencies related to availability of the primary health care workforce (Staines et al., 2016; Wolfe et al., 2016).

Health professionals in Australia, including CFHNs, GPs, Aboriginal health workers or family support workers, are employed across a range of healthcare settings and offer preventative or intervention-based care to infants and children. Australian parents seeking care for their infants and children access a range of health service providers, depending on what they perceive to be the needs of their infants and children. Parents see GPs as the providers of immunisations and illness assessment and CFHNs as providers of parenting advice, well-child checks and sources of a variety of information related to child health and well-being (Rossiter, Fowler, Hesson, Kruske, Homer, & Schmied, 2019). Sometimes, child and family health nursing services are seen as less accessible by parents or less relevant as their child ages. Parents will see the practice nurse in the general medical practice as a viable alternative even though the practice nurse or GP is not always a specialist in well-child care (Rossiter, Fowler, Hesson, Kruske, Homer, & Schmied, 2019).

For example, in their case study of 71 visits in three general practices in Australia, Garg, Eastwood, et al. (2018) found that parents took their children to general medical practitioners to access immunisations or treatment for minor illnesses, while healthy child checks were incidental. The study found that while well-child care was a significant proportion of children's visits to general medical practitioners, the focus was biomedical and fragmented between the general medical practitioners and practice nurses. In addition, there was limited anticipatory guidance, a lack of systematic use of developmental screening tools, and a reliance on parents to identify delays and bring them to the attention of general medical practitioners (Garg, Eastwood, et al., 2018).

The Aboriginal Families Study in South Australia highlighted inconsistencies in availability of primary health care from GPs and CFHNs for rural and urban Aboriginal families in the community,

with access varying between mainstream health services and Aboriginal health services, leading to less-than-optimal care of women and children (Yelland et al., 2016). In the Northern Territory (NT), lack of suitably qualified staff meant that universal monitoring and surveillance of infants and children under five years was conducted by Remote Area Nurses who lacked the specific knowledge and skills to address issues related to child health and well-being (Josif et al., 2017). In rural and regional communities in Australia, it can be personally risky and challenging for CFHNs to address child protection issues with families when they are visible and known members of the community (J. A. Fraser et al., 2016).

Services provided are not always equitable or accessible or meet the needs of infants, children and their families, particularly where there are complex needs. Parents often decide whether to access services, health care professionals or facilities for their infants and children based on whether service fees are charged. In Australia, the lack of early intervention services to prevent problems in infants and children related to their growth and development leads to $15.2 billion spent on high intensity and crisis care (Teager et al., 2019). The challenge for governments that provide funding for health services for infants and children is to decide who is the best placed to offer these services and what services will support the health and well-being of infants and children. Parents seek support from various health professionals depending on what information or treatment they perceive they need to care for their infants and children. Additionally, several health and education professionals and social service providers work with infants and children from birth to five years of age. As infants and children cannot access services of their own accord, how and when they connect with services depends on their parents' or carers' perception of the needs of their infants and children (Hesson et al., 2017).

Theoretically, if child and family health services are provided universally in Australia, then CFHNs potentially have access to thousands of families and the opportunity to affect the health and well-being of many more infants and children. Child and family health nurses work autonomously and collaboratively across a range of primary health settings, yet there are inconsistencies in the qualifications required to do this work, in the recognition that CFHNs receive for advanced practice and in the service delivery models under which they work (S. Fraser et al., 2016). If nurses are to demonstrate a clinically significant and cost-effective contribution to healthcare, the impact of these advanced practice roles' must be measured against clinical processes and outcomes that matter to clients, professions and organisations (Casey et al., 2017).

Child and family health nursing in Australia

In Australia, there is a long history of CFHNs providing health care to infants, children and their families that have developed over time from a generalist nursing role to a more specialised workforce (Grant, 2013). The critical role of the mother in the early part of an infant's life and the need to address infant mortality and morbidity led to the formation of the infant welfare movement in the early 1900s in NSW (Armstrong, 1939). By 1917, Victorian and Western Australian health services had joined NSW in both visiting families at home and setting up Baby Health Centres to educate mothers about breastfeeding, monitoring growth and good hygiene practices to prevent infantile diarrhoea (Armstrong, 1939; Bennett, 2013; NSW Kids and Families, 2015).

As these services evolved, there was a recognition of the need for staff training to care for mothers and babies in the community, which coincided with the legislation of training and examination of nurses (Bennett, 2013; NSW Kids and Families, 2015). In New South Wales, the training of infant health nurses began as early as 1920 and continued to develop through the 1960s as a diploma for child health nurses through organisations such as Tresillian and Karitane (NSW Kids and Families, 2015). Throughout Australia, hospital training existed to gain certificates for nursing, midwifery and infant health nursing, leading to registration to practice in the state or territory where the training occurred (Grant, 2013; Keleher, 2000). Certification enabled infant health nursing to be seen as a distinct area of practice and expertise that differed from general nursing or midwifery. Through the 1970s and 80s, child and family health services expanded to include services such as immunisation and growth and development screening for toddlers and preschool children (NSW Kids and Families, 2015). During this time, the Declaration of Alma Ata (World Health Organization & UNICEF, 1978) saw the focus of child and family health services move to a wellness model based on primary health care and health promotion principles (Borrow et al., 2011).

Along with evolving child and family health practice, registration for nurses and midwives moved to a national registration and accreditation scheme; consequently, state-based registration for child and family health nurses disappeared (Grant, 2013). Even though child and family health services are universal throughout Australia, education programmes for child and family health nursing varies across states and territories. In a survey of specialist courses in child and family health nursing offered by twelve institutions in Australia, Kruske and Grant (2012) found inconsistencies in the titles given to these awards, their prerequisite qualifications, course length

and clinical exposure. There has been no change towards alignment in this specialist education space (Fowler et al., 2015). While many Australian jurisdictions developed organisational and professionally based frameworks to guide practice, it was not until 2017 that a national framework emerged. The National Standards of Practice for Maternal, Child and Family Health nurses in Australia (Grant et al., 2017) provides a framework to guide practice at a national level. It is variously implemented to support the education, management and clinical practice of CFHNs across Australia.

The Australian child and family health nursing workforce is part of Australia's child and family health universal services. This workforce completes early intervention assessments of health and, when necessary, collaborates with other primary health care providers such as GPs, making referrals for infants, children and their families as appropriate (Schmied et al., 2015). Workforce data from the Department of Health and Aged Care (2020a) states that approximately 5,590 CFHNs in Australia work in specialist practice roles to care for the health and wellbeing of infants and children. Australia has state and territory-based Child and Family Health Nursing services, each operating under different organisational structures. Victorian Maternal and Child Health services are governed by an agreement between the state health service and seventy-nine local councils based in local government centres. Maternal and Child Health services in the Australian Capital Territory (ACT), Child and Family Health services in South Australia (SA) and Child Health and Parenting services in Tasmania are governed by territory or state-wide community health services. While Child and Adolescent Health services are statewide in Western Australia (WA), metropolitan and regional community health services manage them separately. There is a similar system in the Northern Territory, as Primary Health Care services are governed independently, delineated into northern and central geographical areas. Child and family health nursing services in New South Wales are based in community health centres governed by fifteen separate local health districts, similar to Child Health services in Queensland, which are independently managed by sixteen different hospital and health services in the community.

Individual jurisdictions and some service providers have created frameworks to guide child and family health nursing practice. Despite the introduction of the national standards of practice in 2017, how these standards are implemented in clinical practice is unknown. The care of children and families is increasingly complex, and to ensure infants and children across the country receive equitable, safe and quality services, health jurisdictions need to consider the employment of a qualified and competent workforce. The unique qualities of child and family health nursing

practice are articulated through the National Standards of Practice for Maternal, Child and Family Health Nurses in Australia (Grant et al., 2017). The standards serve as a structural basis for delivering high-quality, evidence-based care by Child and Family Health Nurses. Nevertheless, the effectiveness of these standards in ensuring the provision of quality care has not been substantiated through empirical research. If CFHNs are responsible for the well-being of these vulnerable populations, it is imperative that child and family health nursing services ensure that their staff possess the necessary skills and knowledge to deliver high-quality care effectively and safely.

The Nursing and Midwifery Board of Australia provides broad professional standards that guide professional practice for registered nurses and a framework to guide the assessment of competence against the nursing standards for practice (Nursing and Midwifery Board of Australia, 2016a). The UK's Nursing and Midwifery Council (2022b) has national standards of proficiency for specialist community public health nurses, including health visitors, that govern practice. For child and family health nurses in Australia, quality is measured differently depending on the jurisdiction. For example, in one jurisdiction, a Child and Family Health Nursing Professional Practice Framework (Briggs et al., 2022) has been developed that focuses on clinical practice consultancy, clinical skills assessment and performance appraisal, along with self-reflection to guide practice development and education. This document is linked to Australia's current National Standards of Practice for Maternal, Child and Family Health Nurses.

Relying on competencies can be problematic as they are predominantly task focused. Practice standards can more fully articulate the scope of advanced practice and guide workforce development (Halcomb et al., 2017). Gardner et al. (2016), for example, utilised an Advance Practice Delineation Tool to define foundational, specialist, and advanced practice to nurse practitioner levels of practice to provide evidence to influence postgraduate education and profiles of nursing practice. Gardner et al. (2017) concluded that rather than being a compilation of roles and titles, advanced practice nursing is measurable as a level of nursing practice. This explanation of advanced practice could be applied to the measurement of the scope of child and family health nursing practice, including the transition from novice to experienced CFHN, utilising the national standards of practice.

Registered nursing standards are broad and do not provide specific guidance around specialist practice. The development of standards for general practice nurses and specialist critical care

nurses, for example, enabled the articulation of the role and scope of contemporary practice and provided guidance for curriculum and workforce development (Gill et al., 2017; Halcomb et al., 2017). The child and family health nursing role is better articulated through specific standards of practice that focus on evidence-based care to support the growth and development of infants and children and the well-being of their families. While some work has occurred in individual jurisdictions, they have not been developed into a national framework for assessment of the quality of practice nor developed for curriculum guidance and workforce development. How the quality and competence of child and family health nursing practice is identified and measured beyond the initial postgraduate qualification of CFHNs has not been visible.

To uphold the standards of proficiency and efficacy in child and family health nursing, it is imperative to establish a minimum standard of education and implement continuous monitoring mechanisms to assess the quality and competency of child and family health nursing practice (Fowler et al., 2015). According to contemporary research, for nurses to contribute meaningfully to the healthcare field, it is imperative to assess the influence of these advanced practice roles on clinical processes and outcomes that have significance for clients, professionals, and organisations (Casey et al., 2017). Further research was warranted to explore how quality and competence are identified and measured in specialist practice of child and family health nursing to inform policy and practice around service provision for children from birth to five years and their families.

Researcher's connection and positionality

To begin, I will reflect on my background in child and family health nursing and its influence on my position as a researcher in this study. I identify as an Australian-born, white, Anglo-Celtic, tertiary-educated nurse and midwife who has worked as a Child and Family Health Nurse for thirty-five years in the community in both government and non-government organisations in three Australian states. Working in different jurisdictions in regional, rural and remote services, I have seen the positive influence that child and family health nurses can have on caring for infants and children from birth to five years and their families. My professional experiences in the fields of nursing and midwifery over a thirty-six-year period have encompassed a range of responsibilities, including specialised clinical roles as well as autonomous community practice. These diverse experiences have provided valuable insights into the complex dynamics of working within child and family health services. I have held executive positions in child and family health nursing professional organisations at state levels. I am a current board member of the peak professional

body for child and family health nurses in Australia; therefore, I am visible to many child and family health nursing professionals.

As a novice researcher, comprehending the impact of positionality on the research project proved to be a challenging task. Specifically, understanding how the roles of the clinician, professional member and personal and professional social connections influenced the project was not easily discernible. The Social Identity Map developed by Jacobson and Mustafa (2019, p. 3) and depicted in Figure 1.1 was a valuable tool to visualise positionality and support my reflexivity concerning my research topic.

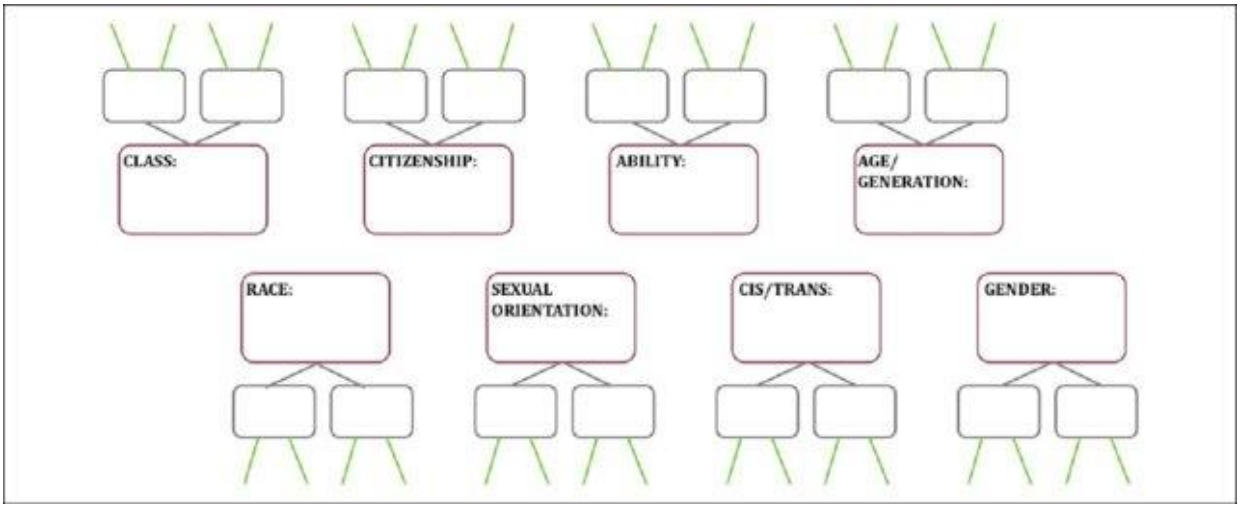

Figure 1.1 Social identity map. Reproduced under license CC BY-NC 4.0 https://creativecommons.org/licenses/by-nc/4.0/

Jacobson and Mustafa (2019) suggest that researchers use the positions they feel may influence their research and use them to explore those positions in more detail. The first tier explores the broader aspects of social identity, such as race, class, or gender, and the second tier asks how these positions impact on our lives. Finally, the third tier delves into the emotions attached to these identity details (Jacobson & Mustafa, 2019). As an individual from the middle class in a caring profession, I have pursued a degree and engaged in postgraduate study. My genuine enthusiasm for acquiring knowledge may influence my expectations of others and shape my perception of how they ought to participate actively in their professional development endeavours. As a middle-aged woman experienced in child and family health nursing, I am relatively inexperienced in higher degree research studies; nevertheless, I possess a strong passion for learning. I identify as a feminist and actively advocate for gender equity in the workplace. A visibly female gender profile dominates child and family health nursing and I am curious as to how that might influence the outcomes of this research.

As a white person, I experience privilege, allowing me to move through the world without fearing racism. I try to be mindful of differences that exist, however, and acknowledge any feelings of guilt that may arise while consistently examining and reassessing privilege, as well as maintaining awareness of the language during research interviews. My Australian heritage comes with a sense of shame, specifically in relation to the history of colonisation, which has pushed me to advocate for people who experience disadvantage. I have had the freedom to travel and experience different aspects of work and life both within Australia and abroad. Travelling has exposed me to various areas of professional practice, presenting challenges that require using culturally safe practices to advocate for fellow clinicians.

Aim and research questions

Leading researchers concluded that supporting families to provide a nurturing environment facilitates children's optimal growth and development from birth to five years (Britto et al., 2017; Richter et al., 2017). This conclusion is reflected in the policies and frameworks that guide the practice of health professionals caring for children in Australia. A range of health professionals, including GPs, CFHNs, community nurses and paediatricians, provide well-child health care. In Australia, primary health care services are not always equitable or accessible to meet the needs of children and families, particularly when families have complex needs. CFHNs work in universal child and family health services, which function differently across Australian states and territories. While national standards of practice have been introduced to child and family health nursing in Australia, the implementation of these standards related to quality and competence in child and family nursing practice is unknown. A national study was necessary to address the aim and research questions below to understand how child and family health nursing practice responds to the diversity of the workplace setting of CFHNs across all Australian states and territories.

The aim of this research was to explore how Australian child and family health nurses identify and measure quality and competence in the specialist practice of child and family health nursing. The primary research question was: How are quality and competence identified and measured in specialist child and family health nursing practice? In addition, three sub-questions were considered:

1. What mechanisms are used by industry and the profession in relation to quality and competence in child and family health nursing practice?

2. How are mechanisms used by industry and the profession to measure quality and competence in child and family health nursing practice?
3. What are the challenges and enablers for identifying and measuring quality and competence in the specialist practice of child and family health nursing practice?

Methodology

A qualitative approach aligned best with addressing the research questions. The study aimed to investigate the participants' perspectives on quality and competence in child and family health nursing practice, utilising a constructivist-interpretivist lens. In addition, the methodology supported the exploration of organisational documents to give context to the health care environment where participants conducted their clinical practice. Focused ethnography was employed as a research methodology to obtain a comprehensive understanding of a specific nursing practice domain that necessitates specialised expertise and knowledge. A significant area of emphasis revolved around the strategies employed by participants and their respective organisations to identify and quantify quality and competence. Moreover, the chosen methodology facilitated the investigation of the obstacles and enablers faced by the participants during these procedures.

Structure of the thesis

This thesis consists of eight chapters. The current chapter outlines the study and provides contextual information on the care of children and families and child and family nursing practice. It describes the researcher's positionality relative to this topic. Chapter two presents an exploration of the international and Australian literature and research into the role of CFHNs in the care of infants and children. A scoping review articulates the elements of the CFHNs' role that contribute to the care of children and families. The review identifies the gap in the literature regarding the identification of the quality and competence of CFHNs' clinical practice. The third chapter presents the research question and a discussion of how the methodology of focused ethnography complements the epistemological and ontological positions of the constructivist-interpretivist paradigm. The methods employed in the recruitment process for participants and the identification of organisational documents are described relevant to the context in which each participant worked. The thematic analysis of data, rigour and validity of the research are discussed. Chapter four presents the findings from the analysis of organisational documents, which were provided by the participants, to facilitate contextual understanding of the participants'

workplaces. The findings from the analysis of the participants' interviews are presented in chapters five and six under themes and subthemes and illustrated using direct quotes from participants. These findings give context to the perceptions and experiences of the participants on how quality and competence are recognised and evaluated in their clinical practice. The discussion in chapter seven critiques the findings from an organisational and professional practice lens to highlight the juxtaposition of the ideology of child and family health nursing practice and the organisation's expectations concerning service provision to children and families. The final chapter provides an overview of the research and its findings, the strengths and limitations of the research and recommendations for clinical practice and future research.

CHAPTER TWO: LITERATURE REVIEW

Chapter two provides a review of the literature related to the role of child and family health nurses in the care of infants and children and their families. It also explores the concepts of quality and competence in nursing and the frameworks, policies and standards that underpin nursing practice and child and family health nursing practice. The chapter begins with a published literature review from 2021, followed by an updated review of the literature. The review has found gaps in the existing literature related to child and family health nursing practice.

Citation:

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Attribution of authorship:

Author contributions to this manuscript are as follows:

LW (90%), JG and AH each contributed to the conception and design of this scoping review. Data were collected by LW (100%). The findings were analysed and interpreted by LW (80%) in collaboration with AH and JG (20%). LW (90%) drafted the manuscript, and the other authors (JG & AH) provided support in revising the work to contribute to its interpretation.

Literature Review: Child and family health nurses' role in the care of infants and children: A scoping review

Introduction

Child and family health nurses (CFHNs) in Australia are the primary workforce tasked with supporting families to promote optimal growth and development in infants and children from birth to five years (Australian Health Ministers' Advisory Council, 2011). The foundation for a productive life trajectory, which has the potential to impact on health and well-being into adulthood, is dependent on healthy growth and development in infancy and childhood (World Health Organization et al., 2018). For brevity in this review, infants and children will be referred to as children unless the discussion specifically relates to infants.

CFHNs work in a variety of settings, including homes of clients, community-based clinics, day stay and residential units. Access to free-of-charge Child and Family Health services for parents and their children enables CFHNs to engage with thousands of families every day. Even though roles of CFHNs vary across jurisdictions in Australia, a similar focus of improving outcomes for children and their parents exists (S. Fraser et al., 2016). CFHNs' work originally focused on monitoring and surveillance of children's growth and development but has progressed to include the assessment and support for parental mental health (Schmied et al., 2014). There is increasing complexity in the work of CFHNs alongside ever more vulnerable children and families (S. Fraser et al., 2016). This work includes a broader focus on child mental health, particularly in relation to child protection and adverse childhood experiences.

In contemporary Australian primary health care practice, CFHNs constitute a substantial workforce that identifies concerns for early interventions that prevent problems that have their origins in infancy and childhood (Schmied et al., 2014). Workforce data from 2017 indicated that there were 5419 Child and Family Health Nurses in Australia (Australian Government Department of Health, 2017). There is currently little understanding of what CFHNs do to enact this complex care with children. While national standards of practice for CFHNs in Australia exist, their use is not mandated and there is no record of their uptake or efficacy in informing practice. To ensure the quality and safety of service provision, and to ensure that children across the country receive equitable care, it is essential to identify the elements of care more fully.

Aim

To identify and contextualise existing knowledge of how CFHNs, both in Australia and internationally, care for children. Outcomes of the scoping review are important because they have the potential to guide future research into the implementation of best practice in Child and Family Health nursing in Australia.

Methods

A scoping review framework developed by Arksey and O'Malley (2005) was chosen to explore the literature because the work of CFHNs covers many different services and jurisdictions and is hard to define. Peters et al. (2015) recognised this systematic process as a means of synthesising a large and complex body of literature to identify knowledge gaps and make recommendations for future research. Peterson et al. (2017) also suggested that a scoping review is useful when considering

clinical practice or changes to practice guidelines. This scoping review examined clinical practice and how CFHNs care for children.

This scoping review was conducted according to Arksey and O'Malley's (2005) framework and Peters et al.'s (2015) reporting recommendations and involved the following steps: 1. Identifying the research question for the scoping review; 2. Identifying relevant studies for the review by using inclusion and exclusion criteria; 3. Study selection; 4. Extracting and charting the data form the review and 5. Collating, summarising and reporting results of the scoping review. The next part of this paper will explain how these steps were used in this scoping review.

Identifying the research question for the scoping review

The scoping review arose from seeking clarity around how CFHNs enact care for children. This consideration framed the research question: How do CFHNs care for infants and children birth to five years?

Identifying relevant studies

Titles for registered nurses who work in the area of child and family health are broad ranging (Kruske & Grant, 2012); therefore, the search terms were broad: *Child and Family Health nurse; maternal Child and Family Health nurse; health visitor; child health nurse; well child nurse; Plunket nurse; family community nurse; public health nurse and family nurse practitioner*. The term Plunket nurse or Health Visitor are included as they are titles for CFHNs in New Zealand and UK, respectively. Similarly, work environments are diverse (Schmied et al., 2014); hence, the following key words were used: *community; clinics; home visiting and general practice.* Infants and children were defined by age group from birth to five years. Key words searched for health, growth and development and wellbeing for infants and children were defined as: *physical growth; physical motor development; cognitive; speech and language; social and emotional regulation (behaviour); sensory (vision and hearing) and mental health.*

A literature search was conducted between February and March 2020 using Medline, Scopus, Cumulative Index of Nursing and Allied Health Literature (CINAHL) and Web of Science databases (see Appendix A: Supplementary material - Database search strings). A search of grey literature including non-commercial global and government sources produced additional documents. These combined searches generated 3165 references. The Covidence™ (Veritas Health Innovation, 2013) platform facilitated a systematic process for importing citations, screening titles and abstracts, and

selection of full text to be reviewed based on a set of inclusion and exclusion criteria. Studies were included if they described and/or evaluated what CFHNs did to care for infants and children and whether CFHNs were involved in the implementation of programs or interventions in community settings. Excluded from the review were studies that focused on models of care, service frameworks/strategies or parental issues rather than the health and wellbeing of children birth to five years. To gain a contemporary understanding of the diverse roles of CFHNs in the care of children, papers published in English from 2009 – 2019 were included.

Study selection

The first author screened the titles and abstracts of articles and the potential studies of relevance underwent full text analysis. Where uncertainties occurred, resolution was achieved through consensus with the two co-authors. A full text review was undertaken on 338 references. As indicated in Figure 2.1, many of these articles focused on models of care (n= 98) and parent issues (n= 60) and other articles were excluded as they did not focus on the work activities of CFHNs as they related to children.

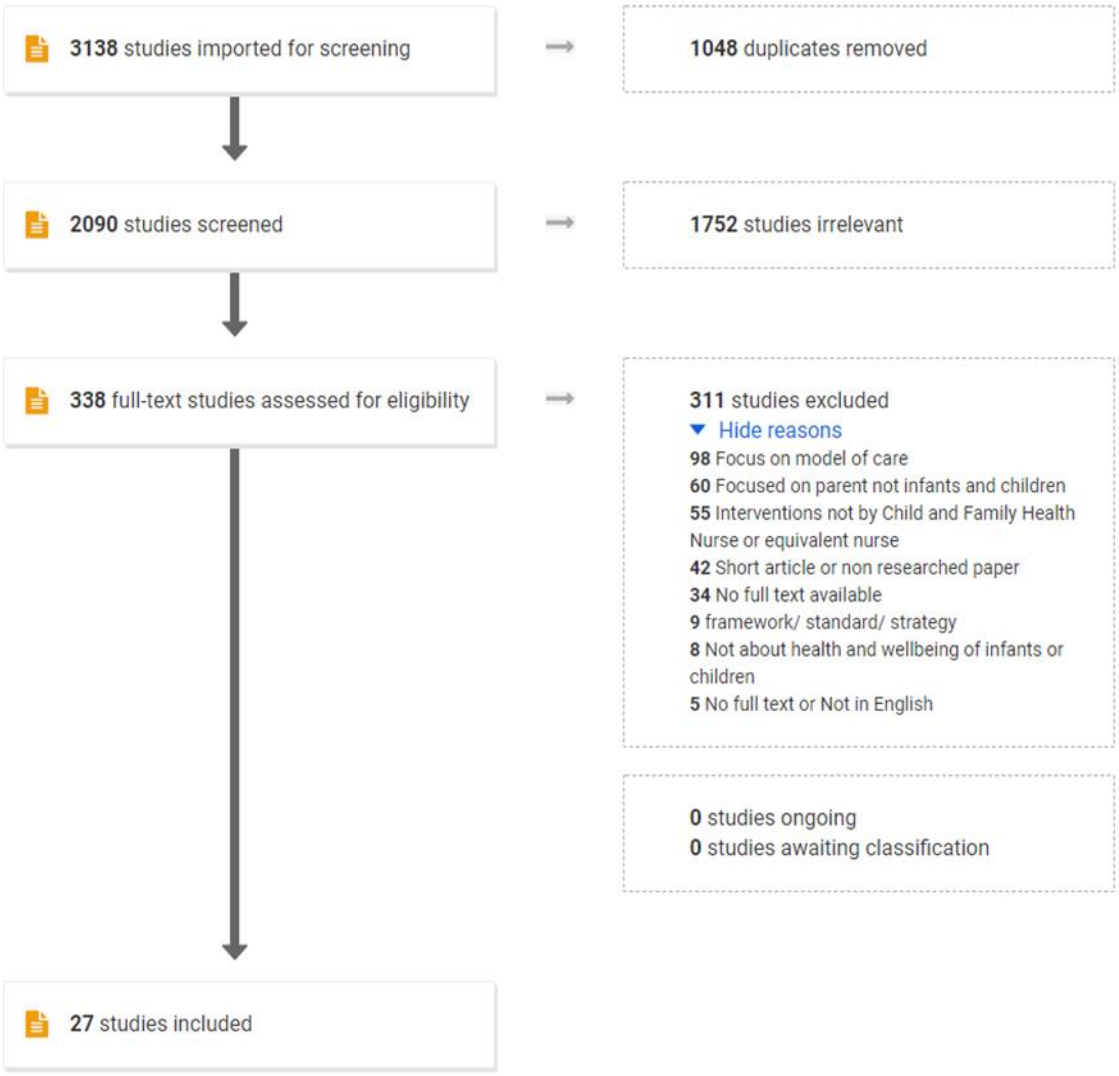


Figure 2.1 Flow diagram of studies selection path

Charting the data

Information drawn from the published studies which met the inclusion criteria became the data for the scoping review. A framework as described by Arksey and O'Malley (2005) and Peters et al. (2015) was used to chart this data by summarising key information that was captured into a purpose made data chart. This chart created by authors, provided a descriptive comparison of both qualitative and quantitative papers (see Appendix B: Supplementary material - Summary of included papers).

Collating, summarising and reporting the results

The research question guided the analysis of the information collated on the data chart. As recommended by Daudt et al. (2013) findings were presented thematically with reference to the

research question. Thematic analysis following (Braun et al., 2019) and was used to identify descriptive codes. Potential codes emerged from the major findings and significant issues highlighted in each paper included in the review. Codes were reviewed and clustered into related areas to define emerging themes that reflected how CFHNs care for children. Thematic development is presented in a detailed table created by the authors (see Appendix B: Supplementary material - Summary of included papers).

In addition, Lockwood et al. (2019) pointed to the importance of critical appraisal of sources of evidence in synthesis and reporting of the results. A Mixed Methods Appraisal tool (MMAT) (Hong et al., 2018) was used to analyse the quality of the published studies. The MMAT aided in the systematic appraisal of both qualitative and quantitative studies (Hong et al., 2018). Studies were rated against the criteria within the category most appropriate for that study, (yes, no or unclear) and then given a value of high, medium or low depending how many elements they met within the category.

Results

There were 27 studies that met the inclusion criteria and reported on the care of children or how CFHNs addressed the needs of children through a range of programs or interventions. These studies were conducted in Australia (n=12), Sweden (n=4), Finland (n=3), United Kingdom (n=3), USA (n=1), Ireland (n=1), Netherlands (n=1), Denmark (n=1) and Canada (n=1). The papers that were reviewed comprised 13 qualitative studies, eight quantitative descriptive studies, three randomised control studies, two quantitative non-randomised studies and one cross-sectional mixed methods study. The majority of the studies rated high (n=16) to medium (n=9) in quality with two studies rated low. The rating of these two studies using the MMAT (Hong et al., 2018), related to the low numbers of study participants and their recruitment from single geographical area (MMAT Hong et al., 2018, see Appendix C: Supplementary material - Appraisal criteria).

Eight studies identified that CFHNs work with parents to provide support to children in community settings. Six studies explored how CFHNs worked in partnership with parents to enable children to access well child care. CFHNs were identified using monitoring and surveillance to care for the health and wellbeing of children with 13 studies exploring the tools and assessments that are used in the work of CFHNs. The results are discussed under the three themes that emerged from the literature. 1. CFHNs care for parents to facilitate the care of children. 2. CFHNs care for children by

working in partnership with parents. 3. CFHNs use assessment tools to identify the health and wellbeing needs of children.

CFHNS care for parents to facilitate the care of children

Parents are integral to achieving positive health outcomes for their children. This theme centres on the support that CFHNs provided parents related to changing or recognising child behaviour, establishing and maintaining parent/child relationships and parent decision making about the care of children. These areas are particularly relevant where parents are dealing with social and emotional issues such as poverty or mental health problems. In such instances parents need support from nurses to help them focus on the care of their children (Cohen & McKay, 2010; Shepherd, 2011).

Three Australian studies found that parents who encountered child behaviour issues needed support in recognising and understanding those behaviours in order for them to make changes to their child's behaviour (Bryant et al., 2016; Fowler et al., 2017; Sarkadi et al., 2015). Maternal child health nurses in Sarkadi et al.'s (2015) study asserted that they were confident in dealing with the child behaviour issues that parents identified. A challenge for maternal child health nurses in dealing with child behaviour issues, was parents' denial or resistance to change (Sarkadi et al., 2015). Fowler et al. (2017) found in their study in residential services, CFHNs needed to support parents with their parental or family issues before parents were able to initiate change in infants with unsettled behaviours or feeding issues. Bryant et al. (2016) study focused on support that maternal child health nurses provided to parents in recognising their infant's interactions as a way to understand and manage their infant's behaviours and needs.

In a Canadian study of 23 Public Health Nurses, Cohen and McKay (2010) found that nurses supported parents with issues of poverty, unhealthy parenting behaviours and lack of parenting skills in order to support healthy child development and prevention of illness. In a small Australian study, Shepherd (2011) explored how CFHNs facilitated mothers to manage their emotional wellbeing in order for them to care for their infants.

Three studies, one from Scotland and two from Australia, explored how CFHNs support parents to understand their relationships with their child and how these relationships impact on child development (Bryant et al., 2016; Fowler et al., 2017; McAtamney, 2011). A Scottish study by McAtamney (2011) explored the importance of Health Visitor's understanding parent- infant relationships and how to support parents in developing relationships with their infants to promote

neurological and emotional development. Bryant et al. (2016) and Fowler et al. (2017) highlighted the importance of CFHNs' supporting parent-infant relationships, by showing parents how to recognise difficulties in their relationships with their infants, which then facilitates change in their infants' unsettled behaviours.

Myors et al. (2014) conducted a study with CFHNs who worked with families with preschool aged children and found that advocating for children involved providing parents with knowledge about child behaviour and supporting parent decision making in changing child behaviour. In exploring the role of CFHNs working with young parents, Eronen et al. (2010) found that providing information about infant growth and development empowered young parents to make informed choices about infant care.

CFHNs care for children by working in partnership with parents

Papers under this theme explored CFHNs working in partnership with parents to make choices about child care and parental wellbeing, accessing services to support parent decision making and address specific child problems. Partnership in child and family health care is recognised as CFHNs and parents working together utilising their complementary expertise with mutual respect and open communication with a common aim of caring for children (Davis et al., 2002).

In an online survey of Australian parents, Rossiter, Fowler, Hesson, Kruske, Homer and Schmied (2019) found that families sought health professionals whom they thought were appropriate to meet the needs of their family. Parents perceived that CFHNs were sources of health information, well child checks and reassurance (Rossiter, Fowler, Hesson, Kruske, Homer, & Schmied, 2019). CFHNs fostered a sense of trust by being empathic and non-judgemental by working in partnerships with parents in decision making about children's care (Rossiter, Fowler, Hesson, Kruske, Homer, & Schmied, 2019). In a UK study that explored views of Health Visitors and parents, Astbury et al. (2017) found that Health Visitors provided information about child health interventions that parents could draw on when making decisions regarding their children's care. Parents perceived that they could make choices about child health interventions even when Health Visitors gave direct instructions that were necessary for addressing child health and wellbeing issues (Astbury et al., 2017). An Australian Randomised Control Trial conducted by Kemp et al. (2011) investigated impacts of a long-term nurse home visiting programme compared to universal child health care on child and family outcomes. This study found that CFHNs worked in partnership with parents to support parental mental health and parent and child interactions to

improve development in children. Outcomes showed improvements in parental mental health but no significant changes in child development compared to universal services (Kemp et al., 2011).

Research in Ireland and Denmark explored regulatory problems in infancy and how parents and nurses worked together to address these issues (Hanafin, 2018; Olsen et al., 2019). In an Irish national longitudinal study of children's sleep patterns, public health nurses and Health Visitors helped parents to make sense of their children's sleep patterns. This understanding enabled parents to identify problems by providing information and education to address sleep issues (Hanafin, 2018). Olsen et al. (2019) found that it was necessary for child health nurses to manage parental expectations related to feeding, sleeping and excessive crying. Once parents understood the impact of their expectations on their infants' behaviours, parents were able to address these problems and support their infants' development.

S. Fraser et al. (2016) undertook in depth interviews with Maternal, Child and Family Health Nurses (MCaFHNs) from across Australia and found that unique skills were required in order for MCaFHNs to work with dyads of parents and children. Building parenting capacity by establishing therapeutic relationships through family partnership, enabled care of children (S. Fraser et al., 2016).

CFHNs use assessment tools to identify the health and wellbeing needs of infants and children

The variety of assessments or tools that CFHNs or their equivalent in other countries used in child health surveillance varied depending on the health setting. In Gellasch (2019) USA study, it was found that nurse practitioners in primary care settings were not confident with using standardised screening tools to assess child development. These nurse practitioners often relied on parents raising concerns before offering assessment and referral. In contrast, three studies, two in Australia (Barbaro & Dissanayake, 2010; Garg, Ha, et al., 2018) and one in Finland (Alakortes et al., 2017) found that CFHNs skilfully utilised developmental screening tools to assess social, emotional and behavioural development and appropriately referred children to specialist services. Swedish research (Johansen et al., 2015; Nayeb et al., 2015) indicated that the depth of training in specialist assessment skills received by Child Health Care nurses may influence the accuracy of developmental assessment.

An important part of the work that CFHNs in Finland undertake in the care of children from birth to five years, involves assessments of growth and development. These assessments include understanding the impact of family life on the child's developmental trajectory (Poutiainen et al.,

2015; Poutiainen et al., 2016). Key developmental assessments around language and motor skills may indicate delay and this is even more critical for preterm infants (Amess et al., 2010). In Sweden, childhood obesity is becoming more of a concern for Child Health Nurses and is an integral part of conversations with parents in managing the health of their children (Sjunnestrand et al., 2019). Bohman et al. (2013) noted that Child Health Nurses were comfortable in surveillance but not always equipped to discuss prevention and intervention with parents and needed more practice at motivational interviewing. Studies in the Netherlands and Australia found that CFHNs who calculate children's body mass indexes during assessments, then need to discuss feeding practices and ways of increasing physical activities with parents as strategies to address overweight issues in children (de Vries et al., 2015; Wen et al., 2012).

Discussion

This scoping review found that CFHNs promote the wellbeing of children aged birth to five years by using partnership approaches to care when working with parents. These nurses are equipped with a range of assessment tools for early intervention and health promotion. Three synthesising features were identified in the findings. Firstly, the work of CFHNs is primarily undertaken in homes and community health care settings. Secondly this work is relational and, as such, salutogenic in nature. Finally, this work is located in the domain of prevention and early intervention. These factors are explored in the following discussion.

The Nurturing Care Framework (World Health Organization et al., 2018) encourages a whole of society approach and considers how parenting and family relationships can impact the growth and development of children in the early years of life. The most powerful impact on child development comes from immediate home and care settings (Britto et al., 2017). Providing support to parents who care for children in these settings, therefore, is fundamental for healthy childhood growth and development (Britto et al., 2017). The work of CFHNs in Australia is based in the community and is supported by the National Framework for Universal Child and Family Health Services (Australian Health Ministers' Advisory Council, 2011). This framework focuses on the child in the context of the family, which is connected to community, health and other services.

The World Health Organization (WHO) recommends that the focus on children shifts from survival alone, to one where children thrive in an environment that can transform their health and human potential and where families and carers provide nurturing care (World Health Organization et al., 2018). The findings from this review suggest that if parental needs are not met, parents are unable

to meet the needs of their children (Cohen & McKay, 2010; Shepherd, 2011). Unpredictable or negative parenting can become the source of distress for children and disrupt formation of positive maternal-child relationships that may moderate effects of adverse experiences (Condon et al., 2019).

Parenting stress can be associated with economic hardship, break down in relationships, mental illness and substance abuse which, in turn, can create unstable environments for children (Crouch et al., 2019). Health outcomes for children may be poor if children are exposed to adverse childhood experiences, with their parents in the home (Condon et al., 2019). In universal and secondary child and family health services, CFHNs provide specialised and timely responses to manage the complex needs of children (Australian Health Ministers' Advisory Council, 2011, 2015b). The Scottish and Australian studies further highlighted the importance of CFHNs and Health Visitors supporting development of positive parent-infant relationships (Bryant et al., 2016; Fowler et al., 2017; McAtamney, 2011).

Key to this relational work is the family partnership approach to care (Davis et al., 2002). Providing good support and health information as a trusted source, was an important role for CFHNs, as it informed parents' decision-making processes about care of their children (Astbury et al., 2017; Eronen et al., 2010; Myors et al., 2014; Rossiter, Fowler, Hesson, Kruske, Homer, & Schmied, 2019). Parents sought information and support from CFHNs when they had concerns about their children's behaviour and wanted to make changes (Bryant et al., 2016; Fowler et al., 2017; Sarkadi et al., 2015). CFHNs worked with parents to manage parental expectations, particularly with dysregulation related to feeding and sleeping. This work enabled parents to understand how they could address their children's dysregulation whilst also supporting their children's development (Hanafin, 2018; Olsen et al., 2019).

Assessments related to growth and developmental are an important part of the work undertaken by CFHNs in caring for children (Amess et al., 2010; Poutiainen et al., 2015; Poutiainen et al., 2016). For example, increasingly CFHNs are taking responsibility for managing obesity in children. Not only are CFHNs identifying obesity through assessments but they are also providing plans and strategies for parents on how to address this issue within the family environment (de Vries et al., 2015; Sjunnestrand et al., 2019; Wen et al., 2012). This approach is important because early intervention and prevention of health issues such as obesity has potential to avert development of lifelong chronic health issues in children and their families (Australian Government Department of

Health, 2019). In Australia, paucity of early intervention services to prevent problems occurring in children related to growth and development, leads to excessive expenditure in high intensity and crisis care (Teager et al., 2019). Early intervention to prevent problems occurring means that children can thrive and become productive members of the future workforce who contribute to the community and the national economy by reducing pressure on government budgets (Teager et al., 2019).

Findings of the scoping review showed that CFHNs have a well-articulated role in conducting assessments for children's social, emotional and behavioural issues in order to make timely referrals for early intervention (Alakortes et al., 2017; Barbaro & Dissanayake, 2010; Garg, Ha, et al., 2018). Research conducted in Sweden and the USA raised questions about consistency of training around specialised infant and child assessments and the confidence, skills and accuracy with which these assessments can be performed (Bohman et al., 2013; Gellasch, 2019; Johansen et al., 2015; Nayeb et al., 2015). These studies highlight a need for further research to help ensure that CFHNs provide quality and competent services to families.

This scoping review indicates that CFHNs work in a dyadic relationship with parents to enable the care of children. This work is embedded in primary health care that is preventative, offers early intervention and is salutogenic. The work of CFHNs differs from other nursing and midwifery roles in the care of children. For example, paediatric nurses work with children who have acute or chronic illness or injury in a tertiary health care setting (Fraser, 2017), while midwives focus on women centred care and neonates in the postnatal period (Nursing and Midwifery Board of Australia, 2018). CFHNs are registered nurses; however, the registered nursing standards do not recognise the unique qualities of practice of CFHNs. These practices are articulated through the National Standards of Practice for Maternal, Child and Family Health Nurses in Australia (Grant et al., 2017). These national standards provide a framework for the provision of preventative care by CFHNs to support health and wellbeing of children and their families, offering early intervention using an approach to care that is primarily relational rather than transactional.

Limitations

Potential limitations of this scoping review include the large number of studies that were excluded because they focused exclusively on models of care or parent issues, which meant information about the work that CFHNs perform may have been missed. Focusing specifically on children, it was necessary to exclude these studies in the scoping review. The extensive list of key words used

for database searches may have contributed to difficulties in finding specific papers on CFHNs' care of children. The literature search excluded any papers that were not in English or published prior to 2009.

Implications for practice

There needs to be a deeper understanding of how the role of child and family health nursing differs from other nursing and midwifery roles in caring for children and their families. Child and family health nursing focuses on prevention, health promotion and early intervention in home and community settings and uses a relational approach to care. The implication for child and family health nursing practice is how to ensure quality in the provision of equitable, safe care for children when there is increasing complexity in the work beyond monitoring and surveillance of children's growth and development.

Conclusions

This scoping review explored how CFHNs care for children birth to five years. The literature highlighted the complexity of the work of CFHNs as it involved caring for children as well as parents. CFHNs took a salutogenic approach by working in partnership with parents to address their children's social and emotional needs so that parents had the capacity to meet the needs of their children. By supporting the parent- child relationships, CFHNs were able to help parents understand their children's needs and use this knowledge to make changes to child behaviours. CFHNs work in universal services that are primary health care focused to provide early identification and intervention in relation to physical, mental and social wellbeing of children. This work included timely referral to secondary and tertiary services for all children and families with identified and increasingly complex needs. CFHNs require a diverse range of skills and knowledge to utilise tools and assessments to identify and manage the needs of children. They are able to practice independently and in collaboration with other health professionals to assess, plan and coordinate care for children and their families. Further research is needed to investigate how quality in practice is ensured for these professionals whose work is embedded in primary rather than tertiary care. The evidence- informed national standards provide a framework to guide the work of CFHNs; however, the efficacy of the standards related to the provision of quality care has not been verified.

Updated literature: 2020-2023

Since the publication of the initial scoping review (Wightman et al., 2021), several studies have been published about the role of CFHNs in the care of children. Regulatory requirements for CFHNs changed in 2010 when state and territory registration as a CFHN was no longer recognised in Australia. The original scoping review, conducted in 2019, on how child and family health nurses care for infants and children birth to five years, was from 2009 to 2019. This period captured contemporary child and family health nursing practice. This section introduces and discusses the relevant new literature from 2020 onwards that builds on the previous scoping review and contributes to understanding how CFHNs care for children.

Methods

The updated literature search used the original search strings for Medline, Scopus, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and Web of Science databases with date range parameters changed to 2020 to 2023. Additionally, the search included informal database searches and automated database alerts to identify new studies. This review used the same inclusion criteria as the original review to identify studies. The selected studies encompassed descriptions and evaluations of the activities performed by CFHNs in providing care for children and their participation in the implementation of community-based programmes.

Updated literature review

Eleven additional studies that met the review criteria have been published about the roles of CFHNs in the care of children since Wightman et al. (2021). Most of the studies included in the updated literature review originated from Australia (n=4) and Denmark (n=2), while the remaining studies were conducted in Norway, Sweden, Canada, Switzerland, and England, each contributing one study. The fundamental findings of these studies remained consistent with the results of the initial scoping review. They are summarised under the themes identified in Wightman et al. (2021), which are “CFHNs care for parents to facilitate care for children”, “CFHNs care for children by working partnership with parents”, and “CFHNs use assessment tools to identify the health and wellbeing of children”.

CFHNs care for parents to facilitate care for children

Four studies published from 2020 onwards continued to show that the support CFHNs provide to parents can impact on the health and well-being of children. The appraisal of parents’ experience during their transition to parenthood and the interventions offered by public health nurses in

Canada were timely in helping parents navigate the early challenges of infant feeding (Buchan & Bennett, 2020). In addition, Buchan and Bennett (2020) found that when public health nurses supported parents to recognise and respond to infant cues, this promoted secure attachment in the infant and developed the parents' confidence. Family violence and its impact on the health and well-being of young children can be a complex topic for CFHNs to explore with parents to keep children safe from harm. A Swedish study by Nimborg et al. (2023) appraised an intervention where Child Health Care nurses provide parents with information and discuss the impact of violence on children's health and development. These conversations occurred during routine child health checks in the first six months after birth in conjunction with a review of both parents' mental health. Generally, parents were receptive to information in this newborn period, particularly how it impacted the health and development of their children and their mental health (Nimborg et al., 2023). Findings from this study involving twenty Child Health Care nurses showed that the nurses gained confidence and skills with training on this topic (Nimborg et al., 2023). Similarly, an Australian study by Hooker et al. (2021) that surveyed 1125 maternal child health nurses about their preparedness to undertake intimate partner violence screening and act to intervene for the safety of children concluded that current education on this topic was vital to increase the confidence and skill level of maternal child health nurses. Responses from rural maternal child health nurses showed they were less prepared to address family violence issues as fewer resources were available to refer families, which increased the risk for children (Hooker et al., 2021).

In contrast to these positive impacts, parents' expectations of CFHNs in helping them navigate challenges with their children's behaviours may be a negative experience when CFHNs lack appropriate skills and knowledge. Sandtro et al. (2022) explored mothers' experiences seeking assistance with sleep programs in children aged six months to three years from public health nurses in Norway. The findings showed that when the therapeutic relationship between mothers and public health nurses breaks down over contradictory or unsatisfactory advice, mothers are left with negative feelings toward themselves as a mother and their children (Sandtro et al., 2022). Public health nurses acknowledged the consequences of sleep problems for parents. They expressed that addressing sleep problems was challenging when mothers and public health nurses were conflicted about their goals around sleep and cited a lack of knowledge, time, and resources to holistically approach complex and intrusive sleep issues for mothers (Sandtro et al., 2022).

CFHNs care for infants and children by working in partnership with parents

Wightman et al. (2021) identified that working in partnership with parents was an essential aspect of CFHNs' role in their care of children. More recent studies from Denmark, Australia, and Switzerland emphasise that working with families with mutual respect and open communication can support the health and development of children (Pedersen et al., 2021; Sprigg dos Santos et al., 2022; Thentz et al., 2022). The Danish study investigated the health visitors' experience implementing a motor development programme with vulnerable families receiving extended home visiting services (Pedersen et al., 2021). The twenty-seven health visitors who participated in the study remarked that if they first addressed the critical needs identified by the families at the home visit, they were willing to engage in specific learning activities related to their children's motor development (Pedersen et al., 2021). The juggle for health visitors was completing the tasks required at each home visit while enhancing families' confidence and knowledge to support their children's health and development (Pedersen et al., 2021).

Effective partnerships with families need to be built on genuine connectedness, sharing decision making and negotiating disagreement to achieve mutually agreed goals (Davis et al., 2007). In exploring how community health nurses in Western Australia put the partnership approach to care with Aboriginal families into practice, Sprigg dos Santos et al. (2022) suggested that using a strength-based approach can create genuine working partnerships. The authors advocated that community health nurses considered the primary goals of the caregiver seeking health care and the broader social factors that influence the health and developmental outcomes of Aboriginal children (Sprigg dos Santos et al., 2022). Early childhood nurses in Switzerland introduced a strength-based nursing and healthcare approach that enhanced parents' ability to identify their strengths in decision-making regarding their children's development (Thentz et al., 2022). In moving from a deficit and problem-focused model of care, early childhood nurses found they worked more in partnership with parents to meet the needs of their children rather than finding solutions for the parents. In this mixed methods study, Thentz et al. (2022) discovered that a group of sixty-one early childhood nurses exhibited the ability to establish a supportive rapport with parents and demonstrated flexibility in meeting the diverse needs of children and parents with this change in clinical practice.

CFHNs use assessment tools to identify the health and wellbeing of children

The literature published since 2019 again showed that using assessment tools are an essential part of the role of CFHNs to support the development of children. Two studies from Australia (Edwards

et al., 2020; Sheeran et al., 2021) and one from Denmark (Pant et al., 2022) and England (Waters et al., 2022) investigate how nurses' assessment tools can identify children's developmental concerns and influence interventions to support development. Waters et al. (2022), in their study of a home visiting programme delivered by health visitors, assessed the impact of parents' speech interaction on their children's language production at twenty-four months of age. The health visitors used parent responsiveness tools to guide the modelling of communication styles during parents' play with their children to promote speech development. The longitudinal study from Denmark investigated whether problems with motor development in infants at eight to ten months of age were predictive of neurodevelopmental disorders in children before their eighth birthday (Pant et al., 2022). The study suggested that as child health nurses have early contact with families through home visit programmes, they are ideally placed to detect motor development problems and facilitate early referral for diagnosis and interventions at this critical point of child development (Pant et al., 2022).

A survey of maternal child health nurses in a small study conducted by Sheeran et al. (2021) in Australia investigated the barriers and enablers experienced by maternal child health nurses using developmental screening tools with children birth to five years. Findings demonstrated that while maternal child health nurses felt confident with using tools, they did not have sufficient time, knowledge and skills to conduct screening and identify the risk of developmental delay (Sheeran et al., 2021). The other Australian study explored improving access for children with culturally and linguistically diverse backgrounds who did not attend mainstream child and family health services to improve early detection rates of developmental delay (Edwards et al., 2020). In this study, children and families were able to access initial screening through early education settings, and then CFHNs and allied health staff offered further developmental assessments and care planning in an environment that was familiar to families. CFHNs' flexibility was important to facilitate the early detection of developmental delays (Edwards et al., 2020).

Discussion

The findings of literature published subsequent to 2019 exhibit similarities to the initial scoping literature review findings (Wightman et al., 2021). The work of CFHNs and their international equivalents is based in homes and community settings, conducted in partnership with parents and focused on early intervention and prevention. The complexity of the role of CFHNs in providing care for children and parents is apparent in the initial and updated literature review. Additionally, existing literature indicates that it is imperative for CFHNs to acquire cultural competence to

enhance the provision of healthcare services for Aboriginal children and children belonging to culturally and linguistically diverse communities. Likewise, there remains an emphasis on the necessity of continuous education to sustain and improve the competencies and expertise of CFHNS in delivering high-quality healthcare services to children and families.

Establishing a therapeutic relationship and working in partnership with parents was crucial for supporting the care of children (Pedersen et al., 2021; Sprigg dos Santos et al., 2022; Thentz et al., 2022). In addition, the dyadic nature of child and family health nursing work with parents involves providing health promotion information that impacts on their health and well-being, which offers the opportunity to influence positive health and wellbeing outcomes for children (Buchan & Bennett, 2020; Hooker et al., 2021; Nimborg et al., 2023; Sandtro et al., 2022). CFHNs also work in partnership with parents when they assess children's health and development using screening tools and collaborate with other health professionals to implement early intervention programs (Edwards et al., 2020; Pant et al., 2022; Sheeran et al., 2021; Waters et al., 2022).

Of particular note from two Australian studies was the need for flexibility in how CFHNs delivered care to children and families from both Aboriginal and culturally diverse backgrounds. Edwards et al. (2020) concluded that the willingness of health services and health professionals to step outside of traditional clinics meant that children from culturally diverse backgrounds had access to early childhood development surveillance. Sprigg dos Santos et al. (2022) suggested that cultural competence goes beyond the relationship between the community health nurse and Aboriginal families to incorporate structures within health organisations. The establishment of an authentic working partnership between non-Aboriginal community health nurses and Aboriginal families can be facilitated when community health nurses demonstrate an understanding of and respect for the perspective and context of the Aboriginal families. The optimisation of the health and well-being of Aboriginal children can be achieved through the implementation of an authentic partnership approach to care (Sprigg dos Santos et al., 2022).

The updated literature concurs with Wightman et al.'s (2021) findings that ongoing education is required for CFHNs to provide competent care to children and their families. In their study, Sandtro et al. (2022) discovered that public health nurses recognised the need for targeted education on children's sleep issues. This knowledge would enable them to offer mothers adequate support and guidance, which was crucial in effectively fulfilling their role. The findings from Hooker et al. (2021)and Nimborg et al. (2023) emphasised the significance of comprehensive

initial training and ongoing updates in family violence education for nurses to equip them with the necessary knowledge and skills to effectively provide information and support to families in addressing issues related to family violence. The maternal child health nurses in Sheeran et al.'s (2021) study recommend implementing targeted professional development programmes and annual competency assessments focused on developmental screening, bolstering skills and augmenting knowledge in this domain.

While the literature provides insight into the role of CFHNs and how they care for children and families, what is remains unclear is how quality and competence are maintained in their clinical practice. In the updated literature review, Thentz et al. (2022) explored Swiss early childhood nurses' competence in implementing a specific care model. They highlighted the importance of reflective practice in embedding new skills and knowledge. The literature has shown that CFHNs in Australia and their international colleagues who care for children and families work autonomously and collaboratively in various primary health settings and service delivery models. In investigating what CFHNs do to care for infants and children birth to five years, no mention was made of clinical practice guidelines on maintaining quality and competence in Australia's child and family health nursing practice.

Summary

This chapter summarised literature related to CFHNs' role in caring for children and their families. It was found from the review of the literature that child and family health nursing is relational, focuses on early intervention and prevention in the care of children and is conducted in homes and community settings. The review indicated that the work of CFHNs in Australia is similar to that of nurses internationally who work with children from birth to five years and their families. It was evident from the updated review that the complexity of contemporary child and family health nursing practice requires continuing education to improve and sustain the skills and knowledge of CFHNs. The updated literature review identified that cultural competence in child and family health nursing practice when working with Aboriginal and other culturally diverse families, requires more than a focus on the relationship between CFHNs and clients. Working in partnership with families who differ culturally from the CFHNs requires changes within the service structure to support CFHNs to meet the needs of clients. In addition, the updated literature review highlighted the importance of targeted professional education and reflective practice for CFHNs to embed new skills and knowledge to improve the quality and competence of their practice. Further research is warranted to explore how quality and competence are identified and measured in child

and family health nursing practice. Research in this area has the potential to advance child and family health practices and policies around service provision for children from birth to five years and their families in order to provide safe and effective care. The next chapter will detail the methodology and method used to conduct this research.

CHAPTER THREE: METHODOLOGY AND METHODS

The previous chapter reviewed the literature on the complexity of child and family health nurses' roles in caring for children and their families. The findings from the review informed the focus and methods used in the current study. Interviews conducted with child and family health nurses (CFHNs) from around Australia and organisational documents from child and family health services who employed CFHNs provided the data for this research. These two methods were used to address the research aim and questions.

The aim of this research was to explore how Australian CFHNs identify and measure quality and competence in the specialist practice of child and family health nursing. The primary research question was:

How are quality and competence identified and measured in specialist child and family health nursing practice?

Three sub-questions provided further guidance for this research.

1. What mechanisms are used by industry and the profession in relation to quality and competence in child and family health nursing practice?
2. How are mechanisms used by industry and the profession to measure quality and competence in child and family health nursing practice?
3. What are the challenges and enablers for identifying and measuring quality and competence in the specialist practice of child and family health nursing?

The methodological approach used to conduct the research was focused ethnography. This chapter presents the ontological and epistemological position that informs the research methodology of ethnography and, more specifically, focused ethnography. It provides an outline of the ethnographic research design and describes the research methods and their rationale. Ethical considerations are explored, and procedural ethics approvals are outlined, including the impact of COVID-19 on health services and the subsequent effects on this research.

Ontology and epistemology

Qualitative research requires critical reflection, questioning skills and the ability to identify one's assumptions, beliefs, knowledge and background that may influence the research approach (Braun & Clarke, 2013). My experience as a CFHN informs my assumptions around the reality of clinical practice and what I believe to be quality and competent child and family health nursing practice. Ontology, as described by Cohen et al. (2011), is the nature of reality, shaped by multiple beliefs and values that can be socially constructed, holding some beliefs and values above others. Multiple realities become evident when applying this definition of ontology to the exploration of the nature of child and family health nursing practice and the context in which this practice occurs in health jurisdictions around Australia. The focus of the research reported in this thesis was to understand the perspectives of CFHNs within their own jurisdictions while considering the organisational documents, for example, frameworks, policies and procedures that guided and shaped the quality and competence of their practice. In conducting this study, I acknowledged that my values and beliefs would be present while exploring the realities of child and family health nursing practice and interpreting the lived experiences of the research participants.

The skills and knowledge I gained through training and experience over many years as a nurse, midwife and CFHN, as well as the influence of clients, colleagues and the communities in which I undertook clinical practice, provided me with the epistemological positioning to undertake this research. This background underpinned the development of a broader understanding of quality and competence in the specialist practice of child and family health nursing. Thus, the knowledge drawn from my experience and the methods selected to explore the CFHNs' perspectives align with Coffey's (2018, p. 129) description of epistemology as the "study and theory of knowledge, including methods, sources and limits of knowledge". Reflecting on what is significant and legitimate knowledge leads to exploring what is possible to know and how that knowledge could be generated (Braun & Clarke, 2022).

Paradigms can shape the method chosen to guide the research. Paradigms refer to collections of assumptions, values, or beliefs concerning the nature of the world and encompass a form of inquiry into the world (Denzin & Lincoln, 2018; Waller et al., 2016). These assumptions, attitudes, or beliefs significantly shape our perception of reality or our understanding of the circumstances of this reality. They can guide inquiry into reality from the participants' perspectives, the researcher's understanding of this reality and the methods used for studying this reality.

This research was approached from an interpretivist paradigm, which sought to explain how people make sense of their world through the meanings they give to situations or behaviours (O'Donoghue, 2019). In this study, the researcher connected with participants through semi-structured interviews to gain insight into how CFHNs view their skills and knowledge related to child and family health nursing practice. Research using an interpretivist lens aims to understand the reality of one person's experiences at a particular time and place and compare other people's realities at different times and places (Cohen et al., 2011), thus creating meaning from many realities to provide a broader understanding of quality and competence. This research had the potential to achieve a greater understanding of quality and competence in child and family health nursing by gathering the emic viewpoints of CFHNs working in diverse settings around Australia.

The constructivist paradigm sits within the interpretivist paradigm, designated by Denzin and Lincoln (2018) as the constructivist-interpretivist paradigm. This paradigm is based on specific, constructed, experientially-based realities and depends on the individuals or groups who hold them. In this paradigm, reality is socially constructed, has multiple truths and can be interpreted through exemplifications, discourse, and practice (Waller et al., 2016). The exploration of child and family health nursing practice through a constructivist-interpretivist approach offers the opportunity for CFHNs to voice their understanding of quality and competence. Organisational documents such as policies, frameworks and standards of practice related to quality and competence in child and family health nursing were used to contextualise participants' perspectives. This research explored what is known about quality and competence in child and family health nursing practice from the perspectives of CFHNs and how they came to this understanding based on their experiences.

Methodology

Ethnography is both a process and product of research into the study of a cultural or social group, inclusive of fieldwork (de Laine, 1997). Classic or conventional ethnographic methodology usually involves a prolonged immersion within a community or culture to observe and document the participants in their natural setting and through in-depth interviews to gain a deeper understanding of that culture (Hammersley, 1989; Morse, 1994; Shapira & Roper, 2012). The context of culture is seen as the social structure, belief systems and practices within a community or social group (Coffey, 2018). The community in this research was child and family health nursing, a specific area of nursing practice conducted in the primary health care space. Ethnography

enabled the researcher to view the data through both an emic position as a CFHN and an etic position as a researcher to gain a holistic understanding of child and family health nursing as a group. The researcher drew on Hoare et al. (2013) to consider the emic viewpoint and utilised knowledge of child and family health nursing practice to connect with the broader etic view of other health jurisdictions.

Wolcott (1990) suggests that ethnography, as a qualitative methodology, provides a specific way of analysing and interpreting data from a cultural perspective. Attention to the processes of ethnography includes collecting data through observation of patterns, structures and routines of the community to give meaning to people's interactions within the community, and the researcher reflexively reports the research through writing (Coffey, 2018). In the context of this research, the aim was to capture the perspectives of CFHNs, through interviews conducted online, about quality and competence in practices within their workplaces. Focused ethnography provided the lens through which quality and competence in child and family health nursing practice were explored.

Focused ethnography

Muecke (1994) proposed that focused ethnography differed from anthropologic ethnography in purpose, defined topic of inquiry, selected participant observation and accessibility of research participants to the researcher. Further clarification of this delineation was described by Knoblauch (2005), which included recording of communicative activities, use of transcripts, use of the researcher's background knowledge, coding and sequential analysis. Knoblauch (2005) depicted focused ethnography as a widely used approach, particularly with research in professional occupation fields and their increasingly specialised and fragmented activities. In the context of this research, child and family health nursing is a distinct nursing practice area requiring specialist skills and knowledge. The work of CFHNs is conducted in homes and community settings that differ in context across jurisdictions in Australia. Focused ethnography is used as a research methodology in health-related fields, including nursing settings, when the aim is to enhance and understand practice situations or problems in the specific context of a professional culture or subculture (Higginbottom, 2011; Shapira & Roper, 2012).

Fieldwork in focused ethnography is characterised by concentrated but not necessarily continuous periods of participant observation, including in-depth interviews with key members of the social group and the collection of specific data related to a limited scope of inquiry (De Chesnay & Abrums, 2015). In more recent research, fieldwork in focused ethnography is considered an

opportunity to be innovative in the way researchers connect with participants and value insider or background knowledge of the specific field of study (Pink & Morgan, 2013; Vindrola-Padros, 2020; Wall, 2015). As this research was conducted during the COVID-19 pandemic that began in 2020, episodic participant observation was through online video conferencing platforms to connect with participants in their workplaces. Prior knowledge of the area to be studied can facilitate a quick building of rapport with research participants when there is an understanding of the jargon used and the context of routine practices (Kelly, 2022). Research into primary healthcare with multiple sites found that using focused ethnography enables the researcher to collect focused data simultaneously across sites within a short timeframe (Bikker et al., 2017). To gain an in-depth understanding of child and family health nursing practice in Australia, focused ethnography using semi-structured interviews and organisational documents was appropriate for this research. Semi-structured interviews provided an opportunity to gain a deeper understanding of participants' perspectives and to probe further ideas presented by the participants.

Research design

The design is the research plan, including approaches to sampling, data collection and analysis (Holloway & Galvin, 2017). The research design for this study was underpinned by the model of focused ethnography adapted by Higginbottom et al. (2013, p. 3) and depicted in Figure 3.1.

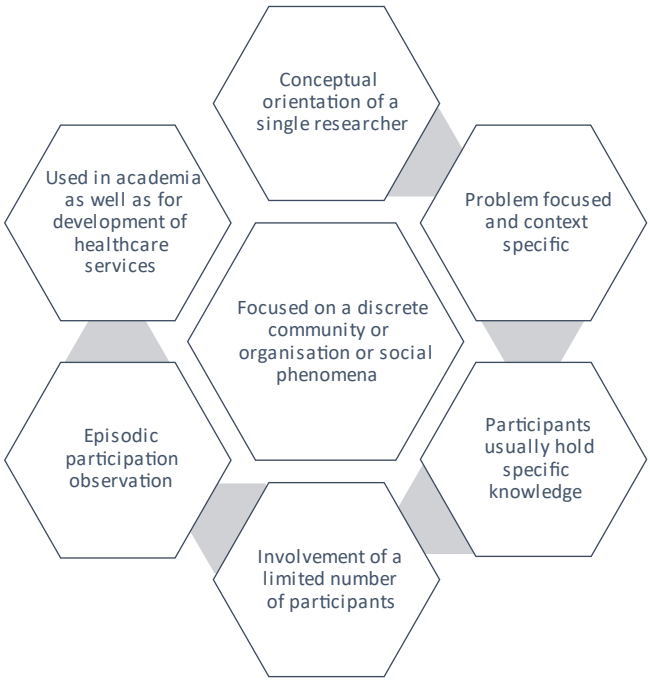


Figure 3.1 Focused Ethnography model: Adapted from Higginbottom et al. (2013, p.3)

Child and family health nursing constitutes a discrete community within the nursing profession, and the structure and roles of CFHNs vary across Australian jurisdictions, as explained in Chapter One. Focused ethnography was used not as an alternative to ethnography but as a specific type of ethnography suited to understanding what Cruz and Higginbottom (2013, p. 43) referred to as the "societal issues that affect different facets of practice". In this research, the facets of practice related to quality and competence in practice from the perspectives of CFHNs to give meaning to their different interpretations within health jurisdictions around Australia. Conducting the study over multiple sites provided the opportunity for the researcher to compare and contrast organisational documents underpinning professional practice and how CFHNs used them to support quality and competence in specialist nursing practice. Documents can be used in ethnographic research as a resource for what is in them, how staff use them, and providing an understanding of how they came into being and what impact they have on the functions of an organisation (Prior, 2008).

Interviews are central to ethnographic research, particularly with focused ethnography, when participant observation is limited across multiple sites and valuable in the construction of knowledge about participants' perspectives and data, such as feelings or attitudes (Andreassen et al., 2020). A semi-structured interview format was chosen to collect data from the interviews with key stakeholders within child and family health nursing services. This type of interview is described as purposeful to obtain descriptions of participants' lived experiences to interpret meaning from these experiences (Brinkman, 2018). This approach enabled the researcher to investigate quality and competence in child and family health nursing practice through the professional experience of CFHNs and seek clarification of the researcher's understanding of child and family health nursing practice throughout the interview process.

Thematic analysis is the process of exploring and explaining the meaning and significance of the data to generate themes to make sense of the data (Braun & Clarke, 2022). Through the analysis of the documents and participant interview data, evidence can be generated that has implications for developing child and family health nursing practice. As the lone researcher in this study, it was imperative to engage in reflexivity throughout the inquiry to balance the position of both the researcher and child and family health nursing clinician.

Reflexivity and positionality

Research does not occur in a vacuum, and the researcher is part of the social world that is being investigated. Social identities, backgrounds and experiences have an impact on motivations for conducting research and how data are viewed and analysed (Jacobson & Mustafa, 2019). As a researcher who is also a clinician, it was essential to consider reflexivity and positionality in this study. Reflexivity involves a focus on self-knowledge, understanding the role of self in the creation of knowledge and self-monitoring of the impacts of biases, beliefs and personal experiences on the research (Berger, 2015). Being reflexive during this research meant acknowledging the researcher's position as an advocate for child and family health nursing through the peak professional organisation in Australia, her role as a clinician within one health jurisdiction and how this might influence both connections to participants and interpretation of the data as a researcher. Constant reflexivity was required to ensure that participants' voices did not become overshadowed by the researcher's interpretation. Reflexivity is not complete at any one point but a constant process of reflection throughout all points of the research (Braun & Clarke, 2022).

An element of reflexivity is positionality, which encompasses our social identity and affects the way we view the world and how the world views us. In understanding our power, privilege or influence, we know what views we bring to the research and can consider how this might be perceived by research participants (Jacobson & Mustafa, 2019). The concept of positionality in nursing assumes the role of nurses, particularly as a female-dominated profession is bounded by the social context in which they work and may dictate the way nurses might speak and interact with people around them (Rushton, 2022). In the context of this study, I identified as both a researcher and a clinician and brought both these viewpoints to all aspects of the research.

Undertaking qualitative research involves both an emic (insider)and an etic (outsider) viewpoint that uses the researcher's experiences and knowledge as a resource and a source for exploring the ideas of others (Holloway & Biley, 2011). Generally, in focused ethnography, the participant has the emic or insider perspective, and the researcher brings the etic or outsider perspective and bridging that gap is the key (Crawford, 2019). In this research, as a CFHN, I had knowledge of a variety of clinical roles and environments as I had worked in remote, rural and regional primary healthcare settings and was connected to child and family health nursing managers across Australia through the peak professional body for child and family health nurses. Whilst this insider knowledge had the potential to support my access to study participants, it also highlighted the critical role of reflexivity in ensuring I was cognisant of subjectivity and worked to be objective in

all aspects of data collection. As a researcher, being invited into a broad range of child and family health nursing settings across Australia provided an opportunity from an etic position to gather the emic perspectives of CFHNs working in these settings. When research is conducted within the researcher's sphere of clinical practice or workplace, consideration needs to be given to the potential power, privilege or bias that may support or impede the research process through access to research sites, participants or interpretation of data and presentation of conclusions (Higginbottom et al., 2013).

Ethical considerations

Ethical considerations in research involve reflecting on the ethical issues in conducting research and how these issues will be addressed to protect participants and the data generated in the research process (Guillemin & Gillam, 2004). To protect the safety, well-being, and human rights of research participants, ethical conduct in research requires that researchers operate with honesty, respect and concern for research participants (National Health and Medical Research Council, 2018a). The researcher acknowledged and addressed through open discussion with participants the potential conflict of roles the researcher held as an executive within the peak professional body for CFHNs in Australia and a clinician in one of the local health districts.

In any research, privacy and confidentiality are central to participant-researcher relationships so that participants can trust that the researcher will make every effort to protect their personal information and minimise any impact of the research on the participants (Holloway & Galvin, 2017). A detailed information sheet regarding the research project that includes the privacy and confidentiality measures for the data collected is provided to participants. The privacy measures included secure storage of data and a disposal plan when the data are no longer required for research purposes, including publications and other determinations of the findings. Using pseudonyms reassures participants that the data obtained is kept confidential and that participants would not be identified, regardless of whether sensitive topics are discussed.

Respect for research participants includes their self-determination, meaning they have the right to withdraw from the research during or after the research has taken place and provide informed consent to participate (Braun & Clarke, 2013). Participants can indicate their understanding of the research process, their option to withdraw from the study at any time, and their willingness to participate by signing a consent form. In addition, participants require the opportunity to clarify

any concerns related to involvement in the research prior to signing a consent form. These considerations will be discussed throughout the methods section of this chapter.

Procedural ethics

Procedural ethics is the process of gaining approval from a relevant ethics committee to conduct a study (Guillemin & Gillam, 2004). Research conducted in Australia with human participants is guided by the National Statement for Ethical Conduct in Human Research, which requires research projects to be reviewed by research ethics committees before approval to commence the research can be given (National Health and Medical Research Council, 2018b). This research was conducted in publicly funded health services across Australia under the National Health and Medical Research Council (NHMRC) national certification scheme, which promotes ethical review of multi-centre research (National Health and Medical Research Council, n.d). The National Mutual Acceptance (NMA) scheme was applied to the Human Research Ethics Application (HREA) that supported a single scientific and ethical review for research in multiple centres (NSW Ministry of Health, 2020). Approval was sought and obtained from Hunter New England Human Research Ethics Committee, 2020/ETH03118, on 25 January 2021 and updated on 3 March 2021 to include nominated sites in all states and territories in Australia (see Appendix D). Flinders University granted cross-institutional approval on 10 February 2021 (see Appendix E).

Before data collection commenced, site governance approval was sought and obtained for each health jurisdiction. Table 3.1 displays the number of site governance applications completed in each health jurisdiction and the number of data collection sites for this research.

Table 3.1 Approved data collection sites

Jurisdiction	Site Specific Application	Data collection Sites
NSW	4 x Local Health Districts 1 x not approved due to staffing issues	3 x Local Health Districts
ACT	Territory Health Service	Territory-wide
SA	State Health Service	State-wide
Vic	State Health Service	5 Local Council sites
Qld	2 x Hospital and Health Services (HHS)	1 x Metropolitan HSS 1 x Regional HSS
WA	1 x Metropolitan Health Service 1 x Regional Health Service	1 x Metropolitan service area 1 x Regional service area
Tas	State Health Service	State-wide
NT	1 x Northern Health Service 1 x Central Health Service	1 x Northern service area 1 x Central service area

Methods

This section of the chapter details the recruitment of participants, data collection and data analysis. Organisational documents were collected from seventeen child and family nursing services. Semi-structured interviews were conducted with sixty CFHNs from all states and territories in Australia. The documents and interview transcripts were coded and then analysed thematically to produce themes from the data related to identifying and measuring quality and competence in specialist Child and Family Health nursing practice.

Recruitment

Australia has state and territory-based child and family health nursing services, each of them operating under different organisational structures and located in metropolitan, regional and rural geographical locations. The differences in the location of services impacted on the staffing levels and the experience of the CFHNs in terms of skills and knowledge of the care required for children and families (S. Fraser et al., 2016). Seventeen sites across Australia that provided access to metropolitan, regional or rural child and family health nursing services were selected and 60 CFHNs participated in the study. The scope and scale of this study were necessary to capture the experiences and views of a diverse group of practitioners within a broad range of settings. In jurisdictions where there were numerous services (Queensland, New South Wales and Victoria), the selection of sites was based on the accessibility of executive managers who were willing to support the research. The potential bias that this approach to the selection of sites could have introduced, was minimised by including in the study a large number of participants from a wide range of sites across Australia. Table 3.2 summarises the structure of child and family health nursing services across Australia, as discussed in Chapter 1, p. 10.

Table 3.2 Child and Family Health Nursing Services in Australia

Jurisdiction	NSW	ACT	SA	VIC	QLD	WA	TAS	NT
Name of service	Child and Family Health Nursing Service	Maternal and Child Health Service	Child and Family Health Service	Maternal Child Health Service	Child Health Services	Child and Adolescent Health Service	Child and Family Health and Parenting Service	Primary Health Care Service
Structure of service	15 Local health districts – based in community health centres	Territory-wide community health services	State-wide community health services	Joint state health and 79 councils based in local government centres	16 hospital and health services based in community health	State-wide community health services	State-wide community health services	Territory-wide primary health services

Discussions with executive managers were held via telephone to enable them to ask questions about the research, seek their support for ethics and governance site applications, and lay the groundwork for the successful recruitment of future participants. These discussions provided opportunities to explain the details of data collection and discuss the potential impacts on service delivery when staff participated in semi-structured interviews. The time spent explaining and discussing the research with gatekeepers is important in qualitative research to address concerns and common questions to allay fear about the impacts on staffing and explore the benefits of their services participating in the research (Rea-Holloway & Hagelman, 2021). Following these discussions, service managers from each of the seventeen child and family health nursing services were identified and contacted via email. Further contact was made after two weeks through an email or a telephone call to the service managers to answer any queries regarding the research and gather vital information about the delivery of child and family health nursing services, including the different roles of the CFHNs who worked within the services. As the researcher had limited familiarity with the services, allocating sufficient time to establish rapport with service managers was imperative to cultivate a sense of trust. Laying the groundwork in qualitative research involves understanding the environment in which the study takes place, building trust and confidence with potential participants and the researcher establishing their expertise to conduct the study (Negrin et al., 2022).

After ethics approval was received, service managers provided access to organisational documents. They identified CFHNs who were involved in the development of policies and guidelines related to child and family health nursing practice, performance appraisal, professional development or mentoring of CFHNs. The researcher was provided with email addresses for potential participants, who were sent an invitation to participate (Appendix F) containing a participant information sheet (Appendix G) outlining all aspects of the study, including what participation would entail and the anticipated time commitment. Prior to the commencement of the research, CFHNs had the opportunity to access the researcher via email or telephone to gain clarification related to their participation in the research. Participants who agreed to be part of the research signed and returned a consent form (Appendix H) that included an agreement for the interview to be recorded. The researcher then contacted participants to arrange an interview via an online videoconferencing platform, conducted at a date and time that was suitable for the participants in relation to their work commitments.

Selection of documents and participants

This study set out to capture contextual organisational documents and the diverse perspectives of CFHNs from metropolitan, regional and rural child and family health nursing services across Australia. Documents were selected purposively based on their relevance to the research questions, an approach recommended by Vindrola-Padros (2021). Service managers and participants were asked to provide documents used in their child and family health nursing services related to identifying and measuring quality and competence in child and family health nursing practice. As the research objectives were aimed at a specific group of people with specific knowledge and expertise, purposive sampling, as proposed by Roller and Lavrakas (2015) for these situations, was also used to select interview participants. The participants were CFHNs who worked in universal child and family health nursing services. Service managers identified them as clinical leaders within their organisations who were responsible for policies and guidelines related to practice, performance appraisal or professional development of CFHNs. A sampling framework can support purposive sampling by aiming to meet a target rather than just recruiting participants who are easier to contact (Vindrola-Padros, 2021). It can support maximum variation to capture as diverse a sample as possible within the context of the research aims (Cohen et al., 2011), which was desirable in this research.

Participants

Participants were included in the study if they held a position as a CFHN within their organisation and were responsible for implementing policies and guidelines related to practice, conducting performance appraisals or providing professional development of CFHNs. While the CFHNs held different roles within their workplaces, they were all involved in different aspects of clinical practice. The following child and family health nursing roles were categorised as meeting the criteria as identified through purposive sampling:

- Nurse Managers, Nurse Directors
- Nurse Unit Managers, Team Leaders or Coordinators
- Clinical Nurse Consultants, Clinical Coordinator
- Clinical Nurse Educator, Clinical Development Nurse, Staff Development Nurse
- Clinical Nurse Specialist, Enhanced Maternal Child Health Nurse
- CFHNs without leadership titles but deemed by service managers as being able to contribute to the research.

As explained in Chapter One and reiterated by the list above, CFHN employment positions around Australia are designated with different titles. For clarity in the discussion of participants, the following titles were used: Nurse Manager, Nurse Unit Manager, Clinical Nurse Consultant, Clinical Nurse Educator, Clinical Nurse Specialist and CFHN. The titles were decided after participants had described their roles during their interviews and the reporting mechanisms of their roles in the child and family health services in which they worked. The participants' key demographics related to qualifications, years working in child and family health nursing, current role and geographical work setting are displayed in Table 3.3. Of the 60 participants, all identify as registered nurses, with forty-three also identify as registered midwives. Most participants had a postgraduate child and family health nursing qualification, for example, a Graduate Certificate or a Graduate Diploma. Of the eight participants who had a Master of Child and Family Health Nursing, three were in Nurse Unit Manager roles, two were Clinical Nurse Consultants and two were Clinical Nurse Educators. The considerable number of years (more than 20 years) working in child and family health nursing did not always equate to senior positions, as only fifteen CFHNs held Nurse Manager, Nurse Unit Manager or Clinical Nurse Consultant roles.

The Modified Monash Model (MMM) (Department of Health and Aged Care, 2020b) was used to classify the geographical areas where participants worked in child and family health nursing services. The model, which categorises metropolitan, regional, rural and remote areas based on geographical remoteness and the population of the towns, was developed to provide target programmes to increase the health workforce in more remote areas (Department of Health and Aged Care, 2020b). For example, rural areas are classified as large rural towns (MM3), medium rural towns (MM4) and small rural towns (MM5). Based on population size, most services are in metropolitan and regional areas, which was reflected in the number of CFHNs (n=46) from these areas who participated in the study.

Table 3.3: Key demographics of participants

Initial qualification	Registered Nurse n=17 Registered Nurse + Registered Midwife n=43
Postgraduate qualification	CFHN postgraduate certificate n=30 CFHN postgraduate diploma n=19 CFHN postgraduate masters n=8 No CFHN qualification n=4
Years in Child & Family Health Nursing	1-10 years n=18 11-20 years n= 25 21-30 years n=16 30+ years n= 1
Current role	Nursing Manager n=7 Nurse Unit Manager n=20 Clinical Nurse Consultant n=11 Clinical Nurse Educator n=11 Clinical Nurse Specialists n=7 Child and Family Health Nurse n=4
Work setting	Metropolitan (MM1) n=30 Regional (MM2) n= 16 Rural (MM3, MM4, MM5) n= 9 Remote (MM6, MM7) n=5

Data collection

There were two forms of data: organisational documents, semi-structured interviews with CFHNs. Reflective notes produced by the researcher following each interview complemented the collection of data. Onsite participant observation was not possible because of the restrictions imposed on travel and access to health services by states and territories during the COVID-19 pandemic. Interaction with participants was made possible through using online videoconferencing platforms Zoom® and MS Teams®. These platforms provided windows into the participants' workplaces. In conjunction with the organisational documents provided by the participants, the researcher was able to establish an intimate familiarity with each workplace setting. Conducting focused ethnography research during the COVID-19 pandemic meant that the concept of the "field or field work" needed to be adapted to consider the virtual "field' in inverted commas as a recognised workplace to conduct research (Eggeling, 2022). In this research, the participants were the gatekeepers who accepted the researcher into their workspace. These workspaces were offices, clinic spaces or home offices, as many of the participants who were managers were encouraged to work from home during lockdown periods. Participants had the flexibility to choose the space for their interview. It was sometimes dictated, however, by the demands of changing workflow related to the COVID-19 pandemic, and the researcher had to be

cognisant of these demands. While there were challenges in shifting to online fieldwork, as noted by Howlett (2021) and Humphries et al. (2022), situations such as these also provided windows into local-level dynamics, access to busy clinicians and connections that could be revisited with access to audio-visual data. The researcher requested access to organisational documents prior to conducting semi-structured interviews. Provision was subject to each organisation's regulations related to the sharing of documentation. In most circumstances, the collection of organisational documents occurred concurrently with the semi-structured interviews. The researcher kept track of the data collection process with detailed spreadsheets, notes taken during each interview, along with reflective field memos. The data collection in this research will be discussed separately for the organisational documents and the semi-structured interviews.

Organisational documents

The review of relevant documents from the field of study can provide context to interviews when participant observation is limited (Higginbottom et al., 2013). Site documents can provide broader context and insight into the environments where participants work, including understanding workplace structures and participants' roles within organisations (Arnout et al., 2020). In accessing organisational documents, the researcher sought to provide an understanding of how the child and family health nursing services viewed quality and competence and how documents were used to identify and measure quality and competence in child and family health nursing practice. Service managers and other participants who agreed to be part of the research were asked to provide any organisational documents used within the child and family health nursing services that they considered related to quality and competence in child and family nursing practice. Through sourcing documents for each health jurisdiction, the researcher sought to determine whether common definitions were used by jurisdictions to identify and measure quality and competence in child and family health nursing practice.

From a constructivist point of view, documents depict the reality at the time the document was produced but are not necessarily a transparent interpretation of the decision-making process or organisational routines for the future (Silverman, 2020). In this research, the organisational documents provided clarification of the policies and procedures that were mentioned during semi-structured interviews. In reviewing these documents, the researcher examined the child and family health nursing services documents from the perspective of intended use by the organisations. This review provided a comparison of how participants perceived the documents were used in relation to quality and competence in their child and family health nursing practice.

Prior to the release of organisational documents, the researcher provided a signed confidentiality agreement to each of the health jurisdictions that participated in the research (Appendix I). The confidentiality agreement meant that electronic copies of organisational documents were provided via email from health service managers or participants. In addition, the researcher accessed publicly available documents from individual jurisdiction websites as directed by service managers. To maintain confidentiality, as some documents were only available to the staff within each jurisdiction and not in the public domain, each document was given a pseudonym. Regardless of when the organisational documents were provided to the researcher, the interviews with the participants were conducted using semi-structured interview questions as per the schedule developed for this study.

Semi-structured interviews

Semi-structured interviews were undertaken with sixty CFHNs from across Australia to explore their perceptions of quality and competence in child and family health nursing. The questions for semi-structured interviews were developed from the research questions to provide prompts to start conversations to gain knowledge about child and family health nursing practice in different jurisdictions across Australia. Lists of questions in semi-structured interviews prompts the interviewer and provides scope for interviewees to raise issues that the researcher may not anticipate (Braun & Clarke, 2013). The semi-structured interview questions (Appendix J) guided the discussion but did not restrict the conversation. The order of questions was adapted over time to suit the flow of interviews. A process of review and reflection of questions after the interview provides an opportunity to check for bias or personal agenda and aids in refining how questions were asked (Roberts, 2020). The researcher took notes to avoid interrupting the free flow of conversation with the participants. The notes were used to prompt the researcher to ask additional questions for clarification of specific topics.

The interviews were recorded verbatim to provide transcripts for further analysis. As health services across Australia adapted to using video conferencing platforms to conduct business during the COVID-19 pandemic, participants in this research were familiar with and comfortable using these digital platforms for their interviews. Conducting online interviews provided the opportunity to overcome travel restrictions, connect with remotely located participants and support a relaxed environment with participants being comfortable in their settings (Gray et al., 2020; Hackett & Hayre, 2020). Virtual face-to-face interviews provide the same opportunity as in-person interviews to capture facial and vocal cues in real-time conversation to establish rapport

between participants and the interviewer (Irani, 2019; Keen et al., 2022). Studies that explored participants' and researchers' experience of Zoom interviews reported positive feedback, including that they were convenient to use and interactive, along with the opportunity to review performances and make adjustments to their interview technique (Archibald et al., 2019; Oliffe et al., 2021). Whilst video conferencing platforms enabled this research to continue when there were numerous restrictions on access to health care services, using it required careful planning to adjust for time zones around Australia, remaining cognisant of confidentiality when sending Zoom® or MS Teams® links via email and persistence when connectivity proved challenging.

Capturing the data

Interviews commenced with questions about qualifications in nursing, the number of years working in child and family health nursing, current roles and the service area that their roles covered. These questions set the scene for the interviews and helped to build a rapport with participants. The interviews lasted between forty-five minutes to one hour. The timing and the choice of video conferencing platform were negotiated with participants to suit their current work commitments and the availability of quiet and confidential spaces to conduct the interviews. At the commencement of the interviews, the researcher clarified participants' consent to interview recording and reiterated that all of the data would remain deidentified by using pseudonyms to protect the anonymity of participants. Participants were reminded that the audio recordings would be transcribed verbatim and were offered the opportunity to receive a copy of their interview transcript for verification. None of the participants, however, requested their transcript. Audio recordings were valuable in capturing the detailed richness of the interview whilst enabling the interviewer to be attentive to the participant to maintain a comfortable rapport (Braun & Clarke, 2013). Even though interviews were audio recorded on the video conferencing platform, a second device, a digital voice recorder, was also used in case the nominated recording device failed. On two occasions where the internet connection was an issue, interviews were conducted on a mobile phone connection, and the audio was recorded on a digital voice recorder to enable transcription of the audio. The digital audio recordings were uploaded to a password-protected online transcription platform, where the transcriptions were saved as Word documents for downloading by the researcher for analysis. The data was checked for accuracy and quality by reading the transcript whilst listening to the audio recording. Audio recordings were uploaded after each interview to enable prompt transcription and analysis to being. Data collection continued until at least four interviews were conducted in each state or territory, as the aim was

to capture the perspectives of metropolitan, regional, rural and remote CFHNs across Australia. Holloway and Galvin (2017) suggest that the researcher must decide when data saturation is reached, as there are no rules or guidelines pertaining to saturation. Other research supports the idea that saturation should be operationalised consistent with the research questions and inclusive of inductive analysis (Saunders et al., 2018). The researcher deemed data saturation had occurred when no new concepts or ideas emerged within or across metropolitan, regional, rural and remote settings.

Data analysis

During the interviews, the researcher took notes that were used as prompts for further questions and provided additional contextual reminders when reading transcripts of the interviews. In addition, when each interview was completed, the researcher added notes that captured thoughts about the online interview environment, including reflections on the tone and feel of the interview that supported the rapport with that participant to shape future interviews. Braun and Clarke (2013) suggest it is helpful to take notes after interviews to provide prompts at subsequent interviews and consider the interviewer's reaction to the participants, participant responses and data analysis ideas. After each group of ten interviews had been conducted, the researcher wrote a memo reflecting on the data, signposting ideas about the data in relation to child and family health nurses' practice, keywords from participants and interview techniques. The process of note-taking and memos assisted with reflection and engagement with the data and supported the iterative process of analysis, as explained by Holloway and Galvin (2017).

Document analysis

The organisational documents were viewed as resources to understand the social construction of the organisation as it related to quality and competence in child and family nursing practice. The researcher collated organisational documents into a spreadsheet as they were received to identify the type of document, its purpose, the target audience, how it was used and whether it was accessible outside the health service. The process of asking questions about documents establishes what the documents are used for at the time of their production (Silverman, 2020). The process was repeated for each set of documents provided by the jurisdictions and enabled an initial comparison to establish whether there were common or similar documents related to quality and competence in child and family health nursing practice across jurisdictions. The initial analysis focused on the content of the documents as resources to provide background information

and context (Coffey, 2014). Each document was read, looking for content related to CFHNs and how the documents were used in clinical practice to identify and measure quality and competence in child and family health nursing practice in each jurisdiction.

Following the initial exploration of the documents, thematic analysis was used to explore the intertextuality between documents and the social reality of the context in which they existed, consistent with the guidance offered by Coffey (2014) and Waller et al. (2016). Documents were imported into NVivo software, where they were coded inductively. Coding is the process of assigning labels that provide meaning to the descriptive data gathered during qualitative research (Miles et al., 2020). The researcher coded the content of the documents one jurisdiction at a time, beginning with descriptive codes to describe the basic topic of passages of texts within the documents. The descriptive codes summarise a section of text with a short phrase or word to provide an inventory of topics and are suited to non-interview data (Miles et al., 2020; Saldaña, 2021). Additionally, as the process of coding documents progressed, the researcher utilised concept coding to capture border ideas across the data where a concept might be applied to a whole document. Saldaña (2021) described concept coding as a word or short phrase representing a bigger picture beyond a single idea or action.

Descriptive code example: Cultural safety and support/cultural sensitivity

> *A number of Aboriginal and Torres Strait Islander people have had challenging experiences with mainstream services due to a lack of cultural awareness and safety, respect and sensitivity of Aboriginal culture, resulting in mistrust and fear of opening their homes to Health Staff. Aboriginal Child Health Programs were funded to ensure Aboriginal families had the opportunity to access a culturally sensitive, safe and appropriate child health service to provide support, education and health screening for Aboriginal children and families. It is important that Aboriginal programs are flexible and meet the needs of each individual Aboriginal community they service. This involves flexibility in service provision and adapting the model of care as necessary.*

This process generated two hundred and fifty codes, making it difficult to see a complete visual on a computer screen. Given the volume of codes and the fact that the researcher was a novice NVivo user, the codes were printed, cut and pasted onto paper to begin clustering codes according to common topics (Appendix K). While computer-assisted qualitative data analysis software (CAQDAS) is useful for managing large data sets, for a researcher who is unfamiliar with the software package, it is common to return to using manual forms of clustering codes (Cope, 2014). After clustering of codes, the researcher moved to construct a descriptive sentence that categorised the central ideas generated from the data to become themes. The approach to theming data categorically is to create themes that correspond to general topics and ideas that are intimated by the data (Saldaña, 2021).

Interview transcript analysis

The interview transcripts were analysed using Braun and Clarke's (2022) six phase process of thematic analysis, moving through familiarisation of the data, data coding, generating themes, developing and reviewing themes, defining and naming of themes to interpretation and reporting. Throughout this process, the researcher was reflexive, continuously interrogating her assumptions and the influences of her perspectives on choices made inductively coding the data. Braun and Clarke (2013) describe reflexivity as "never final and complete but an ongoing process of reflection" (p. 16). The transcripts were imported into NVivo software, where the data were coded inductively. The progressive emergence of codes during familiarisation with data is inductive coding, as opposed to deductive coding, which begins with a list of concepts that come from the reviewed literature or research questions (Miles et al., 2020). As the researchers did not create a separate project for coding interviews, the letter 'I' was added to codes to distinguish codes used for interviews from codes used for organisational document codes.

The researcher began with in vivo coding using some language the participants used to describe situations or experiences. In vivo coding is helpful for novice researchers learning how to code and honour the participant's voice using terms and concepts to capture the significance of a participant's experience (Saldaña, 2021).

In vivo coding example: Clinician supervision

> *There are ways that it is measured, and I suppose there's a variety of opportunities that we actually have to do that. I think from a practice perspective, certainly from a clinical supervision perspective, and monitoring of service delivery, that that is undertaken. In that I think that you can glean from that about the quality and the safety of the services being provided.*

As the coding of transcripts progressed, the researcher used a combination of descriptive and concept codes that labelled topics along with broader ideas and process codes. Process codes use gerunds, that is, "-ing" words that imply actions or routines and rituals that participants do and are deemed action codes (Saldaña, 2021). Codes such as "accountability in practice", "networking", and "mandatory training" were applied to the text. Coding is divided into two major stages: first cycle coding, where initial codes are assigned to the data, and second cycle coding, moving the first cycle codes towards themes or patterns (Miles et al., 2020; Saldaña, 2021). As the researcher moved back and forth across the data while refining codes, it was noted that similar codes had been generated in the analysis of organisational documents and interview transcripts. Through an iterative process, first cycle codes were grouped into second cycle pattern codes. Narrative descriptions were applied to these clustered codes (Appendix L).

Three hundred and twenty-nine codes were generated, which made it difficult to visualise all codes at once using NVivo software. The researcher once again moved to using printed codes to group codes manually into initial themes and create a conceptual diagram of themes (Appendix M). Headings were written beside each group of codes, and the researcher moved between visual representations on paper and NVivo to review quotes to check assumptions and potential bias of themes. Creating a thematic map through re-engagement with the coded data provided a validity check on the quality and scope of the themes based on Braun and Clarke's (2022) guidance on thematic analysis. The thematic map was discussed with colleagues to aid further refinement of overarching themes and sub-themes. The process of thematic analysis supported the researcher to construct themes to provide an interpretation of the data.

Rigor in qualitative research

In qualitative research, rigor is understood to be the trustworthiness of the research and how it is conducted related to the authenticity and transferability of the findings (Lincoln & Guba, 1985; Nowell et al., 2017; Stahl & King, 2020). The Lincoln and Guba framework set out five criteria for enhancing the research's trustworthiness: credibility, dependability, confirmability, transferability and authenticity (Lincoln & Guba, 1985; Polit & Beck, 2020).

Credibility

Credibility in qualitative research refers to having confidence in both the interpretation and truth of the recorded data (Lincoln & Guba, 1985). This process occurs through data triangulation, member checking, or peer debriefing to review preliminary findings and interpretations against the data (Nowell et al., 2017). To compensate for the fact that participants did not accept the opportunity to check their interview transcripts, the researcher reviewed each transcription against the recording. In addition, participants' responses were compared to the analysis of organisational documents to build on initial interpretations of the interview data. The constant review of audio and transcriptions and description of the responses using selected monologic quotes from the participant voices in the interview transcripts, offered a visual representation of what the researcher heard from the participants to provide context to the thematic analysis (Miles et al., 2020). The verification process of theme consistency helps maximise research quality (Roller & Lavrakas, 2015). Peer debriefing with research colleagues about preliminary findings and interpretations of the data provided an external check of the data analysis process and added credibility to the research data.

Transferability and dependability

Transferability refers to the extent to which findings are applicable in another setting by researchers providing enough descriptive and contextual information about the study that consumers can evaluate the relevance to other contexts (Lincoln & Guba, 1985; Stahl & King, 2020). The utilisation of a well-defined qualitative research method, along with a detailed description of the implementation of suitable methods for data collection and analysis, serves as a means to portray instances of transferability and are described in this chapter. Communication with other researchers through peer debriefing and reading the interpretation of data is a process in qualitative research that can create trust (Stahl & King, 2020). Throughout the research, discussions were conducted with research colleagues concerning the findings and the interpretations of the data during thematic analysis, and the documentation of all the discussions created an audit trail.

In qualitative research, validity through generalisability is not the aim; rather, the emphasis is on documenting the process that shows the stability of the data over time (Connelly, 2016). Rich insight can be gained from the perspectives of participants in the research and detailed in the thick description of the data (Lincoln & Guba, 1985; Nowell et al., 2017). Data for this study comprise eighty-four organisational documents and approximately 1,200 pages of text from sixty participant interviews and reflective field notes. The approach to thematic analysis was described in this chapter and is detailed in three findings chapters four, five and six and critiqued within the discussion in chapter seven. The interpretation and analysis of the findings were critiqued and revised during research discussions, and critical feedback was received on presentations of the research findings.

Confirmability

Confirmability refers to the congruence in establishing that the findings are derived from the data and demonstrating how interpretations have been reached (Lincoln & Guba, 1985; Nowell et al., 2017). Using an interpretive paradigm along with an inductive process enabled meaning to be assigned to the participants' perspectives of quality and competence in child and family health nursing practice through coding and developing themes. The process of triangulating data entails the use of several sources of data, such as semi-structured interviews and observations, to corroborate and substantiate the findings (Higginbottom et al., 2013). Data from participant interviews and organisational documents supported the comparison and confirmation of findings in this study. Researcher colleagues offered independent views on thematic development arising

from the data analysis, ultimately providing authenticity regarding the researcher's interpretations. The process of reviewing the relevance and accuracy of data with independent people supports confirmability (Polit & Beck, 2020). Central to reflexivity is an audit trail that records the logistics of the research, sampling and coding decisions, and conceptual or theoretical formulation of interpretive research (Morse, 2018). An audit trail included using spreadsheets to record participant and organisational document data, CAQDAS software for coding and handwritten field notes and memos compiled during and after interviews. Reflexivity was important in deliberations about themes and used during discussions with research colleagues to challenge the researcher's assumptions about the data. The possible biases that may have affected the interpretation of data are addressed in both the introduction chapter and this current chapter.

Summary

This chapter described the ontological and epistemological approach along with the choice of focused ethnography as a methodology for this research. Additionally, it described the ethical considerations, recruitment process, sampling and rationale for choosing participants and organisational documents related to child and family health nursing practice from health jurisdictions across Australia. Finally, thematic analysis and methods of rigor and trustworthiness in qualitative research were described. The findings from the research are presented in the following three chapters.

CHAPTER FOUR: DOCUMENT FINDINGS

This chapter outlines the findings related to the documents that participants indicated informed quality and competence in the specialist practice of child and family health nursing. The data consisted of eighty-four organisational documents from thirteen jurisdictions from all states and territories in Australia. The documents were analysed with an open and inquiring mind to explore how quality and competence in child and family health nursing are represented in service policy and practice across health jurisdictions.

The first main section of this chapter presents an overview of the documents provided by participants in the research, including background information, the origins of the documents and the pseudonyms that were assigned to the documents. This section of the chapter is followed by overviews of the four main themes and their sub-themes that emerged from the analysis of the documentation: Service provision has different governance across jurisdictions; Organisational monitoring of CFHNs' practice is diverse across jurisdictions; CFHNS' role lacks uniformity; and Maintenance of individual CFHNS' practice lacks clarity across jurisdictions.

Overview of the documents

Participants provided the documents to the researcher after interviews were conducted. The participants chose the types of documents that were shared. They were asked to identify the documents that were used by their organisations to guide child and family health nursing practice and what they perceived to be relevant to identifying and measuring quality and competence in practice. National or international documents pertaining to the provision of child and family health nursing services were not provided by participants. Seventy-nine of the eighty-four documents provided were accessible to employees of the health jurisdictions only, while five were accessible via public websites. Jurisdictional documents ranged in publication dates from 2008 through to 2021. Most documents were published within the last five years; six documents were published between 2008 and 2015, and the majority had review timeframes noted in them. The provision of documents was informed by the governance structures of the child and family health nursing services in each jurisdiction, as described in Chapter One and Table 3.2 (p. 46).

The study participants in the Australian Capital Territory (ACT), South Australia (SA) and Tasmania provided documents that related to child and family health services that covered the whole health jurisdiction. In the ACT, South Australian and Tasmanian jurisdictions, all documents provided

were available to staff within the jurisdiction but were not publicly available. These documents related to the delivery of care in child and family health services, including service provision and how clinical practice would be undertaken by CFHNs. Participants from these states and territories provided documents that related to all staff employed in child and family health service provision, including, for example, registered nurses, midwives, and allied health personnel, in addition to CFHNs. Participants from the ACT provided eight documents, SA supplied four, and Tasmania provided three documents, all of which related explicitly to child and family nursing practice.

In New South Wales (NSW), three of the fifteen local health districts, one from a metropolitan area, one from a regional area and one from a rural area, participated in this study. The participants provided documents specific to their local health districts, including three state health department documents for use by all state child and family health services. Whilst the majority of the seventeen documents focused on child and family health nursing practice and services provision, six documents were also aimed at practice guidance for registered nurses, midwives, allied health staff and Aboriginal Health Workers. In the Queensland health jurisdiction, one metropolitan and one regional community child health service of the sixteen Hospital and Health Services (HHS) participated in this study. In contrast to the local health districts in NSW that supplied documents, only one Hospital and Health Service provided documents, as the other HHS had no formal documents that specifically related to child and family health nursing services. Ten of the documents provided relate to all nursing staff working in the community child and youth health service, with one document specifically associated with CFHN clinical practice.

Both the Northern Territory (NT) and Western Australia (WA) health jurisdictions are divided geographically into two large health service regions. These health regions for the NT cover urban and remote primary healthcare services. In WA, however, one health region covers metropolitan child and adolescent health services, and the other region covers regional and rural hospital and community health, including child and adolescent health services. All documents provided by study participants in NT and WA were related to service provision and clinical practice guidance for all health professionals working in child and family health services in these jurisdictions. None of the documents were targeted explicitly at CFHNs or were publicly available.

In contrast to all the other states and territories, Victoria's child and family health nursing services are situated in the seventy-nine local government areas under a memorandum of understanding between the state health department and municipal council services. The participants from five

local council services who were part of this study provided local council child and family health nursing and state health department documents related to service provision and clinical practice. Unlike the other jurisdictions, seven of the ten documents provided were specifically directed at child and family nursing practice. Whilst councils managed the services, CFHNs followed state health department guidelines.

A broad range of documents was provided by each jurisdiction. These included service checklists, templates, policies, procedures, and guidelines; clinical and reflective practice frameworks; and education packages (see Table 4.1). In each jurisdiction, some documents related to the whole community health services, all staff employed in the child and family health service or related to nursing staff more generally or directly related to CFHNs and their practice. Documents were given pseudonyms to provide confidentiality when reporting findings, as only five documents could be accessed via public websites. The naming of documents was inconsistent across jurisdictions even when the documents were similar in their description and purpose. For clarity in reporting findings and maintaining anonymity, the documents were categorised under pseudonyms. This enabled similar documents to be brought together, as shown in Table 4.1. The pseudonyms and numerals differentiate the documents, for example, Model of Care 1 (MoC1).

Table 4.1 Document: Pseudonym, description, origin and quantity

Document Pseudonym	Document Description	Origin and Quantity
Model of Care (MoC)	Service model for delivery of care to children and families	ACT, Qld n=1 each NSW n=2
Clinical Guideline (CG)	A framework or standardised approach to the whole service delivery or programme delivery	ACT, SA, Qld, WA n=1 each NSW, VIC, NT n=2 each TAS n=3
Clinical Procedure (CP)	Standardised safe and competent clinical practice processes	Qld, NT, WA n=1 each ACT, VIC n=2 each NSW n=4
Orientation Guide (OG)	Orientation processes for the child and family health service or the organisation	ACT, TAS, WA n=1 each SA n=2 NSW n=3
Workforce Guide (WG)	Outline of the requirements for the recruitment of the CFHN workforce	ACT, QLD, n=1 each NSW, VIC n=2 each
Transition to Practice (TTP)	Outline of the organisation's transition process for CFHN students and newly qualified CFHNs	NSW, SA, QLD, VIC n=1 each
Performance Review Tool (PRT)	Guide for performance review and professional development planning	ACT, NSW, QLD, VIC n=1 each SA n=2 TAS, WA n=4 each
Reflective Practice Tool (RPT)	Guide to support clinical reflective practice, including clinical supervision	ACT, NSW, SA, QLD, WA n=1 each
Clinical Practice Tool (CPT)	Tool to assess clinical practice (may include observation and discussion)	NSW, WA n=1 each TAS n=2 QLD n=5 ACT n=6
Documentation Checklist (DC)	Audit of clinical documentation	SA, VIC n=1 each NT n=2

Overview of themes

The documents were viewed as a resource to give context to the workplaces and practices of the participants in the study. The initial review of the health jurisdiction documents explored their purpose, their target audience, how they were used by the organisations and whether they were publicly accessible outside the organisations that participated in the study. The findings from the analysis of the documents are presented under four themes and sub-themes that provide insight into how the organisations identified and measured quality and competence in CFHN practice as evidenced by organisational documents (Figure 4.1). The first theme is 'Service provision has

different governance across jurisdictions'. The documents describe how organisations deliver services to children and families. Within this theme are the sub-themes of *1. Delivery of Child and Family Health Nursing services*, *2. Safe and optimal standards of clinical* practice, and *3. Accountability procedures and documentation governing service or practice*. The second theme, 'Organisational monitoring of CFHNs' practice is diverse across jurisdictions', presents the monitoring of child and family health nursing practice. The findings are presented through the sub-themes of *1. monitoring of clinical practice through observation and discussion, 2. clinical assessment related to CFHNs' practice* and *3. cultural safety and community consultation*. The third theme, 'CFHNs' role lacks uniformity across jurisdictions', explores the child and family health nursing role and workforce recruitment. In this theme, the sub-themes were *1. CFHNs' role and concepts of practice*, *2. scope and competence in CFHNs' practice* and *3. domains of practice related to nursing care of children and families*. The fourth theme is the 'Maintenance of individual CFHNs' practice lacks clarity across jurisdictions'. It reflects on the individual child and family health nursing practice through the sub-themes of *1. clinical supervision through reflective practice discussions, 2. enhanced practice through debriefing with peers* and *3. clinical practice development to attain skills and knowledge.*

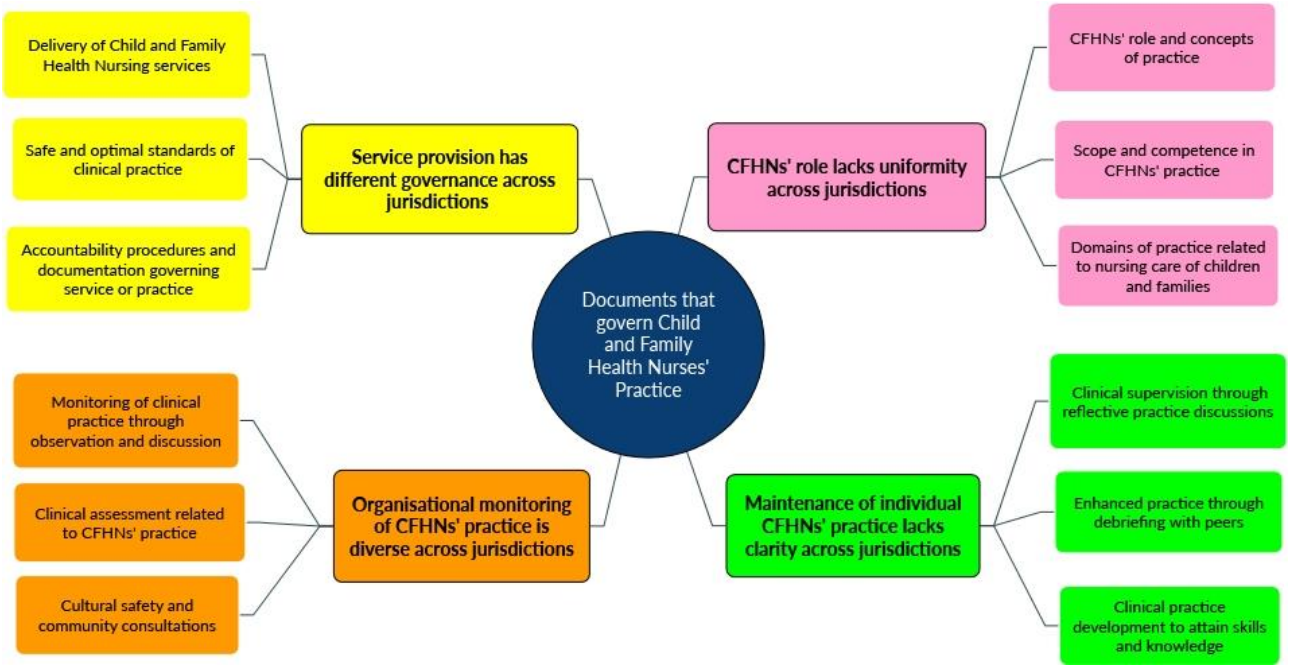


Figure 4.1 Document analysis themes

Service provision has different governance across jurisdictions

Service provision was based around the structure of health jurisdictions, which then influenced the organisational structure of child and family health nursing services. For example, service delivery was based on whether organisations were governed by state, territory, local community health or council services and whether the child and family health nursing services were integrated with other services. The integration of service provision made it difficult to delineate quality and competence specifically for child and family health nursing practice, especially when other health professionals were involved in the service provision of care for children and their families.

Delivery of Child and Family Health Nursing services

Three organisations, one in the ACT (MoC1) and two in NSW (MoC2, MoC3), provided a model of care document that described the delivery of child and family health services. The term 'model of care' broadly defines the overarching service delivery model that outlines best practices for a person, client cohort or population group (Agency for Clinical Innovation, 2013). MoC1 provided a detailed description of the service delivery structure for children and families, including the types of services offered to families, for example, universal home visits and clinic services, and the timeline of when these services should occur. The document included a description of the governance structure and the qualifications required by staff to work in the child and family health service. This document set a standard for care for the service and the qualifications of staff who work within the service. The reference to quality and competence in MoC1 related to the child and family health service's commitment "the quality cycle for improvement to ensure the safety and quality of its service delivery" and did not focus on the quality of child and family health nursing practice.

MoC2 described the broad structure of delivering child and family health nursing services based on a tiered approach from universal access to more targeted access. This approach was centred on identified client needs rather than following a specific timeline for client interactions. Though similar to MoC1 in describing services provision, the MoC2 set parameters for service evaluation connected to outcomes measures to ensure "that families are receiving a service that not only suits their needs but enables the best outcomes for the family" (MoC2). In addition, it focused on professional development for CFHNs to enhance "skill attainment, competence and support" for learning (MoC2). MoC3 was a map of the provision of child and family health services that differed in content from MoC2 with decision-making flow sheets to guide the service delivery. This

document did not describe the evaluation of quality and competence in child and family nursing practice.

Instead of a model of care document, other jurisdictions provided clinical guidelines that were a framework or a standardised approach applicable to service provision for the whole child and family health service or child health programme. Five of the eight jurisdictions provided these clinical guidelines for the whole child and family health service provision. NSW and Tasmania had clinical guidelines that governed specific programmes within the child and family health service. The target client group was children from birth to five years and their families in seven of the jurisdictions. In Queensland, the target group was from birth to eighteen years in the child health service.

In addition to a model of care document, ACT had a clinical guideline (CG1) that focused on the delivery of programmes to achieve optimal health outcomes for children and families through collaboration with families "to identify their individual needs and offer support by providing appropriate, accessible and acceptable services in line with primary health care principles". The WA clinical guideline (CG11) had a similar focus on achieving optimal health and developmental outcomes "by engaging with families and undertaking preventative health initiatives, health surveillance and screening, and health promotion activities". In contrast to CG1, whose target audience was CFHNs, CG11 was directed at all staff, not only CFHNs, who worked within the WA community health services.

The clinical guideline (CG3) from SA was described as a reference guide to "outline the core elements and processes" to enact the organisation's streams of care, which included universal, collaborative and enhanced care. CG3 described, in detail, the service provision of child and family health services in SA with embedded links to further information and resources that were not publicly available. In contrast, the NT clinical guideline (CG10) gave a brief overview of standardised information to be used as a resource guide for providing child and family health services for both urban and remote services in one region of the NT. CG10 referred to acquiring competence in child and family health nursing practice through professional development, stating that professional development "enables a professional voice and the sharing of knowledge and skills. This contributes to child and family health nurse competence, increases networking and peer support" (CG10). Both these clinical guidelines targeted all clinical staff that worked in the respective services in addition to CFHNs.

Compared to all other jurisdictions, the clinical guideline (CG5) from Victoria detailed the requirements of maternal and child health service provision and described funding, governance structures, policy and legalisation along with performance measures and targets and data reporting requirements. The focus in CG5 was not on measuring the quality and competence of CFHNs but on service performance targets, for example, the "percentage of Key Age and Stage consultations completed" and "percentage of fully (exclusively and predominantly) breast-fed infants at defined ages" (CG5). CG1 and CG5 were described as reference material for CFHNs to guide their service provision. All the clinical guidelines were focused on measuring outcomes for services, not child and family health nursing practice.

In Victoria, Tasmania and NSW clinical guidelines also included guidelines for specific programmes within the child and family health services. Tasmania's clinical guidelines (CG7, CG8, CG9) focused on young parents, targeted visits and parenting interventions, and the NSW clinical guideline (CG2) detailed a focused Aboriginal programme. Both Victoria (CG4) and Tasmania (CG8) focused on providing care to vulnerable children and families in an enhanced schedule of contacts through a variety of modes of delivery. Unlike CG4, CG8 was designed to be used by enrolled nurses and allied health professionals in addition to CFHNs. CG2 was designed to address the specific programme requirements to "support the delivery of culturally safe, reliable, consistent and competent Aboriginal child and family health services". In addition to CFHNs, CG2 was used by allied health and Aboriginal Health Workers and Aboriginal Community Controlled Health Services. While the content of each clinical guideline differed across jurisdictions, the focus was on providing consistent and sustainable practice frameworks for the programmes with no specific outcomes for child and family health nursing practice.

Safe and optimal standards of clinical practice

The clinical guidelines directed the delivery of services or programmes, while the clinical procedure documents focused on standardised, safe and competent clinical processes. In SA, CG3 functioned as both a clinical guideline and clinical procedure as it contained detailed practice information and embedded links to clinical practice procedures. Other jurisdictions, ACT, Qld, WA and NT, had detailed clinical procedures that covered the whole child and family health services, whilst NSW provided specific clinical procedures. One local health district in NSW provided three clinical procedure documents (CP3, CP4, CP5) that focused on safe and appropriate clinical practice for monitoring and screening child development, optimal growth and routine home

visiting processes. Whilst these clinical procedure documents dictated safe practice, CP4 identified "the need for the application of clinical judgment in respect to each individual patient".

The clinical procedure (CP1) document from the ACT sets out a detailed practice guide for CFHNs and midwives to conduct routine screening and assessment and to provide support for families. CP1 indicated it was a training tool for new staff and a reference tool for child and family health nursing practice that could be from birth to six years. In contrast, the Queensland clinical procedures document (CP7) describes clinical practice relevant to working with children from birth to eighteen years. Only one section of CP7 pertains to child and family health nursing practice, whilst the rest of the document is designed to support the practice of other health professionals, including school-based nurses and Aboriginal Health Workers. Neither CP1 nor CP7 detailed any outcome measures related to CFHNs' clinical practice.

The clinical procedures documents from WA (CP9) and NT (CP8) are designed to be used by CFHNs and other health professionals, including registered nurses, midwives and Aboriginal Health Practitioners. CP9 is a detailed clinical practice guide for universal child health checks from birth to two years undertaken by CFHNs and community health nurses who work across the community child and adolescent health programs in WA. In contrast to CP9, CP8 guides the standardised clinical practice for registered nurses, registered midwives, CFHNs and Aboriginal Health Practitioners "undertaking a comprehensive physical assessment of infants and children and is relevant for all health professionals conducting the schedule of well-child assessments" of healthy children under five years of age. The scope of practice section of CP8 states, "It is important that Aboriginal Health Practitioners, Registered Nurses and Registered Midwives understand they are not required to hold midwifery or child health qualifications to administer" a well-child assessment. Additionally, in CP8, there was direction for remote area staff to seek guidance from a CFHN if concerns arose during these assessments. All the clinical procedures documents directed the clinical practice to care for children, but only three documents, CP3, CP4, and CP5, were explicitly designed for CFHNs. The other documents, CP1, CP7, CP8, and CP9, were inclusive of the clinical practice of other health professionals.

Accountability procedures and documentation governing service or practice

There were limited references to accountability procedures in the documentation provided by participants. Two organisations, one from SA (DC1) and the other from Victoria (DC2), provided checklists that were used to audit clinical documentation. DC1 was used to review clinical service

provision for all child and family health services and all aspects of client engagement, from assessment to care planning for both parent and child. It set targets against standards and business rules within the organisation but did not stipulate when, how or who completed this audit. In contrast, DC2, focused on meeting key performance indicators through a simple checklist pertaining to electronic file audits on an individual home visiting activity. Like DC1, DC2 did not specify the process to complete this audit.

In terms of accountability, the NT documentation (DC3) was a detailed checklist of key performance indicators set for the provision of the child health program designed to monitor the growth and development of children from birth to five years. DC3 focused on service provision delivered by all primary health care staff and was utilised by managers as a continuous quality improvement measure. The documents from SA (DC1), Victoria (DC2) and NT (DC3) health jurisdictions focused on clinical service provision. These documents did not indicate how quality and competence for child and family health nursing practice is or could be incorporated into the provision of services or clinical practice.

Organisational monitoring of CFHNs' practice is diverse across jurisdictions

Participants provided organisational documents from their jurisdictions to explain the processes of monitoring and reviewing the clinical practice of CFHNs. Four jurisdictions, ACT, Queensland, Victoria, WA, focused on clinical skills assessment as a measure of competence in practice. NSW and SA included observation and discussion as part of the clinical practice assessment. Organisations used diverse processes to monitor or assess the competence of CFHNs, such as demonstrating clinical tasks, peer review and clinical practice discussions.

Monitoring of clinical practice through observation and discussion

The ongoing review of clinical practice in the ACT was described in the clinical procedures as a "strength-based partnership approach to professional practice" that included observation in practice with peers and clinical practice discussions (CP2). The document focused on "opportunities, tools and support that are the stepping stones to safe clinical practice" (CP2). Similarly, in NSW, CP3 detailed observation of practice and discussion processes for CFHNs led by clinical nurse consultants or clinical nurse specialists. Key elements of this process included supporting CFHNs to reflect on their practice during clinical skills assessments and develop their clinical practice goals. Observation and discussion were linked to "a process that ensures

continuous clinical practice development, builds capacity, and ensures competent, consistent practice standards to meet organisational, community and staff expectations of CFHNs" (CP3).

In contrast to CP2 and CP3, where observation of clinical practice and discussion were critical elements in reviewing clinical practice, the performance review tools from Queensland (PRT4) and Victoria (PRT5) relied on discussions about clinical practice rather than including observations. These performance review tools guided the performance reviews and professional development planning to assess competence in CFHNs' clinical practice. PRT 4 was based around "two-way conversations between line managers and employees regarding the requirements of an employee's role, the individual's contribution to organisational objectives and expected performance and conduct standards." While the focus was on guidance and support for the health professional's performance, it directed the practice of all health professionals in this health and hospital service in Queensland and was not specific to child and family health nursing clinical practice. Similarly, PRT5, provided by one organisation in Victoria, was a generic process to guide discussion about the performance of all staff, including but not specific to CFHNs. The position descriptions of staff working within this service guided the essential responsibility statements of PRT5. There were broad statements in this document that guided the discussions between management and staff and briefly mentioned the maintenance of "professional knowledge and skills" (PRT5). The other jurisdictions did not provide documents specific to practice consultancies; instead, there were mentions of observation of clinical practice and discussions woven within documents such as models of care or clinical guidelines.

Clinical assessment related to CFHNs' practice

Several jurisdictions used clinical practice tools to assess clinical practice, and the documents indicated that assessments occurred during staff orientation at the commencement of employment. In the ACT, clinical practice tools related to specific client interactions, such as home visits (CPT4), clinic visits (CPT2) or group programme delivery (CPT3), and specific child health checks, for example, infant (CPT5) or three-year-old assessments (CPT1). These documents are similar to the clinical practice tool (CPT13) from WA, which includes assessments of essential clinical skills used by community health nurses, including CFHNs, to monitor children's growth and development. This tool required the CFHN or community health nurse to perform the tasks of the client interaction or child health check and be deemed "competent or not yet competent" (CPT13). Comparable to ACT and WA clinical practice tools, two organisations from Victoria provided documents that were used to deem CFHNs competent to practice. CPT11 benchmarked

competence against descriptive statements related to clinical skills used in client interactions. In comparison, CP12 benchmarked competence against state-based competencies for CFHNs, for example, “monitor health, growth and development of children from birth to school age to optimise health outcomes” and required an affirmative or negative response.

In contrast, CPT7 from NSW described clinical skills assessment that included reflective practice discussions that were used in conjunction with child health check client interactions. It is designed to orient new staff and support CFHNs to maintain currency of practice through a “process that supports continuous clinical practice development, builds capacity, and ensures competent, consistent practice standards to meet organisational, community and staff expectations of CFHNs” (CP7). Whilst the QLD clinical practice tool (CPT10) is similarly designed to “demonstrate the specific knowledge, clinical skills and behavioural attributes appropriately applied to the relevant clinical setting”, it is used for all nurses working in both acute in-patient and community health services and not specifically for CFHNs. CPT10 is used with new staff members, nurses transitioning into child and family health nursing and when staff are applying for promotional positions within the health service. In addition, there were specific credentialing and annual assessments for skills such as immunisation along with identified processes for reviewers of clinical practice that detailed the credentialing of the clinical assessor role.

Cultural safety and community consultation

While First Nations clients and the vital partnership between CFHNs and Aboriginal Health Workers, were acknowledged in many documents, most documents did not mention culturally safe practices for CFHNs. Documents such as the clinical guideline (CG9) from Tasmania relied on building collaborative relationships with Aboriginal Health Workers, “enabling interventions to be culturally sensitive”. Similarly, the clinical guideline (CG2) from NSW focused on “working in partnership with Aboriginal communities to improve the health outcomes of Aboriginal people”. It mentioned reliance on Aboriginal Health Workers to bring “cultural expertise” and “assists families to engage with the service by providing culturally sensitive advice, support, education and advocacy” (CG2).

Juxtaposed to these documents, SA’s reflective practice tool (RPT3) explicitly states that “cultural competence is central to being a skilled and competent worker and that respect for Aboriginal people and cultures is valued and encouraged within our workplace”. Additionally, the cultural competence of CFHNs, along with other health professionals, is reviewed through a performance

review tool (PRT3) that prioritises “development of Aboriginal cultural competency” and encourages “on the job learning” as well as training. The clinical procedure document (CP7) from the NT, which guides services in remote communities with First Nations populations, did not specifically mention the cultural safety or competence of CFHNs or other health professionals. The cultural competence of CFHNs is featured in three documents, CG2, RPT3 and orientation guide (OG3), which guide orientation and in-service education processes for an Aboriginal child and health programme in NSW.

CFHNs’ role lacks uniformity across jurisdictions

The composition of the child and family health nursing workforce across jurisdictions is dictated by the structure of the child health services and whether they are delivered in metropolitan, regional, rural or remote locations. Child health services often employ a range of health professionals to care for children and their families, including CFHNs. The description of the dedicated child and family health nursing roles, whilst similar in some respects, differed across jurisdictions and amongst organisations that participated in the study.

CFHNs’ role and concepts of practice

The workforce guide (WG) outlines the requirements for the recruitment of CFHNs and varies across jurisdictions. It relates to qualifications for nursing and midwifery board registration and postgraduate qualifications. WG1 describes the structure of the ACT workforce and recruitment pathways for registered nurses or registered midwives into the child and family health nursing role. It sets out the requirement for CFHNs to have postgraduate qualifications in the speciality of child and family health nursing, with the option to complete education whilst employed in a training position. The scholarship pathway maps the assessments required to integrate into the child and family health nursing role through supported clinical practice in the immunisation program, child health checks and group programmes. In contrast, WG3 is explicit in the requirements of the CFHN role in Victoria, which stipulates that CFHNs must be a registered nurses and registered midwives and have completed postgraduate qualifications in child and family health nursing. This is supported in WG4, which stipulates the specialist skills and knowledge required to undertake clinical practice in the CFHN role. For example, it states the CFHN must have knowledge of” child development of children from birth to six years old” along with the “ability to advise parents concerning perinatal health and wellbeing and assess and establish the need to provide preventative advice to parents as required” (WG4).

Whilst most organisations had an orientation guide (OG) that described the processes related to new staff employed, they varied depending on whether they were specific to CFHNs and provided guidance on child and family health nursing practice. OG1 from ACT personalised the pathway of supported clinical practice, which depended on the qualifications of the nurse or midwife to be deemed competent to practice as a CFHN. As with OG1, OG2 from NSW was "tailored to the individual needs of the CFHN qualifications, experience level, knowledge and skills" and "inform the level of support required to reach independent practice". Similarly, Tasmania's OG6 provided a personalised checklist and record of the orientation pathway, including a clinical practice checklist of tasks for CFHNs to complete under the guidance of a preceptor. Differing slightly, another orientation guide from NSW applied to CFHNs, Aboriginal Health Workers and Aboriginal Health Practitioners and focused on specific training and education required to "provide sustainable, culturally appropriate maternity and child health care to Aboriginal families and communities" (OG6). In contrast, OG7 was part of a broader orientation process for regional services in WA. The document was used for any health staff commencing with this organisation and required amendment as there were no specific details related to CFHNs or their clinical practice.

Scope and competence in CFHNs' practice

The scope of CFHNs' clinical practice differs throughout Australia based on the service provision requirements, workforce and postgraduate qualifications. CFHNs work in community settings for most jurisdictions, caring for children from birth to five years and their families. WA's child and youth health services were the exception, as CFHNs focus on children from birth to two years (CG11). These differences in scope of practice for CFHNs were highlighted in the transition to practice (TTP) documents, which outlined the organisations' transition processes for child and family health nursing students and newly qualified CFHNs.

Victoria's TTP4 is distinct in that it applies to newly qualified CFHNs, not registered nurses enrolled in child and family health nursing postgraduate study. It focuses on the identified needs of individual graduate CFHNs to determine their goals for their first year of practice and how child health services can implement the transition programme. Key to the transition to practice programme in Victoria is the review of competence at three, six and twelve months "informed by the National Standards of Practice for Maternal, Child and Family Health Nursing Practice in Australia and competence assessed against the Competency Standards for Maternal and Child Health Nurses in Victoria (VAMCHN)" (TTP4).

TTP3 from Queensland is similar in that it outlines a detailed twelve-month support program for novice CFHNs. Additionally, it applies to registered nurses enrolled in postgraduate child and family health nursing studies commencing work in child health services. This programme uses clinical performance assessment tools during rotations between different levels of services to assess competence towards independent child and family health nursing practice. Likewise, NSW's TTP1 describes pathways to support the employment of registered nurses working towards postgraduate child and family health nursing qualifications. In this organisation, the measure of competence is through detailed self-assessments and a clinical skills assessment conducted during a consultancy with an experienced CFHN. Similarly, OG1 from the ACT included the child and family health nursing transition to practice processes for both novice CFHNs and scholarship employment positions for registered nurses undertaking postgraduate study in child and family health nursing. Meeting mandatory training and education requirements and specific client interaction assessments are necessary for CFHNs to be deemed competent in their clinical practice. Only TTP1 identified that the transition to practice programme aimed to support workforce recruitment and retention of CFHNs, stating "to ensure that succession planning is appropriate for need, the LHD needed to implement an innovative solution to these workforce challenges".

In contrast to the other jurisdictions, TTP2 in SA outlined a very different process as a workforce solution to employ registered nurses in child and family health services without the requirement for a postgraduate child and family health nursing qualification. TTP2 detailed the clinical practice programmes used to support registered nurses transitioning into child and family health services and replaced the need for enrolment in an external postgraduate study programme. Completing internal professional development learning packages related to clinic services and child health assessments along with individual learning plans documenting professional development progress are described as means to achieve competence in child and family health nursing clinical practice. TTP2 is described as a personalised record that "outlines the orientation and education components of your transition to working within Child and Family Health Service and provides details of the professional development days, theoretical requirements and your clinical supports". This pathway approach enables potential credit transfer into formal child and family health nursing qualifications.

Domains of practice related to nursing care of children and families

The range of nursing care provided to children and families by CFHNs is articulated through models of care, transition to practice tools, workforce guides and clinical procedures. CP3 from NSW describes a "strength-based and wellness focus to promote the health and well-being of children and families, identifies variations in health and development, and intervenes when appropriate". The document identifies that CFHNs practice at "an extended level of nursing, working within a primary health care model with families with infants and young children" (CP3). Recognition of working in a primary health care model is reiterated in the ACT MoC1, which acknowledges that CFHNs work "in partnership with families and other agencies in primary health care settings" along with the NSW MoC3 that supports "anticipatory guidance which builds a family's resilience and capacity to strengthen the family's relationship with the child".

In Victoria, TTP4 supports the development of independent child and family health nursing practice, and WG3 conveys the level of qualifications that registered nurses, registered midwives and postgraduate CFHNs, require to facilitate "autonomous practice within community-based services and in local Maternal and Child Health Centres where nurses can be isolated from other health practitioners". In contrast, the challenge in other jurisdictions, such as the NT, was the vast area of remote service provision where there may not be a CFHN accessible to provide a child health service. CP8 indicated that the care of children and families was, at times, provided by remote area nurses or Aboriginal Health Practitioners with differing skills and knowledge, and they would not be "required to undertake the activities of a midwife or a qualified child and family health nurse in their job role". These documents did not provide a definitive list of domains of practice because of the varied workplaces and types of services provision required across Australia.

Maintenance of individual CFHNs' practice lacks clarity across jurisdictions

In the documents provided, there was mention of various ways for CFHNs to maintain quality and competence in their clinical practice; however, access to this support varied according to the capacity of organisations to provide these opportunities. As registered nurses, CFHNs are required to articulate how they maintain their clinical practice to meet registration requirements (Nursing and Midwifery Board of Australia, 2016a). As CFHNs' practice is relational and conducted in community settings and the preventative and early intervention domain (Wightman et al., 2021), the specific activities needed to support the maintenance of clinical practice in the wellness

domain have not been clearly articulated. Some documents suggest that reflective practice discussions, peer review, performance review and professional practice development planning may support the maintenance of CFHNs' practice.

Clinical supervision through reflective practice discussions

Reflective practice discussions are featured specifically in seven organisational documents provided by participants. The reflective practice tools describe guidance for clinical reflective practice, including clinical supervision. RPT1 in the ACT defines a formal and structured means of "supporting nurses in the provision of safe and effective health care by providing regular, dedicated, protected time for facilitated, in-depth reflection on clinical practice". The document describes a facilitated group activity that provides an opportunity for CFHNs to review and reflect on clinical practice to improve the care of children and their families. Similarly, NSW's professional review tool (PRT2) mentions monthly reflective practice to promote "critical thinking and consolidation of existing knowledge". For some jurisdictions, clinical supervision differs depending on the complexity of client work. For example, Victoria's RPT5 discussed the option of individual versus group clinical supervision to achieve "a deeper level of reflection and learning" to gain perspective on complex client interactions.

Whilst not specifically directed at CFHNs, RPT3 from SA reiterates that clinical supervision was a clinician-led "forum for discussion of ethical practice issues" and "promotes enhanced consumer outcomes and safety" through reflective discussion. Likewise, Queensland's RPT4, applicable to CFHNs and School Health Nurses, recognised that nurses in autonomous practice may be vulnerable and exposed to many stressors with complex clients. It highlighted that "guided reflective practice within clinical supervision enables the nurse to develop increasing therapeutic competence, sustaining effective work and supports the maintenance of high-quality clinical practice" (RPT4). In contrast, WA's RPT6 for regional and rural services promotes clinical supervision, although access is at the manager's discretion it is available within health services, and it does not specify whether clinical supervision is available to CFHNs.

Enhanced practice through debriefing with peers

Peer review discussions are mentioned informally in five of the documents provided. The clinical practice tool (CPT6) from the ACT is a formalised peer review tool to guide reflective conversations between CFHNs about clinical practice and forms part of an annual performance review with managers to reflect on clinical practice progress and guide professional development. It guides the

reviewer through a series of questions and task checklists to stimulate a confidential, open and respectful discussion to assist in professional development. Whilst not a formalised procedure, the SA RPT3 promoted peer review to encourage "staff to be active participants in monitoring and improving each other's practice, thus enhancing consumer safety and quality of care". RPT3 describes a willingness "to engage in purposeful observation, evaluation and discussion" as key to the success of peer review. An example referred to in RPT3 was auditing clinical files to monitor and improve a peer's documentation skills.

Clinical practice development to attain skills and knowledge

The development of clinical practice is described in the performance review tools, which guide performance review and professional development planning, as an essential part of being a competent CFHN. Two documents, RPT2 and CPT7 from NSW, are used by CFHNs to reflect on clinical practice and identify professional development needs. While they are designated for use with postgraduate students or novice CFHNs, they can be used by any CFHN to assist in prioritising professional development needs to improve clinical practice. Additionally, PRT2 provided detailed guidance for CFHNs to participate in annual performance reviews and work collaboratively to "review performance, barriers and enablers, professional learning goals, plan development in area of need or interest and discuss career goals". Comparably, PRT 11 from WA supports CFHNs to plan and document education specifically to develop or improve their clinical practice competency. Nurse Unit Managers and preceptors can use this framework to support CFHNs with planning learning and development opportunities. PRT10 described a nursing and midwifery professional development plan and discussion to support access to educational opportunities, but it was deemed optional to complete within the community health services in WA.

In contrast, Queensland's PRT4 describes a regular performance coaching and development conversation along with a six-monthly review focused on a "shared understanding of the employee's key strengths and opportunities for growth, support needs, and establish performance goals for the next six months". Additionally, PRT12 from WA outlined access and compliance to learning and development in a regional health service for all staff, not specifically CFHNs. The document describes "supporting and facilitating learning programs that provide for the development and maintenance of professional skills through contemporary workforce education and learning" (PRT12). Similarly, Tasmania's PRT7 was a service-wide document not specific to CFHNs. It was designed to for staff to promote reflective discussion about performance of their role and explore developmental activities that would assist with achieving an individual's practice

improvement. Likewise, PRT3 from SA was a generic record of professional development and reflection on clinical practice that was used to facilitate discussion between staff and managers on a six-monthly cycle.

Summary

The provision of documents relied on the study participants' interpretation of how the documents related to quality and competence in child and family health nursing practice. Even though there were variations in the content of clinical guidelines among different jurisdictions, their primary objective was to establish uniform and enduring practice frameworks for programmes related to child and family health nursing. These guidelines did not specifically outline desired outcomes for child and family health nursing practice. Various organisations employed a range of methods to evaluate and gauge the proficiency of CFHNs. These methods encompassed activities such as practical demonstrations of clinical tasks, peer evaluations, and clinical practice conversations. They provided a defined procedure for documenting the assessment of clinical practice to encourage self-reflection from CFHNs. This process involved receiving feedback from peers and managers, which facilitated the enhancement of clinical practice.

While many publications recognised the importance of First Nations clients and the crucial collaboration between CFHNs and Aboriginal Health Workers, most of the documents failed to address the topic of culturally safe practices for CFHNs. The transition to practise (TTP) documents shed light on the variations in the scope of practice among CFHNs. These documents delineated the transition procedures implemented by organisations for students studying child and family health nursing as well as recently graduated CFHNs. The lack of a definitive list of domains of practice in these documents can be attributed to the diverse range of workplaces and the varied services provision required throughout Australia. The analysis of organisational documents provides context for understanding the child and family health workplaces, enabling a deeper analysis of the participants' responses at the interviews. The following two chapters present the findings from the participant interviews. Chapter Five focuses on the organisational perspective, and Chapter Six focuses on the professional practice perspective.

CHAPTER FIVE: INTERVIEW FINDINGS – ORGANISATIONAL PERSPECTIVES

The findings from the participant interviews will be presented over two chapters. This chapter presents the findings pertaining to participants' perceptions of how their organisations viewed quality and competence in the specialist practice of child and family health nursing. The data consist of transcriptions of semi-structured interviews with sixty participants from thirteen jurisdictions across all of Australia's states and territories. The transcriptions of the interviews were analysed to explore how quality and competence in child and family health nursing are exemplified in governance and monitoring activities across health jurisdictions.

The first main section of this chapter provides an overview of the roles that the research participants held in their workplaces. It is followed by an overview of two main themes and their sub-themes that emerged from the analysis of the interview transcripts: Governance is experienced as fragmented processes across jurisdictions and Organisational monitoring of CFHNs' practice is diverse across jurisdictions.

Participants

The job titles attached to the workplace roles held by the research participants, who were all CFHNs, varied across jurisdictions. For ease of reporting, therefore, the job titles have been collapsed into the following categories to present the findings: Nurse Manager, Nurse Unit Manager, Clinical Nurse Consultant, Clinical Nurse Educator, Clinical Nurse Specialist and Child and Family Health Nurse (Table 5.1). Nurse Managers were responsible at an organisational or state health department level for the provision of child and family health nursing programmes or services, whereas Nurse Unit Managers were responsible for staff within their community unit. Clinical Nurse Consultants were responsible for the policy development that governed child and family health nursing practice and education within a jurisdiction or an organisation. Clinical Nurse Educators implemented training and development of CFHNs, which was supported in practice by Clinical Nurse Specialists and CFHNs delivering child and family health services to children and their families. Selected quotes from participants are used to illustrate the findings; therefore, pseudonyms and role titles, for example Sarah (NM), serve to distinguish the individuals involved.

Table 5.1 Role title categories

Role Title Category	Role Title in Jurisdictions	Total
Nurse Manager (NM)	Nurse Manager, Maternal Child Health Manager, Coordinator, Community Health Manager, Nurse Director, Acting Deputy Director, Maternal Child Health Advisor, Policy Advisor	n=7
Nurse Unit Manager (NUM)	Nurse Unit Manager, Clinical Nurse Manager, Team Leader	n=20
Clinical Nurse Consultant CNC)	Clinical Nurse Consultant, Clinical Nurse Education Coordinator	n=11
Clinical Nurse Educator (CNE)	Clinical Nurse Educator, Clinical Development Nurse, Staff Development Nurse	n=11
Clinical Nurse Specialist (CNS)	Clinical Nurse Specialist, Enhanced Maternal Child Health Nurse, Clinical Nurse	n=7
Child and Family Health Nurse (CFHN)	Child Health Nurse, Community Health Nurse, Maternal Child Health Nurse	n=4

Overview of themes and sub-themes

The findings are presented under the two themes and their sub-themes to clarify what quality and competence mean to the participants concerning child and family health nursing practice (Figure 5.1). The first theme explores child and family health nursing practice and is designated as 'Governance is experienced as fragmented processes across jurisdictions'. This theme has three sub-themes that feature discussion on accountability, workplace culture and service delivery. The second theme is entitled 'Organisational monitoring of CFHNs' practice is diverse across jurisdictions'. In this theme, the sub-themes relate to discussion and practice, clinical practice and professional development. Verbatim quotes were drawn from interview data to provide rich contextual understandings of the perceptions and experiences of the participants in relation to quality and competence in the specialist practice of child and family health nursing.

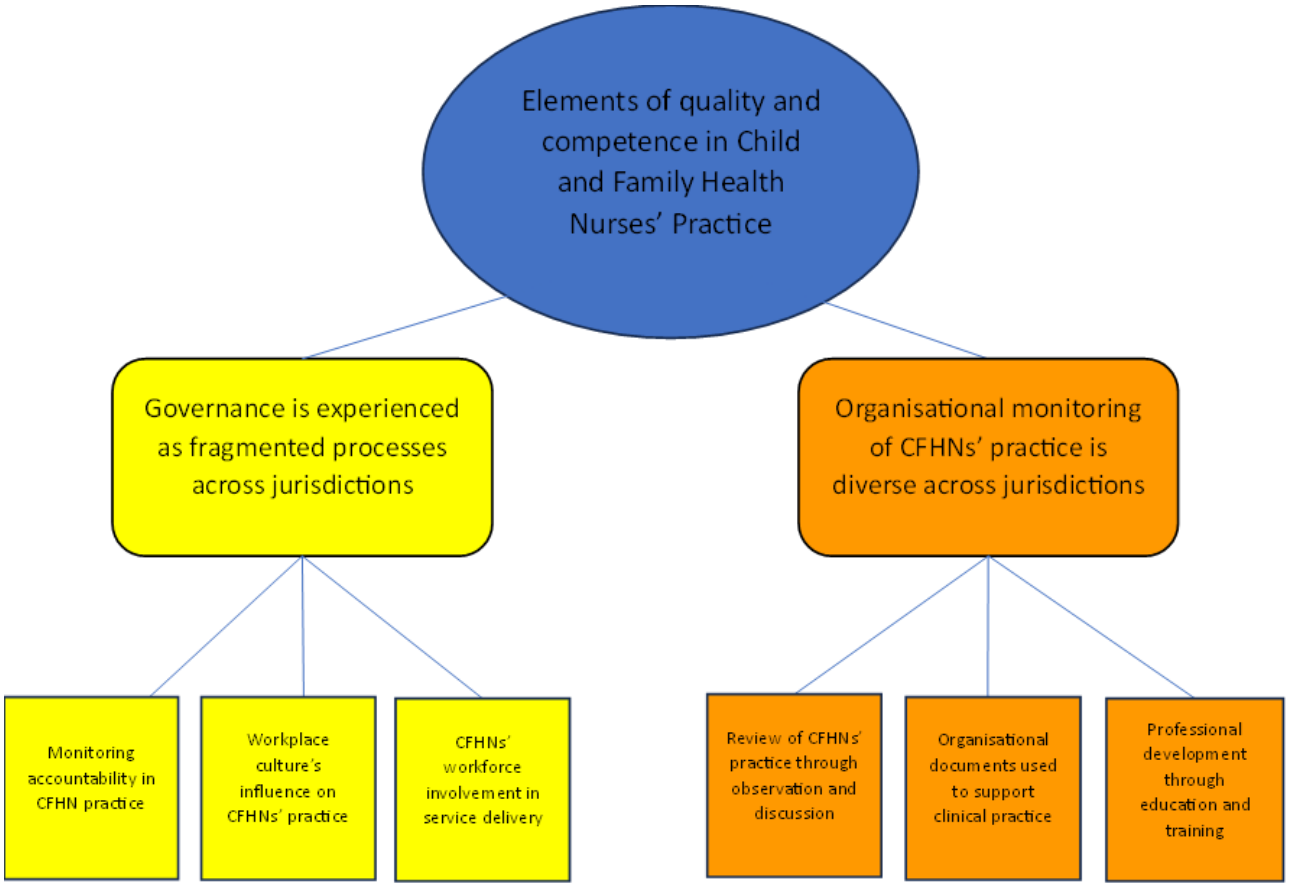


Figure 5.1 Interview analysis: Organisational perspectives

Governance is experienced as fragmented processes across jurisdictions

Quality and safety were frequently mentioned together, in relation to the governance of child and family health nursing care and services. Governance was described by participants as the policies and processes that guide the practice of CFHNs and the delivery of care to clients. Participants mentioned that being accountable in their practice, including having a culturally supportive and positive workplace environment, was important if quality care or services were going to be provided to infants, children and their families. Many participants remarked that the mechanisms to identify or measure these processes were fragmented.

Monitoring accountability in CFHNs' practice

Participants described methods such as consumer feedback, documentation audits and managers touching base with employees as methods to monitor CFHNs in service delivery. From the majority of participants' perspectives, accountability in CFHNs' practice was about accepting responsibility for clinical practice and articulating a satisfactory reason for the performance of activities. For example, Sarah (NM) referred to the use of "contemporary evidence-based practice, ensuring that

everything we do in the way we work with families meets those standards". Participants discussed quality in terms of meeting the client's needs by providing a good standard of care based on current evidence-informed practice.

Consumer feedback on the care provided

Participants indicated that client feedback was needed to assess whether quality care or a quality service was provided. Quality in care or service was seen as providing clients with the correct information and resources to provide the best outcome for children and their families. Participants commented that audits to collect the consumers' perspectives provided information about the service that CFHNs provided, and these audits offered insights into the interactions and relational aspects of CFHN practice. Kylie, for example, stated:

> *So that's also checking in with customers or clients to see whether or not the service is actually meeting their needs. Looking at the data, you know, looking at the data to see whether or not we are actually servicing participation rates, are they actually increasing? I mean, participation rates tell you nothing about the quality, but they do show some indication of actual engagement in the service. Quality? How do I know when we're delivering quality service? Yeah, I think that for looking for outcomes for those children, and this is the frustrating part in maternal and child health because we refer, refer, refer that it's very hard to see.* (NUM)

Another participant, Skye (NUM), commented that consumers can vote with their feet if the CFHN's practice or service does not meet their needs. Skye stated, "That would be a clear indicator to me that they haven't got what they wanted, that they needed from us because they haven't come back. We've seen that drift to another centre. It's been a very obvious trend". Often, the only time consumer feedback is followed up is concerning complaints about a client's experience, then this brings into question the CFHN's clinical practice. As Skye described, "the clients will tell you if there is something not right". For managers, dealing with a complaint about a staff member provided an opportunity to offer extra supervision to the CFHN and to document the discussion.

As Mila (NM) described, the balance in this process is not only reacting to complaints to address competence in practice issues but actively seeking input from clients that highlight positive interactions as well. The feedback from clients can give insight into the quality of service or CFHN practice, as Mila stated:

> *I mean, it's hard to assess an individual's competence. And we certainly do some consumer feedback stuff. And we did a big breastfeeding QA, and things like, you know, the nurse, some of those questions really gave us some rich feedback from the clients. Also, we do get the consumer feedback, some really beautiful compliments.* (NM)

Key quality aspects were identified as client engagement with or participation in child and family health services and data that shows activities and outcomes. According to the participants, a formal or informal process for consumer feedback was not present in all jurisdictions.

The relevance of documentation audits

Participants in management or clinical practice leadership positions noted that auditing clinical notes provided evidence of what was happening in clinical practice. Auditing of documentation varied in health jurisdictions across Australia and was either formal or informal. Participants stated that formal audits were about reviewing the quality and accuracy of the documentation. For example, Ava (CNC) described "the same set proforma that we use to tick off it's been done. So, it's quite I suppose, it's specific across all those aspects of the clinical forms we use, evidence of assessment, planning, implementation and evaluation". Other times, the focus was on informally reviewing and gaining insight into clinical practice, as Hilda explained:

> *The clinical notes, I think, actually is quite a good reflection of the things that have actually just been discussed with the family, as well, too. So documentation, I think is actually quite, is very important, actually. Looking at what our practices, what we're actually doing.* (CNS)

Selina (CNC) lamented the loss of an annual documentation audit in which all staff participated and provided positive written feedback to acknowledge the quality of documentation and clinical practice. For example, she described the feedback as "very thorough notes, well done, or whatever it might say. That just filled my bucket up when I was sole practitioner, when I … didn't see a lot of other people and wanted to know that I was doing okay" (Selina CNC).

Participants also remarked that sometimes, the audits showed a disconnection between clinical practice and documentation. Participants remarked that some staff would discuss their clinical skills and knowledge in care review meetings to discuss a client's progress; however, when it came to evidence to support their discussion, it was often lacking in their documentation, as Selina explained:

> *I just know some of the personalities in my team when they present the care review, a really confident approach but then we will when we might look at documentation or audits around delayed data entry, or whatever, then we see gaps in quality. And so, then we question about competence.* (CNC)

Key performance indicators (KPIs), quality audits, quality activities and improvement projects were mainly related to service delivery rather than child and family health nursing practice. For example, the health management team wanted key performance indicators on assessment tasks to validate process outcomes rather than child and family health nursing clinical practice.

Participants stated that these tools were used as a way to identify and measure quality in programmes and services but had little to do with quality in child and family health nursing practice. In all jurisdictions, participants commented that there was tension between the burden of the bureaucratic process and client relationships, which participants saw as a priority for practice. The bureaucratic process required, as Tara (NUM) stated, "either surveillance or tick box, or whatever that's going on within a consultation" to be completed in that consultation and "that really detracts from relationship building". Further, she stated that it "detracts from the fact that a family comes in with something on their mind, and they may go out without that even being answered or addressed because the nurse is so focused on going through what's in front of her". The focus on meeting KPIs for the services detracted from meeting clients' needs.

Managers touching base with employees

In one jurisdiction, participants described regular rounding as asking staff questions to seek feedback on what is working well or not yet working in their teams. Hayley (CNC) explained, "If you're rounding with people regularly, which we will try and do, you also pick up on things that you might try and investigate", and provided a means to identify how staff were performing or if there were gaps in their practice. Participants reported that when working in isolation on home visits or clinic spaces, there was little oversight or interaction with other practitioners to facilitate monitoring of clinical practice. As Eadie (CFHN) noted, "I think working alone, if you're not sort of regularly not questioned, your practice, the quality of your practice can be rubbish and no one's really picking up on it". Whilst isolated practice occurred in all jurisdictions, it was a particular issue for regional, rural and remote participants. As Selina explains:

> *Our team is all regional. We don't see anything on a day-to-day basis by any means. We basically travel out to our regions as much as we can, but we conduct a lot of meetings and conversations on teams [web platform] or by phone or by email with our sole practitioners. So, they're the only one working in their office in that community. And they wouldn't see each other from one month to the next so. So how do they even know that they … aren't keeping up to date, because they've got no one to benchmark that from as well?* (CNC)

Participants noted that monitoring accountability in practice required both CFHNs and managers to collaborate and work together for the benefit of children and their families. Participants noted that the process of gathering client feedback, auditing clinical notes and rounding with staff pointed towards measuring quality of services rather than the quality of child and family health nursing practice. While participants recognised the need for accountability in monitoring clinical practice, they identified that regular processes, including consumer feedback, documentation audits, or connection with other CFHNs, did not occur.

Workplace culture's influence on CFHNs' practice

Across the jurisdictions, participants reported that a disconnect existed between the expectations of service managers and CFHNs regarding quality and competence in practice to meet the needs of children and their families. At times, this could lead to difficult workplace relationships. Participants commented that service managers wanted process outcomes such as increasing the number of clients accessing services, and CFHNs wanted the focus to be on individual practitioner competence, including up-to-date clinical practice to support families. Participants noted that having a safe space to work and acknowledging their experience to build capacity with staff new to child and family health nursing made for a positive workplace culture.

Importance of safety and trust in the workplace

According to some participants, the challenge for managers was having too many staff and insufficient time to deal with clinical practice issues. As Tara (NUM) said, "There was only one coordinator for like, you know, 38 nurses or whatever it was. So, you know, things are flying under the radar for a long, long time". When new managerial structures were introduced, issues of clinical competence that had gone undetected came to the fore; she described this as being "terrible, because it's been very hard to sort of, you know, start to address some things that are just really poor culture and really poor behaviour" (Tara NUM).

In contrast, in one jurisdiction, participants talked about the feeling of safety and trust in a positive workplace culture that supported them to provide a quality service to clients and feel confident that they were competent in their clinical practice. As a manager, Helga (NUM) described, "We value, you know, their expertise, we appreciate and acknowledge, you know, how tough it is sometimes, and getting our work done". The importance of managers supporting child and family health nursing clinical practice is further explained by Helga when she says, "We have built up a really great workforce and being able to provide them with all these scaffolding effects, I think has actually helped contribute to the work that they are actually able to get through, as well as get down into the higher level standard of care".

Amelia (NM) described a positive workplace as "a safe and accessible environment for the child and their family along with being a safe practice environment for the workforce" to support quality service delivery. Participants commented that a supportive learning environment was essential to increase confidence and competence in their clinical practice. Fran (NUM) explained, "feeling comfortable and trustworthy that you're not being judged in what you're doing. We work

differently, everyone has a different style, but you can actually learn from everybody, we never stop learning". To support learning and changing workplace practices, participants described having managers and other experienced clinicians checking in with them as an important part of a positive work environment. They wanted flexibility to connect with their colleagues via several avenues, including face-to-face, telephone calls or emails, on their own terms and in an environment that felt safe to them. Hayley commented:

> *You can only support people in trying to say right, I'll try and come out to see you. We won't fit a whole lot in, but that might restrict the amount of time. Most of the time people will be able to have a phone call, touch base and see how they are going, or an email to say, look, how are you going, give me a call when you're not busy. So again, being flexible in trying to have them call so that they've got the time. That's just working with people.* (CNC)

Impact of longevity in the CFHN workforce

As a workforce, CFHNs in all jurisdictions have many years of experience in child and family health nursing. For example, twenty-five participants had between eleven and twenty years of experience and sixteen participants had between twenty-one and thirty years of experience in child and family health nursing. Participants who had worked for many years in child and family health nursing noted that previous processes in clinical practice seemed to be reinvented. For example, as management and services changed, past clinical practices were reintroduced without consultation with CFHNs to meet the requirements of new child health service programmes. Participants commented that this was a frustrating experience. As Sofia (NUM) explained, "You're not as invested in those processes as you were, at the beginning or middle of the career, so, you know, I get the old, gosh we can do that again, oh, we used to do this, you know, 15 years ago. Oh, gosh, we're going back to that".

Participants commented that keeping up with changing practices could be challenging, particularly if they had worked in child and family health nursing for a long time, as the information was continually being updated. Experienced CFHNs noted that there seemed to be more tasks to be completed in reduced timeframes with more client contact expected with greater use of digital documentation. Regarding older, more experienced CFHNs, Maree (NUM) explained "you know, they're not as quick" when completing digital clinical notes. From her managerial perspective, the digital workspace got more challenging, particularly "when we were changing lots of things with COVID. We had lots of one-to-one IT support people, like some people having four and five individual sessions, and no difference, frustrating". In addition, when reviewing clinical practice, Cara (CNE) commented, "I'm seeing their notes, or if it's comments that the family has made, and that's not always an accurate reflection of what's happened in clinic either". Instead, Cara (CNE)

noted the CFHNs actually continued to practice as they have always done as “they were frustrated by the constantly changing process”. In contrast, participants expressed the significance of fostering the development of the child and family health nursing workforce by actively promoting the transfer of invaluable practical knowledge from senior practitioners prior to their retirement, thereby preventing the loss of their mentorship.

Building capacity within the workforce

Many participants expressed concerns regarding the impending retirement of the ageing child and family nursing workforce and the subsequent shortage of competent CFHNs available to address this workforce gap. In one jurisdiction, participants described the pressure to employ staff quickly without giving due consideration to the skills and knowledge required by CFHNs; therefore, they questioned the quality of clinical practice and service offered to clients. As Greta (CNE) described, “Feedback from the current staff is we were taking them in too young and too inexperienced and they need the CFHN course”. She further explained her dilemma around waiting for an “experienced staff member with a postgraduate qualification” when “we need more staff and how we get them in and be creative and how we support them to get on board”.

In Child and Family Health Nursing services, participants noted that many positions were offered as fixed contracts, which were less attractive than full-time ongoing positions; therefore, it was difficult to attract qualified CFHNs. As Cara (CNE) explained, “I did twelve interviews in less than twelve months in 2020 and still struggled to get a permanent job. My partner is unfortunately in tourism, so I couldn’t give up a permanent position for fixed-term contracts”. Participants in all jurisdictions commented that the difference in wage levels for an experienced nurse in a hospital to change to a lower wage level to work in the community could be a barrier to encouraging nurses to consider a change in career to a child and family health nursing position. As Willow (CNE) explained, “Sometimes it might be hard to retain the staff because it’s not shift work for one and to take a pay cut. So, some might have been a registered nurse level two in the hospital. But then coming over here, you have to revert back to a registered nurse level one. Yes, sometimes it can be a barrier”.

Cultural safety and competence

Although all jurisdictions acknowledged the requirement for culturally appropriate universal child and family health services through their policies and guidelines, participants commented on the minimal cultural competence and cultural support provided to both CFHNs and their clients. As

Elaine (CNS) described, specific cultural programmes like the "Building Stronger Foundations", which targeted Aboriginal clients, were conducted separately instead of supporting universal services to improve their overall cultural competence. In the areas where these programmes existed, CFHNs were seeking experience in these programmes to bring learning back into the universal services. As Elaine explained:

> *I'm actually about to go and do a secondment in April to the Building Stronger Foundations programme. I actually thought that would be good for me to bring that to our team because I don't know that we support our Aboriginal clients very well*. (CNS)

As another participant described, the key to understanding cultural safety is having a framework defined by the care recipient and supported by specific cultural health practitioners. Poppy explained:

> *I encourage, or advocate that people try and have a bit of time with the Aboriginal Health Workers because you're gonna learn a whole different way of working, being and working with people and talking with people. And until such time as people really get an understanding of that, and unless you've grown up in remote, we all make mistakes, you know, what background you're from, we can all make mistakes. You know, somebody who works in a community that may be different from the community background and different countries, different languages. But it's how we go about the repair. We are working with respect.* (CNE)

They noted that having consideration for cultural safety can facilitate meeting the health needs of children, and it is not a box you can tick off in an orientation programme but a process of observing, listening and learning by being immersed in the workspace.

The participants from rural and remote areas commented that working with complex child and family health clients in a metropolitan area vastly differs from the clinical practice conducted with rural, remote families in Aboriginal communities. Pixie (CNE) commented, "You're there in front of this family who may have English as the third or fourth language, whose child-rearing practices are completely different, then you've got this overlay of culture and remote practice in that you also have to navigate". Experiencing a significant change in the community health environment can be a surprising and disorienting experience for a proficient CFHN as Pixie (CNE) remarked, "you can't even assume anything, so you're incompetent, and you can't assume any of your knowledge has relevance".

CFHNs' workforce involvement in service delivery

Participants described how quality and competence in child and family health nursing practice were influenced by who governed the child health services, either health departments or local governments. They noted that, in some jurisdictions, the child and family health nursing services

are part of a community health team. In contrast, others sit within local government councils that follow health department guidelines. One participant described the stress of working under health department guidelines and continually being asked to do more by the local council services because CFHNs had more opportunities to contact clients regularly. As Grace (NUM) described, the constant comment was, “Let’s just give that to them. Not only does that come from the department, but it comes from local services”. She further stated, “We don’t have the capacity to do a lot of what they want us to do”.

In contrast, participants from other regional communities commented on the lack of understanding about the child and family health nursing practice amongst other health professionals outside of community health services, particularly from private postnatal services and General Practitioners. Elaine (CNS) said, “It’s really challenging. At times people don’t get what we do, and they don’t understand how important what we do is”. From the participants’ perspective, this confusion in services made it difficult for consumers to understand where to get appropriate services to support the growth and development of their children.

The challenges of rural workplaces

Working in a remote setting can be even more challenging as there are a lot of health and social factors that affect the development of children. Participants described doing more for clients than routine child and family health checks, such as treating skin or eye infections and screening for anaemia. Anna (CNC) said, “As a child health nurse remote, I think it’s not like your daily routine, your practice it’s more holistic. Because they’ve got nowhere else to go, you kind of do more for your clients really”. In addition to routine child health checks, participants who worked in remote areas were required to follow additional protocols in the Central Australian Rural Practitioners Association Standard Treatment Manual (Remote Primary Health Care Manuals, 2022) for any unwell children they encountered while completing routine child health checks.

Participants identified access to resources, staff and meeting reporting requirements, and considerable travel distances as factors that impact on the quality and standard of care they could provide to children and families. Fran (NUM) described the CFHNs’ workload as “overloaded with this list of duties that they have to do when they go to each community”. The reporting mechanisms push staff to meet targets for child health checks and immunisations over connecting with families and “immersing themselves in the community”. Another participant described the difficulty in maintaining a relationship with clients when there had been intermittent contact or

CFHNs filling a gap left by the lack of staff. As Pixie (CNE) explained, “You can’t create relationships with families because you may only see them once, because you’re actually just doing a visit to that community, because they haven’t had anybody there for the last 14 months.”

Meeting services requirements

Many community health organisations use key performance indicators to measure how their services are performing in relation to client care, for example, how many child health checks have been completed for a specific age group. From the participants’ perspective, in some metropolitan and regional centres, completing tasks to meet key performance indicators or ticking boxes in the documentation was seen as a priority by management over spending time supporting families with complex needs. Harper (CNE) said that the management was “so focused on the targets, the KPI’s, they’re not really listening, they’re just looking at paper calendars and going, that looks like there is plenty of time, there is plenty of time to do your admin”. She explained, “When you’ve got pockets of really highly disadvantaged, that need longer, that the referrals take longer, you’re using interpreters, that all blows out and the staff are really under the pump”. The participants commented on the constraints with the number of home or clinic visits allowed for clients or the time allocated to a visit with the family, which meant that they felt unable to meet the needs of the families. In order to provide a quality primary health care service, participants commented that they needed to be able to connect with the community to find out what best suited the clients. As Mary (NUM) described, “We actually haven’t even got capacity for the nurses to work within the community to, you know, find out what’s working well, what specifically is needed in this community”. Adequate staffing was required to meet the needs of the children and families. The structure of urban centres compared to regional and rural areas and the workload of CFHNs depended on the number of staff employed and the size of the local government area. Lily (NM) noted “more regional rural places where there is one or two people, and they are universal maternal child health, enhanced maternal child health and the maternal child health coordinator”, so they had to do all the work from routine child health checks to supporting complex clients and manage the service as well.

COVID-19 and the impact on service delivery

The workplace became more challenging for CFHNs throughout the COVID-19 pandemic. In the metropolitan areas of NSW and Victoria, participants reported a significant impact on staff and services as CFHNs were redeployed into the COVID-19 pandemic response. Initially, child and family health services were not seen as essential. Mary stated, “In the health service itself, I think

we're [CFHNs] are seen as a non-essential service that if COVID gets in the way, they called on". During the peak of the pandemic, with the intensity of screening and the immunisation rollouts in all states and territories, participants who were qualified immunisers described being deployed into COVID-19 immunisation hubs and other staff being used in screening hubs so CFHNs were then seen as highly skilled workforce. Sofia (NUM) remarked, "It's been really interesting during a pandemic, because I've got all the immunisation endorsed nurses, and so, you know, with the whole rollout of vaccine clinics, the health service want all my staff because they're experienced immunisers". Participants stated that this situation impacted on staffing and morale as the CFHNs were seen as a highly competent workforce to contribute to the immunisation rollout; however, their skills and knowledge were not valued for the quality care they provided to children and their families. Mary (NUM) explained:

> So, they pulled out nurses at the drop of a hat because I don't think they understand the work we do. I think we're seen as you weigh and measure babies, yeah. They don't understand the complexity that comes with every family, and that if you put the money into the early years that will assist as you know, those clients to grow and function within communities. (NUM*)*

While some jurisdictions during COVID-19 pandemic response saw CFHNs as a valuable resource and an essential service, participants reported that access to remote communities was restricted, which meant children and their families did not receive the health and well-being support they required. Pixie (CNC) stated, "That's overwhelming when services are so understaffed. COVID has just made a very difficult situation almost impossible. We are half staffed in most clinics, we've shut down thirteen remote community clinics and it's not good enough".

Even though the Child and Family Health Nursing services have evolved over many years in all health jurisdictions, participants noted they had to dramatically shift their work practices during the height of the COVID-19 pandemic to meet the requirements of public health orders and still provide quality service to children and their families. Participants described increasing workload pressures with changing telehealth practices, capacity limits in clinic rooms and staff illness as CFHNs struggled to become competent in new service delivery processes. Harper explained:

> *Because we're on Amber [COVID Alert] here with a COVID situation, we've gone to two stage appointments, so a phone call, and then a 15 minute face to face for the physical assessment. That's creating a massive workload for the staff, and you've got clients that are not coming on the same day that you call because they don't understand how it's working. And then everything's got to be documented in two separate appointments.* (CNE).

Participants stated that they were often not consulted about changing processes for clinical interactions with children and families, leaving them feeling undervalued as an experienced and

knowledgeable workforce. The participants stated that executive managers seemed to dismiss the staff distress, for example making quips about not meeting key performance benchmarks so why should staff be stressed and that they needed to work with the changes in appointments.

Organisational monitoring of CFHNs' practice is diverse across jurisdictions

The participants articulated that their organisation monitored their work by reviewing clinical practice through observation and conversation and fostering professional development through education and training. They noted the presence of organisational documents designed to facilitate clinical practice. The extent to which these documents directly contributed to the quality and competence of child and family health nursing practice, however, was not consistently apparent.

Review of CFHNs' practice through observation and discussion

Participants described clinical practice consultancy as an observation of a CFHN's clinical practice by an experienced or senior CFHN. In most jurisdictions, observation of practice occurred during the orientation with new staff or in supporting the clinical placement of students, but it was not a regular process with existing staff unless there was a reason to question their clinical practice. Regular clinical practice consultancy to review competence in child and family health nursing practice was limited by the capacity of staff as Ada (CNC) described, "I know what probably is good to be doing or what maybe works well, but it's having capacity. And I can't maintain checking competency or measuring competency, when I've got 50 nurses across the area". As she further explained, "if there's a request as in part of performance management, for instance, you know, there's somebody identified as not doing what they should be or not doing", then there was a planned opportunity to review clinical practice.

Other participants noted that reflective clinical practice consultancy was limited by the capacity of experienced staff because of their workload and the reluctance of CFHNs who felt challenged by review or observation of their practice. As Elaine (CNS) articulated, "Some people feel threatened, people feel challenged, they don't want their practice to be questioned. So, they don't like the idea of someone watching them do something, and they worry that maybe I'm not doing a very good job". Participants noted that clinical practice review was limited to the orientation process. In another jurisdiction, new staff were given a development plan to follow with a preceptor over several shifts. Then, the Clinical Nurse Educator came out to review the CFHN, and this was where

inconsistencies in practice were noted. Harper (CNE) explained, “It’s usually on those visits where the new staff will turn around and say, oh I’ve never seen my preceptor do that”.

Orientation to the workplace

The orientation process for CFHNs exhibited variability across different jurisdictions, as perceived by the participants. This process encompassed a range of approaches, including buddying and role modelling and establishing connections with a preceptor. It should be noted, however, that in many instances, the orientation process lacked formalisation. Participants suggested that without designated full-time clinical educators, other CFHNs were expected to have the capacity to complete their busy workload and orient new staff. Cara (CNE) described an incident where competencies were approved without “watching that particular nurse working independently. She recently graduated, just someone who needs a little bit more of support”. In other jurisdictions, Selina (CNC) described the informal orientation process of new staff in this way:

> *We like to roster them with two or three different clinicians regularly. So, they get to know both clinicians and but also you can see that there are different ways of approaching practice. And you have to find your own style and what fits well for you.* (CNC)

Some jurisdictions set up formalised processes to support CFHNs to orient into their services, including a series of clinical assessments of their practice. Penny (NM) explained that CFHNs “have this Clinical Performance Assessment Tool conducted” with an assessor observing them perform a number of child health assessments over a day. She further commented, “So the person is orientated and inducted. And then I want to say within four months of them starting I’d probably go back and double check the procedure”. In rural and remote areas, Pixie (CNE) explained, “We do go out with new clinicians to buddy up with them, so we’re with them every step of the way, when they’re in a remote setting for that first three to four months”. Poppy (CNE) made a similar comment, “we do offer a lot of support, we’ll work out something that’s formal, some time out bush, also a lot of traveling to remote communities”.

In contrast, other participants noted that there were no formalised processes and orientation consisted of corporate induction unrelated to child and family health nursing. Grace (NUM) described, “Basically you know, you’ve got your phone, and you’ve got your laptop, and you’ve done fire training, and you’ve done CPR and all those kinds of things”. As the sole practitioner in her area, Eadie (CFHN) said, “I organised like a little orientation program for myself. So, I think it was twice a month the CNC spent a day with me”. She explained that the initial time was spent getting acquainted with relevant documents and computer programmes. Similarly, another

participant discussed the lack of a formal orientation programme but placing newly qualified CFHNs with other nurses in a centre. As Kylie (NUM) clarified, "It's not the other nurse's responsibility in the next room to oversee and supervise a new graduate, but there is support as a buddy or as a mentor."

Using case reviews in CFHNs' practice

Without observation of practice, participants described client case reviews as a way to share knowledge, discuss complexities in practice and gain an understanding of competence in child and family health nursing practice. Participants commented that case reviews were a fairly consistent process that occurred fortnightly or monthly in most jurisdictions, either individually or in group settings. For Mandy (CNC), this was an opportunity for CFHNs to "bring your kind of complex families and help you have a clear care plan and have that discussion with your peers, but also with the Nurse Consultant and a member of the allied health team as well". For some participants working with complex clients, the case review process they described was structured by the organisation to provide escalation of concerns about the client and support the CFHNs' clinical practice. As Penny (NM) explained:

> *So, there is some mechanisms, if you like about you know, we have an escalation matrix. So, if I see a client today, … there is a set of triggers, and then you would either do clinical nurse consultant reviews, so if it was child protection you would do with the CNC, but you might do a peer review and document that.* (NM)

Ada (CNC) described case reviews as a "debriefing". In contrast, she also noted that case reviews were about "advice and care coordination" and an opportunity to "identify perhaps that there were concerns around performance". Similarly, Selina (CNC) commented that case reviews "do give me insight as to how the CFHN is working with that family dyad, what that relationship might look like and how the working with this family might be triggering something for them". In this way, case reviews were opportunities to review child and family health nursing practice through discussion.

Clinical assessment tools and competency

Participants described comprehensive clinical assessment tasks to assess clinical competence when CFHNs commence their employment. Willow (CNE) explained the process for every new staff member as "a competency for each clinic, each group, home visiting and then we would tick them off against the competencies on the tool to make sure that they are meeting those competencies". Comparably, a clinical performance assessment tool (CPAT) was described by one participant as a formal process that involved observation of a clinical assessment with a client

discussion and then a reflective session to review clinical documentation. As Penny (NM) described, “the assessee really needs to explain to the assessor what they’re doing and why they’re doing it. And of course, that needs to be tailored to the client”. Carol (CNE) noted that in the regional area where she worked, there was a “list of competencies that you need to attain, and these are all related to a policy”, but it relied on CFHNs ticking boxes on forms, stating that they had completed training rather than formal assessments. In other jurisdictions, clinical assessments related to specific assessments like hip dysplasia, which Greta (CNE) described as a “quality assurance programme”. She added that all staff were asked to complete “a learning programme, a bit of an update, and then had to do a practical assessment, as well, to show the quality of practice”.

Organisational documents used to support practice

During the interviews, participants acknowledged the presence of organisational documents designed to enhance clinical practice. The extent to which these documents are directly linked to the quality and competence of child and family health nursing practice is not always apparent to them. The participants noted that the narrative around child and family health nursing practice and child and family health service delivery were intertwined. As Sarah (NM) explained:

> *I think it’s both because this quality of the service is dependent on the quality of the practice of the individual. And I don’t think you could fully separate that could have, you could say, fantastic quality of service. But unless the individuals practice his or her standard, … or individuals practicing amazingly, [we] don’t have organisational measures. That can be a nightmare.* (NM)

If the standard of service delivery is not set up for quality and safety, Amelia (ND) stated, “You’re going to find it very hard to work and produce the level of work that you need to do to achieve, even if you’re a very skilled practitioner”. For some participants, the focus was on quality of service rather than quality of practice, and they defined quality using the National Safety and Quality Health Service for Primary and Community Healthcare Standards (Australian Commission on Safety and Quality in Health Care, 2012, 2021). For Greta (CNE), this meant “an understanding of national quality standards and what they mean for us and how I put those into practice”. In one jurisdiction, Harper (CNE) described how clinical development plans were linked to national quality and safety standards and “they are the standards our nurses work against so that’s what we … assess them on”. Many participants mentioned professional practice or competency frameworks and models of care, which Haley (CNC) described as “an expected level of care, and an expected best practice framework to work within”.

Applying local policies to CFHN practice

Participants described a range of competency frameworks, policies and guidelines that were specific to their health jurisdictions. They noted that these documents were driven by what each local service offered, particularly in regional, rural and remote services, and may be used by other health professionals, not just CFHNs. In remote areas, Anna (CNC) explained, "the clinical practice guidelines for remote area nurses had to cover all nursing staff, so it is more than child family health". She then referred to the treatment of illness, "it will tell this is what you do with this, and these are the treatments they will have to provide". Hilda (CNS) described a state strategic policy for supporting families, and "all the clinicians, were actually given a copy and the expectation was that we will be reading that and referring back to that in practice". Mandy (CNC) commented that in her jurisdiction, there were multiple practice manuals, including the "universal practice manual, the collaborative care practice manual, the enhanced levels of care and there is the early parent group facilitators guide; they've got hyperlinks to everything there". In contrast, another participant noted that there were no specific documents in her jurisdiction. Sofia (NUM) chose one overarching state document because of "it's big focus on the first 1,000 days in child health" to guide her practice and that of her staff.

Lily (NM) described her jurisdiction's documents related to competence as guiding principles of practice "designed not to be definitive in the sense of it's not directing to do this. It's designed so that they were operating within the principles of their practice". Participants explained that most of the documents they used were located on the jurisdiction's intranet page, and while they were aware of how to access them, they did not always know the documents in detail. Other participants, like Greta (CNE), commented that quality in practice needed to be more than just being aware of standards, policies and procedures. It was about actually putting contemporary evidence into practice. Greta explained:

> *It's implementing what's out there as what's been up to date, what's been researched based, what's in evidence, implement changes to practice and maintaining that at a high level as well. Not just you know alright, here's a new procedure, here's new policy, here's a new way of doing it. It's actually then doing it, rather than just printing it out and sticking it on the internet. It's actually ensuring that practice matches up with the paperwork, so to speak.* (CNE)

Standards of practice used by CFHNs

In terms of documents that benchmarked competence in practice, participants referred to the use of a range of national standards of practice, but there were no consistent responses from the participants. Their perspectives varied depending on the jurisdiction in which they worked, although most participants did refer to the Nursing and Midwifery Board's standard of practice for

registered nurses and midwives (Nursing and Midwifery Board of Australia, 2016a, 2018). As Greta (CNE) noted, “so, you’ve got to show when you do a reflection that you are a competent nurse in NMBA standards”. Ava (CNC) stated, “Competency, again, I suppose, is about safe practice. Being able to work autonomously and adhere to professional standards”. Participants described competence in child and family health nursing practice as working within a code of conduct and professional practice regulations. The onus is on each CFHN to meet nursing registration standards to be able to practice. Whilst participants referred to these standards, Amelia (NM) questioned whether these standards were used as a measurement tool for competence in practice. She commented:

> *Even though we could refer to these, how do we measure that? We measure someone against you know, the Registered Nurse competencies or midwife competencies, or even looking at the MCaFHNA the core competencies or looking at the Victorian competencies. How do we actually measure that? Yeah, we don’t really have a tool that we can easily measure that.* (NM)

In addition to the registered nurse standards, another participant noted that her jurisdiction focused on the Standards of Practice for Children and Young People’s Nurses (Australian College of Children & Young People’s Nurses, 2016). These standards were promoted by senior management in their jurisdiction over the National Standards for Practice for Maternal, Child and Family Health Nurses in Australia (Grant et al., 2017). Sofia (NUM) clarified, “So I have both of them here. But I’d lean more towards the ACCYPN standard because that’s what the jurisdiction [sic] is looking at adopting”. Poppy (CNE) suggested that the National Standards of Practice for Maternal Child and Family Health Nurses in Australia (Grant et al., 2017) could be used to guide students and new CFHN clinicians through self-reflection of clinical practice. She explains, “Sometimes I get them to identify what standards they’d like to look at and then finding something where I think I might have had some feedback, where it would be good to have some reflection on this area”.

Other participants stated that the National Standards of Practice for Maternal Child and Family Health Nurses in Australia (Grant et al., 2017) were not always spoken about or utilised by CFHNs to reflect on the quality and competence of their practice. Pippa (CNC) commented, “I think that there’s a very poor understanding. I think that child and family health nurses, again, I’m probably talking more for the rural areas and regional areas, they’re very much around their day to day” and didn’t understand how that connected to standards of practice. Selina (CNC) remarked that although these standards are promoted in observation of child and family health nursing practice in her area “we don’t see evidence in the conversations, you probably aren’t seeing a shift in language or using a structure that really reflects that they have really considered the implications”

and connect the maternal child and family health standards to their everyday practice. The participants acknowledged their familiarity with several documents that informed their child and family health nursing practice. They expressed uncertainty, however, regarding the practical use of these documents in their day-to-day work and their relevance to ensuring quality and competence in child and family health nursing practice.

Professional development through education and training

From the participants' perspectives, jurisdictions promoted education and training to provide professional development for CFHNs to maintain or improve the quality and competence of their clinical practice. Most participants described mandatory training as the initial process used to monitor their competence. What that looked like in practice, however, differed in each jurisdiction depending on the child and family health services offered.

Mandatory training and Inservice in jurisdictions

Abby (CNS) described mandatory training in her regional service as a combination of general health service, for example, basic life support combined with specific child health such as safe sleeping. She pointed out that "a lot of the time the child health specific ones aren't mandatory but are very strongly encouraged in kind of child health policies". Bella (CNE) commented, "As the educator, I can run a report and see who's completed in the timeframe that they need to be done". She had to encourage CFHNs to complete online learning packages for child and family health nursing skills, such as hip dysplasia. Bella (CNE) questioned whether "we make sure that people are working with best practice and being driven by current evidence" when a completed learning checklist was all that was required to deem a CFHN competent. Another participant, Kylie (NUM), described child and family health specific training that was only available for a specific period, for example, "the Aboriginal cultural sensitivity training, that's no longer, you can't access it". It was deemed necessary by the health department in her jurisdiction, yet when new staff were employed, they could not access the information. She noted that this had made it difficult for staff to update their current practice. Whilst participants described a range of mandatory training, one aspect that was the same across jurisdictions was an annual immunisation training update for all nurse immunisers. As Carol (CNE) described, "When you are an immunisation provider, you attend annual updates, do an annual eLearning and make sure that your CPR is up to date, that you've done an annual anaphylaxis training". Many CFHNs are nurse immunisers, although being an immuniser is not mandatory in child and family health nursing.

Participants described the expectation of their jurisdictions that they make time in the workload to attend professional development to update their clinical practice. One jurisdiction has a state-wide approach to the education of CFHNs, as Lily (NM) explains:

> *Usually, it gets rolled out as with the new initiatives, so for example, we've just had cultural competency training of 10 and a half hours, and every Maternal and Child Health Nurse across the state has just done that, that was facilitated by the department and every local government area then had to ensure that their staff all attended.* (NM)

Participants in regional and rural settings commented that regular in-service updates were often online as Maya (NUM) described, "It might be toilet training, it might be a crying baby, and it's done from the central office, and everyone logs in, they might get a guest speaker; it's a great way of doing that". While online training was becoming more common since the COVID-19 pandemic restricted access to face-to-face training, this mode of education did not suit all participants. Holly explained, "With documents like the First 2,000 days, before we would have had those cluster network meetings, it would have been discussed there, read through, I would have known a bit more about it than just here's the document". Selina (CNC) commented, "we're giving them time at work to complete those chapters and really supporting their learning and it was surprising how many people didn't complete it or have still not completed it". From her perspective, the CFHNs put service delivery before learning. Anna (CNC) described an initial online training series to inform CFHNs of the requirements for child health practice in remote areas. Conversely, no further training sessions tailored to the unique jurisdictional needs occurred.

Performance or professional development reviews

In most jurisdictions, participants described some professional or performance development review with their managers to discuss progress in their role or plans for education or training. Some participants like Polly (NUM) described a detailed process of individualised bi-monthly discussion that "tends to be a review of all their inputs over the year, which is by far a positive experience more so than a negative" based on the yearly performance plan they have set for themselves. She commented that the aim was to provide a positive experience through conversation and focus on a clinicians' achievement. Similarly, Mila (NM) referred to a new performance planning process with CFHNs, which was a formal six-monthly review of learning requirements and informal feedback about performance. She said CFHNs would "put their goals of what education they'd like and that's just a point in time". She also mentioned the "two-way feedback at a six-month review". She also referred to "informal feedback along the way". Another

participant explained their new workplace process that was generic for nursing and involved peer review and discussion with a manager. Sofia explained:

> *So it's a huge process … they're professional document for the 12 months. So it goes through the values of the organisation, the standards and how they can work within the National Quality and Safety Standards. And then they get a peer review from another clinician, and then we discuss that and then I do a review with them as well and discuss that. And then if we need to, we meet again in six months just to check in or sooner if there's been any time where I would bring up any issues.* (NUM)

In contrast, other participants stated that their review processes were very superficial conversations about their progress in the child and family health nursing role or writing a list of training they would like to access and not about reflective practice. Cara (CNE) remarked, "I'm struggling to do that each year, to think of another thing to do professionally outside of another degree or a different job role". Selina (CNC) mentioned that her jurisdiction's review processes "can be very superficial and I don't think that is the most robust way of checking in if someone is competent". Carol (CNE) expressed concern that, in her jurisdiction professional development reviews "aren't compulsory; they are offered, but not required". She noted that the process relied on staff bringing their requests or concerns to management or clients reporting issues that prompted a performance review. Participants identified that organisations employed various methods, such as mandated training, online education, and professional development reviews, to monitor practice. While several participants acknowledged that the intervention enhanced their practice, others perceived it as shallow and merely a task to be fulfilled.

Summary

This chapter focused on two themes: 'governance is experienced as fragmented processes across jurisdictions' and 'organisational monitoring of CFHNs' practice is diverse across jurisdictions'. The governance relating to child and family health services and CFHNs' practice was experienced by participants as fragmented processes that varied across the jurisdictions. Accountability relied on collecting consumer feedback and clinical documentation audits to check whether CFHNs' practice was meeting the needs of consumers and provided managers with insight into child and family health nursing clinical practice. Participants noted that connecting with peers and managers was necessary for accountability in their practice and described circumstances in the workplace that influenced the quality and competence of their practice. They talked about the importance of being supported by their managers in a positive learning environment building capacity in the workforce where experienced practitioners shared their knowledge and skills. The participants highlighted that cultural competence was lacking in some jurisdictions, and their understanding of cultural practices impacted on their competence. Participants emphasised the challenges of

working in rural and remote areas with limited staff and resources. Sometimes, the service delivery key performance benchmarks impacted on the CFHNs' availability to provide quality standards of care that met the needs of children and their families. Working during the COVID-19 pandemic brought rapid changes to the child and family health workplace and required CFHNs to be flexible in their clinical practice.

From the participants' perspectives, organisational monitoring of child and family health nursing practice was diverse across jurisdictions. Orientation to child and family health services ranged from formal supportive processes with clinical nurse educators to informal reliance on mentors in the workplace. Child and family health services used case reviews and clinical assessment tools to assess competence in clinical practice. These processes, however, were not consistent across jurisdictions, particularly for regional, rural and remote participants. Documents used by participants varied from national standards to state and local policies with no consistency across jurisdictions. Whilst organisations recognised the requirement of mandatory staff training, it was generic for all health personnel and child and family health nursing topics were provided during in-services. Organisations used performance or professional development reviews to monitor clinical practice, although the opportunities for CFHNs to participate were inconsistent across jurisdictions. The next chapter will present the findings from the participant interviews relating to the professional practice perspective.

CHAPTER SIX: INTERVIEW FINDINGS – PROFESSIONAL PRACTICE

The preceding chapter presented the findings of the participants' perceptions regarding how documents and processes were used within their respective organisations to govern and monitor child and family health nursing practice. This chapter presents the participants' perceptions of the professional practice of CFHNs and their efforts to maintain quality and competence in the specialist practice of child and family health nursing. The transcriptions of the interviews were analysed to explore how quality and competence in child and family health nursing are exemplified in the CFHNs' role and maintenance of clinical practice across health jurisdictions.

This first section of the chapter presents an overview of two main themes and their sub-themes that emerged from the analysis of the interview transcripts: CFHNs' role lacks uniformity; and Maintenance of individual CFHNs' practice lacks clarity across jurisdictions.

Overview of themes and subthemes

The findings presented in this chapter are organised into two overarching themes and their corresponding sub-themes to elucidate the participants' understanding of quality and competence in the context of child and family health nursing practice (Figure 6.1). The first theme, 'CFHNs' role lacks uniformity across jurisdictions', presents the sub-themes that deal with the foundation and scope of the CFHNs' role and how it is influenced by leadership and management. The second theme is 'maintenance of individual CFHNs' practice lacks clarity across jurisdictions' and is presented through the sub-themes related to reflective practice, peer support and professional development. Direct quotations were extracted from interview data in order to offer comprehensive contextual insights into the perspectives and encounters of the participants on the quality and competence within the specialised practice of child and family health nursing.

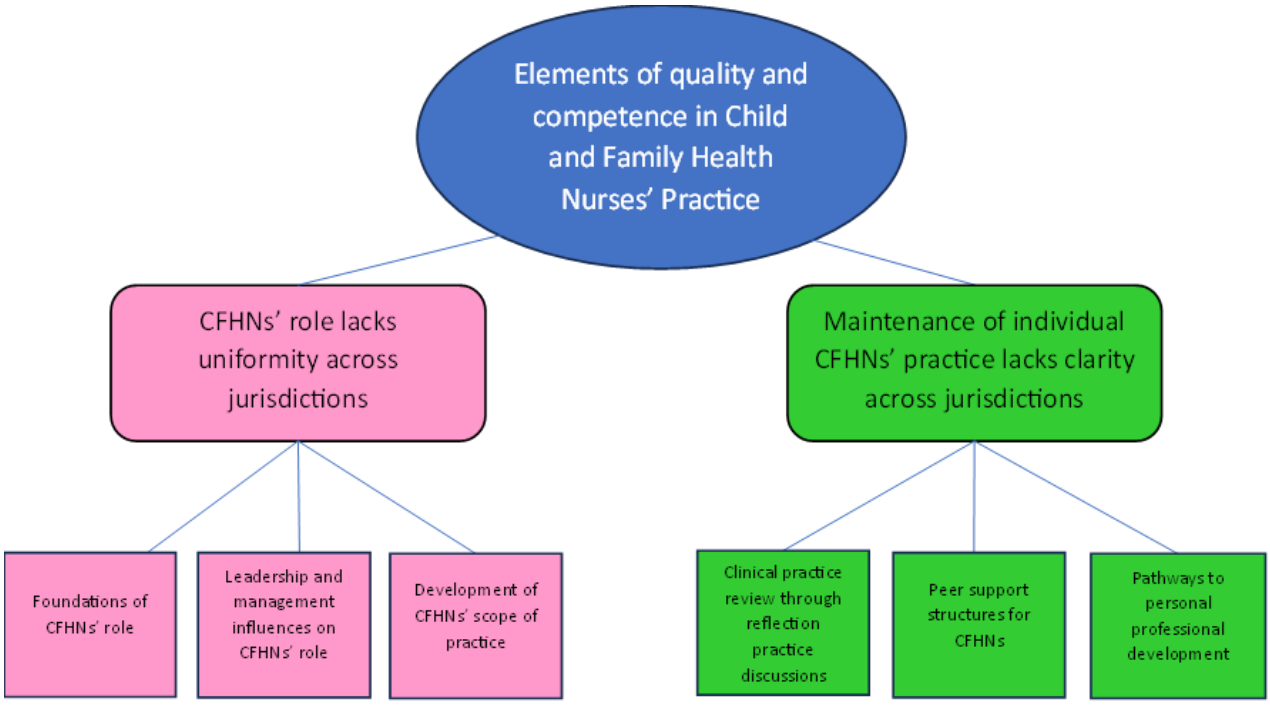


Figure 6.1 Interview analysis: Professional practice perspectives

CFHNs' role lacks uniformity across jurisdictions

This theme was drawn from an exploration of the participants' perspectives regarding the CFHNs' role and the complex factors that shape the role across different jurisdictions. While there are foundational core skills and knowledge that all CFHNs acquire at the beginning of their practice, participants described varying influences on how these skills and knowledge were developed in clinical practice in community-based settings in jurisdictions all around Australia.

Foundations of CFHNs' role

The role of the CFHN has undergone changes through time, as observed by participants. Initially focused on conducting task-oriented assessments of an infant's growth and development, it has now developed to encompass relational work involving the child, family, and community. Participants noted that previously, connection and support happened in the waiting rooms of child health clinics. Mothers conversed and supported each other with minimal input from CFHNs except through monitoring the growth of infants and giving feeding and settling advice. Participants described the increasing awareness to explore the needs of parents and their experiences of parenting.

Changing roles within CFHNs' practice

From participants' perspectives, CFHNs had more than one client, both child and parent, in every health consultation or health interaction. They reported that their role included completing child growth and development assessments and exploring family dynamics through psychosocial and domestic violence screening. The interpretation of growth and development assessments has long been the foundation of child and family health nursing. As Sarah (NM) described, "Child and family health nursing is so holistic, and it includes hundreds of those kinds of tasks". Participants noted a shift in focus to keep the child in mind and consider their mental health and well-being, along with exploring the parenting experiences with an increased focus on parental mental health and well-being. Sarah (NM) clarified the importance of recognising parents' vulnerabilities but not forgetting there is a child in the picture as well by "continually checking how is the child doing, you know, what evidence is there around the child's development and mental health? I think the understanding around infant mental health has really grown".

During the interviews, participants described the importance of understanding psychosocial screening, referral pathways and reporting mechanisms. Anna (CNC) explained, "As an outreach child health nurse, you understand your growth charts, your developmental assessments and complete online training that teaches you about the referral pathways and statistics on domestic violence and mandatory reporting and stuff like that". The expansion in the CFHNs' role required a supportive framework around questioning clients about psychosocial issues as Holly (CNS) noted, "I think it's really important before you ask those questions. No good asking them if you can't do anything, otherwise there was a lot of asking questions and then not having anywhere to refer". In addition to being able to provide safe, evidence-based care to families, Ava (CNC) commented that "having knowledge of the evidence base, having knowledge of local population, local community resources and having appropriate support for clinicians in the work environment" was necessary for CFHNs to perform their role.

Challenges for CFHNs in the workplace

In rural and remote areas, CFHNs described their role as diverse. For some rural CFHNs, that meant they had multiple roles to perform because of available work hours or geographic location; therfore, they were identified not only as CFHNs but also as registered nurses and midwives in other settings. Eadie (CFHN) explained:

> *What I do is really tricky, because I still, like I'm between so many roles at the moment, because I do still do some general nursing, and I do still do some midwifery work. And I do this child and family health role. I'm sort of passionate towards all three. And in my head, I'm still a nurse. (CFHN)*

In more remote areas of Australia, participants noted that the need to care for children across the health spectrum from illness to wellness required them to be the CFHN and the Remote Area Nurse (RAN). They worked beyond child health assessments, immunisations and child/parent relationships into disease management. Fran clarified, "In that remote setting the CFHN is a little frowned upon if they don't look after the sickies and continue the antibiotics and follow them up, then do the iron injections for poor anaemia rates". She added, "There are things that become really clinical here in remote work that's just so far from the maternal parenting relationship work". Another participant described RANs as working in an illness-focused model in contrast to CFHNs working in a well-health model. Pixie (CNS) said "I view that they are in the river pulling people out and we're at the top of the river trying to stop them falling in. That's the difference". CFHNs had to advocate for themselves as clinicians in a workspace that operated in a biomedical model, even though both nursing professions worked in prevention, promotion and early intervention as opposed to primary care.

All the participants described a lack of understanding of the role of CFHNs from other health professionals who did not understand the complexity of the work involved, the importance of child health assessments or that CFHNs worked in primary health care in the community. Regardless of whether the participants worked in metropolitan, regional, rural or remote areas, they all at times encountered similar attitudes from other health professionals. Molly (CNC) commented that "the old, all you do is weigh babies, is still very much out there" from the health professionals in her jurisdiction, "whether it be executives, who don't know the whole deal or whether or not you're in the hospital with the midwives". Mary (NUM) remarked, "I think we're still seen as you weigh and measure babies, yeah. They don't understand the complexity that comes with every family". In addition, Pippa (CNC) noted:

> *I think child and family health in general is very poorly understood, very poorly understood across the district. And it's not just our district but everywhere, people still think we weigh babies. And that's all we do. So, I think there's a lack of that understanding of what our role is.* (CNC)

The participants defined themselves as child health specialists with autonomy as sole practitioners, relating to independence of practice and physically working alone in clinical spaces. They described the unique setting in child health where the day-to-day workings of the CFHN are not as visible compared to nursing in a traditional acute setting. In the acute setting, you have

inexperienced nurses working side by side with experienced nurses, all working as a team side by side. As Hazel (CNC) explained, “In child health, you know, a really common scenario is, you have a single practitioner alone in a room with a family”. Bella (CNC) stated that the challenge of working independently is that “we all sit in our little offices, doing what we believe to be the right thing, same things in the way that we’ve been trained to maintain competence or to gain new skills”. She further commented that by working independently, “we so rarely have the opportunity to sit in with other clinicians, not necessarily to judge or measure their competence but to learn from them as well”. Poppy (CNE) expressed her bewilderment at other nursing colleagues who only recognised a speciality if it were connected to a nurse practitioner (NP) pathway and did not appreciate how this differed from child and family nursing practice. Poppy (CNE) explained, “People who are on the nurse practitioner pathway think that as child and family health nurses, we should be in paediatrics”. She exclaimed, “Why do we want to put a biomedical model on a family partnership model? I do see an advantage of being an NP, as maybe I could write an ultrasound form for baby with clicky hips”.

Qualifications to practice as a CFHN

The majority of participants stated that having a postgraduate CFHN qualification was a critical element of the CFHN role. The postgraduate qualification meant that CFHNs had the required training and resources to be able to perform their roles. As Anna (CNC) commented in relation to rural and remote areas, it is “expected then that you have completed that two year postgraduate qualification for child health”. With minimal support available once the CFHNs are out in the community, she noted, “We really rely a lot on the postgraduate qualification; at that level you are independent, no one’s going to tell you what to do”. Another participant, Ava (CNC), talked about qualifications in child and family health nursing being important to be able to work to “top of license, so maintaining safe clinical practice, both for themselves from a legal perspective and to provide safe evidence-based care to families”. According to Carol (CNE), having “an extra qualification on top of just the community nurse” was essential, as she felt “the integrity of the child health nurse would be lost if they didn’t have that qualification”.

The participants commented, however, that child and family health nursing qualifications were not always seen as equal if qualifications were completed in another state or were from an older course. Helga (CNC) noted in one jurisdiction, “There are courses that we actually know are accredited, we just go through and make sure that according to the standards they’ve actually met everything that we are happy with” for CFHNs to be employed in this jurisdiction. To be employed

in a CFHN position, Hayley (CNC) noted, “We have to be rigorous in making sure that they have been through an endorsed course and that they’re not employed unless they have”. Only one jurisdiction in Australia has legislation to support rigorous standards in the employment of CFHNs. Amelia (NM) stated, CFHNs must be “registered nurses and midwives as well as [holding] postgraduate qualifications in child and family nursing”. Competence in child and family health nursing practice from participants’ perspectives was related to having postgraduate qualifications to enable CFHNs to work to their full scope of practice and as Polly (NUM) described “it’s a very specialist” role and “it’s very targeted to an age group”.

Participants in other jurisdictions described changes in their workplaces with a move against requiring specialist qualifications in order to be able to recruit and maintain a child and family health workforce. This change was perceived to have been achieved covertly through advertising, stating the desirability to have a postgraduate qualification rather than a requirement. Managers had to use their discretion during the recruitment process to shortlist appropriate candidates. Sofia (NUM) described, “I can pick and choose when I shortlist and I always add as the panel chair, has postgraduate qualifications, but we can’t mandate qualifications here for child health”. Juxtaposed to this approach, is the position taken by another jurisdiction to be more flexible in recruitment to employ staff without a CFHN qualification and provide health service based training as a way to combat workforce shortages. As Sarah (ND) explained:

> *Things are changing probably as well, in that we know we can’t expect that people are going to come with the qualification at the point of employment, people are having to recruit more about potential people and the attitude that people come with. And then to know that some of the skills and competencies, we will need to invest in them on a journey to get* them *there.* (ND)

Another participant expressed concern about the employment of nurses without a postgraduate child and family health nursing qualification and the reliance on preceptors to support them in completing a workbook to demonstrate skills and knowledge in child and family health nursing. Harper (CNE) stated, “I feel we’re handing this all over to the preceptors, who are all under the pump and there is potential there for things to get missed”.

Leadership and management influences on the CFHNs’ role

The challenge for CFHNs is leadership that understands the complexity of the role and management that is cognisant of working in a community-based setting. While participants worked in community-based settings, their workplaces were often managed by staff from a broader service programme or an acute hospital setting where the manager may not even be a nurse, let alone a CFHN.

Uncertainty created by lack of development in leadership

In one jurisdiction, participants described the disruption in leadership roles when they were governed by a non-health entity that required the CFHN to be a team leader and a part-time clinician. As Lily (NM) explained, "If you've got a non-clinical maternal child health coordinator, you might have clinicians that are the team leaders underneath them. So, they would be the ones that would be monitoring the staff practice and performance type things" in addition to their clinical roles. Another participant noted that leadership roles might come with a title, but in a practical sense, they received very little time in their workload to review clinical governance or practice. Previously, in her workplace, Kylie (NUM) noted, "There was a token team leader, but they had a full workload". She further described having to put a business case together to get "team leader positions that actually were client free. I got one of them. I got one day a week". Without sufficient time to review and monitor clinical practice, participants noted that these processes were never prioritised in their workplaces. In another jurisdiction, a senior manager was in an acting leadership position, so processes to support the review of child and family health nursing practice were not completed when they moved on to another position. Hazel (CNC) described being tasked by the Acting Director of Nursing to develop a practice portfolio that was child health specific; however, she stated "she is no longer with us" and the practice portfolio "was never endorsed or used".

Other participants commented that CFHNs might come into a management role as experienced clinicians without leadership, management education or experience. Mary (NUM) stated, "When I came in as a NUM, it was a half hour, here's a folder of the staff. This is where the centres are, off to go have a nice life". She noted the process had improved slightly with "being able to sit with the NUM, maybe have a half day to go around to the centres and talk about HR concerns". Tara (NUM) remarked that learning to manage staff issues was challenging "when you've walked into a job like this, you don't get any education or support around that, you know, you just got to kind of come across it".

Impact on CFHN practice of managers who are not CFHNs

In all jurisdictions, participants expressed concerns about having managers who did not have a child and family health nursing qualification and were from a nursing/midwifery role, allied health or not a health professional at all. Participants suggested that when senior managers within a child and family health service were not qualified CFHNs, they did not understand the child and family health nursing role or the support in practice that CFHNs required. As Mandy (CNC) explained, in

her jurisdiction, the ”director is as an allied health, she’s not a child and family health not a nurse, the deputy director is allied health social worker and other deputies are a nurse and social workers”. The managers have supported a collaborative care model of CFHNs and allied health workers. Mandy noted, “It is an 85% workforce of nursing staff with limited allied health services”. With a lack of allied health workers, “nurses are really struggling because we don’t have an allied health workforce”, and then CFHNs are doing the allied health role in addition to their nursing role. Selina (CNC) agreed that there was no an understanding of the complexity of the CFHN role “It’s more of a just get the tasks done”. Other participants in regional and rural areas also noted that child health services and CFHNs are managed in multidisciplinary teams. Pippa (CNC) stated that “the managers could be social workers, they could be occupational therapists, they could be any discipline, so they don’t have that idea of what a child and family health nurse does”. In addition, she remarked, “child and family health in general is very poorly understood across the district”.

When there was a lack of understanding of the child and family health nursing role, participants noted that CFHN positions were lost because they were not filled, or the hours were reduced as there was no one to advocate for these roles. Elaine (CNS) commented, “The challenge is having managers understand the importance of what we do”. The absence of the CFHNs’ role is apparent in annual performance review processes that fit non-health sector processes designed for administration staff, not CFHNs. As Tully (CNS) stated, “There is no clinical component, it’s nothing to do with clinical expertise, it’s actually an admin template”.

Participants commented that even if the manager had a nursing background, without child and family health nursing experience and qualifications, as Ada (CNC) described, they had a “different mindset” about working with children and families. Harper (CNE) recalled that the managers in her jurisdiction had school health and midwifery experience and questioned the value of “bringing somebody back for anything to do with the child, that’s not about child. Staff are being questioned on why they’re making these appointments and bringing these people back”. She cited the misunderstanding that parental mental health reviews were irrelevant to children’s care. Harper (CNE) further stated, “There are a number of staff that have vented that they are worried about the role being reduced”. From a quality point of view, participants in jurisdictions managed by other government services were not always aware of the ongoing education requirements for CFHNs. Kylie (NUM) commented that in her jurisdiction, the quality team leader’s “main focus is early childhood education and care”, and she was a “kindergarten teacher by profession”, so it

was a challenge for her to understand the learning needs of the CFHNs. In the rural jurisdictions, although they might work in a primary health care service, participants described being connected to a hospital health service. In the acute health sector, reflective supervision, which is an essential tool for child and family health nursing practice, is not well understood by managers and is considered more in line with formal assessments of competencies. As Pixie (CNC) explained, managers think:

> *Why would your staff need it? They're all qualified, they don't understand that it's actually a space for staff to be vulnerable space for staff to be supportive, and to move themselves into a higher level of functioning. They don't understand it. So, it's been a bit of a challenge.* (CNC)

Development of the CFHNs' scope of practice

Participants found defining their scope of practice challenging when it is confused with generic job descriptions and is not specific to child and family health nursing. Selina (CNC) expressed concern about the lack of "that maternal child and family health focus, they are too generic, and I think we're devalued ourselves as an organisation and a profession". Mary (NUM) stated from her viewpoint, "competence is working within your scope of practice and working under all our legislations, guidelines, policies and overarching policies". She noted this was particularly relevant in some child health programmes where clients may have drug and alcohol, trauma or family violence issues, "so it's really important that they work as a child health nurse, and refer on to any other areas, because they're not social workers". Another participant, Serena (CNE), indicated that to be employed as a CFHN, you would have "the skills, knowledge base and ability to undertake the full scope of the role in an autonomous setting" and the child and family health service would "be able to offer them support to undertake that role".

Core skills and knowledge in CFHN practice

Participants described that developing the core knowledge and skills required by CFHNs was linked to child health growth and development assessments. They described having the ability to perform essential growth and development assessments as procedural clinical tasks and having the flexibility to alter care based on the family needs. India (NUM) explained, "you need to be able to do your basic developmental checks and identify when to refer onwards or to seek help". In addition, she said, "I think you need to be able to conduct your business safely, safely for yourself and safely for the client and the family". Some participants stated they were unsure if skills should be assessed for competence regularly when it came to particular tasks like hip assessments or, in some jurisdictions, red-eye reflex or hearing assessments. As Abby (CNS) noted, "there are no

consistent guidelines as to how competence is assessed, for child health nurses at least in our state, not sure how it works elsewhere".

Other participants described CFHNs' competence as an individual's awareness of their strengths, weaknesses and ability in clinical practice. For Billie (CNE), core to being a competent CFHN was "looking at a clinical assessment tool, interpreting the data, and looking at where the client sits in expected growth and development". Participants suggested that it took time to develop confidence and skills beyond doing assessments and seeing the nuances in child behaviour and family interactions and interpreting the data. Pixie (CNE) remarked, "you want people who are confident and knowledgeable. Because if you're not either of those, you're not going to really understand the family and you're not going to be able to be an agent of change with the family". Selina (CNC) similarly stated, "it's their ability to read other people's body language and their ability to be perceptive" that is an important skill to develop. Participants reflected that understanding child development was important but so too was understanding parental mental health and the family as unit. Skye (NUM) stated that to able "to assess those clients and be able to pick up when there's something amiss, through listening to the parents, then being able to manage that effectively in a way that the parents and family get the best outcome". It was an important skill for CFHNs to interpret what they are seeing and engage in conversation using interpersonal and relational skills to get answers. Some participants described the child and family health nursing scope of practice as narrowing from previous expectations of having a good grounding in all ages of growth and development assessments to practice being limited. Pippa (CNC) explained:

> *I do think that the actual scope of practice of a child health nurse has changed quite drastically. And I think the new nurses coming in, they do very much think about that early days, they don't really have the same competence around that older children. I think they're a bit lost, because it's very much focused on that first, I'll say six months is probably really the first six to eight weeks, to be honest, but the first six months. That's not Child and Family Health practices we all know it should be.* (CNC)

Transition processes into CFHN practice

According to participants, entry into CFHN practice required transition processes and tools to support skills and knowledge for practice to increase the confidence of new clinicians in establishing their child and family health nursing practice. Participants explained that transition to practice programmes could be utilised for newly qualified CFHNs or nurses working in supported practice whilst enrolled in child and family health nursing postgraduate education or CFHN student placements. A large number of placement hours during postgraduate courses could support independent practice for student CFHNs in addition to initial nursing qualifications and experience.

In one jurisdiction, Amelia (NM) clarified that the expectation is that CFHNs "will be quite competent to practice individually as they're very experienced nurses and midwives as well as the postgraduate diploma in child and family health nursing". Although Polly (NUM) argued, "There's a lot of work when you take on a new grad even if they've been a student with you. We do about a year of mentoring to get them on board". She described, "They have like an hour per client for quite a while and then we allow a lot of extra time for additional trainings for them to make sure they've got all the skills they need". In contrast, Bella (CNE) described her experience as a student CFHN on placements in her jurisdiction, having limited supervision and being "in the room on your own with the CFHN in the next room so you could grab them if you needed them". She further stated, "There was a phone call at the end of that week between the student, the supervising nurse and the university to say that they thought you were safe to the beginning practitioner level. I didn't have anyone watch anything". Another participant talked about informal processes in her jurisdiction. Kylie (NUM) said, "We aim to put a new grad in the centre with another nurse. Not that it's not that the other nurse's responsibility, but we don't have a formal programme, but we do have we buddy them up".

In another jurisdiction, the transition to practice process for a qualified CFHN began with one aspect, such as an infant home visit check to gain the CFHNs' confidence in this assessment before progressing to an older age child health assessment in a clinic setting and using a clinical practice development tool to guide their learning. Pippa (CNC) reported, "I will go into a practice consultancy with them for a one to four week visit or a six to eight week visit, then look at another six months down the line doing another practice consultancy with an older child". Ava (CNC) commented that, for qualified CFHNs in the jurisdiction in which she worked, the transition process involved buddying up new staff members with more senior CFHNs and undertaking "assessments across two different clinical decisions as a way to support new clinicians to identify any gaps in their knowledge, skills or behaviour and if necessary to work with nurse educators to put a learning plan in place".

Additionally, transition to practice programmes were used to address workforce issues and employ staff who were registered nurses while completing postgraduate child and family health nursing education. Penny (NM) described a "workforce strategy to create a pathway into child health nursing and it's a 52 week course that's a 12 month contract to begin their post grad qualification in child health nursing". In another jurisdiction, Mila (NM) commented, "we've got

like five different pathways into maternal and child health. We find that we just do more of developing novice sort of people". Helga explained in more detail:

> *We have four scholarship petitions for registered nurses, and they work within the early childhood immunisation service for the first year, while they're studying their certificate, the second year that they're studying their diploma, they actually work with maternal and child health nurses, as a registered nurse one.* (NUM)

In addition, Helga described a process for registered nurses/registered midwives and said, "Because they've already done midwifery, they can work in the home visiting space, so they get through very quickly, within one year" while they are completing a postgraduate child and family health nursing course . Another jurisdiction took a different approach and looked for transferable skill sets like paediatric nursing experience without a postgraduate CFHN qualification and provided education and training within their service to upskill these nurses to work as CFHNs. Greta (CNE) described the creation of an "online learning platform of six learning packages, which is broken into modules based on the infant's age that's moving through the trajectory of growth over nought to five" that provided the skills and knowledge required to work as a CFHN.

Maintenance of individual CFHNs' practice lacks clarity across jurisdictions

This theme relates to how individual CFHNs maintain the quality and competence of their child and family health nursing practice. Participants identified that reflective practice conversations, use of reflective tools and clinical supervision were processes for them to review the quality and competence of their practice. In addition, they described informal and formal peer support as a way to gain insight into their clinical practice. Participants recognised that professional development increased their knowledge and skills in child and family health and improved the quality and competence of their practice.

Clinical practice review through reflective practice discussions

Participants described a process of reflective practice as a way for CFHNs to consider their clinical practice and how their practice might improve in the future. Reflective practice is an opportunity to depict, explore and question patterns of working that may lead to possible change in actions (Driscoll, 2007; Driscoll et al., 2019). Hilda (CNS) described reflective practice as an opportunity "to be able to look back and sort of think to yourself" She asked herself, "Are there things that I could have done differently? Are other things that I've actually missed?" Elaine (CNS) had similar thoughts on the importance of self-review or self-reflection. She asked questions such as "How did that go?" and "What could I do better?" Participants noted that part of being a competent CFHN

was using reflective practice. As Sarah (ND) explained, “Part of being competent is actually continually reflecting, seeing areas for improvement, identifying learning and development needs, I think that’s probably one of the challenges”. From other participants’ perspectives, competence for CFHNs was the ability to reflect on their work and also to demonstrate it in their practice, for example in how they engaged with children and their families. Billie (CNE) described competence as “the individual’s awareness of their ability to do the job that they need to do, in the context of developing a relationship with a client”. Greta (CNE) remarked, “Competence is not just, ‘I think I’m doing the job’. It’s, ‘I know I’m doing a good job’. I can demonstrate it in our practice and what we do with our clients”.

Using reflective practice tools

Participants in one jurisdiction described the use of a clinical practice development tool to provide an appraisal of CFHNs’ skills and knowledge through the process of reflection rather than using it as a skills assessment. Hayley (CNC) noted, “It’s not really an assessment, so to speak, it is really about reflecting practice, and looking at confidence and competence. It’s about being honest with me and with themselves”. Ada (CNC) talked about using the reflective tools with CFHN students to “identify their level of competence” during clinical placements in child and family health services. In addition, participants mentioned that reflective practice could be used to support staff who were experienced CFHNs to build their skills and enthusiasm beyond their current clinical practice. Hayley (CNC) explained:

> *So, you know, some people are exceptional at their work, and they need to be also feeling like they’re still getting something. So, you might explore, what are some areas that you’re passionate about? Have you thought of doing a quality project? Have you thought of, you know, how do we try and build skill beyond basic area of practice?* (CNC)

One regional jurisdiction used a programme-based approach to support reflective practice. The participants from this jurisdiction described this process as a way to hone their skills in the programme and be supported in guided reflective practice. Abby (CNS) referred to “family partnership training and its guided reflective practice” to work through “tricky situations” in clinical practice.

Dedicating time to clinical supervision

Clinical supervision is defined as a prescribed time for facilitated, in-depth reflection on clinical practice (Driscoll et al., 2019). For Willow (CNE), the concept of clinical supervision as a time “dedicated to critical reflective practice” was more than “just having a chat to a colleague”. For her, clinical supervision was an opportunity to collaborate with colleagues, “people that aren’t

necessarily in your teams, they all bring different knowledge and it's always better for our practice". Similarly, Helga (NUM) noted that having a mix of experience in the clinical supervision group was valuable, particularly for junior staff to "cross pollinate if there is a combination of people across the regional teams". One rural participant described clinical supervision as an essential medium to help CFHNs work through clinical issues that confronted them. She explained that these sessions could help staff identify strategies to move forward, adjust their perspective and manage their expectations of their clinical practice. Pippa explained:

> *I think clinical supervision, reflective supervision is absolutely essential. I think all child and family health nurses should be getting it. I think supervision helps with quality and competence by being able to work with nurses around case discussion. I will say that in clinical supervision, case discussion often comes up, talk about cases. But it's actually being able to move them back to around how and why that's come up? Why is this a big issue for you? What's going on with you, that makes you feel that this is something you're not necessarily feeling that you're managing that? And usually, we bring it back to the nurses around her feeling confidence or lack of confidence.* (CNC)

Similarly, Eadie's (CFHN) reasoning was that clinical supervision provided an opportunity to gain a different perspective on her clinical practice. She said, "it gives you an outlook on a situation that might be from the outside and work out what you're learning from that situation, what you're taking away from it, and what you're putting into it as a professional". Participants described different structures of how clinical supervision was provided and how they viewed the experience of clinical supervision. Ava (CNC) remarked that clinical supervision was "a safe and confidential space that people have that feeling towards". She continued, "it's this sacred space". For this reason, most participants agreed that it was important not to have their immediate manager or CNC as the clinical supervisor to provide an opportunity to explore their thoughts about clinical practice freely. Hilda (CNS) reiterated that the functioning of group supervision depended on who was in the group and "the trustworthiness within the group and the confidentiality within the group". She further stated that if "there is some flexibility" with group formation then "clinical supervision is a wonderful place, a non-threatening sort of environment for you to look individually at your work practice". The participants explained that having the right skill mix and a combination of staff who do not usually work together is essential for confidentiality, learning opportunities, and strengthening the child and family health service.

In contrast, Helga (NUM) described her jurisdiction's clinical supervision structure that had peer-led reflective discussions. She stated, "The staff really enjoy that what we have is peer driven and they coordinate clinical reflective practice sessions for a group of around five to six staff". The group decided the format of the session. The catalyst to stimulate discussion could be a client

case, research paper or another learning experience. In addition, Helga (NUM) commented, “We have provided extra training, to the clinical reflective practice leads, to be able to help support them supporting the rest of the staff, but it is working very well”. Other jurisdictions employed outside clinical supervisors, for example a psychologist, as the participants felt it was important to have a highly skilled leader of the sessions. Tara (NUM) described that engagement of an external clinical supervisor as being “a really good learning opportunity for all of us” both for managers and CFHNs. She went on to add that the external clinical supervisor “has been available to follow up and do some debriefing and unpacking in a timely manner” . All participants agreed that regular and timely access to clinical supervision was essential to support quality clinical practice, but this was not always possible in their jurisdictions.

Differences in access to clinical supervision

Monthly or bi-monthly group supervision was the common structure for most participants. Individual one-to-one clinical supervision sessions were typically offered to CFHNs working in programmes with highly complex clients. Participants noted that the frequency of the clinical supervision sessions were dictated by funding, availability of supervisors, workload or negative experiences and lack of support from management. In contrast to the expected format for clinical supervision, for some participants, the only option for clinical supervision was with a line manager. Mary (NUM) explained:

> *I’ve never had a problem. These are autonomous workers, they actually find that you care enough to ask then, how are you? How are things going? I’ve always said to them, if there’s any performance management issues, it does not come under supervision, there will be a separate meeting. So, it’s seen as supportive, it’s seen as discussing complexity within their workload, it’s about discussing the environment they work in, it’s about discussing any deficits that they might have, or any celebrations they might want to share. And it’s also about talking about, well, this is what’s happening with this client, these are the resources I want. And then it’s up to me to say, well, that’s something I can support or not, let me take it to my manager, it is a very supportive model.* (NUM)

By comparison, in the same jurisdiction, the consistent, supportive process from upper management was not afforded to NUMs who provided the clinical supervision. Mary (NUM) commented that her clinical supervision with her manager was “around issues with nurses” and not tailored to supporting her role as a manager because “anything you bring up, it’s seen as whingeing”. Another participant suggested that prioritising clinical supervision was challenging with limited clinical supervisors, part-time and low staff numbers. Abby (CNS) reported that “its very ad hoc, the supervision for child health nurses, lining up the days that you’re all there, it can be difficult”, particularly when the clinical load is prioritised.

Participants from rural and remote areas expressed their frustration with little or no access to clinical supervision because of remote workplaces and the lack of understanding by their management of the that role supervision played in supporting CFHN clinical practice. Pixie (CNE) described having to argue for funding for six sessions a year to enable reflective practice in her jurisdiction, as management did not understand the concept of reflective practice to enhance clinical practice. Pixie stated, “They don’t understand that it’s actually a space for staff to be vulnerable, space for staff to be supportive, and to move themselves into a higher level of functioning” . Another participant, Poppy (CNE) was asked by management to explain why nurse educators could not supervise clinical practice with qualified CFHNs and she had to explain “the importance of clinical supervision with a trained psychologist” was not about overseeing the practical application of skills but supporting a more profound reflection into clinical practice.

Several participants were particularly critical of being offered employment assistance counselling programmes instead of clinical supervision or management’s suggestion that they meet with colleagues to discuss their workplace issues. They said that neither option was appropriate for reflective practice. Anna (CNC) stated, “What they wanted is just someone that could have a meeting and talk about issues. But if you don’t have anybody trained to facilitate, then it can end up with just one person debriefing on everybody”. Fran (NUM) noted that counselling services were not a good option, and remote work made it difficult for CFHNs to commit to timeframes for these services. She remarked that, with limited timeframes offered by counselling services “our nurses are out remote and trying to get them in on that same day can be difficult. So, they’re really struggling to actually say they can confirm that they’ll be at a supervision”.

For other regional participants, clinical supervision in their jurisdiction had been hard to implement because of a lack of understanding by management and team members who were not invested in the change to practice. Sofia (NUM) remarked, “We probably didn’t spend enough time talking about it” with staff as it “wasn’t correctly implemented because it didn’t last long, I think we did it for six months”. In another jurisdiction, clinical supervision functioned as an “opt-in system”. Harper (CNE) commented, “We did a trial, or I should say it was compulsory for a short length of time, but that didn’t get off the ground very well”. Elaine (CNS) suggested that newly qualified, inexperienced CFHNs may wonder, “How am I going to benefit from that?” and how they will use clinical supervision in practice. Another difficulty with access to clinical supervision encountered by participants was a change in the mode of delivery to online platforms during the COVID-19 pandemic. Molly (CNC) suggested, “I don’t think the nurses valued supervision like they

did, especially with COVID, because of the Skyping[1]". Molly (CNC) indicated that CFHNs were conflicted as "they kind of want to go back to face to face, but they don't want to because it impacts on their workloads". This scenario made it difficult for some CFHNs to prioritise their reflective practice over workload, even when they could return to group supervision. Another participant noted that resistance to attending clinical supervision came from poor experience. Elaine (CNS) felt that she was resistant about going to the next clinical supervision because "I had a poor experience and it wasn't helpful, and it was actually quite traumatic and destructive, which I was very surprised about".

In contrast, some participants did not want clinical supervision and valued case discussion or case review instead because they wanted direct answers to their queries. As Pippa (CNC) remarked, "I have had a couple of CFHNs who went to supervision and wanted it to be a case review or a case discussion. When we were trying to move away from that, they were like, oh, but I just want you to tell me what to do". Novice CFHNs or CFHNs who were struggling with managing their workloads did not value reflective supervision to enhance their clinical practice as they just wanted answers to help them complete their work with clients. Participants found access to suitable clinical supervisors difficult without supportive managers who understood the difference between reflective supervision and case discussion concerning quality clinical practice. Other participants commented that, while they valued reflective supervision to support their complex clinical practice as CFHNs, the mode of delivery, online instead of face-to-face sessions, impacted on their positive experiences of supervision.

Peer support structures for CFHNs

Peer support was a concept mentioned by all participants that ranged from informal processes like debriefing with colleagues to formal peer reviews and networking at team meetings. Participants described an informal process of more experienced staff working alongside less experienced staff. Mila (NM) remarked that in her jurisdiction, "we've really tried to develop a supportive culture that nothing's too silly to ask. No-one's going to ever think less of anybody. I feel like we've got a learning and supportive culture". In addition, participants commented that having CFHN managers and peers who could support their learning was very valuable. As Fran commented, "We work differently, everyone has a different style, but you can actually learn from everybody, we never stop learning". Other participants agreed that knowing they could gain new insight from others

[1] Skype is an online video link platform

and share experiences was a valuable opportunity to improve the quality and competence of their practice. Participants sought support informally through a chat in the office or speaking to a colleague on the telephone. Maya (NUM) remarked on her connection with a newly qualified CFHN, “She’s always on the phone talking to me, because she’s quite a new practitioner, she knows that if something happens, they prefer to talk to me or each other”. In addition, she described a workplace environment, “we have got little pods there and we sit around and, you know, discuss something that’s troubling us”, that cultivated the opportunity to connect with peers.

An informal debrief explained by participants was an opportunity to connect and create a safe space to discuss challenges in clinical practice and give feedback to support learning. In the rural and remote areas, participants remarked that having a buddy system was valuable for integrating new staff into the child and family health services. As Anna (CNC) explained, when a CFHN commenced employment, “either myself or another CFHN who has been in the position for a while, we’re traveling with a person and teach them because the training is all about the system that they’re going to use”. Poppy (CNE) had a slightly different focus with a weekly meeting when somebody was new to her team and asked them, “How you are going, how’s your week, highlights, crappy bits, everything in between?” She felt that it was necessary to follow up on CFHNs’ welfare as they developed their clinical practice in the workplace. The challenge, participants noted, was having funding and time allocated to integrate staff gradually, giving them space to consolidate their skills and knowledge to gain competence in child and family health nursing practice. Serena (CNE) explained:

> *I think one of the biggest problems and the biggest fight is about the money to get the time to be supernumerary to gain the skills towards their competence. So, I feel there’s a lot of pressure for me to sign somebody off that they are competent … staff really would need a little bit extra time. And that makes it hard when managers don’t appreciate how much goes into making a MACH* [Maternal and Child Health] *nurse responsible, reliable and competent.* (CNE)

Mentorship

Some participants use the word ‘mentorship’ when describing the process of an experienced CFHN engaged in supporting a less experienced CFHN. The process, they explained, was about working individually in a clinical spaces and having time allocated each day or week to review queries about clinical practice. As Bella explained:

> *So you’ll always have another clinician in the building. They’ll be seeing their own clients, but at least you’ve got the opportunity, if there something you’re really unsure of, to go and ask another clinician. So that would be the first time you sort of fly on your own, to have someone in there that was sitting with*

you or that they could be in the room next door, and you can just come and get them if you need them, and they wouldn't be seeing clients of their own so that they're more accessible. (CNE)

Hilda (CNE) commented that mentorship often occurred when CFHNs were introduced to another part of the child health service, like new parent groups; "they would actually be mentoring someone in new parent groups that haven't actually done those before, sitting in and giving feedback" on their facilitation skills. Following initial CFHN training, Pippa (CNC) expressed the view that "I'd be expecting the mentor to support that CFHN in her practice, reflect on what she's doing, be able to think about where she needs more support, to ensure that she is feeling confident and competent to actually practice autonomously".

Participants who worked in rural areas identified that having support available was a challenge when they worked in isolated clinics. In addition, public health orders impacted on travel during the COVID-19 pandemic, which isolated rural CFHNs from senior and experienced clinicians to support them in transitioning into practice once they had gained a postgraduate qualification in child and family health nursing. Eadie (CFHN) described her and her colleagues' experience, "I think we both found the last 12 months quite difficult during COVID because we didn't see each other for months, we would talk every second day about clients and handovers and stuff like that". She noted they had limited orientation to the CFHN role, including clinical practice support conducted primarily via online platforms or telephone instead of face-to-face interactions. Eadie said, "different things that might have been planned for us like team days where we could go over, policies or ideas of how we're going to run things, just all went out the window with COVID". During this time, CFHNs had to rely heavily on transferable skills from previous health roles, such as midwifery, to facilitate working independently, often as sole practitioners.

Other participants supported a formal mentorship programme that encourages constructive feedback in a structured process and provided guidance and support about their developing child and family health nursing practice in general. Billie (CNE) described her experience with a mentor, who was a nursing director, "She meets with me once a month. I would see mentoring is more about just providing advice and guidance, questioning and supporting, just general support" to develop a CFHN career pathway. Participants acknowledged that mentorship was required when CFHNs transitioned to senior roles without specific training to fulfil those roles. Ada (CNC) felt that "as a new CNC it's very important to have your own mentor and you're learning all the time from the more experienced CNC's and probably adapting some of their ways into education and training". In this way, connection through CNC network meetings facilitated access to mentors.

Networking

Participants mentioned networking through CFHN team meetings or multidisciplinary collaborations as an opportunity for workplace exchange and working in partnership with other colleagues. Whilst team meetings were in a formalised timeframe, participants cited them as an informal networking opportunity to explore many facets of their CFHN practice. Harper (CNE) remarked, "We've had queries that have come out to meetings that have led to group education when a number of staff have commented that they needed upskilling or refreshing on something". She noted that clinical practice updates, that provided learning and networking opportunities had disappeared from their workplace calendars. Harper said that staff "really valued those[updates] because we would get updates from different guest speakers. It was a good time to network as well with their colleagues. More importantly, they felt like some of the organisation was invested in them". Without this opportunity, she commented, "I think our staff feel like they're just another number and now they feel very undervalued".

Regional participants in one jurisdiction welcomed the opportunity in their monthly meetings to get feedback or support and connect with other CFHNs, as they usually worked in isolation. Cara (CNE) reflected, "A child health nurse meeting here starts at lunchtime, and it often goes past four. And I think a lot of the time, it's just that a lot of these people are working in isolation. That's the networking". The meeting presents an opportunity for CFHNs to get support in a collaborative environment. Tully (CNS) remarked that "talking about cases, providing education, so people will have input into what they think the course of action should be or just start talking one-on-one to other staff as well." Team meetings presented the time and space for exchange of ideas. Holly (CNS) emphasised that networking, particularly in person, was necessary. Even though the CFHNs in her jurisdiction had met monthly online for education, with many people on the call, it was hard to ask questions and chat about issues. She described past district-level face-to-face meetings that supported CFHNs to network and share their stories about implementing child and family health nursing practice in their jurisdictions. Holly (CNS) commented, "We've got different great ideas and different ways of doing the same thing" and sharing helped to validate competence in practice for CFHNs who worked in isolation. Additionally, participants described connection in rural and remote communities as a very important part of supporting clinical practice and the clients. Anna (CNC) explained:

> *It's that building of relationships with other early childhood services. Yes, very important in your practice. You've got four communities, there are only four weeks in a month, how can you be in those clinics every week? You can't. So you have to be a partner with families as first teachers. Those are very early*

childhood programmes, the play first, I think they mesh for any early childhood programme, we need to be in partnership, because you can't do this on your own. (CNC)

Pathways to personal professional development

Undertaking professional development was identified by participants as a critical part of maintaining quality and competence in their child and family health nursing practice. Lily (NM) noted, "We have a professional obligation with our general and midwifery training to maintain registration". Completing a required number of hours of continuing practice development was part of this process. In some jurisdictions, CFHNs can easily access educational opportunities offered by the health department. Tully (CNS) noted, "Each year that we have a conference with guest speakers and are provided other educational opportunities for example, there's the cultural competence training for maternal and child health nurses". While training is available, CFHNs needed to factor accessing this training into their daily workload. Pixie (CNE) suggested that, "Through professional development, you're constantly refreshing your knowledge in order to maintain your competency". There was not always equitable access to professional development. Participants like Elaine (CNS) expressed concern. She said, "It's very disproportionate, some people tend to get a lot of money for training, and we get nothing. It was really very inconsistent, and I find that incredibly frustrating in this organisation". Without an educator employed, the child and family health services access to learning and development in some justifications can be problematic, and CFHNs have to seek out and pay for their own online learning.

Personal responsibility for learning

While jurisdictional organisations potentially supported professional development, participants concurred that CFHNs need to take control of their professional development. Hayley (CNC) argued that "individuals bear some responsibility in their own professional development. I often think it's within a suite of lifetime learning and that, you know, the trajectory of learning for all is not exactly the same all the time". As an autonomous practitioner Mila (NM) stated, it was a CFHN responsibility to "identify any learning gaps, to make sure that they have the opportunity to attend whatever training or experience they need to fill any of those gaps".

One of the participants questioned whether CFHNs were engaged in lifelong learning as, historically, moving into child and family health nursing was seen as an option to escape from shift work. Sarah (NM) suggested nurses thought, "I've done my time of shift work; I'm now going to look at how do I get myself into a nine to five role. If I do this qualification, then I can go work for the child and family health service". She suggested that registered nurses employed in her

jurisdiction without CFHN qualifications actively sought to be in child and family health nursing. Sarah remarked, “I think what’s different about these nurses, is the enthusiasm and more of a thirst for learning. So, I think learning is such an individual thing”. Once engaged in the child and family health nursing workspace, they usually looked to do further postgraduate study.

Participant mentioned the different mechanisms they used to record their professional development. Molly (CNC) commented, “There’s a few of the nurses who are actually very reflective, and they will actually write a reflective journal” and this became part of a portfolio for their practice. In contrast, Pippa (CNC) remarked, “Most of them, say they have a portfolio to maintain a record of all the learning that they do. I think there’s quite a few just don’t, even though we talk about it quite a lot”. Ada (CNC) noted, “There’s the expectation from APHRA and the professional development review, that they have one, but they are never really monitored”.

Professional development reviews to support goal setting

The participants discussed professional development reviews with their managers to establish learning goals to maintain or improve their clinical practice. Penny (NM) said “I think it’s a really good conversation to see where people are at in terms of their goals and what I can be doing to support their goals. I’m really conscious of keeping people engaged in the service.” Mila (NM) commented that performance planning was an opportunity for CFHNs to put forward “their goals of what education they’d like and a point in time that they can they get two-way feedback”. Polly (NUM) stated, “It’s usually the end of year review of all the positive projects, things they’ve done across the year and setting the pathway for three or four more areas of what they would like to do in the upcoming year”. For other participants, a professional development review was an opportunity to map out a personal plan of clinical skills development. Skye (NUM) noted, “It’s about looking at what they identify as some growth or development that they would like to do for the next 12 months. They might say,that I’d really like to do a new parents group, but I haven’t done it before”. Willow (CNE) described this process as a performance management assessment but said, “It is good, because it does make you think about what you want to continue doing. Do you want to have a go at clinical development nurse or have a go at being a manager?”. Hayley remarked:

> *I like to see that they have some emotional intelligence, and we can be building that with our staff, and create that positivity so that they will drive their annual review, and not just wait for the dreaded thing to come around every 12 months.* (CNC)

Participants commented that sometimes CFHNs treated the professional development review as a task to be completed rather than a means to promote opportunities for their learning and development.

Summary

This chapter focused on two themes: 'CFHNs' role lacks uniformity across jurisdictions' and 'Maintenance of individual CFHN practice lacks clarity across jurisdictions'. While the foundational skills and knowledge were similar across jurisdictions, participants described a shift in focus from a child-centred to a child and family-centred approach in the CFHN role. They noted that CFHNs required an expanding awareness of community resources to support children and their families. In rural and remote settings, CFHNs may be required to take on additional roles to care for children and families across the health and well-being spectrum. A challenge for all participants was the lack of understanding of the child and family health nursing role across jurisdictions, particularly if management did not have a child and family health nursing background or was not a health professional.

In some jurisdictions, different leadership and management structures made it difficult for CFHNs to gain support and guidance in their clinical practice. Across jurisdictions, the expectations about nurses requiring a postgraduate qualification to work in child and family health nursing differed. Different qualification expectations concerned the participants as the core skills and knowledge required in child and family health nursing practice were complex. In supporting the development of CFHNs, participants noted that the transition to practice process was experienced differently across jurisdictions. In one jurisdiction in particular, this meant the employment of registered nurses without CFHN postgraduate qualifications. Instead, the organisation provided a detailed orientation process rather than require completion of a postgraduate course in child and family health nursing. In other jurisdictions, participants indicated that transition to practice related to student CFHNs or newly qualified CFHNs.

From the participants' perspectives, maintaining their individual child and family health nursing practice lacked clarity across jurisdictions. Participants identified reflective practice discussion and tools as beneficial in improving their clinical practice. Across jurisdictions, CFHNs noted that dedicating time to clinical supervision was important to enhance their child and family health nursing practice. What differed was the access to clinical supervision because of limited availability of clinical supervisors, workload demands and the remoteness of workplaces. In addition,

managers of CFHNs did not understand the value of clinical supervision to practice improvement. Participants explained that peer support was cultivated to complement clinical practice either through informal debriefs with colleagues or a more formal mentorship process. Networking was described by participants as an opportunity to gain knowledge and validate clinical practice. Professional development was viewed by participants as an essential part of maintaining quality and competence in CFHNs' practice. Many of the participants relied on access to professional development from their organisations, they said that it was the responsibility of individuals to complete continuing professional development. Participants noted that using a professional development or performance review was an opportunity to identify their learning needs and plan for future education to support their chld and family health nursing practice.

Overall, the findings present four major themes that connected the organisational documents and participant interviews. These major themes were: 1. 'Governance of services is experienced as fragmented processes', 2. 'Organisational monitoring of CFHNs' practice is diverse'; 3. 'CFHNs' role lacks uniformity' and 4. 'Maintenance of individual CFHNs' practice lacks clarity'. The next chapter will discuss the synthesis of these thematic findings in the context of the current literature and how the findings from organisational and professional practice perspectives inform quality and competence in the specialist practice of child and family health nursing.

CHAPTER SEVEN: DISCUSSION OF THE FINDINGS

The previous three chapters presented the findings of the study. These findings were based on the analysis of organisational documents (Chapter Four) that were provided by the participants and analysis of the semi-structured interviews (Chapters Five and Six) that explored the perspectives of Child and Family Health Nurses (CFHNs). This chapter integrates the findings from these two sources of evidence and discusses the implications for determining quality and competence in the specialist practice of child and family health nursing.

Focused ethnography was used to explore this distinct area of nursing practice that requires specialist knowledge and skills to care for children and their families. A constructivist/interpretivist paradigmatic lens was used to develop an understanding of child and family health nursing workplaces from multiple CFHNs' perspectives at the time they were interviewed. Organisational documents added context to the experiential realities for CFHNs working in Australia's child and family health services. The interpretation of the data from these perspectives informed an understanding of how identification and measurement of quality and competence in child and family health nursing practice could be enhanced. Reflexivity on the part of the researcher was critical to ensuring that the construction of the narrative around quality and competence in practice was an interpretation of participants' perspectives in the context of their work environments.

This chapter begins with an overview of the synthesis of themes from the findings as viewed from organisational and professional practice perspectives and the three key focus areas that emerged. It then presents a discussion, informed by the current research literature, of the key focus areas as they relate to quality and competence in child and family health nursing practice.

Synthesis of thematic findings

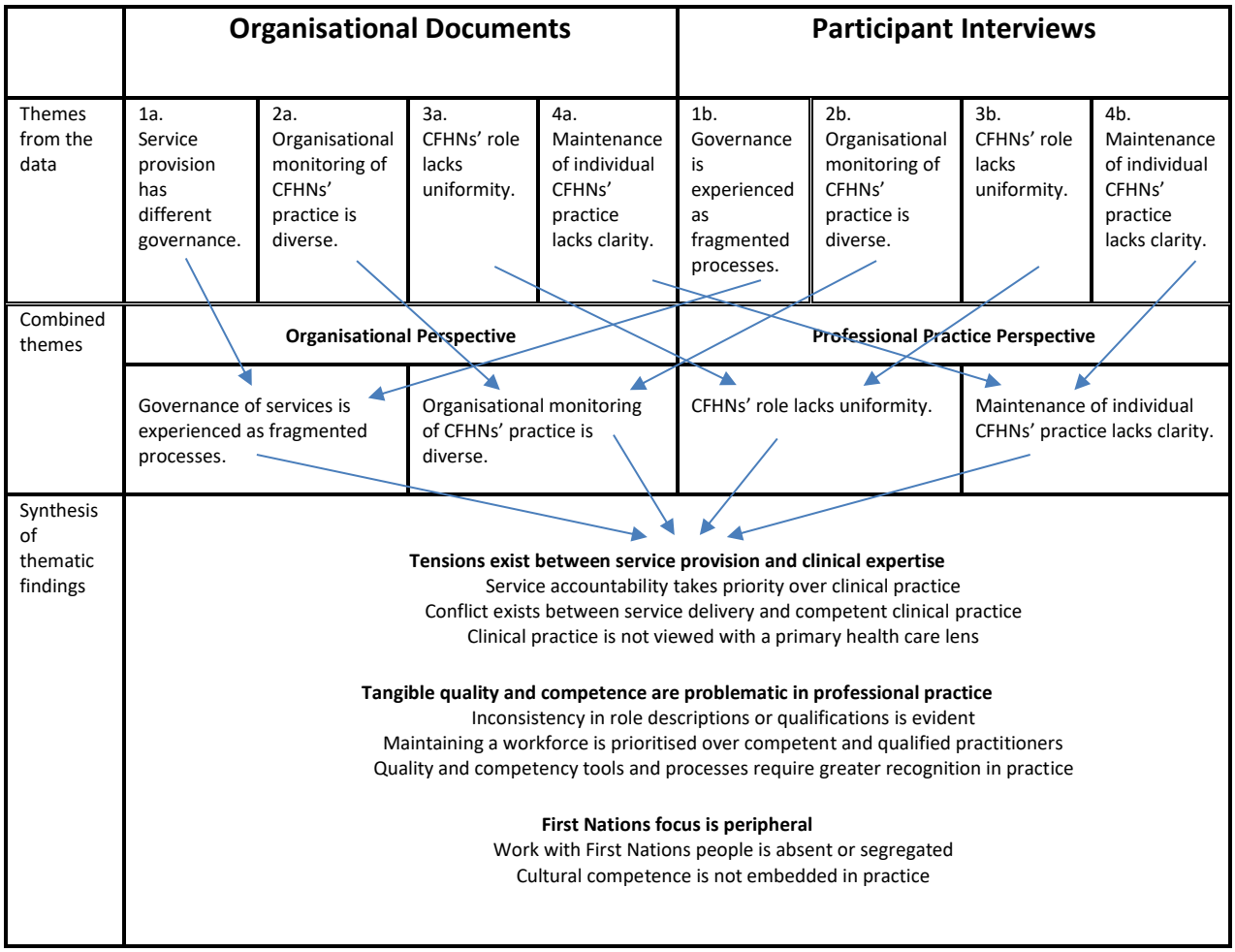
The original themes that arose were similar or the same across the findings from the organisational documents and CFHNs' interviews. With further synthesis, four major themes emerged, situated within organisational and professional practice perspectives. The themes 'governance of services is experienced as fragmented processes' and 'organisational monitoring of CFHN practice is diverse' highlighted the organisations' governance processes and demonstrated how CFHNs interpreted monitoring of practice in terms of quality and competence. From a professional practice perspective, the themes 'Child and Family Health nursing role lacks

uniformity' and 'maintenance of individual CFHN practice lacks clarity' illustrated how child and family health nursing practice was viewed in documents and how CFHNs viewed their professional practice.

As a result of synthesising these thematic findings, three key focus areas emerged for discussion in the remainder of this chapter (Table 7.1). The key focus areas highlighted the tensions that exist between what is written in organisational policy and procedure documents and what is experienced in CFHN clinical practice. These tensions make enacting tangible quality and competence in clinical practice difficult, particularly when there are no consistent role descriptions or qualifications for child and family health nursing practice across Australia. There is a juxtaposition between what organisations deem necessary to provide a service to children and their families and what CFHNs see as the ideal in clinical practice to meet the needs of children and their families. Child and family health nursing practice was not viewed from a primary health care lens, even though service provision is delivered under the guidance of the National Framework for Universal Child and Family Health Services (Australian Health Ministers' Advisory Council, 2011).

Furthermore, this framework was designed to provide early intervention and preventative health care to children and their families. The education that CFHNs receive through postgraduate qualifications and the guidance from the National Standards of Practice for Maternal Child and Family Health Nurses in Australia (Grant et al., 2017) sets up expectations of ideal clinical practice that, from participants' points of view, does not seem achievable in their current work environments. Across the findings, a First Nations focus is peripheral, as the work with First Nations children and families was either mentioned briefly or as specific clinical programmes. Culturally competent clinical practice, however, was not fully embedded in child and family health nursing practice. While these key focus areas will be discussed separately for clarity, they are interrelated and impact on how quality and competence are identified and measured in the specialist practice of child and family health nursing.

Table 7.1 Thematic analysis and synthesis



Tensions between service provision and clinical expertise

The participants provided organisational documents that focused on jurisdictional priorities and the procedures or guidelines that supported their current child and family health nursing structure. The focus on quality and safety within these documents was about the accountability of the service rather than the quality of clinical practice. According to the participants, there was a conflict between service delivery and competent clinical practice. For CFHNs, this conflict centred on supporting the health and well-being of the entire family and not merely completing assessments of the growth and development of children. Furthermore, the findings of this study suggest that clinical practice is not viewed from an early intervention and prevention lens when the biomedical lens of tasks and assessment is the focus.

Service accountability takes priority over clinical practice

The organisational documents examined in this study described clinical practice concerning tasks such as monitoring the growth and development of children rather than defining the components

of competent clinical practice. Similarly, clinical practice was linked to key performance indicators, such as the number of client contacts and the number of assessments that needed to be completed to achieve service delivery targets related to organisational accountability. Cahill et al. (2022) suggested that, while organisations need to be fiscally responsible in delivering services, the quality of services is unclear without outcome measures.

CFHNs in this study were required to focus on tasks such as achieving a set number of universal home visits related to key performance indicators rather than relational work with clients. The relational work that participants described involved partnering with parents, utilising their complementary expertise, and supporting parental decision-making about the care of their children through mutual respect and open communication. These key performance indicators restricted the time that CFHNs spent exploring the needs of families in order to prioritise an increased number of tasks and assessments.

These processes do not appear to have changed since Schmied et al. (2015) researched health processionals' views about implementing a national approach to child and family health services. These researchers found that CFHNs considered that their workload was driven by home visiting targets, which meant that their role was restricted, leaving them dissatisfied with their job, and unable to meet the needs of children from birth to five years. It is apparent that clinical practice dictated by organisational accountability remains unchanged. Johnston et al. (2020) found that CFHNs' increased workload through administration tasks reduced the CFHNs' job satisfaction, as it impacted on developing interpersonal relationships with families. From the perspectives of CFHNs in this study, quality and competence in practice were not prioritised, as key performance indicators were the primary focus of their organisations.

A neo-liberal approach to primary health care, which reduces universal, comprehensive care in favour of increased clinical service provision, emphasises outputs such as the number of tasks or assessments over health outcomes (Baum et al., 2016). Keleher (2020) argued that the rationalisation of primary health care has seen governments preferring to fund general practitioners in primary care with chronic disease management rather than community health prevention programmes. Additionally, Fisher et al. (2017) observed that the dominance of an individualised approach to health policy did not address the social determinants of health or health equity but increased the need for consumers to access multiple services to address health issues. Research in Canada by Lavoie et al. (2018) found that community health centres were

committed to meeting the needs of their communities but were constrained by funding models and policies that concentrated on service delivery rather than adequate resourcing for complex health needs. Child and family health nursing practice in Australia is underpinned by frameworks that support addressing the impact of social health issues through advocacy for the health and wellbeing of families and communities (Taylor et al., 2021). The health departments that finance public health; however, favour an individualised approach, focusing on treatment rather than prevention and a user pay system (Clendon & Munns, 2023). When child and family health services focused on throughput, complex family issues that impact on the health and well-being of children were unable to be addressed adequately by CFHNs. To support families in achieving positive health outcomes for their children, CFHNs require adequate time to explore client's concerns and provide anticipatory guidance. This requirement is a challenge in a neoliberalist primary healthcare environment, where child and family health services are focused on the number of clients seen rather than the health outcomes of children and families.

Participants stated that service audits and checklists, designed to review service provision targets, were used by managers to identify clinical practice issues concerning client care. The service audits and checklist documents recorded the number of tasks attended, such as immunisations or scheduled child health checks, but not any details about the interactions with individual clients. Without context, participants saw these audits and checklists as not representative of the quality of clinical practice activities and outcomes. Participants described these audits as "tick box" exercises to ensure data capture for key performance indicators. Checklists do not explain the procedural or sociocultural narrative behind the practice nor yield performance or outcome benefits (Catchpole & Russ, 2015). While checklists are helpful for specific procedural tasks in health care, Catchpole and Russ (2015) suggested that they do not capture nuanced communication like feedback and discussion required to enhance the clinical and client experience in a health care interaction.

Another form of client care checklist found in health care settings is rounding. This is a structured interaction to review client care and is documented regularly in client's clinical notes. In exploring documentation of intentional rounding, Sims et al. (2020) suggest that the primary focus of reviewing client care through conversation is lost in the effort to ensure documentation is completed and the requirement for good documentation replaces compassionate care. Participants in this study felt that record keeping was privileged over their clinical judgement related to client care, and organisational accountability overrode clients' needs. For example,

clinicians cited that through ticking boxes, relational work was dismissed, and they believed as a direct result, clients did not return. Consequently, they felt that building trusted relationships between families and CFHNs was not prioritised. The inability to build trusting relationships made it more challenging for CFHNs to prevent families from disengaging with child and family health nursing services.

These findings align with Michl et al.'s (2023) research in documentation audits, which discovered that nurses were constantly balancing competing managerial, organisational, professional, and legal demands to maintain a therapeutic relationship with patients and prioritise quality patient care. Audits on documentation do not capture the quality of care provided to clients; when nurses use their clinical judgement to provide holistic care that meets the client's needs but may not be captured in a standardised form. Organisational requirement for electronic data collection that related to service performance indicators and not client care, was experienced as imposing on time spent connecting with clients in their clinical practice. Research by Rossiter, Fowler, Hesson, Kruske, Homer, Kemp, et al. (2019) asked Australian parents what was essential to them in their healthcare support and found that parents wanted clinicians who were encouraging, compassionate, nonjudgmental and capable of careful listening. Weller-Newton et al. (2021) argued that being with children and families is person-centred nursing care, not a task that can be quantified. For participants in this study, developing a relationship with their clients was an important part of providing quality and competent care to children and families that were overlooked.

Auditing quality

The process of monitoring quality was argued to be through documentation audits and consumer feedback. Industry standards within Australia, such as the National Safety and Quality Primary and Community Healthcare Standards (Australian Commission on Safety and Quality in Health Care, 2021), create the expectation that healthcare organisations have processes to monitor the quality and safety of the services they deliver to consumers. In addition, these community healthcare standards require that services have processes that monitor their providers' qualifications, knowledge and skills to ensure they are operating within their scope of clinical practice. Participants in this study described consumer feedback as a means to assess the quality of services, which may also provide some insight into the quality of child and family health nursing practice. From a management point of view, monitoring the quality and safety of service delivery was also about quality and safe clinical practice. Managers saw consumer feedback as a metric to

provide information about the quality of clinical practice based on their comments about the service provided. There was no consistency or agreement in how consumer feedback was used across jurisdictions.

Worsley et al. (2016) acknowledged the value of consumer feedback in quality improvement; however, they noted that there is still work to do to utilise this feedback to improve healthcare services fully. Similarly, Oakman et al. (2021) found that consumers could contribute to improving health professionals' practices. Still, the evidence to date is minimal regarding whether consumer feedback is translated into evidence-based practice. In comparison, Boston-Fleischhauer (2017) suggested that consideration be given to asking patients about their experiences and whether they see value in the services that were provided to them. She noted the difference between patients receiving care and consumers making choices about their care. Understanding the value consumers place on services or health professionals in that service can influence service delivery and the clinicians employed (Boston-Fleischhauer, 2017). Consistent consumer feedback is valuable to health services, enabling them to provide quality services that meet the needs of children and families. A clear delineation, however, is required between feedback on services and feedback that is relevant to clinical practice.

This study found that collecting consumer feedback was an ad hoc process, along with the inconsistent monitoring of documentation in clinical practice. Both processes, however, were treated as part of the quality processes around service provision to improve the quality of services and clinical practice for the benefit of the consumers. Participants mentioned documentation audits as a means of reviewing the quality of clinical notes and providing evidence of the quality of CFHNs' clinical practice. The documentation audit process was inconsistent across jurisdictions, although the participants who were managers stated that documentation audits provided them with insight into the clinical practices of their staff. Audits of patient records are necessary to ensure patient safety as they reflect the care provided (El Amouri & Ramukumba, 2019). For documentation audits to be of value for improvement in the quality of nursing care, El Amouri and Ramukumba (2019) suggested that audits need to be conducted using a consistent framework, findings clearly articulated to nursing staff and time allocated for implementing recommendations. In contrast, participants in Mich et al.'s (2023) research pertaining to nursing documentation reported that audit and feedback activities generated minimal change in service delivery. Furthermore, these mechanisms did not adequately capture nursing care and sacrificed patient

interaction, leaving the nurses dissatisfied with their work. In this study, CFHNs sought a process that reflected the quality of their work with clients.

Conflict exists between service delivery and competent clinical practice

Organisational documents such as clinical guidelines or procedures discussed the scope of practice of CFHNs based on service provision that referenced clinical assessments such as growth and development checks for children, as opposed to the relational aspect of care with families. Participants described relational care as CFHNs working in partnership with families through mutual respect and open communication using their complementary knowledge to care for children (Davis et al., 2002; Hesson et al., 2017). In child and family health nursing services, CFHNs are expected to review the mental and physical health of both children and parents (Turley et al., 2018). Participants in this study noted that their organisations needed to prioritise family-centred care over child health examinations to provide competent care for children and families in light of this expectation around mental health screening. Eichner et al. (2012) described family-centred care as a relational, strength-based approach that aims to improve child health outcomes through family engagement and collaboration. Family-centred care requires organisational support, flexibility in the delivery of programmes and effective communication skills (Ridgway et al., 2020).

From the point of view of participants, CFHNs were acknowledged as being ideally positioned to interact with clients. For example, Segal et al. (2018) found that CFHNs were seen as easy access points for families with complex and competing needs who required support for mental health issues. Participants, however, reported that new programmes or duties were added to their workload without recognising the time needed for relational work. Consistent with these findings, Magnusson et al. (2012) suggested that more time to meet the demands of the increasing complexity of delivering effective child health care was not factored into the CFHNs' workloads. For participants in this study, adding more tasks to their workload hampered their ability to provide quality and competent care to their clients to the full extent of their clinical expertise.

There is inconsistency in the service provision across jurisdictions, which made comparisons of the clinical practice of CFHNs challenging to achieve. For example, the work of rural and remote nurses covered the client's lifespan, including preventative and emergency management, chronic disease, and maternal and child health (Office of the National Rural Health Commissioner, 2023). In regional and metropolitan settings, participants described working in the community with children from birth to five years and their families from the perspective of health promotion, monitoring

and surveillance of growth, development and wellbeing. Participants from rural and remote areas reported that they felt conflicted between managing ill health, promoting health and well-being and prevention to provide a holistic service. In addition, in rural and remote areas, the limited resources and large distances between services meant that service targets were impracticable and adversely affected the quality of their clinical practice and client interactions. McCullough et al.'s (2021) earlier research on providing primary health care nursing in remote regions was consistent with these findings, as it showed that inadequate resources and lack of time had a deep impact on the care nurses could provide versus the care they desired to provide for their clients. Blanchet Garneau et al. (2019) concluded that organisations need to reconsider their universal approach to mainstream services and adapt to more nuanced services that meet the needs of individuals and communities to address inequities. From the CFHNs perspectives, their knowledge of their communities and their ability to adapt to meet the needs of their clients meant they could provide quality care if service delivery targets were not prioritised over client care.

CFHNs questioned whether providing a quality service should be linked to ongoing professional development to maintain competent clinical practice. For organisations, access to professional development is driven by governance and risk management, whereas for clinicians, it is about meeting professional standards and evidence-informed practice (Edward et al., 2019; Vernon et al., 2019). Participants in this study reported that mandatory training was about the delivery of programmes or corporate accountability, and the only requirement was a completed list of activities for CFHNs to be deemed competent. Participants frequently defined in-service training as optional when service delivery was difficult due to a scarcity of staff and training was not prioritised.

CFHNs considered clinical supervision an essential part of their professional development to improve the quality of client care and their competence in clinical practice (Briggs et al., 2022; Grant et al., 2017). In addition, participants expressed their concern that some organisations did not deem clinical supervision as essential for maintaining competent clinical practice for all CFHNs. Organisations prioritised service delivery over reflective clinical supervision. CFHNs' access to group supervision was limited by the shortage of clinical supervisors and the need to manage large numbers of part-time staff needing access to supervision. Participants stated that managers who did not understand the context of child and family health nursing practice regarded reflective clinical supervision as counselling around issues in practice rather than an essential tool in ensuring development in clinical practice. A systemic review by O'Neill et al. (2022) acknowledged

that leadership support and an organisational culture that provides resources for reflective clinical supervision of CFHNs are essential elements in providing quality care to children and families. CFHNs were continually juggling service delivery with making time to ensure they maintained their competence in clinical practice through professional development. Clinical supervision enabled CFHNs to engage in self-reflection and hone their critical thinking skills to benefit the clients in their care.

Clinical practice is not viewed with a primary health care lens

The Declaration of Alma-Ata in 1978 first articulated primary health care as a social model of health that focused on promoting health for all through equity of access (World Health Organization & UNICEF, 1978). Primary health care in Australia operates through a wide range of community health services, including child and family health nursing services, to provide universal access to preventative health care (Keleher, 2020). Historically, the primary role of CFHNs was the monitoring and surveillance of the growth and development of children. Over the years, understanding the impact of family environment and caring for the health and wellbeing of both children and parents have become part of the CFHN's role (Fowler & Stockton, 2020). CFHNs work in early intervention and prevention, but participants believed their organisations viewed their work through a bio-medical lens rather than the whole family's health and well-being. Monitoring children's growth and development using a biomedical lens assumes that health professionals are looking to treat ill health rather than view monitoring as part of an early intervention process to promote healthy growth and development (Taylor et al., 2021).

The health services' focus on the biomedical approach to health care was highlighted during the COVID-19 pandemic. Participants with skills and knowledge in immunisations were moved to other clinical areas to support public health initiatives. Meanwhile, CFHNs found their roles were temporarily deemed unnecessary. Clendon and Munns (2023) argue that CFHNs' knowledge of the social determinants of health and how they impact families enable them to work as partners in healthcare decision-making, and their work sits firmly within that primary health approach. Participants noted that there appeared to be a disconnect between their understanding of primary health care, the clinical practice of CFHNs, and their organisation's knowledge of primary health care. The focus on acute health care overshadowed primary health care and left children and families with reduced access to routine health checks or support for mental health or other social issues as organisations prioritised other health care issues (Chanchlani et al., 2020).

The COVID-19 pandemic brought into focus the unfamiliarity of other health professionals with the child and family health role and their understanding of the needs of children and families. For participants, this reinforced that the skills and knowledge of CFHNs were not valued and that primary health care is not understood within the health system. While the COVID-19 pandemic highlighted issues, primary health care services in Australia have been slowly eroding over time. This erosion has occurred as funding has shifted to a mix of the commonwealth, state and territory governments sources, with limited focus on prevention and early intervention (Keleher, 2020). The challenges in primary health care are not confined to the work of CFHNs. As Baum et al. (2014) described, many community health sites are pressured to use their funding on curative services instead of health promotion activities. In reflecting on the importance of the World Health Organization's Ottawa Charter for Health Promotion, Thompson et al. (2018) suggested that health promotion strategies will not be prioritised in community health settings while government policy supports an individualistic approach to health care.

Teager et al. (2019) suggested that early intervention can improve children's lives by identifying health and well-being problems that can be referred to before they become more severe and problematic. CFHNs articulated that they were well placed to provide this care. Participants expressed concern, however, about a lack of visibility of the CFHNs' primary health care role around wellness, anticipatory guidance and the parenting relationship at the executive level within their organisations. There was talk of prevention, but the focus was on acute settings. This focus was particularly relevant for participants in rural and remote areas as they were caught between developmental monitoring and dealing with acute illnesses that impacted on child growth and development, such as ear infections that, left untreated also have an impact on speech development.

Within Australian health jurisdictions, primary health care is often considered the general medical practice domain. Their practice is illness-focused, however, unlike child and family health nursing services, which are wellness-focused (Jeyendra et al., 2013). Even though child and family health nursing is briefly mentioned in Australia's national primary health care plan (Department of Health, 2022), funding models for primary health care focus on general medical practice and leave community health nursing services to be funded by state and territory health departments (Alexander et al., 2017). Rather than accessible primary health care for all, as envisioned in the World Health Organization and UNICEF's (1978) Declaration of Alma Ata, Australian state and territory health services have focused on clinical service provision favouring outputs over health

outcomes (Baum et al., 2016). The World Health Organization and The United Nations Children's Fund (UNICEF) (2018) acknowledged in the vision for primary health care that prevention and promotion of health care services are "generally underfunded", and there needs to be an increased allocation of public funds to ensure the "availability of core services and access for marginalized communities and people in vulnerable situations" (p. 10). Heslop (2019) argued that the activity-based funding model used for public health services does not adequately capture nursing activities. Finding evidence to justify increased spending on these services, therefore, is challenging. In addition, Schwarzman et al. (2019) found that the cuts in government funding for health promotion programmes meant that services had limited funds to evaluate programmes to support service continuation away from treatment focused service delivery. CFHNs' ideal clinical practice in the early intervention and prevention space is at odds with organisational structures that are jostling with acute health services for funding.

Tangible quality and competence are problematic in professional practice

Participants reiterated throughout this study that being a registered nurse with a postgraduate qualification in child and family health nursing was an essential part of quality and competence in clinical practice. CFHNs considered that they worked in a speciality area within nursing, although there is currently no national regulation to support their specialist clinical practice. The Nursing and Midwifery Board of Australia (2020, May) stated in a fact sheet, based on research conducted in 2014, that regulation of speciality areas within nursing was unnecessary, as professional organisations had developed processes that acknowledged specialist practice that employers and the broader health industry may accept. This section of the discussion will explore how the inconsistency in role descriptions, qualifications, and the maintenance of a child and family health nursing workforce impacts on the quality and competence of clinical practice for CFHNs. The discussion will also consider the lack of recognition of available tools and processes.

Inconsistency in role description or qualifications is evident

This study identified that jurisdictional policies and procedures provided statements about generic workforce qualifications for registered nurses or were generalised to various professions rather than specific requirements for CFHNs. No equivalent or minimum qualifications, therefore, were consistent across Australian health jurisdictions in child and family health nursing. Following the change to national registration for nurses and midwives in Australia in 2010, the certification as a CFHN has ceased to exist nationally (Breach & Jones, 2017). Without national registration as a

CFHN, it is difficult to require CFHNs to have specialised qualifications that define the scope of their practice.

CFHNs were noted as a vital part of the workforce in the National Framework for Universal Child and Family Health Services. The only requirement was that nurses work under the national regulation standards and the various state-based competencies currently available (Australian Health Ministers' Advisory Council, 2011). This national framework continues to underpin Child and family health services, although it has not been reviewed since its implementation. The standards for registered nurses and midwives have since been updated, along with the defined scope and capabilities of nurses and midwives (Nursing and Midwifery Board of Australia, 2016a, 2018, 2022, September). Other standards of practice, such as the Standards of Practice from Child and Young People's Nurses (Australian College of Children & Young People's Nurses, 2016) and the National Standards for Maternal Child and Family Health Nurses in Australia (Grant et al., 2017) are referenced in clinical practice documents provide by organisations in this current study.

Participants in this study remarked that these standards had little bearing on the current job descriptions within their organisations, as the job descriptions did not target the specialised skills and knowledge outlined in these standards by requiring a postgraduate qualification in child and family health nursing. From the participants' perspectives, their organisations cited workforce shortages as a reason for dismissing the mandatory requirement for CFHNs to have a child and family health nursing postgraduate qualification. Participants expressed concern that employing staff without the postgraduate qualification devalued and reduced the integrity of the CFHNs' role. The exception is the Victorian jurisdiction, which requires the applicant to be a registered nurse and a registered midwife with a postgraduate diploma in child and family health nursing (Department of Health and Human Services, 2021). A position statement by the Australian College of Nursing (2021) and the NSW Child and Family Health Nursing Professional Practice Framework (Briggs et al., 2022) highlights the importance of CFHNs having specialist skills and knowledge to provide competent care to children and families in an increasingly complex primary healthcare environment. In this study, participants noted that nurses without a child and family health nursing postgraduate qualification could only complete basic child health assessment tasks rather than provide nuanced and holistic care to children and their families.

In contrast to Australia, the Nursing and Midwifery Council in the UK has recognised standards of proficiency for specialist community public health nurses and standards for post-registration

programmes leading to specialist community public health nurse qualifications (Nursing and Midwifery Council, 2022a, 2022b). These documents provide national guidance for the education and clinical practice of Health Visitors, which are equivalent to CFHNs in Australia. Participants in this study identified that educational preparation for child and family health nursing practice varied across jurisdictions from graduate certificate and graduate diploma to master's level. A survey of maternal, child and family health education programmes, found marked differences in content and clinical placement through to titles of awards in courses across Australia (Kruske & Grant, 2012). Another survey of CFHNs across Australia showed agreement in the requirement for minimum education standards, adequate clinical placement to ensure students were ready to work independently as CFHNs, and the need to remove obstacles to accessing education (Fowler et al., 2015).

Research conducted by Ridgway et al. (2022) into child and family health nursing education before and during the COVID-19 pandemic found continuing disparity across Australian jurisdictions regarding nurse and midwife registration and postgraduate education requirements for employment as a CFHN. Participants in this study reported the continued lack of nationally consistent education standards and an increasing push to provide online learning in the workplace in lieu of an accredited child and family health nursing course. Without accredited education in the specialist skills and knowledge related to child and family health nursing, participants believed there was no assurance that children and families are receiving quality and competent care.

Transition to practice programmes

The findings in this study referred to transition to practice programmes as an opportunity to engage novice practitioners and build a competent workforce embedded in early intervention and preventative care of children and families. There were inconsistencies throughout the jurisdictions, as participants reported varying formal and informal transitions to clinical practice programmes. Moreover, transition to practice programmes were used differently in each jurisdiction. Some conducted in-house online training with registered nurses, others had registered nurses enrolled in postgraduate child and family nursing courses, while others employed the transition to practice programme for novice qualified CFHNs. Other jurisdictions used the transition to practice programme to orient staff working as CFHNs within services.

Participants in this study were concerned that unqualified CFHNs transitioning into child and family health services could only operate at a novice level of supported practice. Instead, they

worked independently in clinical practice to care for children and families with complex issues without the knowledge and skills to nuance their approach to the client's needs. According to Ozdemir (2019), novice practitioners lacked the skills and knowledge to individualise and critically assess care without constant support from experienced clinicians. The elements participants suggested that unqualified CFHNs were missing were the critical skills and knowledge to interpret data, make recommendations to parents or referrals to appropriate services to maintain positive growth and development trajectories for children or seek interventions. Research by Rossiter, Fowler, Hesson, Kruske, Homer, Kemp, et al. (2019) found that parents wanted support from CFHNs who were qualified and competent to provide up-to-date evidence-based knowledge.

A structured transition to practice programme for registered nurses enrolled in a child and family health nursing course was suggested to support the application of theoretical learning whilst providing safe and competent care to children and families. Participants described this process for CFHN student clinical placements and registered nurses who were employed on specific contracts conditional on completing their study. Research into a specialist transition to practice framework for emergency nursing conducted by Morphet et al. (2017) across Australia found that a structured programme mitigated the risk to patients when experienced clinicians supported nurses while gaining and embedding new skills and knowledge into their clinical practice. A study related to a mentorship programme to bridge the gap in students' practice between university and healthcare institutions found that the transition programme addressed mentee's concerns about the realities of clinical practice and facilitated a smoother transition into the workplace (Lavoie-Tremblay et al., 2020). Participants in this study commented that the transition into practice for newly qualified CFHNs was not always structured. Instead, it was an informal process that included seeking guidance as required from a preceptor, who was an experienced CFHN, when they had questions or concerns about their clinical practice. Experienced CFHNs were expected to support novice CFHNs whilst maintaining their current workload and without additional training in preceptorship. Harvey et al. (2019) suggested that without structured pathways in orientation and learning, preparation for practice focused on service-related tasks rather than transition to new clinical practice. Mitchell et al. (2018) suggested that nurses who take on the preceptor role would benefit from specialised education that increased their confidence to give feedback and assess clinical skills to support the competent practice of novice CFHNs.

Maintaining a workforce is prioritised over competent and qualified practitioners

The National Framework for Child and Family Health Services identified outcome measures related to priority areas for children's health and service performance measures to guide the delivery of services (Australian Health Ministers' Advisory Council, 2011). Priority areas related to children's health identified in the national framework included breastfeeding, obesity, social and emotional wellbeing and child abuse and neglect (Australian Health Ministers' Advisory Council, 2011). Research into breastfeeding rates of children showed that rates have not improved, with only 57% of babies breastfeeding at six months of age (Reynolds et al., 2023). In Australia, rates of children in out-of-home care have risen by 34%, and since 2011, the rate of obesity in children and young people aged 2-17 has increased by 17% (Teager et al., 2019). While the Australian Early Development Census for 2021 showed that children's development in language and cognitive skills, communication skills, general knowledge, and physical health are on track, there remains little progress in improving social and emotional development (Harman-Smith et al., 2023).

The findings in this study suggest that organisations focused on having a workforce to meet key performance indicators for service provision rather than a workforce with the appropriate knowledge and skills to support the growth, development and wellbeing of children and their families. From the participants' perspectives, the workforce situation was exacerbated by managers who were not CFHNs, such as allied health professionals or other nursing professionals. They did not understand the context of child and family health nursing practice, and tasks were prioritised over understanding the family environment and its effect on children's growth, development, and well-being. Research into workload, care rationing, and work environments by Harvey et al. (2020) found that nurses were concerned that their professional expertise was not valued when organisational targets were prioritised over quality patient care. In this study, participants reported that managers who were qualified CFHNs understood the context of clinical practice and were conscious of competent clinicians' importance in providing safe, quality care to children and families.

Participants in this study acknowledged the aging workforce in child and family health nursing who were about to retire, with a limited supply of qualified CFHNs to fill the gap in the workforce. A key issue with an aging CFHN workforce highlighted by Johnston et al. (2020) was the loss of extensive skills, knowledge and experience that would lead to child and family health services being unable to meet the needs of children and families. This loss of knowledge and expertise of more senior nurses is reflected across many areas of nursing (Peters, 2023). From the participants'

perspectives, organisations did not have succession planning in place, leaving CFHN managers faced with the dilemma of waiting to find qualified staff or being creative about employing nurses and supporting them with in-house training to provide competent staff. Participants in this study were concerned that in-house staff training was a short-term measure that builds a workforce that can only work in one jurisdiction and limits the capacity of the staff to gain formal professional expertise.

Peters (2023) proposed retention strategies that offered flexible working arrangements or opportunities for experienced nurses to mentor junior nurses or students, which might incentivise them to remain in the workforce. Johnston et al. (2020) suggested that one way to increase the CFHN workforce is for organisations to target newly-graduated nurses and assist them to study child and family health nursing and obtain credentials while working in the field. Transition to practice programmes described by Morphet et al. (2017) provided better professional development outcomes while mitigating the risk to patient safety and improving the quality of care. Other research into workplace planning for child and youth community health services conducted by Penny and Fennah (2020), highlighted that creating new entry pathways for child and family health nursing students was limited by the availability of nurse educators and resources for preceptorship or mentorship. These programmes require collaboration with providers of postgraduate programmes and health services. No such collaborations were mentioned by participants in this study.

Rural and remote practice

Participants in this study noted that child and family health nursing in rural and remote areas was far more diverse than their metropolitan and regional colleagues, and they were usually sole practitioners. In remote primary health care settings, participants commented that they fulfilled multiple roles of generalist nurse, midwife and CFHN, including a management role to meet service demands that took their focus away from the client's needs. In this study, organisational documents from rural and remote services combined service delivery and the scope of practice for the workforce. As health services were responsible for providing services, this allowed them to use a variety of health professionals who were not CFHNs to ensure that a service was provided. Challenges in the rural and remote workforce exist within several health professions, including medicine, acute care nursing and allied health. Organisations struggled to manage the high staff turnover that impacts on clients' safe and optimal care (Wakerman et al., 2019). It was suggested by Zhao et al. (2019), however, that providing improved training pathways that contextualise and

support postgraduate employment could improve workforce stability, enhance therapeutic relationships, and improve client health outcomes. According to Russell et al. (2021), there is a lack of evidence around the retention of nurses, allied health professionals and Aboriginal Health Practitioners that is needed to support policy decisions around a qualified and competent rural workforce. Rural and remote practice poses challenges for CFHNs working as sole practitioners. Without adequate resources and mentoring of a skilled workforce able to provide a nuanced approach to service delivery, the quality of client care may be compromised.

Quality and competency tools and processes require greater recognition in practice

Participants in this study described varied tools and processes related to reviewing the CFHNs' competence in clinical practice that led to providing quality care to clients. These practices included structured observations and clinical practice assessments or working alongside an experienced clinician for a few days, which occurred at the beginning of their employment, but were not repeated during their employment. The organisational documents provided by several jurisdictions in this study stipulated the details of the procedures required for a clinical practice observation. Still, this process was described as a recommendation for other jurisdictions and was not specific to CFHNs. Franklin and Melville (2015) proposed that clinical competency be assessed over a continuum rather than focussing on a snapshot of time and use multifaceted approaches adapted to the nurse's experience, including skills assessments, client feedback, reflective questioning and observation of practice. While the participants in this study acknowledged the value of observation of clinical practice, including a reflective discussion, some CFHNs saw it as a punitive measure to criticise their practice. Despite the underlying influence of the philosophy of reflective practice, its explicit articulation through guidelines and frameworks was lacking, failing to extend the implementation of the process beyond the initial orientation period. An evaluation by Guest et al. (2013) of the implementation of a professional practice framework in child and family health nursing found that the framework provided CFHNs with an opportunity to have their clinical practice validated through observation, reflection and discussion during the consultancy. On the whole, it was a positive experience, mainly as it was an opportunity for isolated CFHNs to connect with other clinicians. Less positive responses in this research related to the CFHNs' anxiety about having their practice examined, the potential conflicting perspectives between reviewer and clinician and the time consumed for both clinicians to particpate in the process (Guest et al., 2013).

In this study, participants expressed frustration with their managers' expectations that experienced staff would preceptor or mentor new clinicians whilst maintaining a full client load. The participants were concerned about the quality of care provided to children and families when they could not observe their practice or respond to requests for support from inexperienced CFHNs. Aparicio and Nicholson's (2020) review of the literature on preceptorship and supervision to support the transition into clinical practice suggested that preceptors needed quarantined time and reduced workload to provide effective guidance and training for new clinicians to establish safe and competent clinical practice. Moreover, Chigavazira et al. (2018) revealed in their research that being an experienced nurse did not directly translate into being an effective and knowledgeable preceptor, and additional professional development and training were required. Pohjamies et al. (2022) recommended that managers and leaders refrain from selecting preceptors solely based on availability. Instead, they proposed a more thoughtful approach, considering factors such as effective communication, leadership abilities, clinical proficiency, and a willingness to foster professional advancement. Boyer et al. (2018) advocated for structured transition programmes incorporating coaching and goal setting to integrate specialist practice knowledge into clinical capability that reflects competent and safe practice.

In this study, participants described performance or professional development reviews as a discussion with their manager about completing professional development activities and plans for future professional learning to enhance their evidence-based clinical practice. Across jurisdictions, this discussion varied from an annual formalised activity to an ad hoc, non-compulsory activity reflected in various organisational documentation and not directly connected to quality care for children and families. Participants in this study reported that professional development reviews were treated as a process to be completed rather than an opportunity to set goals for improving quality and competence in their clinical practice. As ongoing professional development is the personal responsibility of CFHNs, a key driver for completing activities is the requirement attached to nursing registration in Australia (Nursing and Midwifery Board of Australia, 2016b).

Participants in this study also reported that for some jurisdictions, access to training within organisations was not equitable. In contrast, other jurisdictions built access to training into the structure of the Child and Family Health Service provision. Research into competencies and skill development by Edward et al. (2019) found that the motivations for continuing professional development were risk management and professional standards requirements, while the barriers were limited resources or support from organisations for participation in activities. Participants in

this study reported that managers who were not CFHNs lacked understanding about child and family health nursing practice. They also reported limited support for professional development to maintain safe and competent care for children and families.

In a review of nursing leadership and its influence on evidence-based practice in contemporary health care settings, Bianchi et al. (2018) noted that nurse managers need to have current knowledge of the evidence required for competent practice and utilise their leadership positions to influence access to resource and training where deficits occur. In contrast, Leung et al. (2016) suggested that there is ambiguity and disagreement regarding the requisite levels of evidence-based practice competence for nurses, which has implications for establishing a reasonable competence-based benchmark for a larger group of nursing stakeholders. This ambiguity is consistent with the current study's findings, which showed that two different standards of practice were mentioned in organisational documents. No information was provided, however, regarding how they were applicable to monitoring clinical practice. In addition, CFHNs could not articulate how the standards of practice were employed to ascertain and evaluate their level of competence. This predicament posed a challenge for them, prompting them to contemplate the means through which they could provide substantiation for their proficient practice.

Reflective practice

In Australia, CFHNs must benchmark their practice based on the registered nurse standards for practice by the Nursing and Midwifery Board of Australia (2016a) to confirm that they are safe and competent to practice. Vernon et al.'s (2013) research on the perception of continual competence among New Zealand nurses questioned the idea that completing a tool is a mechanism that can infer competence and, therefore, guarantee that nurses are fit to practice in every circumstance. Further research by Vernon et al. (2019) suggested that a lack of insight or self-awareness may hinder nurses' abilities to contemplate their performance, pursue opportunities for continuing professional development, or recognise when their work performance is unsafe.

Participants in this study conceptualised case review, case discussion, and peer review as reflective practices that modelled relational and collaborative approaches to enhance clinical practice for the benefit of children and their families. These formalised processes validated the informal peer support that existed among CFHNs, created a culture of support among staff, and translated discussion into action. Wihlborg et al. (2017) described how collaborative peer feedback, self-evaluation, and reflective practice were favoured over technical skills in the development of

competence in ambulance nurses. In contrast, the objective of clinical debriefing, as explained by Toews et al. (2021), was to evaluate, investigate, and exchange information regarding clinical practice, professional education, and the emotions of individuals involved in a critical incident. From the perspectives participants' in this study, the opportunity to connect with peers, scaffold the clinical practice of new clinicians, and receive assistance in completing clinical tasks increased satisfaction. It led to a higher standard of care, even though this opportunity was not always available in rural and remote jurisdictions.

Participants in this research also identified reflective clinical supervision as a crucial element in fostering the development of quality and competence in practice. They viewed reflective clinical supervision as a specified time and space to explore issues in their clinical practice under the guidance of a competent facilitator who understood the context of child and family health nursing practice. In addition, it allowed clinicians to seek advice without fear of being judged. In group settings, the combination of experienced and inexperienced practitioners facilitated knowledge sharing and role modelling of a relational mode of working. These findings align with Bolg et al.'s (2020) research, which found that experienced nurses used critical reflective inquiry to challenge themselves to recognise inconsistencies between actual and preferred practice. They did this by identifying the need to change practice, identifying knowledge deficits and potential barriers to change, and taking action. The research also indicated that the embedded knowledge of experienced nurses is an underutilised resource that can be shared with novice nurses through reflective practice discussions to promote the growth of clinical practice. Asselin and Schwartz-Barcott (2015) found that peer group discussions deepened and enhanced nurses' reflective processes, which they used to re-examine challenging situations and implement practice changes.

Findings from this study suggested that successful clinical supervision required dedicated time, an experienced facilitator, organisational endorsement and clinician appreciation of relevance and separation of facilitation from line management. Participants also expressed concern that, without adequately trained facilitators, the clinical supervision experience could be less than optimal and had the potential to erode the confidence of child and family health nurses in their clinical practice. A systematic review by O'Neill et al. (2022) of clinical supervision practice by community-based CFHNs emphasised the significance of organisational commitment to clinical supervision, supervisor training, and supervisee orientation to the process for effective participation. Access to networking opportunities for professional development, skill building, and clinical supervision was

considered essential to maintaining quality and competence in clinical practice by rural and remote CFHNs in this study.

Miller (2020) observed that supervision via videoconferencing offered rural and remote clinicians the opportunity to connect with and receive support from colleagues. Videoconferencing requires additional skills in using digital technology, negotiating privacy in an unfamiliar setting, and understanding the difference between virtual communication with the loss of nonverbal cues or screen buffering and freezing. While the COVID-19 pandemic presented numerous challenges to child and family health nursing, participants in this study acknowledged the opportunity for connection in group settings with colleagues that digital platforms offered to CFHNs in rural and remote areas. This occurred despite their preference for face-to-face contact. Observation of practice, assessment instruments, peer review, and clinical supervision are complementary processes that support the development of quality and competence in child and family health nursing practice to ensure that children and families receive safe, high-quality care.

First Nations focus is peripheral

Mainstream health services aim to deliver culturally safe care to individuals from diverse cultural backgrounds. A disparity in health outcomes exists between Aboriginal and non-Aboriginal children nationally (Hanly et al., 2018). Despite the implementation of various initiatives by federal, state, and local governments in Australia aimed at enhancing the health outcomes of Indigenous children, empirical evidence consistently indicates that nearly half of all Aboriginal children are classified as vulnerable, which is twice the proportion observed among non-Indigenous children (Australian Institute of Health and Welfare, 2015). It was anticipated, therefore, that participant interviews and organisational documents would encompass the provision of care for Aboriginal children and families.

While this study did not have a deliberate focus on First Nations peoples, the majority of organisational child and family health documents provided lacked specific references to care for Aboriginal children and families. Aboriginal Health Workers or Aboriginal Health Practitioners were mostly acknowledged within these documents, however. In this study, organisational documents for the mainstream child and family health nursing services described a reliance on Aboriginal Health Workers or Aboriginal Health Practitioners to connect CFHNs with Aboriginal children and families to conduct growth and developmental monitoring. To facilitate engagement with Aboriginal children and families, Austin et al. (2022) argued that all CFHNs must comprehend First

Nations culture and have a positive relationship with the First Nations community in which they operate, as well as an authentic understanding of what is needed. Based on the participants' perspectives and the organisational documents provided, it was found in this study that work with Aboriginal children and families was absent or segregated, and cultural competence was not embedded into practice. Understanding what is required for CFHNs to provide culturally safe and competent care within mainstream services would enhance the quality of care provided to Aboriginal children and families.

Work with First Nations people is absent or segregated

In this study, one jurisdiction provided organisational documents to guide the clinical practice of CFHNs that acknowledged the vulnerability of Aboriginal children concerning growth and development and the need to provide comprehensive assessments of health and treatment of illness. In another jurisdiction, the organisational document described a separate child and family health service designed to be delivered by various health professionals to meet the needs of Aboriginal children and families. Participants in the study acknowledged that the child and family health services with which they were involved did not always engage effectively with Aboriginal families, and they felt inadequate in their clinical practice. According to Austin's (2022) research, care provided by CFHNs in mainstream child and family health services was inflexible in approach, did not consider broader family issues, and there were miscommunications regarding the health and well-being of children and their families. Family-centred care was recognised by McCalman et al. (2017) as a means for primary health care services to enhance health and well-being outcomes for Aboriginal children and families, as well as consumer satisfaction and access to mainstream services.

Previous research indicated that primary health care services are constrained by policies and practices that challenge the nuanced environment required to address social determinants of health issues for vulnerable populations effevctively (Baum et al., 2013). The findings from Yelland et al.'s (2016) research into primary health care for Aboriginal women and children in the year after birth suggested that the involvement of Aboriginal health workers provided support and advocacy in facilitating the connection of CFHNs with Aboriginal families. Further to this, Austin and Arabena (2021) discovered that, for Aboriginal families to avail themselves of mainstream services, it was necessary to amalgamate traditional Aboriginal child-rearing practices with Western beliefs and values through the facilitation of shared knowledge, engaging in yarning, fostering mutual trust, and establishing connections.

Cultural competence is not embedded in practice

According to participants in this study, cultural competence, cultural support, and the provision of culturally appropriate services were all mentioned in organisational documents but not consistently implemented in the child and family health clinical practice setting. Sivertsen et al.'s (2022) exploration of health workers' perspectives on culture-centred care for Aboriginal women and their infants showed that culturally safe practice appeared to be an addendum to mainstream care rather than an integrated and safe care method. To provide competent care to children and families, participants in this study who worked in remote child and health nursing services stated that they initially felt ill-equipped to work in Aboriginal communities and may have inadvertently imposed their Western cultural views, such as advising on parenting practices. These findings align with research into CFHNs' understanding of racism conducted by Grant and Guerin (2018). The research suggested that nurses effectively navigated their clients' cultural and personal preferences and their own understanding stemming from personal or professional experiences. Nurses accomplished this by adapting their approach to deliver services and information that they deemed suitable. It is important to note, however, that this approach inadvertently perpetuated existing structural and ideological biases.

In this study, CFHNs who worked in metropolitan and rural areas reported that Aboriginal children and families were referred to Aboriginal health programmes because they were more culturally appropriate. As a result, mainstream child and family health nursing services did not prioritise enhancing cultural safety. To provide quality and competent care to Aboriginal families, experienced CFHNs in rural and remote areas knew they needed the patience to observe, listen, and learn from particular cultural health practitioners. In research that examined Indigenous narratives, the authors argued that by engaging in discourse with Indigenous people as recipients of care, their knowledge and experiences are elevated and their influence in health communication and policy are recognised (Jennings et al., 2018). The idea that cultural competence can be accomplished through a static process centred on acquiring knowledge, skills, and attitudes was challenged by Curtis et al. (2019). Instead, the authors emphasised the significance of conceptualising cultural safety as an ongoing, reflective process centred on critical awareness. In order to ensure culturally safe and respectful care, practitioners must consider the socioeconomic and cultural backgrounds of their clients, as well as the environment in which care is delivered. This consideration is crucial for extending care beyond Aboriginal community-controlled organisations and into mainstream services (Mackean et al., 2020). In this study,

examination of organisational documents uncovered that the work of CFHNs is governed by multiple policies and guidelines that do not necessarily articulate cultural competence for CFHNs or culturally safe care for Aboriginal children and families.

Summary

The factors that emerged from an analysis of the findings related to the qualifications and experiences that CFHNs bring to their practice and how they build on their qualifications and experience in child and family health nursing settings. Ideology and organisational expectations to meet child and family health service provision did not meet the clinical practice expectations of CFHNs, leading to decreased quality and competence in practice. Organisational initiatives to measure quality diminished CFHNs' feelings of competence as they believe they are unable to work to the full extent of their role to provide comprehensive primary health care to children and families. The CFHNs placed high value on reflective practice and peer review tools and processes, as these methods afforded them the chance to validate the quality and competence of their professional practice. CFHNs need to provide culturally safe care for Aboriginal children and families within mainstream services to support the optimal growth and development of Aboriginal children.

CHAPTER EIGHT: CONCLUSION

This research explored the perspectives of CFHNs from metropolitan, regional, rural and remote health jurisdictions across Australia regarding how quality and competence are identified and measured in the specialist practice of child and family health nursing. Semi-structured interviews were conducted with sixty CFHNs who were purposively sampled from community organisations across all states and territories in Australia. Furthermore, the participants submitted eighty-four organisational documents that they deemed pertinent to their clinical practice to provide workplace context. These documents outlined procedures, evaluations, or instruments that signify the standards and proficiencies required in clinical practice.

Previous research that informed the current study investigated quality and competence in child and family health nursing practice by exploring the role and scope of CFHNs' practice and the requirement of pre-requisite qualifications to work as a CFHN. A small-scale study conducted by Borrows et al. in 2011, for example, explored the scope of clinical practice for CFHNs in WA. It mapped the roles of CFHNs and the extent of their clinical practice. It also highlighted the importance of the child and family health nursing role in caring for children and families and the need for formal reflective clinical supervision to support professional development. Educational preparation of CFHNs was the focus of Kruske and Grant's (2012) study, which found that no universal standards across postgraduate education courses existed. These researchers recommended the development of minimum education standards to ensure quality and competence in child and family health nursing practice. Fowler et al. (2015) confirmed that no changes in postgraduate education courses regarding minimum standards had occurred in the intervening years since the Kruske and Grant study was published in 2012. The current study reported in this thesis also recognised the importance of CFHNs' work with children and families and the requirement to have a qualified and competent workforce.

A small-scale study involving two CFHNs from each state and territory conducted by S. Fraser et al. (2016) found variations in the role descriptions and scope of practice of CFHNs across Australia. This study informed the standards of practice for CFHNs, which were developed in 2017, but did not extend to identifying quality and competence in child and family health nursing practice. These previous studies, from 2011 through to 2016, collectively pointed to the need for a larger-scale Australian study that built on the conduct and findings of previous research in child and family health nursing. The research reported in this thesis extended the scope and participation base of

the previous studies and focused on how quality and competence in child and family health nursing practice are identified and measured. This focus was important because of the impact that levels of quality and competence in the clinical practice of CFHNs have on the provision of care in the early years, which influences the growth and development of children.

This chapter begins with an overview of the findings, followed by reflections on the strengths and limitations of the study. It then presents recommendations for clinical practice and future research.

Overview of the findings

The findings of this focused ethnography provide in-depth insights into CFHNs' identification and measurement of quality and competence in clinical practice as it relates to care for children from birth to five years and their families. These findings emphasise the complex nature of child and family health nursing practice that strives to provide quality and competent care to support the growth and development of children.

Analysis of the data from the semi-structured interviews and the content of the policy and procedural documents provided by the participants led to the finding that there were inconsistencies between clinical practice as experienced by CFHNs and the organisational documents intended to guide their practice. These inconsistencies pose challenges in implementing concrete measures of quality and competence in clinical practice, especially in the absence of standardised role descriptions or qualifications for child and family health nursing practice throughout Australia. A contrast, therefore, exists between the criteria that organisations consider essential for delivering services to children and their families and the clinical practice that CFHNs perceive as the optimal approach to address the requirements of children and their families.

It was also found that organisations did not always apply the perspective of comprehensive primary health care to the practice of child and family health nursing. Instead, they focused on biomedical processes, such as weighing and measuring children, rather than early intervention and health promotion. This study did not have a deliberate First Nations focus; however, participants mentioned in passing their lack of skills and knowledge to engage effectively with Aboriginal clients. Cultural competence, cultural support and the provision of culturally appropriate services

appeared in some organisational documents, but these processes were not consistently implemented in child and family health nursing practice.

Postgraduate qualifications obtained by CFHNs, coupled with guidance provided by the national standards of practice, potentially provide the basis for a tangible framework for ideal clinical practice. Participants often remarked that expectations around postgraduate qualifications and national standards of practice, however, are difficult to achieve in environments where the work of CFHNs is undervalued.

CFHNs are a vital part of the universal child health system that seeks to provide a high quality service to all children and families regardless of where they access child and family health services; therefore, uniformly raising the standards of clinical practice is an important step. The research findings show variability in the standards of clinical practice and professional development of CFHNs and point to the importance of providing a qualified workforce with access to reflective supervision, peer review, professional development and embedded transition to practice programmes to maintain competent child and family health nursing practice.

Research strengths and limitations

One of the strengths of this research was its scope, as it provided windows into the personal experiences of 60 CFHNs working in metropolitan, regional, rural and remote workplaces across all Australian states and territories. Individual semi-structured interviews, which were conducted online, enabled these experiences to be shared with the researcher for the purpose of exploring how quality and competence in the specialist practice of child and family health nursing are identified and measured.

The online platform for interviews could also be regarded as a limitation because of the potential for technological interruptions. These interruptions were uncommon and were circumvented, however. For example, participants working in rural and remote locations had occasional connectivity issues with internet signals, which were resolved by rescheduling the interviews or conducting them via telephone. The latter occurred on two occasions. While the online opportunity to observe participants in their workplaces and non-verbal cues was lost, the interviews were still able to be audio-recorded for transcription and analysis.

The restrictions imposed on travel and access to health services across Australia during the COVID-19 pandemic removed the opportunity for the researcher to undertake field observations of

participants in their workplaces. The widespread use of technology in workplaces to maintain connections with colleagues during this period heightened familiarity and comfort with online platforms. The CFHNs' experiences with these methods enabled the optimal use of online platforms to collect data through the semi-structured interviews conducted in this research. Further, the branch of ethnography known as focused ethnography was already established as a viable and accepted methodological approach to qualitative research in health-related studies. Unlike ethnography more broadly, the focused ethnographic approach does not depend on physical immersion in the field. Coupling the semi-structured interviews with relevant organisational documents provided by participants in this research enabled the aims of the research to be achieved. In terms of this study, replacing immersion in the field with immersion through online platforms for most interviews removed the challenges that extended travel would have presented and enabled more participants across Australia to be involved in the study.

Document access in this study relied on participants' perceptions of what was relevant to child and family health nursing practice. Hence, it is possible that additional documents were overlooked if the participants considered them to be unrelated to the discourse. Additionally, participants could not share online organisational documents that required workplace login access. On balance, however, the number and range of documents available amply complemented the data from the interviews to enable triangulation.

Recommendations for clinical practice

The findings from this research provide an unique insight into the quality and competence of child and family health nursing practice. Participants identified complexity in assessing quality and competence in child and family health nursing practice. They also indicated, however, that some organisations had tools and processes to support the identification and measurement of quality and competence in clinical practice. The research findings point towards recommendations for clinical practice. These recommendations are improving reflective practice, implementing a transition to practice programmes, and pursuing postgraduate qualifications to support quality and competence in child and family health nursing practice.

Reflective practice

The research highlighted the need for greater recognition of reflective practice processes and peer review tools that validate quality and competence in child and family nursing practice. The first recommendation, regular formalised peer review, resulted from participants identifying the

benefits of having a colleague observe their clinical practice, including a reflective discussion, to promote safe and competent practice. CFHNs work independently in clinics and homes, which limits the opportunities for colleagues to view their work practices and provide feedback to validate clinical practice. From an individual perspective, the provision of peer review opportunities for CFHNs would facilitate their ability to express and record their proficiency in professional practice. CFHNs can use peer review documentation for the purpose of constructing practice portfolios and for inclusion in performance evaluations conducted by managers. Using a strength-based approach to peer review, focusing on positive attributes and identifying practice areas for improvement promotes confidence in the CFHN's ability to provide safe and competent care to children and families.

Participants identified that formalised peer review contributes to the professional performance review process and monitoring of the quality of care provided to clients attending child and family health services. The recommendation of conducting peer reviews regularly, for example every six months, would enable managers to address clinical practice issues proactively to improve the quality of care provided to children and families. Documentation of the peer review process would be of benefit to managers who are not CFHNs to understand the context of child and family health nursing practice. Effective implementation of peer review would require managers and organisations to value the process and outcomes by providing the time for CFHNs to conduct peer review as a regular part of their workplace practices.

While the findings showed that several jurisdictions supported reflective clinical supervision, it was not fully embedded in all jurisdictions. The second recommendation is the implementation of regular reflective clinical supervision for all CFHNs across Australia. Without the processes and practices to enable the development of insight, CFHNs cannot truly reflect on their practice and whether they provide safe and competent care to children and families. Clinical supervision can offer the opportunity for CFHNs to develop the reflective capacity to address their concerns or issues related to individual clinical practice. Compared to informal debriefing with colleagues, formalised clinical supervision can offer a non-judgemental and confidential space to reflect on practice. From an individual perspective, clinical supervision could enhance the capacity of CFHNs to develop self-awareness regarding their support needs and effectively manage challenging situations with clients.

From an organisational standpoint, clinical supervision can support CFHNs as an effective workforce providing safe and competent care to children and families. Through clinical supervision, managers can support the health and well-being of their staff working with increasingly complex families, providing a confidential space for reflection to reduce stress and burnout. Group clinical supervision can offer the prospect of knowledge sharing between experienced and novice CFHNs. It also has the potential to benefit clients who attend child and family health nursing services. The successful implementation of the recommendation for regular reflective clinical supervision would require a commitment from the organisations to offer CFHNs the opportunity to undertake education to become clinical supervisors within the child and family health nursing profession. In addition, CFHNs would require organisations to provide guaranteed release time from client work to attend education. Offering clinical supervision to rural and remote CFHNs requires flexibility in providing both face-to-face and online access based on the accessibility of services. Reflective practice confers numerous advantages onto CFHNs, as it can support their competence in clinical practice, potentially enhance the quality of services offered by organisations, and enable safe and competent care to be provided to children and families.

Transition to practice programmes

In light of the issues of maintaining a qualified workforce, the research identified that comprehensive transition to practice programmes connected to tertiary qualifications could effectively build a safe and competent workforce into the future. The third recommendation is to implement comprehensive transition to practice programmes in child and family health nursing services across Australia. The findings highlighted the value of the transition to practice programmes for postgraduate student and novice CFHNs in building their skills and knowledge to establish independent practice. These programmes can offer opportunities for experienced CFHNs to impart their valuable knowledge and skills through precepting or mentoring both student and novice CFHNs. In addition, the transition to practice programmes can provide pathways to support child and family health nursing services to address the issue of employing a competent CFHN workforce.

Registered nurses enrolled in postgraduate child and family health nursing education, whilst working in modified child and family health nursing roles, can embed their theory into practice in meaningful ways. From a tertiary education perspective, the transition to practice programmes can potentially address the clinical placement hours students must complete during their training. Offering paid employment with or without supported scholarships to complete postgraduate

study would incentivise registered nurses to choose child and family health nursing as a career. While this practice occurs in a few jurisdictions, the recommendation is to expand these transition to practice programmes to address workforce solutions across Australia. Transition to practice to programmes would provide novice CFHNs with opportunities to gain confidence in clinical practice in a supportive environment that creates safety for clients.

Many areas of nursing are experiencing workforce shortages as nurses are retiring. Child and family health nursing is particularly vulnerable to this situation, with a sizeable part of the workforce over 50 years of age with more than 15 years of experience (Johnston et al., 2020; Thentz et al., 2022). This situation also presents an opportunity to retain experienced CFHNs by reducing their clinical load and buddying them with novice CFHNs as preceptors in transition to practice programmes. Furthermore, these initiatives can facilitate the establishment of clinical nurse educator positions for skilled CFHNs that serve to oversee the supervision of clinical practice, promoting safety and competence in this space.

Postgraduate qualifications

The fourth recommendation is for all CFHNs to complete a postgraduate child and family health nursing qualification to work in Australian child and family health services. Currently in Australia, specialisation as a CFHN is not required to be registered with Australia's Nursing and Midwifery Board and a postgraduate qualification in child and family health nursing is not a mandated requirement to practice. Postgraduate education programmes also differ in content and award from certificate to master's level. Tertiary accredited postgraduate child and family health nursing qualifications can provide a higher degree of knowledge and expertise in this specific field to provide safe and competent clinical care to children and families. Nurses undertaking postgraduate education in the area of child and family health nursing would gain access to a unique body of evidence-based knowledge that can support their critical thinking in clinical practice to assess and adapt their anticipatory guidance to support the health, development and wellbeing of children and families. The findings highlighted the importance of child and family health nursing qualifications as CFHNs practice independently, particularly in rural and remote areas and therefore would require the knowledge and skills to offer children and families safe and competent care. In addition, managers with child and family health nursing qualifications were better able to understand the context of the role of CFHNs and advocate for the support required by CFHNs to maintain their competence in practice. Clinical leadership that recognises the value of

a postgraduate child and family health nursing qualification can support the recommendation that organisations employ qualified CFHNs to provide safe and competent care to children and families.

Recommendations for future research

The direction and scope of the research reported in this thesis builds on and extends previous research into child and family health nursing practice in Australia, both substantively and methodologically. The findings, drawn from an exploration of the perceptions of a wide participant base around how quality and competence in child and family health nursing practice is identified and measured, enabled several main pathways for future research to be discerned. Further, the constructivist-interpretivist lens and the focused ethnographic approach applied to the study offer methodological possibilities for researchers who aspire to advance research by exploring one or more of these pathways.

The first recommendation for future research is broader conversations with health service organisations and CFHNs about transition to practice programmes and how the composition of these programmes can support and sustain the specialist child and family health nursing workforce nationally. Research that explores both service provision requirements and the essential aspects of the clinical practice of CFHNs, could provide a deeper understanding of how organisations are able to deliver safe, competent and culturally appropriate child and family health services. Findings from studies that pursue this pathway may lead to suggestions for enhancement of services that currently draw on a workforce that comprises workers with varied qualifications as well as a wealth of wisdom drawn from a range of experiential backgrounds.

The National Standards of Practice for Maternal Child and Family Health Nurses in Australia were designed to guide clinical practice. This research found that CFHNs' knowledge of how these standards can be used to inform quality and competent child and family health nursing practice was limited. The second recommendation for future research is an exploration of the applicability and implementation of these standards in postgraduate child and family health nursing education, clinical practice or health services. This recommendation not only builds on the findings of the research reported in this thesis but also has precedence in the UK, where standards for specialist practice qualification programmes exist. These standards are based on proficiency standards for health visitors (equivalent to CFHNs in Australia) to provide safe clinical care for children and families. The research could explore the potential for National Standards of Practice for Maternal, Child and Family Health Nurses in Australia to guide the standardisation of tertiary education

programmes and be implemented into CFHNs' clinical practice. An aspect within this pathway might focus on how cultural safety and competence are acknowledged in the standards of practice through broad consultation with child and family health service employers, nursing managers, CFHNs and consumers.

In conclusion, the aim of this study was to explore how quality and competence were identified and measured in the specialist practice of child and family health nursing. The focused ethnographic methodology combined with a constructivist-interpretivist paradigmatic approach uncovered the complexity of the work of CFHNs and how that work involves more than just weighing babies.

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APPENDICES

Appendix A: Supplementary material – Database search strings

Medline	CINAHL	Scopus	Web of Science
1.Nurse/ Work Environment descriptors			
exp community health nursing/ or family nursing/ or maternal-child nursing/ or public health nursing/ or Nurses, Community Health/ or (((child or maternal or family or plunket or community or public health or public-health) adj3 (nurse* or nursing)) or (“home visitor*”)).tw,kw.	**(MH "Family Nursing")** OR **(MH "Maternal-Child Nursing+")** OR **(MH "Community Health Nursing+")** OR **(MH "Primary Nursing")** or TI((((child OR maternal OR family OR plunket OR community OR "public health" OR "public-health") N3 (nurse* OR nursing))) OR ("home visitor*")) OR AB ((((child OR maternal OR family OR plunket OR community OR "public health" OR "public-health") N3 (nurse* OR nursing))) OR ("home visitor*"))	TITLE-ABS-KEY (((child OR maternal OR family OR plunket OR community OR "public health" OR "public-health") W/3 (nurse* OR nursing)) OR "home visitor*")	TS= (((child OR maternal OR family OR plunket OR community OR "public health" OR "public-health") NEAR/3 (nurse* OR nursing)) OR "home visitor*")
2.Infant/ Child descriptors			
exp child, preschool/ OR infant/ OR infant, newborn/ or (newborn OR infant* OR infancy OR neonat* OR child* OR toddler OR baby OR babies OR preschool* OR "pre-school*" OR kindergarten* OR "nurser	(**MH "Child+"**) OR (**MH "Infant+"**) OR TI ((newborn* OR infant* OR infancy OR neonat* OR child* OR toddler OR baby OR babies OR preschool* OR "pre-school*" OR kindergarten* OR "nursery school*" OR "post-partum" OR "post partum")) OR AB ((newborn* OR infant* OR infancy OR neonat* OR child* OR toddler OR baby OR babies OR preschool* OR "pre-school*" OR kindergarten* OR "nursery school*" OR "post-partum" OR "post partum"))	TITLE-ABS-KEY (newborn OR infant* OR infancy OR neonat* OR child* OR toddler OR baby OR babies OR preschool* OR "pre-school*" OR kindergarten* OR "nursery school*" OR "post-partum" OR "post partum")	TS= (newborn OR infant* OR infancy OR neonat* OR child* OR toddler OR baby OR babies OR preschool* OR "pre-school*" OR kindergarten* OR "nursery school*" OR "post-partum" OR "post partum")

3.Growth, Development, Health and Wellbeing descriptors			
"growth and development"/ or exp growth/ or exp human development/ Or child development/ or exp language development/ or **exp Adaptation, Psychological/ or Mental Health/ or "Quality of Life"/** or ((wellbeing OR well-being) or ((physical OR motor OR cognitive OR cognition OR speech OR language OR sensory OR vision OR hear* OR emotion* OR social) adj3 (growth OR develop* OR milestone* OR mile-stone* OR progress* OR regress* OR stall OR stunt* OR arrest* OR thrive OR regress* OR stall)) or "mental health" or ((social OR emotion*) adj2 regulat*)).tw,kf	**(MH "Human Development") OR (MH "Child Development") OR (MH "Emotional Maturity") OR (MH "Human Needs (Psychology)+") OR (MH "Infant Development") OR (MH "Language Development") OR (MH "Quality of Life") OR (MH "Psychological Well-Being")** OR TI (((physical OR motor OR cognitive OR cognition OR speech OR language OR sensory OR vision OR hear* OR emotion* OR social) N3 (growth OR develop* OR milestone* OR mile-stone* OR progress* OR regress* OR stall OR stunt* OR arrest* OR thrive OR regress* OR stall))) OR AB (((physical OR motor OR cognitive OR cognition OR speech OR language OR sensory OR vision OR hear* OR emotion* OR social) N3 (growth OR develop* OR milestone* OR mile-stone* OR progress* OR regress* OR stall OR stunt* OR arrest* OR thrive OR regress* OR stall))) OR TI "mental health" OR AB "mental health" OR TI (((social or emotion*) N2 regulat*)) OR AB (((social or emotion*) N2 regulat*))	TITLE-ABS-KEY (((physical OR motor OR cognitive OR cognition OR speech OR language OR sensory OR vision OR hear* OR emotion* OR social) W/3 (growth OR develop* OR milestone* OR "mile-stone*" OR progress* OR regress* OR stall OR stunt* OR arrest* OR thrive OR regress* OR stall)) OR "mental health" OR ((social OR emotion*) W/2 regulat*)))	TS= (((physical OR motor OR cognitive OR cognition OR speech OR language OR sensory OR vision OR hear* OR emotion* OR social) NEAR/3 (growth OR develop* OR milestone* OR "mile-stone*" OR progress* OR regress* OR stall OR stunt* OR arrest* OR thrive OR regress* OR stall)) OR "mental health" OR ((social OR emotion*) NEAR/2 regulat*))
1 AND 2 AND 3			
Limited to 2009 - 2019			
Search results - 666	Search results - 1374	Search results - 652	Search results - 463
Grey literature sources produced 10 documents			

Appendix B: Supplementary material – Summary of included papers

Final theme: CFHNs care for parents to facilitate care of infants and children

Author , Title, citation	Year and Country	Aim/ Objective	Sample/ setting	Methods/ Methodology	Major finding	Limitations/ rigour and validity	Significance of the issue	Potential coding label/ theme
Sarkadi, A., Gulenc, A., & Hiscock, H. (2015). Maternal and child health nurses' self-perceived confidence in dealing with child behaviour problems. Child Care Health and Development, 41(2), 324-328.	2015 Australia	assess MCHNs self percived confidence in dealing with child behaviours problems	153 MCH nurses in 9 LGA in greater Melbourne	Crossectional Questionnaires study using survey and descriptive statistics to analysis responses	63% deal with behaviour rather than refer, 86% found task rewarding, 96% advice should be universal, 60% found parents response challenging	undertaken in limited setting but large cohort	dealing with child behaviour issues with parents is core work for MCHN and they need to work with parents to support change	supporting parents with child behaviour change
Myors, K. A., Schmied, V., & White, E. (2014). Child and family health nurses working with families of preschool-aged children. Journal of Clinical Nursing, 23(1-2), 181-190.	2014 Australia	examine CFHNs perceptions of and practices related to working with families of preschool aged chidrenand their child's behaviour	48 CFHNs, 8 managers in 2 metro health services in NSW	Qualitative interpretive study (focus groups, interviews and observations of 23 clinical interactions between CFHNs and parents/ preschool children	CFHNs the expert, perceiving parents lacked knowledge; advocating for the child, promoting parenting strengths; accepting parents decisions, flexibility; time pressures related to observations of children, and changing programs	small sample of nurse, known researcher may have pos /neg influence on data collections	supporting parents, accepting shared responsibility of decision making	supporting parents , shared decision making
McAtamney, R. (2011). Health visitors' perceptions of their role in assessing parent-infant relationships. Community Practitioner, 84(8), 33-37.	2011 Scotland, UK	explored HV perceptions of their role in assesing and supporting parent-infant relationships	6 health visitors	Interpretive study (interviews)with Health Visitors	understanding maternal social and infant factors, knowledge related to parent/infant interactions and relevant tools to support assessment	small scale study in one geographical area	importance of understanding parent/infant relationships and how to support parents in developing relationships with infants	supporting parents with parent/infant relationships
Cohen, B. E., & McKay, M. (2010). The role of public health agencies in addressing child and family poverty: public health nurses' perspectives. The Open Nursing Journal, 4, 60-71.	2010 Canada	explored perspectives of PHNs and their protential role in addressing thet impact of poverty on children and families health	23 Public health nurse in large urban regional health authority	Qualitative descriptive study (Focus group interviews) public health nurses	PHNS support parents with issues of poverty, unhealthy parenting behaviour, lack of parenting skills in order to support healthy child development and prevention of illness	small scale study in one geographical area of developed country but detailed analysis	supporting parents with their needs enables them to support their children's needs and growth and development	supporting parent to support their infants and children
Fowler, C., Schmied, V., Dickinson, M., & Dahlen, H. G. (2017). Working with complexity: experiences of caring for mothers seeking residential parenting services in New South Wales, Australia. Journal of Clinical Nursing, 26(3-4), 524-534.	2017 Australia	investigate staff perceptions of the changing complexity of mother and infants admitted to residental parenting services	35 CFHNs and 10 physicians in residential parenting service	Qualitative descriptive study (focus group interviews)	address infant /child issues such as unsettled behaviours and feeding by addressing parental or family issues including DV, mental health, trauma relationship of parent and infant/child to support change in infant /child dysregulation	phase 3 of larger study, site specific findings , detailed anlaysis	increasing need seen to address parent needs to support change in infant/child behaviour	supporting parents to support infant and children
Shepherd, M. L. (2011). Behind the scales: child and family health nurses taking care of women's emotional wellbeing. Contemporary Nurse, 37(2), 137-148. doi:https://dx.doi.org/10.5172/conu.2011.37.2.137	2011 Australia	looked at CFHN role of supporting mother's emtional health and wellbeing and caring for baby	12 CFHNs in regional city and surrounding riral area	ethnographic study including group and individual interviews and observation of home visits	CFHNs balancing growth and developmental check of infants and managing parental mental health and wellbeing.	small scale study in one geographical area	Recognising that caring for mothers is supportive of the health and wellbeing infants	supporting parents is supportive of infants
Bryant, E., Ridgway, L., & Lucas, S. (2016). Attachment icebergs: Maternal and child health nurses' evaluation of infant-caregiver attachment. Community practitioner : the journal of the Community Practitioners' & Health Visitors' Association, 89(5), 39-43.	2016 Australia	explored how MCHNs asses parent-infant attachment	12 MCHNs in universal health service	qualitative descriptive study	MCHNs knowledge and skill in observations of the interaction of infants and carers to assess difficulties in the relationship between infants and carers.	small study of one group of MCHNs, detailed themeatic analysis	Observing infant behaviours gave insight into their health and wellbeing and observing parental behaviours and how well they were managing their infant's needs.	supporting parents to see their infants needs when parents weren't seeing them
Eronen, R., Pincombe, J., & Calabretto, H. (2010). The role of child health nurses in supporting parents of young infants. Collegian: Journal of the Royal College of Nursing, Australia, 17(3), 131-141.	2010 Australia	explored role of CFHNs in suporting parents of young infants	413 parents accessing CFHNs in metro health service	self reported questionnaires analyseed using descriptive and inferenetial statistics	Focused on support provide by CFHNs to parents in caring for their infants. Providing information about child growth and development. Supporting parent with knowledge so they could care for their infants. Showed respect and empowered parents	ststicial significance p=0.05 and allowed for data analysis of subgroups	79% parents valued CFHNs professional support but concerns about being respected as parent, parenting skills, supported in infant care choices	Important to support parents in the parenting to make informed chioices in infant care

Final theme: CFHNs care for infants and children by working in partnerships with parents

Author , Title, citation	Year and Country	Aim/ Objective	Sample/ setting	Methods/ Methodology	Major finding	Limitations/ rigour and validity	Significance of the issue	Potential coding label/ theme
Rossiter, C., Fowler, C., Hesson, A., Kruske, S., Homer, C. S. E., & Schmied, V. (2019). Australian parents' use of universal child and family health services: A consumer survey. Health & Social Care in the Community, 27(2), 472-482.	2019 Australia	explore how parents use universally available well child health services	783 parents and carer survey of use of universal CFH services	exploratory study - online cross sectional survey	Parental choice to access services of CFHNs to obtain regular development checks, immunisations, advice about child health concerns and mental health support . May see pharamacy or nurse at GP if more accessible	internet survey may have limited access and skewed towards older well educated parents, limited generalisability	A sense of trust or reassurance fostered by their CFH nurses and working together with parents	working together with parents to care of infants and children
Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., . . . Zapart, S. (2011). Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. Archives of Disease in Childhood, 96(6), 533-540.	2011 Australia	investigate impact of long term nurse home visiting programme embedd within a universal child health system	208 (111 intervention, 97 comparison) eligible at risk mothers	RCT Routine universal care vs long term home visiting by CFHNs	CFHNs provide care to infants and children through home visits at prescribed developmental points. Focused on parental mental health and parent child interaction to improve development of infants and children though working in partnership with parents.	sample size power of analysis, and low particpation rates at some data collection points	Whilst positive outcomes for parental mental health, there were no significant changes for infant/child development compared to universal services	Working in partnership with parents to improve child health and development
Astbury, R., Shepherd, A., & Cheyne, H. (2017). Working in partnership: the application of shared decision-making to health visitor practice. Journal of Clinical Nursing, 26(1-2), 215-224.	2017 Scotland, UK	explore the process of shared decicion making around infants and children's care by health visitors and parents	9 health visitors and 9 parents	phase1 recording health visitors/parent dyad, questionaires . Phase 1 semitstructured interviews with parent and health visitors	(HVs) working with parent to make decisions about interventions related to their infant or child's care. HVs providing information about benefits, priorities and choices. HVs giving direct instructions if they thought it was necessary to address infant and child well being	small sample size and existing HV parent relationship may have influenced findings	Parents viewed they had a choice in decision making.	partnership with parenting decicison making
Fraser, S., Grant, J., & Mannix, T. (2016). Maternal Child and Family Health Nurses: Delivering a Unique Nursing Speciality. Maternal & Child Health Journal, 20(12), 2557-2564.	2016 Australia	describe MCaFHNs' perception of their role across Australia	16 from MCaFHNA committee	in depth telephone interviews and analysis of transcipts for themes	MCaFHNs have skills and knowledge in child growth and development, maternal mental health, provide health information. Building parenting capacity through establishing therapeutic relationships and family partnership and family centred care enables care of infants and children	small sample size limit of 2 particpants per jusrisdiction	unique skills to work with dyads and support parents to care for their infants and children	working with families as partners in care
Olsen, A. L., Ammitzboll, J., Olsen, E. M., & Skovgaard, A. M. (2019). Problems of feeding, sleeping and excessive crying in infancy: a general population study. Archives of Disease in Childhood, 104(11), 1034-1041.	2019 Denmark	explore regulatory problems in infancy and the influence of maternal mental health and parent-child relationship problems	reviewed data from CH assessments and national register on 2598 infants	descriptive statitics and logistic regression models	Explored how CHNs worked with parents around regulatory problems related to feeding, sleeping and excessive crying to support infant development. Reguatory problems (RP) at 2-6 months of age are highly assocaited with RPs at 8-11mths	large sample size from national register	Acknowledging that addressing parenting expectations, maternal mental health problems, parent-infant relationships, influences infant development trajectories	working with parents to address problems, acknowledging their role and decision making
Hanafin, S. (2018). Sleep patterns and problems in infants and young children in Ireland. Child: Care, Health and Development, 44(3), 470-475.	2018 Ireland	explored sleep behaviour patterns and problems in infancy and early childhood	national longitudinal study of children - 9mths - 11,112 3yrs - 9,790 5yrs - 8,996	descriptive statistics analysis	Explored how public health nurses and health visitors helped parents make sense of infants and young children's sleep patterns to identify problems by providing information and education and monitoring the health and wellbeing of infants and young children experiencing sleep problems	large sample size from national register	Public health nurses and health visitors have a key role to play in workingwith parenting to address sleep issues	partnering with parents to address sleep issues

Final theme: CFHNs use assessment tools to identify the health and wellbeing needs of children

Author , Title, citation	Year and Country	Aim/ Objective	Sample/ setting	Methods/ Methodology	Major finding	Limitations/ rigour and validity	Significance of the issue	Potential coding label/ theme
Poutiainen, H., Hakulinen, T., Maki, P., & Laatikainen, T. (2016). Family characteristics and parents' and children's health behaviour are associated with public health nurses' concerns at children's health examinations. International Journal of Nursing Practice, 22(6), 584-595.	2016 Finland	whether family characteristics and health behaviour and illnesss of parents and children are associated with PHNs concerns about children's physical health and psychosoical develepment	part to larger study looking a 1684 3-5yrs and 3111 7-16yrs	cross sectional study of health data collected at health check and parent questionnaires	PHNs examination of children included physical health measures e.g. BMI and psychosocial measures around behaviour and the impact of parental health and wellbeing issues. E.g. Mother's functioning capacity and limits set on child's behaviours impacted on child physical health particularly in relation to obesity.	large sample size statistical analysis using SPSS	Asessments of children's health and wellbeing along with family wellbeing is key concern for PHNs for good family health	assesments are important and key role for PHNs to address whole family health
Sjunnestrand, M., Nordin, K., Eli, K., Nowicka, P., & Ek, A. (2019). Planting a seed - child health care nurses' perceptions of speaking to parents about overweight and obesity: a qualitative study within the STOP project. BMC Public Health, 19(1), 1494	2019 Sweden	CHC nurses perceptions of speaking to parents about children's overweight/obesity and referrals	17 CHC nurses over 10 municipalities	phone semi sturctured interviews recorded, thematic analysis	CFHns utilise BMI chart plant the seed of a conversation about child's obesity with parent. Need clear intervention guidelines and cooperation of other health providers to support change for child. Discussion about obesity requires trusting relationships and time to explore family environmental and genetic factors	not a representative sample size, though findings similar to other international studies	Concern over adequate skills and knowledge of CHNs in relation to obesity assessments to communicate in a postive way with parents	CHC nurses need skills and knowledge about assessment tools
Bohman, B., Eriksson, M., Lind, M., Ghaderi, A., Forsberg, L., & Rasmussen, F. (2013). Infrequent attention to dietary and physical activity behaviours in conversations in Swedish child health services. Acta Paediatrica, International Journal of Paediatrics, 102(5), 520-524.	2013 Sweden	investigate conversations between parent and CHC nurses regarding dietary and physical activity	23 CHC nurses from 7 counties	audio recorded converstions parent and Nurse during child (2-4yrs)health assesment	CHNs focused on mostly on physical examinations, talking to child to maintain contact and interest, development of language skills whilst dietary habits and physical activities discussion were not often discussed.	part of larger cluster controlled trial, controll group, SPSS analysis	Noted CHNs were comfortable in surveillance but not always equipped to have discussion about prevention and intervention, need more opportunity to practice motivational interviewing	confidence in using tools and assessment, internvention and prevention topics
de Vries, A., Huiting, H. G., van den Heuvel, E. R., L'Abée, C., Corpeleijn, E., Stolk, R. P., & de Vries, A. G. M. (2015). An activity stimulation programme during a child's first year reduces some indicators of adiposity at the age of two-and-a-half. Acta Paediatrica, 104(4), 414-421.	2015 Netherlands	effect of early stimutaion of phyiscal activity on growth, body compostion and motor activity and developement in toddlers	13 nurses, 143 children in well child clinics	Cluster randomised controlled trial skin fold assessment before and after interventions	Involvement of nurses in well baby clinics to advise on stimulating motor development and promote physical activity at regular well baby checks. .	Program developed by physiotherapists so unsure if this requires further training for nurses.	Optimal opportunity to connect with infants and parents at routine growth and development checks and potentially reduce obesity in infants	Routine growth and development checks are important
Wen, L. M., Baur, L. A., Simpson, J. M., Rissel, C., Wardle, K., & Flood, V. M. (2012). Effectiveness of home based early intervention on children's BMI at age 2: randomised controlled trial. BMJ, 344, e3732.	2012 Australia	effectiveness of home based intervention on BMI at 2 yrs olds	667 first time mothers and their infants, trained community nurses	randomised controlled trial	CFHNs spent time with mother and infants teaching them skills and knowledge related to health infant feeding practices, child nutrition and active play, family physical activity and nutrition and social support.	Limited to local area but well developed outcome measures validated survey tools	Home visiting at key developmental check timeframes allowed time for discussion and delivery of messages to improve child health.	anticipatory guidance deliveredd by CFHNs can provide important information to parents for growth and development of children
Poutiainen, H., Hakulinen, T., Laatikainen, T., & Kettunen, T. (2015). Public health nurses' concerns in preschool-aged children's health check-ups. Journal of Research in Nursing, 20(7), 536-549.	2015 Finland	described PHNs concerns during regular check up for preschool aged children	12 PHNs from child health clinics and school services	indepth focus group interviews	Child health checks included parent child interaction, children's behavioural problems, setting boundaries, cognitive and motor development problems. Increasingly mental health and social problems in families, parenting skills and capacity to care for infants and children	small group but analysis backed up by data	PHNs conduct regular health check of infants and children 0-6 years and focus on growth and development with broad assessments of whole family	asssements include growth and development and psychosocial assessments

Final theme: CFHNs use assessment tools to identify the health and wellbeing needs of children (continued …)

Author , Title, citation	Year and Country	Aim/ Objective	Sample/ setting	Methods/ Methodology	Major finding	Limitations/ rigour and validity	Significance of the issue	Potential coding label/ theme
Amess, P., Young, T., Burley, H., & Khan, Y. (2010). Developmental outcome of very preterm babies using an assessment tool deliverable by health visitors. European Journal of Paediatric Neurology, 14(3), 219-223.	2010 England, UK	health visitors assessing development of very preterm infants using developemental tool	113 preterm infants in joint community and neonatal clinic	Cohort study - schedule of growing skills assessment at 12 and 24 months	Health visitors utilised a tool called Schedule of Growing Skills to assess developmental skills including posture, locomotor, fine manipulation, vision, hearing, speech, language and social development.	defined cohort study analysis not shown	Results showed that HV could screen for developmental delays with this tool as part of their routine care of preterm infants	screening tools can be applied in routine follow up assessments in community setting
Nayeb, L., Wallby, T., Westerlund, M., Salameh, E. K., & Sarkadi, A. (2015). Child healthcare nurses believe that bilingual children show slower language development, simplify screening procedures and delay referrals. Acta Paediatrica, 104(2), 198-205.	2015 Sweden	investigation of CHCN perceptions of language screening of bilingual children	863 CHC nurses from across 21 counties	questionnaire and multilevel Regression analysis	CHN simplified screening procedures or delayed referrals potentially leading to delayed diagnosis of language disorders. Reliant on outdated manuals of practice in a country known to have at least 30% bilingual pre-schoolers. CHN lack training	may not be representative of all CHN but detailed analysis shown	Whilst screening for language development is standard practice in child health checks there is no instructions for screen bilingual children	approapriate screening tools and training are required for correct assessments
Garg, P., Ha, M. T., Eastwood, J., Harvey, S., Woolfenden, S., Murphy, E., . . . Eapen, V. (2018). Health professional perceptions regarding screening tools for developmental surveillance for children in a multicultural part of Sydney, Australia. BMC Family Practice, 19(1), 42.	2018 Australia	examined attitudes, enbalers and barriers to current developmental surveillance practices	3NM, 1 SW, 2 GP practice nurses, 17 CFHNs, 6 GPs, 7 Paeds, 1 CMO	Semi structured individual and focus group interviews qualitative analysis	Perceived barriers - parents not aware or accessing routine health checks, transport to services, language barriers for screening tools, inflexibility of CFHN service access, Lack of knowledge about tools from GP , use of tools that are appropriate for multicultural clients.	defined local health district but findings consitnent with other international papers, good reflextivity	Useful as developmental guide and discussion point for parent and CFHNs, reliance on clinical judgement rather than evidence-based tools	Knowledge and skills related to use of developemental tools are important
Johansen, K., Persson, K., Sarkadi, A., Sonnander, K., Magnusson, M., & Lucas, S. (2015). Can nurses be key players in assessing early motor development using a structured method in the child health setting? Journal of Evaluation in Clinical Practice, 21(4), 681-687.	2015 Sweden	examineif nurses can apply structured early motor assessment to identify early , children at risk	55 infants and 10 nurses in child health centres	Structured observation assessment by 1 nurse and 1 physiotherapist	CHNs conducted regular milestone checks to monitor infant's development but not necessarily with evidence-based tools. Detailed tools available if infant referred to physiotherapist.	several assessors to prevent bias but lakc of significant defiencets in children to test accuracy	Potential to upskill CHN as they have regular access to infants and proven that CHN can competently assess motor development with education and training.	Routine screening provides opportunity for deined assessments
Gellasch, P. (2019). The Developmental Screening Behaviors, Skills, Facilitators, and Constraints of Family Nurse Practitioners in Primary Care: A Qualitative Descriptive Study. Journal of Pediatric Healthcare, 33(4), 466-477.	2019 USA	explored screening bahaviours, skills, environmental factors of FNP	24 Family nurse practitioners primary care settings with chilren 0-5 yrs	qualitiative descriptive design demographic questionnaire and semi structured interviews via online video conferencing	Used when concerns raised by parent, depends on familiarity with guidelines, recall of validated tools. experience using tools, uncertainty with assessments. Variation in practice setting, lack of time, parent resistant to concerns, accessible referral system, design of validated screening tools	reliant on subject recall and experience, detailed analysis backed up by data	Nurse practitioners used developmental screening behaviour at well child check, used tools such as ASQ, PEDS but inconsistently and only in part.	Validated developmental screening tools used in well child checks
Alakortes, J., Kovaniemi, S., Carter, A., Bloigu, R., Moilanen, I., & Ebeling, H. (2017). Do child healthcare professionals and parents recognize social-emotional and behavioral problems in 1-year-old infants? European Child and Adolescent Psychiatry, 26(4), 481-495.	2017 Finland	examine the reporting of Social and emotional behavioural problems of infants at 12mths old	1008 CHCN and 518 parental reports	questionnaires for CHCN and parents and brief infant toddlers social emational assesement (BITSEA), triangualtion of resuts and satatistialc analysis using IBM SPSS	Results showed CHCN and parents often differed in how they rated worries about SEB. Often parents and CHCN were reluctant to talk about concerns with SEB. Important to have sufficient education about SEB screening measures to ensure they effective and reliable	randomised selection of parent participants and detailed analysis	Regular use of BITSEA or other SEB screening tools might see more identification of SEB problems in infants as well as referral, interventions and follow up assessments.	Validated SEB tools are useful in early identification of SEB issues

Appendix C: Supplementary material – Appraisal criteria

				1. QUALITATIVE STUDIES					2. RANDOMIZED CONTROLLED TRIALS					3. QUANTITATIVE NON-RANDOMIZED STUDIES					4. QUANTITATIVE DESCRIPTIVE STUDIES					Value*
First author	Year	S1.	S2.	1.1.	1.2.	1.3.	1.4.	1.5.	2.1.	2.2.	2.3.	2.4.	2.5	3.1.	3.2.	3.3.	3.4.	3.5.	4.1.	4.2.	4.3.	4.4.	4.5.	
Sarkadi	2014	Y	Y																Y	Y	Y	Y	Y	H
Myors	2013	Y	Y	Y	Y	Y	U	Y																H
McAtamney	2011	Y	Y	Y	Y	Y	Y	U																H
Cohen	2010	Y	Y	Y	Y	Y	Y	U																H
Fowler	2016	Y	Y	Y	Y	Y	Y	Y																H
Shepherd	2014	Y	Y	Y	U	N	Y	U																L
Bryant	2016	Y	Y	Y	Y	Y	Y	Y																H
Eronen	2010	Y	Y																Y	U	Y	N	Y	M
Rossiter	2019	Y	Y	Y	U	Y	Y	Y											Y	N	Y	N	Y	M
Kemp	2011	Y	Y						Y	Y	N	U	Y											M
Astbury	2016	Y	Y	Y	Y	Y	N	U																M
Fraser	2016	Y	Y	Y	Y	Y	Y	Y																H
Olsen	2019	Y	Y																Y	Y	Y	Y	Y	H
Hanafin	2017	Y	Y																Y	Y	Y	Y	Y	H
Poutiainen	2016	Y	Y																Y	Y	Y	U	U	M
Sjunnestrand	2019	Y	U	U	U	Y	Y	Y																M
Bohman	2013	Y	Y																Y	Y	Y	U	Y	H
De Vries	2015	Y	Y						Y	Y	U	Y	Y											H
Wen	2012	Y	Y						Y	Y	Y	Y	Y											H
Poutiainen	2015	Y	Y	Y	Y	Y	Y	Y																H
Amess	2010	Y	Y											Y	Y	Y	U	U						M
Nayeb	2015	Y	Y	Y	U	Y	Y	U																M
Garg	2018	Y	Y	Y	Y	Y	Y	Y																H
Johansen	2015	Y	Y																Y	U	Y	Y	Y	H
Gellasch	2019	Y	Y	Y	Y	Y	Y	Y																H
Alakortes	2017	Y	Y											Y	Y	N	U	Y						M
Barbaro	2010	Y	Y																Y	U	Y	U	U	L

Mixed Methods Appraisal Tools ([MMAT] Hong et al., 2018
Y= yes evident, N= not evident, U= unclear
*Value - H= 80%, M= 60-79%, L= less than 60% of elements

Appendix D: HNE HREC Approval updated Version 3

From: Debbie Madden (Hunter New England LHD) <Debbie.Madden@health.nsw.gov.au>
Sent: Monday, 29 March 2021 6:34 AM
To: Louise Wightman <louise.wightman@flinders.edu.au>
Subject: 2020/ETH03118: Application HREA - Approved - 3RD RE-ISSUE

3rd RE-ISSUE 29 MARCH 2021 - 2ND RE-ISSUE 24 MARCH 2021 - RE-ISSUED 4 FEBRUARY 2021 - Date of Decision Notification: 25 Jan 2021

Dear Professor Grant

Thank you for submitting the following Human Research Ethics Application (HREA) for HREC review;

2020/ETH03118: Determining quality and competence in the specialist practice of Child and Family Health Nursing.

This Application was reviewed as a Greater than low risk review pathway and was initially considered by the Hunter New England Human Research Ethics Committee at its meeting held on 16 December 2020.

The project was determined to meet the requirements of the National Statement on Ethical Conduct in Human Research (2007) and was APPROVED.

This email constitutes ethical and scientific approval only.

This project cannot proceed at any site until separate research governance authorisation has been obtained from the Institution at which the research will take place.

This project has been Approved to be conducted at the following sites:

- ACT Site/s
  - The Canberra Hospital
- NSW Site/s
  - Hunter New England Local Health District
  - Community Health, Non-hospital based Mental Health Sites only) - Nepean Blue Mountains Local Health District
  - Western NSW Local Health District
  - Integrated and Community Health - Western Sydney Local Health District
- Northern Territory Site/s
  - Primary Health Care, Central Australia Health Service
  - Primary Health Care, Top End Health Service
- Queensland Site/s
  - Child Health Service, Child and Youth Community Health Service, Children's Health Queensland
  - Child, Youth and Family Health, Darling Downs Health Service
- South Australian Site/s
  - Child and Family Health Service, Women's and Children's Health Network
- Tasmanian Site/s
  - Child Health and Parenting Service, Tasmanian Health Service
- Victorian Site/s
  - Maternal and Child Health Service, Primary and Community Health, Department of Health and Human Services
- Western Australian Site/s
  - Child Health, Community Health, Child and Adolescent Health Service
  - Child Health, Western Australia Country Health Service

The following documentation was reviewed and is included in this approval:

- **HREA** (Version 3 created 19 January 2021)
- **Response to HNEHREC Requirements** (dated 17 December 2020)
- **Project Description** (Version 1 dated 17 December 2020)
- **Master Email Invitation** (Version 0 dated 30 November 2020)
- **Master Information for Participants** (Version 2 dated 19 January 2021)
- **Master Consent Form** (Version 1 dated 19 January 2021)
- **Master Semi Structured Interview** (Version 1 dated 19 January 2021)
- **Master Organisational Documents Confidentiality Agreement** (Version 1 dated 19 January 2021)

Application Documents - (link will only be active for 14 days from the decision date. The approved documents are also available to download from forms section of this project in REGIS)

The approval is for a period of 5 years from the date of this e-mail **(25 Jan 2021)**

The Coordinating Principal Investigator will:
• provide the HREC with an annual report and the final report when the project is completed at all sites. This will be through the submission of a milestone in REGIS.
• immediately report anything that might warrant review of ethical approval of the project.
• submit proposed amendments to the research protocol, including; the general conduct of the research, changes to CPI or site PI, an extension to HREC approval, or the addition of sites to the HREC before those changes can take effect. This will be through a notification of an amendment in REGIS
• will notify the HREC if the project is discontinued at a participating site before the expected completion date, with reasons provided.

Submission of annual progress/final reports (milestone), amendments and safety reports should be done through the forms provided in REGIS. Guidance on these processes can be found on the REGIS website.

It is noted that the **Hunter New England Human Research Ethics Committee** is constituted in accordance with the National Statement on Human Conduct in Research, 2007 (NHMRC).

The processes used by the HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.

Please contact us if you would like to discuss any aspects of this process further, as per the contact details below. We look forward to managing this study with you throughout the project lifecycle.

Kind regards

Debbie Madden
Ethics Administration Officer
Research Office
Hunter New England Local Health District
Ph: 02 49855929
Email: Debbie.madden@health.nsw.gov.au

Appendix E: Flinders University cross institutional approval

From: donotreply@infonetica.net <donotreply@infonetica.net>
Sent: Wednesday, 10 February 2021 3:38 PM
To: Louise Wightman <louise.wightman@flinders.edu.au>
Cc: Louise Wightman <louise.wightman@flinders.edu.au>; Julian Grant <julian.grant@flinders.edu.au>; Alison Hutton <alison.hutton@flinders.edu.au>
Subject: Cross-Institutional Approval

Dear Mrs Louise Wightman,
Please be advised that your request for cross-institutional approval has been approved for the below project:
Project ID: 4193
Project Title: Determining quality and competence in the specialist practice of Child and Family Health Nursing
Expiry Date: 25/01/2026
Please note:

- Any modification requests and annual or final reports must be submitted to the responsible Human Research Ethics Committee which has approved the original application.
- Extension of time requests must be submitted prior to the Ethics Approval Expiry Date listed in this email.
- Researchers must advise Flinders University's Research Ethics & Compliance Office immediately if:
  - any complaints regarding the research are received,
  - a serious or unexpected adverse event occurs that impacts participants, and
  - an unforeseen event occurs that may affect the ethical acceptability of the project.

Regards,

Mr Hendryk Flaegel
on behalf of
Human Research Ethics Committee (HREC)
Research Development and Support
human.researchethics@flinders.edu.au
P: (+61-8) 8201 3116
Flinders University
Sturt Road, Bedford Park, South Australia, 5042
GPO Box 2100, Adelaide, South Australia, 5001
http://www.flinders.edu.au/research/researcher-support/ebi/human-ethics/human-ethics_home.cfm

Appendix F: Email invitation

Dear colleagues

I am writing to request your consideration to participate in a qualitative study I am undertaking as part of my PhD at Flinders University.

The research aims to explore how quality and competence is identified and measured in the specialist practice of Child and Family Health Nursing.

To do this I will request access to some internal organisational documents that relate to quality and competence in specialist Child and Family Health Nursing practice. I would like to contextualise analysis of these documents by interviewing Child and Family Health Nursing staff whose roles relate to implementing these policies.

Please be assured that no organisation or persons will be individually identified in the findings from the study. Confidentiality will be strictly adhered to.

If you would like to read more, please see attached Participant Information Sheet and Consent Form. If you have any questions or would like further information, please feel free to contact me via email.

Please forward this email to anyone in your organisation who may be better suited to participate in this study or contact me to discuss.

If you would like to participate in this research, please complete the consent form and return to me via email Louise.Wightman@flinders.edu.au

Yours sincerely

Appendix G: Participant information sheet

Louise Wightman Professor Julian Grant Professor Alison Hutton

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PARTICIPANT INFORMATION SHEET

Determining quality and competence in the specialist practice of Child and Family Health Nursing.

This research is being undertaken by Louise Wightman as part of her PhD research. Professor Julian Grant, Charles Sturt University School of Nursing, Midwifery and Indigenous Health, and Professor Alison Hutton, Newcastle University School of Nursing and Midwifery, Faculty of Health and Medicine are supervising this research.

Invitation

You are invited to take part in a research study which will investigate how quality and competence is identified and measured in the specialist practice of Child and Family Health Nursing. This study is being conducted in Child and Family Health Nursing services across Australian health jurisdictions as part of my PhD at Flinders University

1. What is the purpose of this study?

This study will describe how quality and competence is identified and measured in the specialist practice of Child and Family Health Nursing. The researchers are interested to know if any common policy and guideline practice documents exist across Australian jurisdictions. Your perspective will provide a deeper understanding of the challengers and enablers for both individuals and organisations in defining quality and competence in Child and Family Health Nursing.

2. Why have I been invited to participate in this study?

You have been invited to this study as you have been identified as a leader within your organisation who is responsible for policies and guidelines related to practice, performance appraisal or professional development of Child and Family Health Nurses

3. What does this study involve?

Participating in this study involves providing electronic copies of policies and guidelines related to quality and competence in Child and Family Health Nursing practice. You will also be invited to take part in semi structured interview of 45minutes to one-hour duration, at time and location that is negotiated between you and the researcher. The content of the semi structured interviews will relate to the quality and competence in Child and Family Health Nursing practice and take place either face to face if applicable or via videoconference platforms such as Microsoft Teams or Zoom. Semi structured interviews will be audio recorded and then transcribed verbatim.

4. Are there risks to me in taking part in this study?

The researchers do not expect the questions to cause any harm or discomfort to you. However, if you experience feelings of distress as a result of participation in this study, please let the researcher know immediately. You can also contact HNELHD Employee Assistance Program on *(insert appropriate number for each area)* The Principal Investigator is a Registered Nurse and as such is a mandatory reporter of information that relates to the safety of children.

5. Will I benefit from the study?

The study aims to provide information about how quality and competence is identified and measured in the specialist practice of Child and Family Health Nursing. Although you may not directly benefit from the results of the study, the findings will be used to inform Child and Family Health Nursing practice and policy around service provision for children birth to five years and their families.

6. How is this study being paid for?

This study is part of a PhD research project for Louise Wightman who is a PhD Candidate at Flinders University.

7. Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything and you will not be paid to participate.

8. What if I don't want to take part in this study?

Participation in this study is entirely voluntary. You may, without any penalty, decline to take part in this research study. Your participation will contribute to ongoing learnings about Child and Family Health Nursing practice.

9. What if I participate and then change my mind and want to withdraw later?

If you decide to take part and later change your mind, you may, without any penalty, withdraw at any time without providing an explanation.
Documents: If you decide to withdraw documents, any information you provided prior to withdrawal cannot be removed as the researchers will have already used the data for analysis but there will be no information kept that can identify your organisation.
Interviews: You can withdraw from the interview at any time even if the interview has started. You don't have to tell us why. If you attend the interview but later decide to withdraw you can contact Louise Wightman on Louise.Wightman@flinders.edu.au and request your data be removed from the study. We can do this for up to two weeks after the interview. If this happens, we will destroy your interview recording and transcript. After this time the researchers will have already used your data for analysis but there will be no information kept that can identify you.

10. How will my confidentiality be protected?

Only researchers listed on this form have access to the individual information provided by you. Privacy and confidentiality will be assured at all times. The only exception to this is if we are required to by law. The information collected may be stored securely on a password protected computer and/or Flinders University server throughout the study. Any identifiable data will be de-identified for data storage purposes unless indicated otherwise. All data will be securely transferred to and stored at Flinders University for at least five years after publication of the results. Following the required data storage period, all data will be securely destroyed according to university protocols.

11. What happens with the results?

The research outcomes may be presented at conferences, written up for publication or used for other research purposes as described in this information form. However, the privacy and confidentiality of individuals will be protected at all times. You or your organisation will not be named, and your individual information will not be identifiable in any research products without your explicit consent. No data, including identifiable, non-identifiable and de-identified datasets, will be shared or used in future research projects without your explicit consent.

12. What should I do if I want to discuss this study further before I decide?

Thank you for taking the time to read this information sheet which is yours to keep. If you have any further questions please contact Louise Wightman by emailing Louise.Wightman@flinders.edu.au.
If you accept our invitation to be involved, please sign the enclosed Consent Form and email to Louise.Wightman@flinders.edu.au

13. Who should I contact if I have concerns about the conduct of this study?

This research has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Local Health District, Reference **2020/ETH03118**.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to Dr Nicole Gerrand, Ethics Manager, Research Office, Hunter New England Human Research Ethics Committee, Hunter New England Local Health District, Level 3 POD, HMRI, Lot 1 Kookaburra Close, New Lambton Heights NSW 2305, Telephone (02) 49214950, Email: HNELHD-HREC@health.nsw.gov.au

AUTHOURISATION STATEMENTS
The conduct of this study at the *[name of site]* has been authorised by the *[name of Organisation]*. Any person with concerns or complaints about the conduct of this study may also contact the *[Research Governance Officer or other officer]* on *[telephone number]* and quote reference number *[insert SSA reference number]"*

PhD Candidate
Louise Wightman
College of Nursing and Health Sciences
Flinders University

Supervisor
Professor Julian Grant
Professor of Nursing – Research, School of Nursing, Midwifery & Indigenous Health
Charles Sturt University

Supervisor
Professor Alison Hutton
School of Nursing and Midwifery, Faculty of Health and Medicine
Newcastle University

Appendix H: Consent form

This research is being undertaken by Louise Wightman as part of her PhD research. Professor Julian Grant, Charles Sturt University School of Nursing, Midwifery and Indigenous Health, and Professor Alison Hutton, Newcastle University School of Nursing and Midwifery, Faculty of Health and Medicine are supervising this research.

Consent Statement

☐ I have read and understood the information about the research, and I understand I am being asked to provide informed consent to participate in this research study. I understand that I can contact the research team if I have further questions about this research study.

☐ I am not aware of any condition that would prevent my participation, and I agree to participate in this project.

☐ I understand that I am free to withdraw at any time during the study.

☐ I understand that I can contact Hunter New England Research Ethics and Governance Unit if I have any complaints or reservations about the ethical conduct of this study.

☐ I understand that my involvement is confidential, and that the information collected may be published. I understand that I will not be identified in any research products.

☐ I understand that I will be unable to withdraw my data and information collected prior to my withdrawal from this project. I also understand that this data will be used for this research study.

I further consent to:

☐ providing electronic copies of policy and guidelines related to Child and Family Health Nursing practice

☐ participating in an interview

☐ having my information audio recorded

☐ my data and information being used in this project and other related projects for an extended period of time (no more than 10 years after publication of the data)

Signed:

Name:

Date:

Appendix I: Organisational documents confidentiality agreement

CONFIDENTIALITY AGREEMENT

Organisational Documents

Determining quality and competence in the specialist practice of Child and Family Health Nursing

I, _____, the researcher, agree to maintain full confidentiality in regards to any and all documentation received from [Organisation's name] related to the study on **Determining quality and competence in the specialist practice of Child and Family Health Nursing**. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed in any associated documents;

2. To not make copies of computerized files of the documents;

3. To store all study-related materials in a safe, secure location as long as they are in my possession;

4. To return study-related documents to [Organisation's name] in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices once analysis is completed.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the files to which I will have access.

Researcher's name (printed) _____

Researcher's signature _____

Date _____

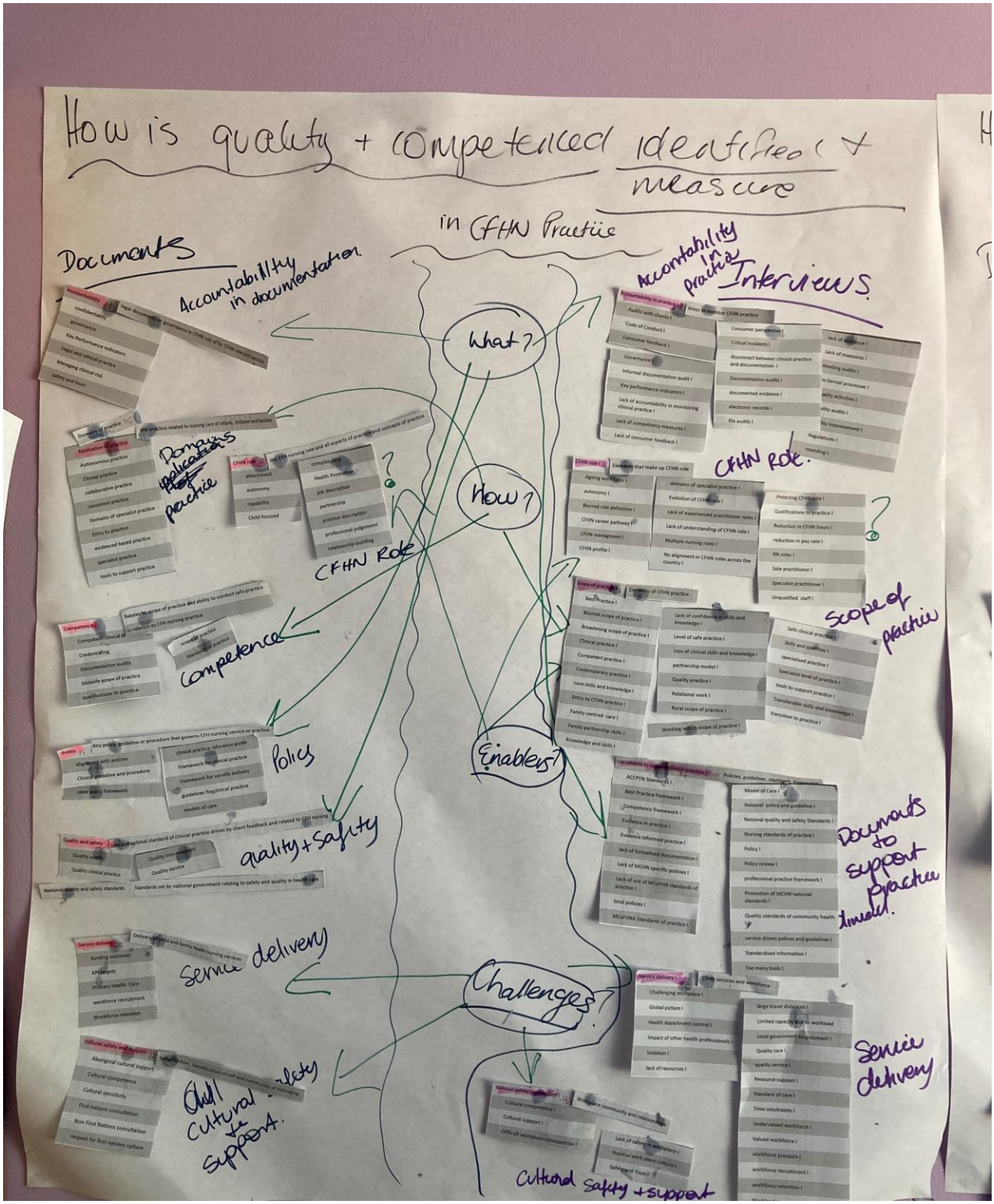
Appendix J: Semi-structured interview questions

Semi-Structured Interview

Prompts for general questions to open up conversation about Child and Family Health Nursing

1. What do the words quality and competence mean to you?
2. How would you describe quality in relation to Child and Family Health Nursing?
3. How would you describe competence in relation to Child and Family Health Nursing?
4. What mechanisms are used within your organisation to identify quality in Child and Family Health Nursing?
5. What mechanisms are used within your organisation to measure quality in Child and Family Health Nursing?
6. What mechanisms are used within your organisation to identify competence in Child and Family Health Nursing?
7. What mechanisms are used within your organisation to measure competence in Child and Family Health Nursing?
8. What are the challenges or enablers that might impact on how quality and competence in Child and Family Health Nursing are identified and measured in your organisation?

Appendix K: Code clustering



Appendix L: Code descriptions

Name	Files	References	Description
Accountability	5	5	legal documents or governance in CFHN role of for CFHN role and service
Accountability in practice I	42	286	Ways to monitor CFHN practice
CFHN role	16	43	the CFH nursing role and all aspects of practice and concepts of practice
CFHN role I	36	161	Elements that make up CFHN role
Clinical Assessment	15	29	any assessment related to CFH client or work practice
Clinical Practice consultancy	55	295	Observation of clinical practice, review and discussion
clinical practice consultancy I	40	277	Processes to review practice
Clinical practice development	35	160	anything that relates to skills and knowledge attainment
Clinical Supervision	28	148	Reflective practice discussion, one to one or in a group
Clinical supervision I	38	163	Reflective practice discussions
Competence	61	240	Relates to scope of practice and ability to conduct safe practice
COVID impact on practice I	17	26	Implications of Covid pandemic on CFHN practice
cultural safety and support	12	31	belief system, identification of self and community of belonging
Cultural safety and support I	34	83	Workplace community and relationships
Documents to support clinical practice I	41	181	Policies, guidelines, standards, frameworks
Domains of practice	49	151	any practice related to nursing care of infants, children and families
Leadership I	21	31	leadership and management of CFHNs
Networking I	33	107	support structures for CFHNs
Peer support	11	24	discussion or debriefing with peers
personal professional development I	30	43	professional development related to individual practice
Policy	38	99	Any policy, guideline or procedure that governs CFH nursing service or practice
Professional development I	40	228	education and training to support CFHN practice
Quality and safety	40	111	Safe and optimal standard of clinical practice driven by client feedback and related to CFH nursing
Scope of practice I	41	253	Elements of CFHN practice
Service delivery	21	42	Delivery of child and family health nursing services
Service delivery I	40	207	CFHN services and workforce

Appendix M: Code groupings