THE FACTORS INFLUENCING, AND THE NATURE OF THEIR IMPACT, ON THE ABILITY OF CHILD AND FAMILY HEALTH NURSES TO WORK IN THE FAMILY PARTNERSHIP MODEL WITH PARENTS:

A FOCUSED ETHNOGRAPHY

Eileen Mary Dowse

MN (Research); Grad. Dip. Hlth Sc. (Women's Health); Dip. CFHN (Karitane); RN; RM

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Statement of Originality

The thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968.

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Acknowledgement of Authorship

I hereby certify that the work embodied in this thesis includes a published paper of which I am a joint author. I was responsible for the writing of the paper which is based on the data collection issues I experienced during the study. My supervisors contributed to the editing and proof reading of the paper. The paper is titled:

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Signed:

Principal Supervisor: Associate Professor Pamela van der Riet

Date:

Dedication

This thesis is dedicated to my wonderful children and their partners: Avrell & Joey, Emerson & Amie, Gelina & Nicholas and, of course, my grandson Louis who was born and kept me enchanted during this time. Each of you have played your own special part in giving me the encouragement to keep going when things got tough as well as reminding me when it was time to lighten up!

My Master's thesis I dedicated to my father. This PhD would not be complete without providing tribute and dedicating this to my mother, Catherine (Kitty) Dowse. Mum and Dad were unwaveringly faithful to each other demonstrating partnership well before it was part of any training program. Mum continues to show us all how to live a good life.

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ABSTRACT

Background: Child and family services in Australia have evolved this century from expert led ways of working with families to a greater emphasis on therapeutic approaches underpinned by the Family Partnership Model (FPM) (Davis & Day, 2010). The FPM involves a particular way of interacting with the family that is based on mutual respect and recognition of complementary expertise. There are numerous challenges facing the current NSW Child and Family Health Nursing workforce that required consideration in relation to the model being adopted into clinical nursing practice (Bennett, 2013).

Research Design: Adapting Bronfenbrenner's (1979) ecological model and using focused ethnography, this study examined the views of one nurse manager, nine child and family health nurses and nine mothers regarding the factors influencing, and the nature of their impact on the child and family health nurse's ability to work in the FPM with parents (mothers/fathers and infants).

Data Collection: Data was collected via interviews and participant observation. Participant observation included the use of video recordings of nurse-mother/baby consultations held at the nurses' centres. These video recordings informed the content of follow-up interviews held with nurses. Thematic analysis was used to analyse the aggregated data (Braun & Clarke, 2006).

Findings: The findings from this research comprise the macro to micro factors arising for CFHNs that impact on their ability to work in the FPM with mothers. CFHNs are subject to multifactorial influences and challenges which emanate from their work environment and from the intrinsic distractions of their physical bodies and emotions. These influences were identified by CFHNs as both positive and less positive in terms of their impact on their ability to work in the FPM with mothers.

Four major themes were identified: Theme 1: The CFHNs' Work Environment and Culture; Theme 2: Managing the Body: CFHN Body Work and Partnership Practice; Theme 3: A Mindful Space; and, Theme 4: The Mother's Evaluation of CFHN Care. The findings from this study provide empirical evidence of the clash between the institution's neoliberal policies and governmentality practices, the reality of the CFHN's work environment and the lack of congruence with CFHNs' values of holistically caring and working in the FPM with mothers. Findings from this study suggest that NSW Health and other agencies invested in the promotion of parenting capacity and the health and well-being of children consider the implementation of processes that support and sustain the emotion work and FPM practice of CFHNs with mothers. This study found that the practice of mindfulness

was one such process not previously associated with being essential to the implementation of the FPM. Mindfulness, if integrated within the FPM, could assist CFHNs find the necessary "space" and agency required to sustain family partnership work with mothers/babies. It could also provide a means for CFHNs to experience enhanced personal well-being and greater practice accord between their own values and beliefs and that of the organisation in regard to care of families and working in partnership.

Conclusion: Recommendations arising from this study have been identified for nursing practice and further research. A key recommendation is that the framework of the FPM evolves to incorporate the concept and practice of "mindful partnership" within the FPM framework. Mindfulness is recommended as both a self-care strategy for CFHNs' well-being as well as a fundamental mechanism to enhance their ability to be present and to communicate effectively in working in the FPM with parents and others

Chapter 1 INTRODUCTION

The NSW Child and Family Health Nursing Service has a history spanning over one hundred years of specialty practice with the mothers, infants and children resident in that state. In recent years, greater emphases on father inclusive and whole family approaches to child and family health care have been incorporated into practice (NSW Department of Health, 2009; NSW Health, 2011a; NSW Kids and Families, 2014). Health policies and new models of care which impact on child and family health nurses' work with parents and children have been introduced (NSW Department of Health, 2009, 2010a, 2010b). These new policies and care models are enacted to enable CFHN[1] service delivery to keep pace with societal changes and emerging research from developmental neuroscience and recognition of the importance of the early years of life (McCain & Mustard, 1999; Mustard, 2010; Perry, 2002, 2004 2005; Perry, Pollard, Blakely, Baker, & Vigilante, 1995). One such model of care introduced across NSW into CFHN nursing services is known as the *Family Partnership Model* (FPM) (Davis & Day, 2010; Davis, Day, & Bidmead, 2002).

Known originally as the Parent Adviser Model, the Family Partnership Model was developed in the UK in the mid-1980s to help practitioners provide effective care and communication to children with chronic illness and disability (Davis & Day, 2010; Davis et al., 2002). It now more broadly offers a conceptual framework that enables practitioners to provide "effective, holistic support for families, while also treating the specific problems of their children" (Davis & Day, 2010, p. 1). The evidence for the efficacy of the FPM in helping parents was derived from studies conducted in the UK in paediatric and community child mental health services (Davis & Rushton, 1991; Davis & Spurr, 1998). The FPM is practiced in Australia, Finland, Greece, New Zealand and the United Kingdom (Davis & Meltzer, 2007, p. 22). Its theoretical origins, however, date back to the 1950's to the work of psychologists George Kelly (1955), Carl Rogers (1959), and, Gerard Egan (1990). The FPM framework clearly sets out the stages of the helping process, the qualities required of a skilled helper and the nature of an effective relationship, namely a partnership. The FPM also has the added dimension of the Personal Construct theory (Kelly, 1955). Essentially, however, it is a model of helping similar to Rogers' (1959) client-centred approach that has been recommended as an optimum way to deliver health care to clients in a number of countries for many years. A brief description and diagram of the model follows (see Figure 1).

[1] These initials are used to indicate child and family health nurse/nurses and child and family health nursing.

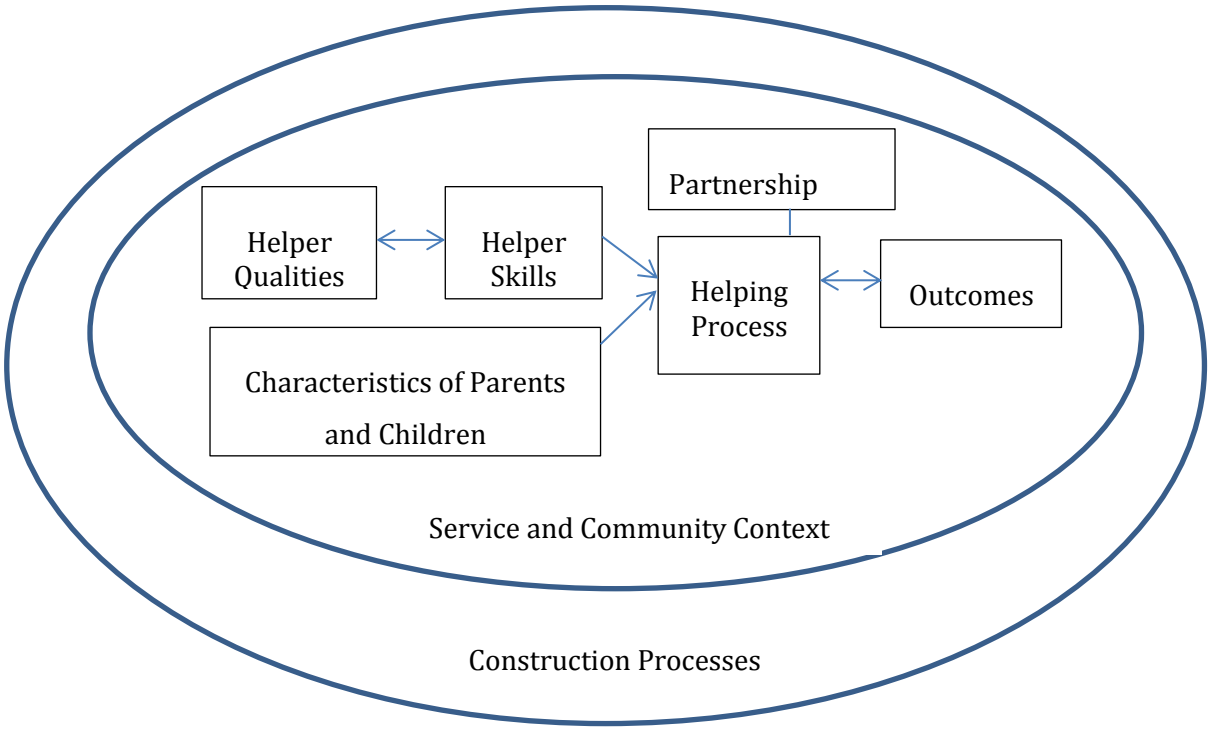

Figure 1: The Family Partnership Model (Day, Ellis, & Harris, 2015, p. 9)

The major concepts of the FPM are identified in Figure 1 above with the arrows indicating how the different aspects relate to each other (Day et al., 2015, p. 9). The position of each of the boxes, text and the arrows connecting them represent how the components work together (Day et al., 2015, p. 9). The figure shows how the *Outcomes* of helping are dependent on parents and practitioners working together through the tasks of the *Helping Process.* Successfully undertaking the tasks of the Helping Process is most likely to occur when the family and practitioner work together in a "supportive, purposeful and connected *Partnership*" (Day et al., 2015, p. 9). This partnership is a specific type of professional relationship where parents and practitioners work together toward a shared purpose. The efficacy of the partnership and the outcomes of the helping process is determined by the *Qualities* and *Helping Skills* of the practitioner, the *Characteristics of Parents and their Children* and the *Service and Community Context* within which it occurs (Day et al., 2015, p. 9). The aspects of helping included in each of the boxes can be understood in terms of how the parent and practitioner both function psychologically. This last component of the FPM, construction processes, is represented by another ellipse because it has the most significant influence on all the other components within the Model (Davis & Day, 2010, pp. 9-13).

The focus of this study was to explore the factors influencing, and the nature of the impact, on the child and family health nurse's ability to work in the FPM with parents.

1.1 BACKGROUND AND CONTEXT OF THE STUDY

I set out in this study to investigate the factors influencing and the nature of the impact on NSW CFHNs' ability to work in the FPM with parents. An evolving personal journey, shifts in knowledge about the FPM (Davis & Day, 2010; Davis et al., 2002; Day et al., 2015) and my field work experiences in one NSW CFHN Service had led to this specific focus on the CFHNs' ability to incorporate the FPM into their practice. Challenges in the workplace to working in partnership were a source of conflict and consternation for nurses who appeared very personally motivated to work in the FPM with parents. It led me to wonder what the factors were that influenced their ability, and the nature of this impact on working effectively in the FPM with parents and children. Further, could the FPM evolve to incorporate these elements if they were found to be missing from the current FPM; and/or, did they have potential to enhance nurses' capacity to work in the FPM with parents? This chapter presents the background to my research, a concise summary of the study and an explanation of the thesis structure.

1.1.1 Developments in Child and Family Health Nursing Practices – Towards a Family Partnership Model Approach

To situate the study, I present an outline of the changing role of the CFHN over the last one hundred years and the broad areas of policy and evidence that advocate a FPM approach be adopted by CFHNs when working with families.

A movement toward partnerships between health and other providers to improve outcomes for maternal, child and family health has occurred at the international, national and state governmental levels (Australian Health Ministers Advisory Council, 2011; NSW Department of Health, 2009; NSW Government, 2014; NSW Health, 2011a; World Health Organisation, 2013). There has been a parallel growth in the evidence base to support and sustain the practice of CFHNs (and nurses working in similar roles internationally), to work in partnership with families (Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chircop, 2006; Bidmead & Cowley, 2005b; Davis & Day, 2010; Davis et al., 2002; Olds et al., 1997; Olds et al., 2014; Olds et al., 2010; Sawyer et al., 2013). The evolving nature of the role and work of the CFHN in NSW has been influenced by these events and health policies adapted to meet the contemporary needs of families (NSW Department of Health, 2009).

The original purpose of the CFHN service in New South Wales (NSW) in the early 1900's, known then as 'The Infant Welfare Movement', was to target the unacceptably high rates of infant mortality and morbidity (Armstrong, 1939). Infant mortality rates reflect the number of deaths in children under twelve months of age per one thousand births in any particular year (O'Connor, 1989). By the 1950's, the rapid social changes of the post war years led to urbanisation and social isolation for mothers raising children. The particular needs of migrants and Indigenous Australian families were receiving greater recognition (O'Connor, 1989, p. 73). Baby Health Centres, as they were known, evolved to become more of a community health education facility as well as providing health services to mothers and babies (O'Connor, 1989).

In the post-World War II years, the Baby Health Nurse's role broadened to address the needs of the mother and family, not just the infant's well-being (O'Connor, 1989). NSW Health publications such as *Our Babies* and *Healthy Motherhood*, reflected the growing community awareness of the problems associated with the emotional development of the child, the mother-child relationship and caring for infants generally (O'Connor, 1989, p. 80). In the early 1960's, mothers' discussion groups providing support and education were commenced at nineteen Baby Health Centres in NSW in conjunction with the Mental Health Association (O'Connor, 1989). Separate mothercraft groups providing advice to expectant mothers on infant care also began around this time (O'Connor, 1989, p. 78). Nurses came to realise that mothers' confidence grew as their social supports were enhanced (O'Connor, 1989). This confidence improved their parenting capacity and general family relations.

By the 1970's, Baby Health Centres offered mother's groups, preparation for parenthood classes, parent effectiveness training as well as home visiting services and well-baby clinics. A *Baby Health Activity Survey* cited in O'Connor (1989, p. 107) was conducted by the NSW Health Department in 1984. Its purpose was to document the Baby Health Nurses' role, the image of which was perceived by many to have remained unchanged over the previous eighty years. The study's major finding was that the nurses' activities were most influenced by the socio-economic context in which they worked. The major activities were preventive in nature and included general health assessments, teaching and training mothers in infant care, infant screening checks, individual counselling and administration (O'Connor, 1989).

In 1987, NSW Health Circulars 87/159, 87/156 (now obsolete) mandated that the name "Baby Health Centre" be changed to "Early Childhood Centre" and the title of the Baby Health Nurse was changed to "Early Childhood Nurse" (O'Connor, 1989, p. 108). These

changes to the nurses' and Centres' title reflected the changing nature of the nurse's role. In 1995, in the then Hunter Area Health Service, one of seventeen Area Health Services into which NSW was divided, Baby Health Centres became known as Child Health Centres. From 2002, although in some Area Health Services Centres the name continued to be known as Early Childhood Centres, a new NSW Health Circular No. 2002/54 (now obsolete) changed the title of the nurse to "Child and Family Health Nurse" (NSW Health, 2002). This change reflects the expansion of the role which now encompassed community based care to the whole family This change in nomenclature demonstrated the gradual shift in focus of the CFHN Service over one hundred from the infant to the young child to a child and family health perspective. O'Connor (1989, p. 111) asserts that in Baby Health services in NSW:

> There has been continual emphasis on the mother-child relationship from the commencement of organised infant welfare services….now there is a continuing emphasis on the role of the family in the wider context of the community.

However, despite the emphasis on the whole family, father inclusive practices and the engagement of fathers by CFHNs remains ad hoc and fathers have reported feeling marginalised by maternal and child health services (Fletcher, Dowse, et al., 2014; Fletcher, Matthey, & Marley, 2006; Rowe, Holton, & Fisher, 2013).

Aligned with changes to the CFHNs' role over the last century have been changes to their model of care (Barnes, Courtney, Pratt, & Walsh, 2003; Borrow, Munns, & Henderson, 2011). The early model of CFHN care up until the 1970's focused on provision of individualised infant welfare, surveillance of child health development and "instructing mothers in infant care" (Borrow et al., 2011, p. 72). After the 1970's and the *Declaration of Alma Ata* (World Health Organisation (WHO), 1978), the CFHN role evolved to use wellness models of health underpinned by primary health care and health promotion principles (Borrow et al., 2011). The importance of the early years and social determinants of health to child health and well-being also came to feature in child health policy (Borrow et al., 2011; Schmied et al., 2011). Contemporary child and family health policies utilise population health approaches (NSW Department of Health, 2009; Schmied et al., 2011). Population health principles closely align with those of health promotion principles and feature a universal service platform to provide basic services to families (Schmied et al., 2011). This universal approach facilitates the identification of children and families requiring further assessment and support (Schmied et al., 2011).

In 1998, the NSW State Government launched the *Families First* initiative (NSW Government The Office of Children and Young People, 1999). *Families First* (now known as *Families NSW*) is a whole of government strategy that is a shared responsibility of three government agencies "working together to make a positive difference for children and families" (NSW Government, 2014). These agencies are: NSW Health; NSW Department of Education and Communities; and, the Department of Family and Community Services (NSW Government, 2014).

Families NSW was developed for families with children aged zero to eight years (NSW Government, 2014; NSW Government The Office of Children and Young People, 1999). It was implemented as a result of the burgeoning international evidence of the importance of children's early years to their future well-being and adjustment (McCain & Mustard, 1999; Mustard, 2010; Perry, 2004 2005; Perry et al., 1995; Shonkoff, 2010; Shonkoff & Phillips, 2000). There was also growing evidence on the economic advantages and cost savings of investment in the early years, particularly amongst disadvantaged young children (Heckman, 2006; Hertzman & Power, 2003; Keating & Hertzman, 1999).

As an example of the evidence related to the importance of the early years, seminal research conducted by Olds et al., (1997) revealed in a fifteen year follow up of a randomised control trial conducted in the United States that regular home visits by nurses to new mothers had benefits for a period up to fifteen years after the birth of their first child. These benefits included reduced levels of child abuse and neglect, lower levels of criminal behaviour and a reduced number of subsequent pregnancies as well as reduced reliance on social security payments by the mothers in the intervention group. Significantly, the nurses in the Olds et al. (1997) research used a partnership approach to engage and work with the vulnerable mothers in the study. Studies similar to this influential research have since been conducted both in the US and elsewhere with comparable results (Eckenrode et al., 2010; Kitzman et al., 2010; McDonald, Moore, & Goldfeld, 2012; Olds et al., 2010).

In relation to the importance of the early years, pivotal research was also being conducted in the field of developmental neuroscience. Research conducted into the development of the brain of infants and children has demonstrated how traumatic events during the early years of a child's life affect the brain's capacity to function (Perry, 2002, 2004 2005; Perry et al., 1995). Perry (2005) suggested specific early intervention should be available in order to support parents to enhance their ability to provide their child(ren) with stable, predictable and nurturing environments in which to grow.

In 1999, under the *Families NSW* initiative (NSW Government, 2014), CFHNs were seen as the appropriate professional group to reorientate their service and commence universal and sustained home visiting to all new parents. Around the time of this study's commencement, the suite of *Supporting Families Early* policies and guidelines issued by the NSW Ministry of Health were introduced (NSW Department of Health, 2009, 2010a, 2010b). These policies underscored the importance of the primary health approach of midwives and CFHNs in providing comprehensive antenatal and postnatal assessment and tailored health care to mothers, their infants and families (NSW Department of Health, 2009, 2010a, 2010b). The term "universal health home visiting" (UHHV) refers to the first health home visit conducted by a CFHN in NSW and is offered to all new parents within two weeks of birth (NSW Department of Health, 2009, p. 21). The objectives of this first home visit are to engage families early and facilitate parents' access to the network of services available to support families in the community. When working with families, the preferred approach under *Families NSW* is to work from a strengths perspective in partnership with families (NSW Department of Health, 2009), focusing on capacity building rather the traditional approach to working with families which focuses on amelioration of family problems or deficits (Early & GlenMaye, 2000). Sustained home visiting by CFHNs in NSW is a funded program of scheduled visits over a two year period provided to vulnerable families who may require additional support following the UHHV (NSW Department of Health, 2009). The premise behind the universal approach is to home visit and support parents and carers with young children in their home environment and to help them solve problems early before they become entrenched. It is important to note, however, that evidence from a systematic review of CFHN sustained home visiting programs suggests that:

> …whilst relationship building and a social support role are necessary for the success of home visiting, they are not sufficient to change parent behaviour. Rather, the relationship forms the context and conduit for the interventions provided by the nurse. (Kemp et al., 2006-2007, p. 314)

In recent reviews of effective sustained home visiting programs for vulnerable families and children, those begun in the antenatal period and provided by trained health professionals, in particular registered nurses, were found to be more effective (McDonald et al., 2012). Home visits by registered nurses produced long term effects on a broader range of infant and maternal health outcomes than home visiting programs conducted by paraprofessionals (McDonald et al., 2012; Olds et al., 2014; Olds et al., 2002).

In summary, the original CFHN service aim in NSW of providing support and guidance to families with children has remained fundamentally the same, however, how the service is now delivered is very different (Barnes et al., 2003, p. 19; NSW Kids and Families, 2014). The contemporary CFHN is required by policy (NSW Department of Health, 2009) to work in partnership with families using the *Family Partnership Model* (FPM) (Davis & Day, 2010). This model provides a strength-based approach to the provision of nursing care and support of families. The evidence supports the effectiveness and acceptability of the FPM approach by health workers to engage with a family and to commence working with them to meet their health needs (Davis & Fallowfield, 1991; Davis & Rushton, 1991; Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Papadopoulou et al., 2005). This evidence provided grounds for the incorporation of the FPM into CFHN policy and practice.

1.2 PURPOSE OF THE RESEARCH

The purpose of this research was to undertake a focused, in depth exploration of the factors influencing, and the nature of their impact, on the ability of CFHNs to work in the FPM with parents in the practice setting. Examination of these factors using a systematic macro to micro level approach builds on current understandings (Fowler, Rossiter, et al., 2012; Hopwood, Fowler, Lee, Rossiter, & Bigsby, 2013; Keatinge, Fowler, & Briggs, 2007; Rossiter et al., 2011) regarding the factors influencing CFHNs' ability to work in the FPM with parents.

I was interested in investigating the views of CFHNs and their managers about these factors as well as their ideas for solutions to facilitate more effective and sustained FPM practice with parents. Study participation by CFHNs was envisaged as prompting critical reflection and a shared, raised awareness of developing and existing CFHN work practices. These include education processes, work context, roles, responsibilities and scope of practice in relation to the factors that influence and impact on their ability to work in the FPM with parents.

This research was also conducted to seek parents' views of their experience of the relationship with their CFHN and the interactions that had taken place. I sought parent's views regarding improvements that could be made to the interpersonal nature of CFHNs' interactions with them. I also sought to ascertain from parents what improvements generally the CFHN service could make to improve services to families in the community. However, despite seeking to recruit both mothers and fathers to the study, no fathers

volunteered. Therefore, I will generally refer to mothers (rather than parents) when referring to parent participants from hereon.

1.3 SIGNIFICANCE AND IMPLICATIONS OF THIS STUDY

This study is significant because the qualitative, focused ethnographic approach enabled an in depth exploration of CFHNs' practice regarding the factors influencing, and the nature of their impact on their ability to work in the FPM with mothers. Focused ethnography is used when there is a specific research question and culture to be investigated, as was the case in my study (Wall, 2015). Previous research into CFHN practice in Australia has used different research methodologies or focused on other research aims (Bennett, 2013; Briggs, 2008; Fowler & Lee, 2004; Fowler, Rossiter, et al., 2012; Grant, 2008; Hopwood et al., 2013; Kruske, 2005; Rollans, Schmied, Kemp, & Meade, 2013; Rossiter et al., 2011; Schmied et al., 2011; Schmied, Fowler, Rossiter, Homer, & Kruske, 2014; Schmied et al., 2015). This knowledge, therefore, adds to the body of research available on the FPM model; its implementation by CFHNs in primary health settings; and, on CFHN services in NSW and Australia. The study also has implications for CFHN policy, education and clinical practice and highlights areas requiring further empirical research.

1.3.1 Significance for Nurses

This research provides evidence of CFHNs' firm belief in the value of working in the FPM with mothers. The systematic, focused exploration of influences emanating from the macro to the microsystem level has identified numerous previously unidentified factors that either constrain or support nurses' ability to work in the FPM with them. The findings from this study provide empirical evidence of the clash between the institution's neoliberal policies and governmentality practices, the reality of the CFHN's work environment and the lack of congruence with CFHNs' values of holistically caring and working in the FPM with mothers. My study highlights the significant surveillance role of CFHNs and the tension between their role as a screening agent of the State (Perron, Fluet, & Holmes, 2005b), and working in the FPM with mothers. The study findings highlight inequities in the work place and historical and structural factors including gender, which impede CFHNs' ability to work in the FPM with parents.

This study has revealed the physical and emotion work (Hochschild, 1983, 2012) that CFHNs undertake in their work. In particular, the findings highlight the emotion work undertaken by CFHNs when working in the FPM with mothers. Emotion work, that is, the

emotional labour of service sector workers, was first described by Arlie Hochschild (1983). This term refers to the "induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for in a convivial and safe place" (Hochschild, 2012, p. 7). Issues such as ageing, menopause, exposure to workplace bullying, and, the presence of colleagues and nurse managers supportive of the FPM were all found to influence the CFHNs' ability to work in the FPM.

Of particular significance is my identification of the need by CFHNs for reflexivity, self-care and especially, mindfulness practice, to assist with and the provision of the therapeutic presence necessary when working in the FPM with mothers. The capacity to be mindful, that is, to "'experience being present' with 'acceptance', 'attention' and 'awareness'" (White, 2014, p. 282) when working with mothers was found to be an essential component of CFHNs' ability to sustain their FPM work with them. Central to this capacity for mindfulness by CFHNs is my study finding which identified the incorporation of mindfulness within the FPM as being a logical evolution of its theoretical framework.

Having a greater awareness of the factors which support or constrain working in the FPM with parents may be emancipatory for CFHNs through this shared learning. It may provide nurses with agency to seize opportunities to use this empirical evidence to challenge or initiate policy, practice and education that is more tailored to the needs of this specialist workforce in their important work with Australian mothers and children.

1.3.2 Significance for Mothers/Children

Mothers participating in this study were happy overall with the care they received from the CFHN Service. They characterised their professional relationship with the CFHN by the term "*trusted advisor*". This is significant because it is important that mothers can seek help and advice that they trust for themselves or their baby during the transition to parenthood and beyond.

Mothers identified their preference for the development of a rapport before the CFHN commenced asking personal and sensitive questions during consultations. CFHNs appeared task rather than relationship focused when this occurred and did not detect mothers' cues of discomfort with the questions. Mindfulness was identified in this study as essential to CFHN practice and the ability to work and sustain FPM approaches with mothers. A shift to education approaches and workplace cultures that foster mindfulness may facilitate CFHNs' capacity for therapeutic presence with mothers and a focus on "being" rather than "doing". A greater understanding by CFHNS of the factors that

influence them to work in the FPM arising from my study findings may lead to more effective care provided to mothers and children.

A significant finding identified in my study that is related to the mothers' experience was their recommendation that the CFHN service develop improved information technology systems. Mothers do not want to receive education pamphlets from their CFHN service. Instead they prefer to have website, email, social media and apps for their communication and education needs. This is significant because it appears that at the time of my data collection the CFHN communication technology system was not relevant or useful for this Gen X and Gen Y group of parents. Innovation in information systems informed by consumer feedback may facilitate CFHNs' ability to work in the FPM with mothers from a distance.

1.3.3 Significance for the Health Organisation

The findings of my study identify a misfit between State health policies and performance indicators which govern CFHN practice, and, the ethos and ability of CFHNs to work in the FPM with mothers. This misalignment has resulted in constraining the ability of many CFHNs to sustain their ability to work in the FPM, and, provide continuity of care of mothers and children. This is significant because a recent systematic review of trials involving 16,242 women concluded that professional partnerships and continuity of care models can optimise outcomes for women during the childbearing year (Sandall, Slotani, Gates, Shennan, & Devane, 2013). It is recommended that health services revisit current health policies and performance indicators governing universal CFHN services and reorient them so that CFHNs have a greater capacity to work in the FPM and flexibility to provide continuity of care in their relationships with mothers and children.

My study identified the crucial role of CFHN managers in supporting the FPM and modelling it themselves in their relationships with their staff. Although this is not a new finding, it lends weight to the need for organisations and managers to have a culture that is congruent with the FPM rather than undermining. CFHNs also need more regular access to education updates in the use of the FPM and opportunities for reflection on practice. The use of videoing of consultations with the informed consent of participants may be an option that adds depth to the clinical supervision encounter.

Further investigation is required into the current inequity across CFHN services regarding the time allocated for centre based, child health check consultations. There was a thirty minute discrepancy found between centres in the same LHD for the same type of child

health check consultation. This disparity preferentially provided nurses who had the additional thirty minutes greater flexibility to develop partnership based relationships with the mother/child than their colleagues who felt rushed to complete the same amount of work in half the time.

Consideration should also be given by the organisation to the extra time required by CFHNs to complete their documentation on computerised medical records rather than the paper based medical files of the recent past. Nurse participants said they had not received additional time during appointments for their computerised data entry resulting in them necessarily shortening their face to face time with the mother to complete their documentation. This impacted adversely on their ability to work in the FPM with them.

Lastly, the major significance of this study for the organisation includes my study finding which identifies the importance of mindfulness in the workplace. Providing opportunities for regular mindfulness education and practice provides positive benefits for nurses' well-being and may lead to more harmonious collegial and managerial relationships. A regular mindfulness practice can enhance CFHNs' capacity to work in the FPM by strengthening their therapeutic presence and, therefore, their care of families and children.

1.3.4 What This Study Adds To Current Knowledge

This study adds to current understandings regarding the factors that influence, and the nature of the impact, on the CFHN's ability to work in the FPM with mothers from a systematic macro to micro level approach. It adds to current understandings the significant influence of the Australian neoliberal political economy and governmentality practices on the work environment of CFHNs. It has identified that the push for CFHNs to meet the organisation's UHHV performance indicators is inconsistent with CFHN policy espousing nurses' work in the FPM with parents and children. This inconsistency is linked to contesting discourses where the organisations' population health surveillance approach and requirement to meet UHHV targets impacts with the ability of the CFHN to provide their primary role of care in partnership with parents.

This study identified inequities across the CFHN work environment that constrained their ability to work in the FPM. These constraints included disparities in nurses' physical work environments; in time allocated for appointments; the support or lack thereof from the CFHN nurse manager; and, the presence of workplace bullying from managers and/or colleagues. The presence of workplace bullying within the CFHN workforce is new knowledge not previously identified in the literature.

My study adds new knowledge to current understandings of the challenges CFHNs experience sustaining their FPM work with mothers from being a predominantly female and ageing workforce. For example, the reality of the physical body as a distraction from being able to work in the FPM with mothers was highlighted by one nurse's account of the experience of menopause on her energy levels and ability to think clearly. In addition, my study findings identified the significant toll on CFHNs' well-being from the emotional labour (Hochschild, 1983, 2012) required to work in the FPM with mothers. This toll was exacerbated by the continuous requirement to conduct numerous surveillance and screening checks on both mother and child, complete new computerised medical records, and keep up with UHHV requirements. Nurses experienced a value conflict regarding the care they wished to provide mothers and children with what they could actually manage. Many of the nurse participants also reported having little, if any, time for reflection or to recharge during their work day.

My study importantly identifies the new knowledge of *mindfulness* as the key to CFHNs' ability to find a "mindful space" to work in the FPM with mothers. Despite the constraints of the work environment and the distractions presented by the body (such as hunger, fatigue) two nurses in this study demonstrated an innate capacity to sustain a therapeutic and mindful presence with the mothers/babies they were linked to in this study. This "mindful space" between the mothers and these two nurses is where the work of relationship building and the FPM occurs. The mindfulness of the CFHN, I argue, is the conduit which enables them to sustain their attention and awareness in the present moment and, therefore, their ability to effectively work in the FPM with the mothers. On the basis of this finding, my study recommends the next evolution of the FPM incorporate mindfulness into its theoretical framework. Consideration by the authors of the FPM I suggest, should also be given to renaming the term "helper" in the model. From the analysis of the FPM I undertook throughout this study including language usage, the word "helper" may lead practitioners to construe parents as "helpless" and "helper" does not indicate a two way relationship based on equality.

Lastly, this study adds new knowledge about mothers' perceptions and experiences of care by universal CFHN services in NSW. Mothers in this study strongly recommended the CFHN Service improves its information technology services to catch up and keep pace with the information and communication needs of contemporary parents. Mothers in this study also identified their positive experiences of care from their CFHN. However, there was an important reminder from some mothers that CFHNs be mindful to engage and develop a rapport with them before launching into asking them the sensitive psychosocial maternal

assessment questions. Mindfulness is something that is so far omitted from the awareness of mothers' needs in relation to CFHNs' working in partnership with them.

1.4 RESEARCH QUESTION AND METHODOLOGY

The research question developed for this study was derived from my personal experiences in CFHN. In my role as a Clinical Nurse Consultant in CFHN, I was responsible for nurse education, clinical practice standards and the development and implementation of policies and procedures. This included the roll out of the FPM for CFHNs in my Local Health District. I wanted to understand what factors supported or constrained CFHNs' ability to work in the FPM with parents and babies within the challenges of the work environment. A qualitative methodology was selected as the most appropriate approach to enable a focus on this specialty nursing workforce and obtain the views of their members as well as the parents who are the recipients of CFHN care.

Therefore, the following research question for the study was developed:

> *What are the factors influencing, and the nature of their impact, on the child and family health nurse's ability to work in partnership with parents, as described in the Family Partnership Model?*

This research question guided the development of the study design and choice of qualitative method. A focused ethnographic methodology was ultimately selected to conduct this study (Cruz & Higginbottom, 2013; Knoblauch, 2005; Wall, 2015). This methodology is used when there is a defined culture and research question to be explored (Polit & Tatano Beck, 2008; Wall, 2015). It enables a researcher, like myself, who is both "insider" and "outsider" to use their knowledge and previous experience of the group or situation (Wall, 2015). Further, a focused ethnographic approach enabled a critical analysis and reframing of the findings to occur in the discussion, the learning from which provide shared new understandings for both me and the participants.

1.5 THESIS STRUCTURE

This chapter has provided a description and diagram of the FPM conceptual framework and background to the study including the historical developments in CFHN and the development of policies which feature the use of the FPM in practice. It has identified the purpose and significance of the research and the methodology used to answer the research question. Chapter 2 provides an overview of the literature informing this study. The narrative literature review is relatively broad in scope in order to address

contemporary issues affecting CFHN practice and the experience of parents as well as to provide a context for a study which focuses on the ability of CFHN to work in the FPM with mothers.

Chapter 3 describes and provides the rationale for the chosen methodology and conceptual framework for this study as well as the methods used for data collection, analysis, and issues related to rigour and ethical considerations. Chapter 4 presents the findings that provide information that adds to the body of knowledge of the factors influencing, and the nature of the impact, on CFHNs' ability to work in the FPM with mothers. Finally, Chapter 5 presents the discussion of the focused ethnographic findings. This final chapter ends with the study conclusion, implications for clinical practice and further research as well as a critique of the study's rigour, strengths and limitations.

Chapter 2 LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this narrative literature review (Green, Johnson, & Adams, 2006) is to provide insight into the context and rationale for this study. Narrative literature reviews are useful when a broad overview of a topic or subject area is required that pulls together many pieces of information (Green et al., 2006). They often describe the background of an issue and how it has developed or been managed (Green et al., 2006). The review provides a summary and critique about the topics under investigation (Cronin, Ryan, & Coughlan, 2008). I have used a narrative literature review in order to provide a broad perspective on issues relevant to contemporary CFHN practice; and, the introduction of FPM in Australia.

The literature focuses, therefore, on:

- The concept of partnership;
- The origins of and models of working in a partnership approach including the Family Partnership Model (FPM) (Davis & Day, 2010; Davis et al., 2002)
- How communication features within the model;
- Potential nurse and parent factors when working in a partnership approach;
- Issues related to a neoliberal political environment, changing CFHN service context and an ageing nursing workforce;
- Issue of power and governmentality and how these may feature in CFHNs' practice in relation to their working in the FPM with mothers ; and,
- The reality of the CFHN's ability to work in the FPM with vulnerable parents.

I recognised from my roles as a child and family health Clinical Nurse Consultant and student researcher that the issues outlined above are key considerations for CFHN in NSW and Australia in relation to working in the FPM with families. Further, specific emphasis within this review is given to the FPM because it is the model of CFHN care provision that is the focus of study.

This chapter opens with an overview of the search methods for the study followed by an exploration of the concept of partnership as it applies to the nursing care of families. This is followed by a review of the importance of partnership and communication in providing

effective, safe patient care. This includes an overview of types of "centredness" in health care as it relates to the theme of working in partnership. Next, I provide a brief overview of the emerging role of contemplative practices such as mindfulness in developing therapeutic, professional-client partnerships. The FPM and its related theoretical background is described and the process of its implementation into the Australian CFHN is discussed. Finally, I provide an overview of a number of issues identified in the literature related to establishing partnership based relationships between CFHNs [and similar health professionals] and parents. This includes a review of broader issues impacting on CFHN such as the Australian neoliberal political economy, nursing workforce, and clinical practice issues in relation to their potential influence on CFHNs' ability to work in the FPM with parents.

2.2 SEARCH METHODS

I commenced the literature review for this study with a sequential search of the CINAHL and Scopus databases. The search focus was for papers that examined or explored key terms in the title, abstract or key words related to "child and family health nurse" and "partnership" and was unrestricted by year of publication. Related terms were required because the nomenclature of the CFHN differs in Australian States and territories as well as internationally (Guest et al., 2013; Kruske & Grant, 2012). Nurses providing these services in Australia are known as Child and Family Health Nurses (CFHN), in NSW, Queensland, South Australia Tasmania, the Australian Capital Territory and the Northern Territory, Maternal and Child Health Nurses (MCH), in Victoria, and Child Health Nurses (CHN) in Western Australia (Fletcher, Dowse, et al., 2014). As mentioned in the introduction, in NSW CFHNs were previously referred to as Baby Health Nurses and Early Childhood Nurses (NSW Health, 2002; O'Connor, 1989) while internationally nurses providing this role are known as Health Visitors in the United Kingdom, Plunket nurses in New Zealand, Child Health Nurses in Finland and Sweden and Public Health Nurses in Canada (Kruske & Grant, 2012). Key terms related to partnerships in health care included family-centred care, person-centered care, partnership-in-care, and family partnership.

An ongoing, automated, electronic, search strategy was established in 2008 in the Scopus and CINAHL databases using the above identified key search terms. I continued to receive monthly updates of published journal articles related to these terms until July 2013. In addition, I undertook specific searches of the literature and bibliographies throughout the study period for papers and theses with key terms relevant to issues I identified while developing the original research proposal and as the findings of the study emerged.

Inclusion Criteria:

Papers were included if they were original research involving humans, literature reviews, discussion papers and theses.

Exclusion Criteria:

Papers were excluded if they were not published in the English language or if they were clinical protocols, conference abstracts or editorial papers.

In February 2014, a thorough review of the literature was repeated using the following limiters, databases and terms:

Limiters:

a) Published date: January 2008 - February 2014

b) English language

c) Human

Databases:

a) CINAHL

b) Scopus

c) Mosby's index

d) Trove

e) Dissertation and thesis library

Key Terms

a) Partnership, family partnership, partnership in care, patient centred care, family centred care OR family centered care, Parent advis*[2] model

AND

b) Health visitor*, child* or family or maternal or early or baby or public or plunket* nurse*, child health nurse

In addition to the updated search above and based on developments in the field and the direction of the thesis from the new knowledge obtained from my exposure to field study, the key terms used were expanded to include the following:

[2] The * indicates the search strategy known as truncation. Truncation is used when the root of a word that has multiple endings, for example, nurse, nurses, nursing, is truncated by a symbol such as "nurs*". This enables the search to be broadened to include the various word endings.

- Autonomy in nursing practice
- Benefits of professional development on practice/ motivation
- Clinical supervision
- Collegial relationships and support
- Cultural influences
- Ecology/ environment
- Menopause and nursing practice
- Nursing burnout
- Nursing leadership
- Power
- Surveillance, and
- Technology influence, e-records, digital medical records

In addition to the above search strategies, I continued to manually search for relevant literature from bibliographies and from Google searches including Google scholar. The relevant articles and theses from manual searching were exported into the EndNote™ referencing system. I grouped the literature within EndNote™ under key terms related to the thesis; for example, child and family health nursing, family partnership model, focused ethnography and this organisation helped with searching and retrieval of relevant articles.

The main themes and sub-themes drawn from the literature that informs the structure of this narrative review are:

Theme 1 Working in Partnership with Families

Sub-themes:

- Overview of the concept of partnership
- Origins and models of partnership
- Effective, patient safe communication and the emerging role of contemplative practice in building therapeutic professional partnerships
- The Family Partnership Model
-

Theme 2 Factors Potentially Influencing the CFHNs' Ability to Communicate and Work in the FPM with Parents

Subthemes:

- Neoliberal influences
- Issues related to working in the FPM in a changing service context and ageing nursing workforce
- Issues in establishing and maintaining partnership based relationships between CFHNS and parents
- Issues working in the FPM with vulnerable families

Theme 3 Governmentality and CFHN Practice

2.3 THEME 1: WORKING IN PARTNERSHIP WITH FAMILIES

The essential value of working in partnership with families is a concept that often goes unquestioned by health professionals. However, when I commenced this study in 2008, understandings of how professional partnership relationships occurred between nurses and parents "remain[ed] unclear and contested as a way of working" (Bidmead & Cowley, 2005a, p. 203). The purpose of this section of the literature review is to describe the concept of partnership in relation to the nurse-parent relationship; provide an overview of the historical use of the term in nursing; and, to critique the discourse and implementation of the FPM particularly in relation to the role of the CFHN in NSW, Australia.

2.3.1 An Overview of the Concept of Partnership

Gallant, Beaulieu, and Carnevale (2002) conducted an analysis of the literature between the years 1982-2000 for the concept of partnership from disciplines such as nursing, medicine and the social sciences. Their findings identified that the concept of partnership had evolved over fifty years from advancements in democratic thinking and progress in the clarification of how to "honour basic human rights in health care relationships" (Gallant et al., 2002, p. 149). The authors' state the:

> …structure of partnership includes the phases of the relationship, focus and aims of each phase, and roles and responsibilities of the partners. The process of partnership embodies power sharing and negotiation. The main consequence of partnership is client empowerment, which is understood to be the improved ability of the client to act on his/her own behalf. (Gallant et al., 2002, p. 149)

The concept of partnership has also been analysed by Bidmead and Cowley (2005a) in relation to health visiting practice in England. This analysis is pertinent to this review because the role of the health visitor in the United Kingdom is similar to the role of the

CFHN in NSW (Guest et al., 2013). The timeframe for the literature review of this conceptual analysis of partnership was similar to that used by Gallant et al. (2002), that is, 1980-2003. The conceptual analysis conducted by Bidmead and Cowley (2005a) led to the following definition of partnership:

> Partnership with clients in health visiting may be defined as a respectful, negotiated way of working together that enables choice, participation and equity, within an honest, trusting relationship that is based in empathy, support and reciprocity. It is best established within a model of health visiting that recognises partnership as a central tenet. It requires a high level of interpersonal qualities and communication skills in staff who are, themselves, supported through a system of clinical supervision that operates within the same framework of partnership. (p. 208)

Working in partnership with the client encourages the nurse to make a shift away from working within an "expert" model (Bidmead, Davis, & Day, 2002, p. 256). In the expert model, the nurse believes that she/he is educated to "solve people's problems and tell them how to live healthier and happier lives"; and, that their knowledge is the only truth and way of knowing (Bidmead et al., 2002, p. 256). Working from an "expert" model may become an obstacle to progress for both the nurse and client (Davis & Day, 2010). Thic Nhat Hanh stated "if we cling to what we have learned as the absolute truth we are caught by that knowledge" (2006, p. 114). The expert model can also be burdensome because the nurse assumes responsibility for holding the answers to peoples' problems, many of which may be outside the scope of their expertise (Davis & Day, 2010). This way of working may also impede new parents' development of self-efficacy, confidence and self-determination in their new child-rearing roles and evidence suggests that it is not effective in the longer term (Davis & Day, 2010). Although an individual problem may indeed be solved, the parent may believe the nurse was the one that solved it. Thus, the parent is not encouraged to develop the skills to initiate problem solving regarding their future parenting concerns (Bidmead et al., 2002; Davis & Day, 2010).

Briggs (2007) states that forming a partnership with a family is a process that is virtually invisible because it is embedded within CFHN practice. She uses the term "mutuality" to describe how both the CFHN and the parent come to invest in the relationship when it is based on partnership (Briggs, 2007, p. 8). It has also been suggested that CFHNs intentionally use attachment theory in order to form a close relationship with the mother (Karl, Beal, O'Hare, & Rissmiller, 2006). Briggs states that this close relationship between the CFHN and mother can be expressed as "mothering the mother" (2007, p. 9); the aim of

which is the CFHN modelling a relationship with the mother that parallels the relationship the mother is developing with her infant. This process is also known as scaffolding the parent (Brand, Morrison, & Down, 2014). It is a similar model to that of the parent-infant interaction model described in the FPM literature (Davis & Day, 2010; Davis et al., 2002). Considerable skill is needed on the part of the CFHN to negotiate the complexities in negotiating this relationship for it to meet the criteria of a partnership (Briggs, 2007). In order to provide a platform for this research into the factors influencing the ability of the CFHN to work in the FPM, further exploration of the key terms related to partnerships in health care follow. These include the antecedents and explanation of terms related to partnership such as 'centredness' and includes family-centred care, patient-centred care, person-centred care, and finally, the FPM.

2.3.2 Origins of and Models of Partnership

A number of terms have evolved over the last seventy years to describe philosophies and recommended approaches to the delivery of health care. This movement has occurred in parallel with societal and ideological movements in the latter half of the twentieth century (Gallant et al., 2002; Hughes, Bamford, & May, 2008; Morgan & Yoder, 2012). In a literature review of types of "centredness" related to partnerships in health care, Hughes et al. (2008) identified ten conceptual themes that are common among all types of centredness. These themes were recurrent in the following types of "centredness in care", for example, person-centred care, family-centred care. patient-centred care and partnership-in care (Hughes et al., 2008, p. 458). The identified themes were:

1. Respect for individuality and values
2. Meaning
3. Therapeutic alliance
4. Social context and relationships
5. Inclusive model of health and well-being
6. Expert lay knowledge
7. Shared responsibility
8. Communication
9. Autonomy
10. Professional as a person

2.3.2.1 Partnership and Family-Centred Care

The chosen nomenclature and application of centredness, for example, family-centredness versus person-centredness is selected by its practical use and the requirements of different settings (Hughes et al., 2008; Morgan & Yoder, 2012). For example, family-centredness may apply to a situation involving the family in care decisions about a sick child (Harrison, 2010) whereas person-centred or resident-centred care may more aptly apply in the context of an elderly resident's care needs in an aged care facility (Lopez, 2013; Morgan & Yoder, 2012). However, the application of the correct term is not so clear. Although "person-centred" care seems to relate more appropriately to the care of an adult individual, care of the elderly, for example, also requires "family" involvement (Lopez, 2013). Family-centred care, however, can apply to all patient groups. Hughes et al. (2008) state that:

> Patient centredness and related concepts have become important for ideological and structural reasons as well as for professional and ethical ones. They are part of the body of ideas through which professionals and others make sense of their work and attribute moral meaning and value to it…The notion of centredness itself,…reflects a movement in health and social care, away from the narrower biomedical view, in favour of the broader view, which involves increasing the social, psychological, cultural and ethical sensitivities of our human encounters. (Hughes et al., 2008, pp. 456, 461)

The importance of working in a "family centred-care" approach with families and children has been documented in the nursing literature since the 1950's and is now established practice in paediatric nursing (Harrison, 2010; Newton, 2000). Family-centred care recognises the importance of the family during a child's illness and "acknowledges and respects the experience of the family in caring for the child both within and outside of the hospital environment" (Newton, 2000, p. 2). Parents and family members' presence is encouraged during the child's hospital experience and they are encouraged to take an active role in their child's activities. The United States Division of Services for Children with Special Health Care Needs developed the following definition of family-centred care:

> Family-Centered [sic] Care assures the health and well-being of children and their families through a respectful family-professional partnership. It honours [sic] the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice

> which results in high quality services. (Maternal and Child Health Bureau Division of Services for Children with Special Health Needs, 2005)

Although the development of the family-centred care approach in nursing appears to have originated in paediatrics, it has recently been introduced more widely into adult health services (Institute for Family-Centered Care, 2008). The United States Institute for Family Centered Care uses the term "patient-and family-centered [sic] care" more often now as it has become more involved in adult and geriatric care. One of the reasons given for the change in terminology is because the original definition of patient-centered care, as discussed in the literature in the late 1980s and early 1990s, did not include the concept of patients and families as advisors and essential partners in improving care practices and systems of care (Institute for Family-Centered Care, 2008).

2.3.2.2 Partnership and Person-Centred Care

The origins of the concept of person-centred care is purported to have stemmed in the 1950's from two parallel movements (LePlege et al., 2007). The first of these movements included the growing awareness in medicine of the importance of the "subjective experience of the patient [as] a new reference point for medical care" (LePlege et al., 2007, p. 1564). The second movement encouraged patient participation in their care and in decisions regarding their health (LePlege et al., 2007). The inclusion of the client in medical decisions and recognition of the client's unique experience and situation was championed by American psychologist Carl Rogers who first coined the term "person-centred approach" (LePlege et al., 2007, p. 1564). The work of Carl Rogers also comprises part of the underpinning theoretical framework of the Family Partnership Model (Davis & Day, 2010). Morgan and Yoder (2012) combined a number of definitions of person-centred care to provide the following definition of the concept:

> A holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualised, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care. (p. 8)

There is obvious value and enthusiasm of nurses, patients and families for the provision of care in either a person or family centred approach that is based on partnership. However, research has shown that neither of these models of care are easy to implement in practice (Coyne, 2013; McCormack, Karlsson, Dewing, & Lerdal, 2010). McCormack found in a qualitative metasynthesis of four unrelated research studies into person-centredness that

despite nurses' willingness to use this approach, the care provided remained "routinised, ritualistic and affording few opportunities for the formation of meaningful relationships" (2010, p. 620). Similarly, the findings from Coyne's qualitative study which used grounded theory to examine nurses, parents and children's perspectives of the implementation of family-centred care found that "there was minimal evidence of collaboration or negotiation of roles which resulted in parents feeling stressed or abandoned" (2013, p. 1). Nurses reported that busy workloads, being under-staffed and having unsuitable documentation as contributing factors which resulted in their over reliance on parents and impacted on their ability to work in partnership with them (Coyne, 2013). Coyne adds that these findings are consistent to similar results found world-wide regarding the difficulty of implementing family-centred care in practice (Coyne, 2013). Consequently, it has been identified that the context of the health care culture, environment and leadership is pivotal to nurses' ability to be able to place people as partners at the centre of their care (McCormack et al., 2015; Morgan & Yoder, 2012). At the beginning of this study, my own experience of the increasing workload and changing work environment affecting my CFHN colleagues led me to wonder whether these factors similarly impacted on their ability to work in the FPM with parents.

2.3.3 Patient Safe Communication and the Emerging Role of Contemplative Practice in Building Therapeutic Professional Partnerships

Despite difficulties in enacting family-centred care and partnership in practice, it has been clearly identified that health professionals' ability to communicate effectively with each other and with their patients increases patient safety (Levett-Jones, Gilligan, Outram, & Horton, 2014). The ability of health professionals such as nurses to use therapeutic communication approaches with patients and clients is also known to improve patient satisfaction and lead to more positive clinical outcomes (Rossiter, Scott, & Walton, 2014). Health professionals, (in this instance CFHNs'), personal qualities, characteristics and skills in communicating with parents is inextricably related to their ability to work in the FPM with them (Davis & Day, 2010).

The use of a contemplative practice such as mindfulness by health practitioners is increasingly recognised as critical to their ability to establish a therapeutic presence and relationship with clients (Razzaque, Okoro, & Wood, 2013). A well-known definition of mindfulness is the "awareness that emerges through paying attention on purpose, in the present moment, and non-judgementally to the unfolding of experiences moment by

moment" (Kabat-Zinn, 1994, p. 4). Research into mindfulness and its association with clinicians' therapeutic relationships with patients/clients is predominant in mental health services research (Hick & Bien, 2008; Razzaque et al., 2013) and in general nursing literature (Cohen-Katz, Wiley, Capuano, Baker, Deitrick, et al., 2005; Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2004; Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2005; White, 2014). The FPM, while noted to be an evolving process and one which clearly advocates that practitioners incorporate reflective practice and access to regular supervision to enhance their effectiveness, to date does not include the concept of mindfulness within its framework (Davis & Day, 2010; Day et al., 2015).

2.3.4 The Family Partnership Model (FPM)

In 2002, the FPM previously known as the *Parent Adviser Model* (Davis et al., 2002) was introduced to CFHNs in NSW, Australia (Guest, Gillard, & Kirk, 2003). This education was deemed relevant for CFHNs who as a result of policy changes, were selected as the professional group to provide universal and sustained home visiting to families (NSW Department of Health, 2009). The FPM training program (Davis et al., 2009) was selected based on evidence that it would enhance the nurses' ability to engage and work effectively with families, and in particular, those vulnerable families receiving targeted or sustained home visiting services (Kirkpatrick et al., 2007; Papadopoulou et al., 2005). The name Family Partnership Model was coined by health staff in Western Australia as it was felt that it better described the nature and intent of the model (Davis & Day, 2010; Guest et al., 2003, p. 1).

It can be seen from the preceding discussion that the presence of the FPM is fairly recent in the literature (Davis & Day, 2010; Davis et al., 2002; Day et al., 2015). It was first introduced into NSW in 2002, around the time of implementation of the UHHV program (Guest et al., 2003) although it had already been introduced into Western Australian child health services in 2001 (Lamont, 2002). A senior paediatrician within NSW Health was impressed by the evidence underpinning the FPM and its application with families after hearing its merits discussed at an international conference. On return to Australia, this physician advocated with key CFHN and NSW Health representatives resulting in the NSW Health Department (now called the NSW Ministry of Health), supporting and subsidising the initial FPM training which occurred in October 2002 (Guest et al., 2003). Those CFHN and allied health professionals originally trained in the FPM were, thereafter, charged with establishing FPM Facilitator Training Programs for CFHN staff within their Local Health Districts (LHDs) (Guest et al., 2003). I was a participant in this first FPM training program

facilitated by Hilton Davis and Christine Bidmead in 2002. I thus held joint responsibility for providing FPM training to the CFHNs in our LHD.

Since then, there has been a growing body of research into the implementation of the FPM in the Australian CFHN context (Briggs, 2007; Fowler, Rossiter, et al., 2012; Grant, 2008; Grant & Luxford, 2008; Hopwood et al., 2013; Keatinge et al., 2007; Kemp et al., 2006-2007; Kruske, 2005; Kruske, Barclay, & Schmeid, 2006; Rossiter et al., 2011). Studies have focussed on issues related to forming the CFHN – parent partnership (Briggs, 2007); its implementation in the antenatal period by CFHNs (Kemp et al., 2006-2007); evaluation of its implementation in NSW (Keatinge et al., 2007); sustaining practice innovation (Fowler, Rossiter, et al., 2012; Rossiter et al., 2011); and more recently, critiques regarding issues of power within the CFHN-parent relationship, particularly with low income mothers (Shepherd, 2014).

The introduction of the FPM into the Australian CFHN context has also been critiqued by Grant and Luxford (2008). These authors, (the first of whom is a CFHN and senior academic from South Australia), acknowledge the value of the FPM but question the evidence for its universal application with families in the diverse, Australian, multicultural context (Grant & Luxford, 2008). They suggest that the communication approach of the FPM, derived from theories developed in the US by white, male psychologists in post-World War II, does not sufficiently address issues of race, gender and class (Grant & Luxford, 2008). Taking for granted that the FPM provides a universal, empathic communication approach to use with families was found to mask CFHNs' ability to see and tailor care to account for the specific needs of families from culturally and linguistically diverse (CALD) backgrounds (Grant & Luxford, 2008).

A further critique of the FPM by Hopwood (2014a), suggests that the FPM and similar "partnership-based agendas contribute to new regulatory [professional practice] regimes [where] partnership and accountability fuse in complex ways" (p. 3). The FPM has become incorporated into CFHN ideology and constituted as a form of governance with expectations of "acceptable" forms of CFHN practice now written into health policy (NSW Department of Health, 2009) and practice (NSW Health, 2011a). These changes involve a refashioning of CFHN professional identity and practice (Fowler, Rossiter, et al., 2012). However, despite these critiques, and the growing body of CFHN and FPM literature, none of these studies to date have used a focused ethnographic methodology or explored the macro to microsystem level factors influencing, or the nature of their impact, on the ability of the CFHN to work in the FPM with parents. My study was designed to address this gap in the research literature.

2.3.4.1 The Family Partnership Model and Primary Health Care

Kruske et al. (2006) suggest the concept of working in partnership is "strikingly similar to the principles of primary health care that was introduced to the [CFHN] profession twenty-five years ago" (p. 61). The authors claim that partnership and primary health care both aim to shift power from the health system to the community and individual client (Kruske et al., 2006). Primary health nursing care has been described as an environment where parents are free to choose to attend as independent, competent adults whose autonomy and right to determine what is right for their child is respected (Keatinge et al., 2007, p. 5). Both primary care and the FPM also recognise the "complementary expertise" that both practitioner and parent bring to the relationship (Davis & Day, 2010, pp. 82-83). Contact with a client also generally occurs before a health issue arises (Keatinge et al., 2007). The FPM approach and the concept of primary health care are identified as core CFHN knowledge and skills in the *NSW Child and Family Health Nursing: Professional Practice Framework 2011-2016* (The Nursing and Midwifery Office, 2011).

2.3.4.2 NSW CFHN Professional Standards and Education in the Family Partnership Model

The Child and Family Health Nursing Association (NSW Inc.) (CAFHNA) is the professional organisation representing CFHN issues at the state and national level. The assessment cues and processes of working in the FPM are meticulously outlined in the *CAFHNA Competency Standards for the Child and Family Health Nurse* (Child and Family Health Nurses Association NSW, 2009). This document, implemented in conjunction with the *NSW Health Child and Family Health Nursing: Professional Practice Framework 2011-2016* (The Nursing and Midwifery Office, 2011), emphasises the importance of the FPM in its philosophy, core skills and clinical practice approach of the CFHN when working with families (Child and Family Health Nurses Association NSW, 2009; Keatinge et al., 2007). Therefore, the importance of the FPM as a foundation for work is a policy (NSW Department of Health, 2009) and clinical practice standard of NSW Health and endorsed by the body representing NSW CFHN professional issues.

Education of NSW CFHNs in the *Family Partnership Foundation Course* (Davis et al., 2009) takes place in a small group setting over five full days or ten half days (Fowler, Rossiter, et al., 2012) preferably at weekly intervals (Davis et al., 2009). Each group is recommended to have two facilitators and a maximum of twelve participants to enable supervised small group work practice sessions (Davis et al., 2009). The programme is carefully structured and experiential in order for participants to be introduced to the various components of

the model and practise the required skills (Fowler, Rossiter, et al., 2012).There are limited processes in place, however, to sustain and build on the provision of the *FPM Foundation Course* (Davis et al., 2009) to CFHNs across NSW LHDs on an ongoing basis (Rossiter et al., 2011).

Twelve Australian tertiary institutions offer specialist postgraduate education programs in CFHN (Kruske & Grant, 2012). The FPM forms part of the core curriculum of these education programs. However, there are reportedly marked differences in their "course titles, length, content, clinical exposure" with many of these facilities inadequately preparing CFHN students with the core knowledge and skills required to be workforce ready (Kruske & Grant, 2012, p. 200). Further, despite early widespread implementation of the FPM course in CFHN services across Australia (Fowler, Rossiter, et al., 2012), there has not been a similar ongoing availability of easy access by nurses to refresher courses or continuing education in the FPM (Rossiter et al., 2011).

2.4 THEME 2: FACTORS POTENTIALLY INFLUENCING THE CFHNS' ABILITY TO COMMUNICATE AND WORK IN THE FPM WITH FAMILIES

Factors related to the characteristics of the nurse are known to potentially aid or impede the development of their relationship with parents (Davis & Day, 2010). These factors are particularly impactful in the contemporary environment where there is increasing complexity in the issues that families face (Davis & Day, 2010; Gallant et al., 2002). Engaging the parent is facilitated by nurses who are flexible, who can construe the situation accurately and are able to "…fit in with the parent" by matching their style of interaction including speech patterns (Briggs, 2007, p. 7). The recommendation of the nurse by a referral agent known to the family can facilitate the link and beginning of the relationship with the parent (Briggs, 2007).

Factors that may impede a relationship forming include nurses who use "controlling talk" by ignoring cues from the parent and keeping to the schedule (De la Cuesta, 1994b, p. 9). This works to keeps the relationship at a superficial level and prioritises the nurse's schedule and tasks over the needs of the parent. Morse (1991) cited in McNaughton (2000), states that mutual and unilateral relationships can occur between clients and nurses. Unilateral relationships develop when one person is not committed to the relationship or when external factors (such as time constraints and lack of continuity of nurse-client contact) impede relationships from developing (McNaughton, 2000, p. 411).

In contemporary CFHN practice in NSW, it is often difficult to provide continuity of care with parents and children due to workloads and rosters. For example, one nurse may provide the universal home visit and other nurses may provide the subsequent follow up visits either at the home or at the Child and Family Health Centre (NSW Department of Health, 2009).

Kruske & Barclay maintain that parents manage as equals when a relationship with the nurse based on partnership is developed over time (2006, p. 22). However, the emphasis on the provision of the UHHV (NSW Department of Health, 2009), may limit the ability for ongoing contact with families beyond this visit (Hopwood et al., 2013; Schmied et al., 2011) and the ability to develop a partnership based relationship that develops over time. Normandale (2001, p. 148) suggests that a "collaborative relationship" is built through good listening skills and allowing clients to be part of the decision making process. However, Normandale's use of the word "allowing" in the preceding sentence indicates a power differential exists with the nurse able to exercise power over the parent. In contrast, Chalmers suggests there are two actors exercising control over the interaction (1992, p. 1319). The use of the term "control", like "allowing", appears to preclude a relationship based on partnership.

Briggs (2007, p. 6) states women act as "gatekeepers" to entry into the home. Mothers can also act as gatekeepers to their partner's participation in their baby's care and attendance at services (Rowe et al., 2013). This is exacerbated by the gendered nature of parenting and services that are not father inclusive (Fletcher, Dowse, et al., 2014; Fletcher, May, St George, Stoker, & Oshan, 2014; Rowe et al., 2013). However, fathers and grandmothers may also be influential in women's decision to seek access and to receive home visits from the CFHN service. In some cultures, the grandmother can act as gatekeeper to entry into the home as well as a source of conflict for the mother in accepting health information from the nurse rather than lay information (Wilson, 2003). These factors can act as potential detractors from the CFHNs' ability to work in the FPM with parents.

Studies of nurse home visiting programs conducted in Australia and internationally have endorsed the value and effectiveness of working in a strengths-based, partnership approach particularly with vulnerable families during the antenatal and postnatal periods (Kemp, Anderson, Travaglia, & Harris, 2005; Kemp et al., 2006-2007; Kirkpatrick et al., 2007; Kitzman et al., 2010; Kitzman et al., 1997; Olds et al., 2010). Many of the women in these studies initially had negative perceptions of health professionals. However, they came to greatly value the relationship that was established with their nurse and found the termination of the service difficult where a trusting relationship based on partnership and

continuity of care had occurred (Kirkpatrick et al., 2007, pp. 32, 43). There is a general consensus internationally among early intervention parenting programs that a "foundation premise…is the use of a partnership model to identify, recognise, and use parent strengths" (Attride-Stirling, Davis, Markless, Sclare, & Day, 2001; Graybeal, 2001 ; Keatinge et al., 2007, p. 30).

There is emerging evidence to support what Keating and Hertzman (1999, p. 1) have described as the concept of "modernity's paradox". This paradox arises because despite increased wealth and declining death rates, psychosocial forms of morbidity are increasing in children such as mental health problems, child abuse and childhood obesity (Li, McMurray, & Stanley, 2008). Developmental scholars have suggested that micro-level influences on a child's early years may assist in explaining the social inequalities across the lifespan (Li et al., 2008). Li et al. (2008) argue that there are also wider or macro-level forces which influence a child's life. These macro influences include the contemporary political, economic, demographic, cultural, technological milieu of the family environment as well as the changes in the natural environment (2008, p. 67). If these interactive macro forces influence the family environment, they may similarly influence CFHNs' ability to work in the FPM with parents. The following sections of this review explore the nature of the current political and economic forces impacting on Australian families and the role of the CFHN. It also calls into question whether it is truly possible to practice in partnership with families in the current political, economic and health care environment.

2.4.1 Neoliberal Influences

Li et al. (2008) argue that neoliberal policies and globalisation have adversely impacted on the family environment and child development. The neoliberal era began in the late 1960's in the United Kingdom (UK) and in the 1970's in the United States (US) (Navarro, 2007; Zuzelo et al., 2008, p. 67). Neoliberalism is closely associated with globalisation and is a "doctrine that spans economics and social philosophy" (Ramon, 2008, p. 116). The term "neoliberalism" refers to two notions, namely "neo" meaning new and "liberal" meaning free from government intervention (Horton, 2007a, p. 1). Horton states that "liberalism stems from the work of Adam Smith, who, in the mid 1770's advocated for a minimal role of government in economic matters so that trade could flourish" (2007a, p. 1). In the 1960s- 1970s,

> …liberalism, or the cry for deregulation, privatisation and deletion of government intervention in the market economy, resurfaced with a

> vengeance; hence the name renewed liberalism or neoliberalism. (Horton, 2007a, p. 1)

Australian neoliberal health policies are pertinent to this study's literature review because they redefine governance and human behaviour in terms of a market economy (Henderson, 2005). They undermine traditional notions of society and government responsibility, stigmatising welfare dependence and devolving responsibility for health and social care to families and communities (Henderson, 2005).

Lane (2006, p. 342) reports that in response to globalisation, neoliberal governments such as Australia have implemented instruments of corporate governance in the public sector known as marketisation, managerialism and consumerism. Marketisation refers to services being subject to the market economy and encouragement of "competition between public sector agencies" (Lane, 2006, p.342). Managerialism involves managers becoming the "key actors in operationalising the new regulatory mechanisms applied to public sector agencies" (Lane, 2006, p.341). Managers are responsible for creating efficiencies using "various disciplinary technologies (such as policy directives, competitive contracts and accountability measures)" (Lane, 2006, p.342). A managerialist ideology is similar to governmentality in that its technologies are designed to assist in "govern[ing] at a distance" (Rose & Miller, 1992, p. 200). These techniques include the use of measures such as benchmarks and audits that can calculate efficiencies.

What this means in practice is that responsibility for access and maintenance of health care has moved from government and health service responsibility to the individual person, families and communities. In neoliberal societies such as Australia, the UK and the US, there is an "ambivalent treatment of service users as either consumers and/or deviants and scroungers"; there is a "zero tolerance for welfare dependency" and, no room for unsuccessful people (Ramon, 2008, pp. 116-117). Recently, the outgoing Australian Treasurer pointedly announced in a very unpopular budget statement: "We are a nation of lifters, not leaners" (Hockey, 2014). The message from the Treasurer clearly indicated the need for people to be self-reliant and the pejorative view of those more dependent on support from services.

A recent example of the push back of health care to the individual was in the 2014 Australian Federal Budget released by the Abbott Coalition Government (Australian Government, 2014). The Treasurer announced that from 1 July 2015, "previously bulk-billed patients can expect to contribute $7 per visit towards the cost of standard GP consultations and out-of-hospital pathology and imaging services" (Australian

Government, 2014). There were concerns this radical change to the Medicare public health insurance program in Australia would endanger the most vulnerable in society such as the Australian Aboriginal population and "widen the gap between indigenous and non-indigenous health" (Hutchens & Swan, 2014). This widely unpopular budget measure, however, did not find support in the Senate and the legislation was withdrawn (Heath, 2014).

An exploratory study of the CFHNs' role in Brisbane, Australia identified that the planning and development of [contemporary CFHN] services was influenced by the "predominant political, social and economic climate of the day" (Barnes et al., 2003, p. 18). CFHNs perceived there had been an undermining of the value of their nurturing relationships with clients. The nurses were concerned about dealing with constant change; and having:

> …limited involvement into decisions for changes in and to services, the shift from the individual to groups with the associated perception of undermining of the value placed on nurturing relationships developed between nurses and clients; and dealing with constant change itself [which] impacted on job satisfaction and has the potential to influence the quality of services offered to clients….The relationship between the nurse and the client was challenged and it was recommended that a balance be found between individual and population health approaches to meet the health needs of all clients (Barnes et al., 2003, pp. 18-19)

It appears from this and related literature, (Reiger, 2006; Reiger & Keleher, 2004), that a health service environment controlled by a neoliberal political economy is unconducive to supporting CFHNs to work in partnership with women and families. In the current workforce culture, efficiencies in both expenditure and client throughput are seen as benchmarking goals (Henderson, Curren, Walter, Toffoli, & O'Kane, 2011). This is not to criticise improvements to critical care and clinical indicators such as reducing waiting times in emergency departments. The issue is that the two paradigms, that is, working in the FPM and neoliberalism, appear to be contesting discourses (McIntyre, Francis, & Chapman, 2012). Given these contesting discourses and the continuing existence of a neoliberal society in Australia and globally, it is particularly pertinent to examine the factors that may influence the ability of the CFHN to work in the FPM with parents and their impact, if any, in the practice setting.

2.4.2 Issues related to working in the FPM in a changing service context and ageing nursing workforce

Kruske et al. (2006) found the age and education level of the nurse, and the conflicting demands placed upon them, were aspects of the CFHN service structure in NSW that negatively impacted on their ability to establish ongoing relationships with parents. These findings centred on the tension of working within a health district that:

> … expects them to monitor, screen and detect problems (expert model); give health information (expert model); provide psycho-social support (partnership model); and support community networking while acting as a conduit to other secondary and tertiary services (partnership and expert model). (Kruske et al., 2006, p. 62)

The requirement for NSW Health CFHN Services to achieve performance indicators which focus on occasions of service (for example, counting numbers of UHHVs conducted within two weeks of birth) (NSW Department of Health, 2009), appears to reflect the concerns of Kruske et al. (2006). The UHHV performance indicators do not appear to focus on meaningful outcomes or the quality of the encounter and is in contrast to the holistic approach of the FPM. Further, it has not yet been established that a UHHV leads to greater engagement or improves outcomes for families (Schmied et al., 2011). The purpose of my study is to shed light on these factors to determine their influence, if any, on the ability of CFHNs to work in the FPM with parents in the practice setting.

Kruske et al. (2006, p. 61) examined the contemporary role of the CFHN in NSW and found that nurse participants were able to describe the partnership model but that "observations showed the application of the principles of partnership in practice was difficult for most of the nurses". The authors' state that tertiary institutions prepare undergraduate nurses to work in the acute sector and that these nurses are ill prepared to work outside the hospital (Kruske & Barclay, 2006). Most new nursing graduates work in hospitals and have biomedical work practices formed there (Kruske & Barclay, 2006; Kruske et al., 2006). These nurses have to unlearn this biomedical medical model when working in the community and instead strive to adopt a partnership paradigm (Kruske & Barclay, 2006). Further, contemporary post graduate education preparatory requirements for CFHN education in Australia, as mentioned, have inconsistent content and requirements (Kruske & Barclay, 2006; Kruske & Grant, 2012). The difficulty with current preparatory courses for child and family health nurses is similar to the situation for health visitors in the UK (Mitcheson & Cowley, 2003). Kruske and Barclay (2006, p. 23) argue that the amount of

clinical experience required in these courses is insufficient to "change the style of practice necessary for [CFHNs] to work in partnership with families". This makes it even more important that new CFHNs work in environments where colleagues exemplify this partnership approach.

The issues related to an ageing nursing workforce have become more prevalent in the nursing literature (Duffield, 2008; Gabrielle, Jackson, & Mannix, 2008; Graham & Duffield, 2010; Ryan, 2015). Older nurses report areas of concern such as high stress levels from workplace conflict, poor working conditions and lack of support from management in relation to their changing needs (Gabrielle et al., 2008, p. 89). This is significant as CFHNs are generally older than nurses working in other disciplines (Australian Productivity Commission, 2011). Nursing shortages are predicted as nurses transition to retirement (Graham & Duffield, 2010). It is also evident that the role of the CFHN has broadened to become "multifaceted" over time with consequent challenges for those nurses currently in the workforce (Borrow et al., 2011, p. 71).

In addition, concerns related to the emotional labour experienced by nurses and midwives in the course of their work have been identified (Hunter & Deery, 2009; Smith, 2012). Unrelenting work demands and the emotional toll that consistently working with parents can take on practitioners is recognised (Day et al., 2015). However, there appears to be no specific research conducted into the emotional labour of either CFHNs and/or its relationship to working in the FPM with parents. Therefore, these issues of an ageing CFHN workforce within a changing service environment; and, the emotional labour of CFHNs represent a gap in the literature requiring further investigation for their potential influence on nurses' ability to work in the FPM with parents.

2.4.3 Issues in establishing and maintaining partnership based relationships between CFHNs and parents

A number of authors have cast doubt on whether it is possible in reality for child health nurses in the community to work in partnership with parents (Andrews, 2006; Wilson, 2001, 2003). Research conducted both in Australia and overseas on the language used by community CFHNs to describe how they initiate and strive to maintain a relationship with parents calls into question the notion of a partnership (Andrews, 2006; Keatinge et al., 2007; Roche et al., 2005; Wilson, 2001, 2003). This is important as language use is a critical component of communication and establishing partnership based relationships (Davis & Day, 2010).

Initial contact of families by the CFHN Service to organise the UHHV generally occurs by "cold calling" (Briggs, 2007, p. 6). This is a term for a marketing strategy where the nurse (or administrative assistant), tries to sell the service by informing the client about the service and having an identified "health promotion product" (Briggs, 2007, p. 6). The service is presented to the client as routine in order to make it acceptable (De la Cuesta, 1994a) and the nurse's profile in the local community helps to advertise the service (Briggs, 2007). This identification of selling a product fits aptly in a market driven, neoliberal society where the health care recipient is seen as a consumer. Horton cites Irvine (2002), suggesting "the discourse associated with neoliberalism, and in particular the word 'consumer', sets the scene for [power] relationships between the various participants of health care – based on individualistic policies" (2007b, p. 8). However, in CFHN, the individual family members enrolled in the service are generally known as clients, indicating a more professional relationship rather than a marketing target.

Wilson describes Plunket nurses' methods of contacting mothers as "gentle surveillance" (2003, p. 284). The New Zealand Plunket nurses, similar to health visitors in the UK and CFHNs in Australia, use a non-threatening approach and endeavour to build a rapport with the mothers in order to "keep them coming" (Wilson, 2003, p. 285). The notion of gentle surveillance stems from the Foucauldian perspective where the disciplinary power characteristic of established social institutions [such as Plunket], leads to the self-regulation of individuals and reduces the need for direct state interference (Wilson, 2003, p. 286). According to Foucault (1980, p. 121), a major transformation in the exercise of power occurred in the late eighteenth century when "sovereign" power was replaced by "disciplinary" power. The micro-techniques of disciplinary power are purported to operate through the discourses and practices of traditional social institutions (Weedon, 1987). The subtle administration of disciplinary power results in people (meaning parents in this context), taking responsibility for regulating themselves and their children to comply with the "…disciplinary intent intrinsic to contemporary practices of surveillance" Wilson (2003, p. 286). In addition Rose (1990, p. 121) states by "capitalizing on parental aspiration for 'normal' children,…childhood has become the most extensively governed sector of personal existence".

McNaughton (2000) states the client's control of the interaction has been identified as an important element of the client-nurse interaction, particularly in home visiting. Being sensitive and open to clients' preferences for control can help strengthen the nurse-client relationship, enhance communication, and provide a basis for health promotion work (McNaughton, 2000). However, the increasing use of structured health assessments by

health visitors [and CFHNs] serves to highlight the predominance of a "professional lead" rather than having "an open agenda" which genuinely values client participation during consultations (Mitcheson & Cowley, 2003, p. 423). These structured health assessments actively contribute to the nurse retaining control of the content and manner of the consultation and the interaction that occurs with the mother (Mitcheson & Cowley, 2003). South Australian participants in Grant's (2012) ethnographic research into intercultural communication in CFHN voiced frustration when using structured questionnaires with mothers referring to them as "stupid questions" (p. 11).

The concerns about the use of structured assessments in place of clinical judgement have also been raised by child health nurses from Tasmania (Wilson, 2007). An increasing number of maternal and child structured assessments are now used in NSW by CFHNs (NSW Department of Health, 2009, 2010a, 2010b). Fowler, Rossiter, et al. (2012) suggest that CFHNs' have a dual role of inquirer and facilitator that implies a tension requiring careful negotiation because of the potential for uneven power relationships. Similar to discussions regarding the practices of governmentality and exercise of power by Family Health Nurses "the gaze of the [CFHN] is not superficial, but rather a penetrative one" (Thompson, 2008, p. 81). Fowler, Rossiter, et al. (2012) suggest there is potential for future research of issues of power and its management within the FPM. Shepherd (2014) has recently explored the areas of power, care, knowledge and good mothering ideologies in CFHN, particularly in relation to low income, marginalised mothers. My research study, however, explores more specifically, the gaps in the literature regarding the factors influencing, and their nature of the impact, on the CFHN's ability to work in the FPM with parents. This includes exploring the use of power within this nurse-parent relationship via the use of a focused ethnographic methodology.

2.4.4 Issues in Working in the FPM with Vulnerable Families

Jack, DiCenso, and Lohfield (2005) highlight the vulnerability of client mothers in beginning a relationship with public health nurses in Canada. They describe three phases to the building of the relationship: "'overcoming fear of appearing inadequate in their mothering, building trust, and seeking mutuality" (Jack et al., 2005, p. 182). The mothers attempted to bolster their image through activities such as house cleaning and tested the nurse for trustworthiness and reliability or they would keep the relationship at a superficial level (Jack et al., 2005). The nurses' success at establishing a relationship is described as "winning ground slowly" (Briggs, 2007; De la Cuesta, 1994a, p. 351). This phrase does not describe a relationship based on partnership but rather signals a binary of winners and losers in this process.

A more honest assessment comes from Chalmers (1992) in a UK study of health visitors and clients. Health visiting work was described as a "pattern of mutual interaction between health visitors and clients in which both parties control the interaction by regulating what they offer and accept from each other" (Chalmers, 1992, p. 1319). Nurses undertake "entry work" in order to "undertake the work of optimising family health" (Briggs, 2007, p. 6). The CFHN conducts her covert surveillance of the mother's wellbeing "behind the scales" and legitimacy of the baby check (Shepherd, 2011, p. 137). The process of getting to know each other requires a "conscious tolerance of ambiguity and diversity on the part of the nurse" (Briggs, 2007, p. 7).

Barlow et al. (2003, p. 178) reporting on a home visiting service for vulnerable families in the UK describe these families as often feeling "disempowered, disenfranchised and marginalised… [and they] lack experience of trust and acceptance in relationships". Similarly, Barlow, Kirkpatrick, Stewart-Brown, and Davis (2004) found that some vulnerable women refuse services because of an unwillingness or inability to trust people including professionals and there was a discordance in the perception of risk held by professionals compared with the participants. Discrepancies regarding the perception of need for support and the level of vulnerability on the part of the woman differed to the professional referring them for the service. Some women didn't think their problems were unusual and didn't define themselves as needing support (Barlow et al., 2004, p. 202). There were difficulties engaging young vulnerable women. Some were overburdened and not able to contemplate another demand or the time required to participate each week, particularly if they had a number of children; there were misperceptions and misgivings about the service; a lack of trust and unwillingness to obtain emotional support from a professional; and a number of women perceived they had sufficient existing supports; however, some, with the benefit of hindsight, could later see the benefits of the service (Barlow et al., 2004, p. 202).

The preceding concerns of vulnerable women regarding the Health Visitor Service calls into question the efficacy and value to the women of a professional helping role. The UK Health Visitor Service is similar to the role of the CFHN in Australia. Shepherd (2014, p. 90) states that mothers, especially those who are low income, "exercise agency in resisting normative behavioural expectations of motherhood, many of which are implicated in the child and family health nurse-mother interaction". Sutton, Murray, and Glover (2012) argue that health professionals require an understanding of the process of helping and effective communication skills to enable them to develop a relationship based on working in partnership with clients. Barlow et al. (2003, p. 178) state that working in the FPM with

the family may have "the potential to increase [their] self-esteem and self-efficacy". They go on to describe helper qualities and skills and suggest the relationship will be enhanced through the helper's use of enthusiasm and humility "in order not to undermine the parents' own confidence and ability" (Barlow et al., 2003, p. 178). This phrase suggests an apparent unequal power relationship between the parent and professional. There is also an assumption inherent in labelling families as "vulnerable" and feeling "disempowered, disenfranchised or marginalised". Labelling families as vulnerable could also be described as marginalising or stereotyping. As Horton (2007b, p. 2) states "Categorizing the powerless by using labels is often the response by those in power".

Wilson (2001) interviewed five New Zealand Plunket nurses in order to explore whether their child health surveillance practices had implications for power relations in their work with families. Contemporary Plunket nurses are expected to work within the FPM in the same way as Health Visitors in the UK and CFHNs in NSW (Hopwood et al., 2013). It is prudent to note that Wilson's (2001) study was conducted fifteen years ago and that Plunket nursing practice may have changed since then. Nevertheless, Wilson's study of the nurses' discourses "presented the nurse-mother relationship as complex and precarious" (Wilson, 2001, p. 294). There was a movement of power between the nurse and mother and the security of this relationship was never assured. Issues of mothers' honesty and resistance in the discourses of the nurses indicated that there were issues of a power differential despite the nurses' best efforts in establishing a relationship based on partnership. The practice of nurses' home visiting provided opportunities for observation of the family living situation and dynamics in the form of covert surveillance (Wilson, 2001).

Perron, Fluet, and Holmes (2005a, p. 536) have questioned whether nurses' act as benevolent "agents of care or [rather, are they strategically positioned] agents of the state"? Shepherd (2011, 2014), likewise, in her doctoral research into contemporary Australian CFHN practice has been troubled by this concept of CFHNs acting as agents of the state via their covert surveillance role. Plunket nurses, like health visitors and CFHNs, are required to seek and record information related to family and child wellbeing. The nurses in Wilson's (2001) study valued the opportunity to visit the family in their home to get the whole picture that was difficult to achieve if the family was seen only at the child health centre. However, Wilson (2001), like Shepherd (2014), Sutton et al. (2012) and Barlow et al. (2004), states that it is the women from lower socio-economic groups and sole mothers who found the surveillance activities of the nurses intrusive.

2.5 THEME 3: GOVERNMENTALITY AND CFHN PRACTICE

This literature review has explored issues of power, neoliberalism and the reality of CFHNs' ability to work in the FPM with parents. The works of Foucault (1994) and Rose and Miller (1992) are valuable when critiquing the use of power, neoliberalism and the concept of governmentality and their potential influence on the ability of the CFHN to work in the FPM with parents. Governmentality, according to Foucault (1994), originated in the eighteenth century and refers to:

> The ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific and albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and as its essential technical means apparatuses of security. (1994, pp. 119-120)

Rose and Miller (1992) propose that "programmes of government are set up around the problems, difficulties and failures that the government seeks to address. Hence proposals, papers, and evidence of experts is gathered to seek solutions to the problems" (1992, p. 182). Rose and Miller (1992) call this activity "the problematising activity of government". Graham (1984) cited in Wilson (2003, p. 286) states "there is an assumption that mothers are not considered competent to raise their children without the supervision of experts".

It can be conjectured that the use of the terms "helper" and "helping process" cloak the true nature of the expert role of the practitioner within the FPM and its utility as an apparatus of government. The term "helper" used in the FPM also implies an unequal balance of power within the professional-parent relationship. It suggests that the parent requires helping or fixing by the practitioner which is the antithesis of a partnership based relationship. The need for expertise and experts is an apparatus of government which facilitates "by means of expertise, self-regulatory techniques [which] can be installed in citizens that will align their personal choices with the ends of government" (Rose & Miller, 1992, pp. 189-190).

In particular, liberal and neoliberal governmental technologies are linked to developments in knowledge and expertise that are designed to assist in "governing at a distance" (Rose & Miller, 1992, p. 200). Rose and Miller argue that the purpose of "governing at a distance" in relation to health care is to centralise power and to "transform the terms of calculation from medical to financial" (1992, p. 200). It is the managers rather than the consultants who hold the power and are the decision makers. This is relevant to this discussion because over the last fifteen years there have been numerous changes and expansion to

the roles and responsibilities of the CFHN in NSW. These policy changes are often made in response to a new government initiative. This planning and decision making may occur without sufficient consultation of the CFHN workforce (Barnes et al., 2003) and without consideration of the impact of new initiatives on nursing workloads. Increases to CFHN workloads via role expansion have the potential to impact on their ability to work in the FPM with parents.

The *NSW Health/Families NSW Supporting Families Early Package – Maternal and Child Health Primary Health Care Policy* has been framed as a universal service for all families (NSW Department of Health, 2009). This was a purposeful attempt to reduce the stigma for families attached to targeted services. However, in built into the universal program is a grading system known as *Level of Care* which classifies families on enrolment into the public health service at either the antenatal or postnatal phase of entry based on their identified vulnerabilities (NSW Department of Health, 2009, pp. 16-17). The *Level of Care* attached signifies the parent or family's level of vulnerability and in part determines the subsequent intervention of the midwife or CFHN (NSW Department of Health, 2009). Those with Level 3 (more complex vulnerabilities) are assessed as less competent to safely raise their children and require more intensive intervention from services. These parents and families are also at risk of being stereotyped and labelled (Horton, 2007a).

Rose and Miller (1992) state that experts [such as CFHNs], play a crucial role in establishing the legitimacy of government by:

> …offering to teach them [families] the techniques by which they might manage better, earn more, bring up healthier or happier children and manage much more besides.... The freedom and subjectivity of citizens can in such ways become an ally, and not a threat, to the orderly government of a polity [geographic area] and a society (pp. 188-189)

In addition, as experts assisting families:

> Nurses are at the flexing point of the state's requirements and of individual and collective aspirations. They occupy a strategic position that allows them to act as instruments of governmentality. Consequently, nurses constitute a fully-fledged political entity making use of disciplinary technologies and responding to state ideologies (Perron et al., 2005a, p. 536).

The FPM may be viewed as an apparatus of government that helps to position CFHNs as agents of the state (Perron et al., 2005a). The FPM is designed to foster CFHNs'

relationships with parents in order for them to conduct maternal and child surveillance, early intervention and health promotion activities required by government. CFHNs potentially play a significant role in the government's ability to "govern from a distance" (Rose & Miller, 1992, p. 200).

The other technologies used to assist in governing at a distance are the use of calculations such as statistics and monetarisation (Rose & Miller, 1992, pp. 185, 200). The new electronic community health records documentation program "and the requirements to provide data to those who make fiscal and other decisions based on the data provided" are technologies used to provide government at a distance (Rose & Miller, 1992, p. 187). Electronic medical records enable data to be collected by nurses related to occasions of service and the details of consultations conducted with families. Managers can review this data entry and compile reports on nurses' activities which are then forwarded to higher levels within the Health District. Managers play an essential link in the monitoring of service delivery and "become the powerful actors in the neoliberal network and increase the ability to govern from a distance the functions of health services…." (Rose & Miller, 1992, pp. 200-201).

Andrews (2006), in her qualitative study of thirty Norwegian public health nurses working with parents and children 0-5 years, also describes the conflicting discourses of public health approaches recommending standardisation and positivism versus nurses' use of discretionary judgement gained from professional experience. Andrews (2006) identified the presence of a conflict of caring versus scientific rationality. In her conclusion, Andrews (2006) stated "the requirements for both standardisation of practice and more detailed documentation of activities has intensified" (p. 201). As mentioned, this is similar to the CFHN experience where the obligation to use electronic record keeping has intensified documentation requirements and increased nurses' workloads (Ridgway, Mitchell, & Sheean, 2011), potentially impacting adversely on the amount of time for service delivery and the amount of client face to face interaction. A reduction in the time available for face to face interaction with clients as a result of the requirement to use electronic records in an environment of increasingly complex workloads has likely negative consequences for CFHNs' ability to work in the FPM with parents. Andrews (2006) recommends a closer examination of how these demands are put into practice along with their implications; and a need to identify what sources of knowledge and types of approaches are relevant in order to support parents in their care giving.

While the CFHN philosophy of practice advocates the need to work in the FPM with individual families, the health system and the activities and health promotion the nurse is

required to provide to families is based on “epidemiological data from population studies” (Lupton, 1995) cited in (Wilson, 2003, p. 290). This health promotion may hold meaning at the level of populations but is not always relevant to the individual needs of the parent, child or family. In conclusion, the prevailing discourse of “keeping mothers coming” for the purposes of surveillance highlights the ambiguous nature of nurses’ relationships with mothers (Wilson, 2003, p. 290).

2.6 SUMMARY

Health policy suggests that working in partnership is the optimum way to deliver CFHN services to families (NSW Department of Health, 2009). The reality, however, is that there appears a considerable array of factors influencing CFHNs’ ability to work in the FPM with parents. There are issues of power and control both in the immediate interaction between the nurse and parent as well as in the broader context where the effects of globalisation and neoliberal policies influence health care and family practices. Other factors impacting families may include: the cost of living; the necessity of two household incomes; shift work; finding affordable childcare; all of which may contribute to the complexity of life for some families (Li et al., 2008). Similarly, the wider social context of forces impacting on healthy family functioning may influence parents’ ability and desire to engage in a relationship with health professionals such as CFHNs.

The contemporary CFHN works within a neoliberal political and economic environment that influences government policies and health care practices. This environment impacts nurses via requirements for greater accountability, moves toward standardisation of practice, and the need to work within the finite budgets of the primary health care sector. Competing demands on both nurses’ time and energy may adversely impact on their ability to engage and communicate therapeutically in the FPM with parents. The older CFHN workforce may feel this more acutely than a younger generation of nurses.

Due to the evidence discussed regarding the importance of the early years of a child’s life and the value of early intervention approaches for issues identified in the child and/or parent(s), it is essential that CFHNs are able to engage, communicate and work effectively with parents to achieve optimum health outcomes. There was a significant need for my research to explore and critique the factors influencing, and the nature of the impact, on CFHNs’ ability to work in the FPM with parents. There appear to have been no previous studies of these specific issues using a focused ethnographic methodology or that have explored the potential macro to microsystem level factors influencing the CFHN specialty in NSW, Australia, to work in the FPM with parents. Further, there appears to be no

specific research conducted into the emotional labour of either CFHNs and/or its relationship to working in the FPM with parents. Therefore, the issues of an ageing CFHN workforce within a changing service environment and the emotional labour of CFHNs require further investigation for their potential influence on nurses' ability to work in the FPM with parents. My study will add these elements to the existing body of research regarding CFHN and working in the FPM.

Chapter 3 METHODOLOGY and METHODS

3.1 INTRODUCTION

The previous chapter presented a review of the literature that informs this study. This chapter follows on from the literature review by presenting an overview of focused ethnography which is the qualitative research methodology used to conduct the study. I discuss how Bronfenbrenner's (1979) *Ecological Model of Human Development* was adapted for the study's conceptual framework and describe the research methods and their rationale. I begin this chapter with a brief summary of my background and position as researcher within this study.

3.2 ABOUT THE RESEARCHER

It is important for the integrity of any qualitative research, including focused ethnography, to be cognisant and acknowledge how one's own background, assumptions, beliefs and position may influence the research and participants (Fetterman, 2010). Therefore, I speak from a position of being an Australian born, white, first generation Irish descent, female. I am a tertiary level educated health and academic professional who, at the beginning of this doctoral study, held a hierarchical clinical position of work place based power relative to the majority of nurse participants. However, my role within this research was as a neophyte ethnographer completing a part-time PhD.

My position of power was related to my position as the Clinical Nurse Consultant (CNC) of a large, CFHN service in regional New South Wales during the initial phases of the research. I held this position for the ten years prior to my current role as an academic lecturer in midwifery. My position as a university lecturer commenced around the time of data collection and was my primary work role for the remainder of the research. As a CNC, however, I was privileged with a more powerful work role status relevant to the position of the CFHN participants. This is because Child and Family Health Clinical Nurse Consultant positions are responsible for nursing clinical governance by ensuring nursing clinical practice standards are met, policies are implemented, and education programs and other nursing workplace initiatives are conducted (New South Wales Health, 2011). This included responsibility for provision of FPM training to nurses and its incorporation into CFHNs' policy and practice in my Local Health District. There is generally just one CNC position per CFHN service within LHDs in NSW. Following the discussion of the research

question, study aims and choice of methodology, I provide a more detailed account of my researcher position further in this chapter.

3.3 RESEARCH QUESTION AND STUDY AIMS

3.3.1 Research Question

The research question was derived from my personal experiences in CFHN. I was concerned about the quickly evolving breadth of the CFHN role that had occurred over the preceding several years prior to the commencement of my study. In particular, I was concerned about the impact on CFHN practice of the introduction of additional maternal and child health assessments and commencement of electronic, medical record keeping systems. In addition, the policy performance indicators set for CFHN in relation to the number of universal health home visits (UHHVs) conducted within two weeks of birth (NSW Department of Health, 2009), seemed to me to conflict with same policy's requirement to working in the FPM with parents and provide holistic care to individual families. In addition, the time required to meet UHHV performance indicators risked precluding other clinical practice areas such as the facilitation of parent groups. I wondered whether CFHNs could, in fact, effectively sustain their ability to work in the FPM with parents given all that was expected of them.

I also felt somewhat uneasy about the increasing surveillance activities CFHNs arising from NSW Health policy (NSW Department of Health, 2009; NSW Kids and Families, 2013), that were required to be conducted on parents and children and that few Australian CFHN researchers had provided critiques on this aspect of care (Grant, 2012; Shepherd, 2014). While there was a growing appraisal of the FPM regarding its implementation into CFHN practice in Australia present in the literature (Fowler, Rossiter, et al., 2012; Grant, 2012; Grant & Luxford, 2008; Grant & Luxford, 2011; Hopwood et al., 2013; Kruske et al., 2006; Rossiter et al., 2011), there was still significant room for further investigation.

Therefore, my concerns about developments affecting CFHN practice and their potential impact on CFHNs' ability to work in the FPM with parents led to the development of the final, primary research question below:

> *'What are the factors influencing, and the nature of their impact, on the child and family health nurse's ability to work in partnership with parents, as described in the Family Partnership Model?*

This question is informed by prior research conducted into the implementation of the FPM within CFHN practice in Australia (Bennett, 2013; Fowler, Lee, Dunston, Chiarella, & Rossiter, 2012; Fowler, Rossiter, et al., 2012; Grant, 2008; Grant & Luxford, 2008; Grant & Luxford, 2011; Hopwood et al., 2013; Kruske et al., 2006; Rossiter et al., 2011). It is also linked to my misgivings gained as an experienced CFHN as outlined above, and my own personal development during the course of this study.

I considered that the scope and findings from this study may inform future CFHN policy and practice and enable CFHNs to have a greater understanding of factors which influence their ability to work in the FPM with parents. Also, the focused ethnographic methodology and conceptual framework used in this study would itself, enable me and my participants to view these factors more critically and from a macro to micro systematic approach. Another significance of this study lies in its ability to enable methodological and conceptual developments regarding the conduct of research into the CFHN specialty once the research findings are disseminated.

While exploring the potential factors that influence CFHNs' ability to work in the FPM with parents through a focused ethnographic perspective, the following questions were also considered:

- What are nurses' understandings of working in the FPM?
- What are the cultural aspects of the organisation that might influence practice and what hierarchies are at play?
- What do nurses think are the factors that influence their ability to work in the FPM with parents?
- What are the self-care needs of nurses that may contribute to working in the FPM with parents?
- How do these factors impact on their communication and ability to work in the FPM in the practice setting?
- What suggestions do nurses have to improve their ability to work in the FPM?
- What suggestions do parents have in relation to developing a helpful relationship with CFHNs?

3.3.2 Aims of the Study

As a focused ethnography that explores the factors influencing, and the nature of their impact, on CFHNs' ability to work in the FPM with parents the study aims to:

1. Identify CFHNs' and managers' views of the factors that may influence the ability of the CFHN to work in the FPM with parents (mothers/fathers/babies) and investigate how these factors may impact on this ability in the practice setting

2. Identify parents' experience of their relationship and interaction with the CFHN

3. Enable CFHNs and managers to reflect critically on developing and existing work practices, education processes, context and scope of practice in relation to the factors that influence and impact on their ability to work in the FPM with parents.

3.4 CHOICE OF METHODOLOGY: FOCUSED ETHNOGRAPHY

In any research study, the primary research question determines the most appropriate study design (Sackett & Wennberg, 1997). In the process of identifying this study's method I first considered using a conventional interpretive paradigm and method. Ethnography and other qualitative methodologies such as phenomenology belong to the interpretative paradigm where the goal of the research is to understand what is going on (Lather, 2006). Next, I considered the use of critical ethnographic methodology which sits within the critical paradigm where the researcher's goal is to emancipate (Lather, 2006). To exemplify the difference, an ethnographic approach is concerned with "cultural description through analysis, identifying cultural themes, typologies or categories" [however],... a critical ethnographic approach [provides] a more detailed study of "[the] macro-social factors, such as power, language and the critique of common sense assumptions" (Muir-Cochrane, 2000, p. 294).

I initially believed that critical ethnography was the appropriate research methodology and would provide the study with a highly critical lens and a purposeful attention on issues of power and control (Dowse, van der Riet, & Keatinge, 2014; Thomas, 1993). However, as I became further immersed in the study during the data collection phase and in discussions with my supervisors, it became clear that my study purpose was to explore *all* potential influencing factors without specifically looking for the presence of power or solely having an emancipatory or political purpose that is the hallmark of a critical ethnography (Thomas, 1993). Therefore, I selected focused ethnography (Cruz & Higginbottom, 2013; Higginbottom, Pillay, & Boadu, 2013; Knoblauch, 2005; Muecke, 1994; Roper & Shapiro, 2000; Wall, 2015), as the methodology used to conduct this study. The distinction between focused ethnography in comparison to a traditional or critical ethnography is research characterised by:

> Fieldwork during intense but not necessarily continuous periods of participant observation, interviews with key members of the culture who are willing to be interviewed in depth, and collection of specific data that relate to a narrower research question than in a traditional ethnography. (De Chesnay, 2015, p. 9)

Focused ethnographic methodology also retains the necessary capacity to reveal any underlying "tensions that exist in dynamic cultural contexts" including issues of power and control, should this be required (Wall, 2015, p. 11).

A further rationale for the use of focused ethnography in my study is its appeal in dealing with fragmented and specialised fields (Wall, 2015), such as CFHN. It is also relevant for researchers (like myself) who have inside knowledge of the cohort studied and use technologies such as video recording as part of data collection methods (Knoblauch, 2005; Wall, 2015). The main features of focused ethnography compared with conventional ethnography are listed in Table 1 below.

When considering critical and focused ethnography I recognised my impetus for conducting this research influenced my choice of focused ethnographic methodology and the conceptual framework used in this study. I was interested in examining the broader context of issues that may impact on children, families and health services within society, for example, the state of the economy, politics, resources and changing technologies. I had an interest too, though not exclusive interest, with how power and language was used by health services and CFHNs and how these may feature in relation to their influence on nurses' ability to work in the FPM with parents. Prior to the commencement of this study I recognised that all nurse and manager participants in the study would have an understanding of the FPM through their workplace education and practice. I anticipated that as a result of the research, I would be able to help provide these participants and their colleagues with a greater understanding of the influences, and the nature of their impact, on their ability to work in the FPM with parents. This enhanced understanding will enable participants and their colleagues to have a greater say in the development of future policy and service arrangements that affect their CFHN practice.

New fields of inquiry, research questions and study aims have led to the emergence and applications of focused ethnography rather than the more conventional, anthropological ethnography (Wall, 2015). However, focused ethnography is recommended to be viewed as a complementary rather than an opposing methodology to conventional ethnography

(Knoblauch, 2005). In a focused ethnography, the researcher explores a “distinct issue or shared experience in cultures or sub-cultures and in specific settings, rather than through entire communities” (Cruz & Higginbottom, 2013, p. 36) or a cultural group or people as a whole (De Chesnay, 2015).

Table 1: Comparison between Conventional and Focused Ethnography

(adapted from Knoblauch (2005, p. 7), Cruz and Higginbottom (2013) and De Chesnay (2015)

Conventional Ethnography	**Focused Ethnography**
Traditional methodology	Complementary methodology (Knoblauch, 2005)
Long-term field visits	Short-term field visits
Experientially intensive [in the field]	Data/analysis intensity [large amounts of data is collected and requires intensive analysis in a short time]
Time extensity	Time intensity
Writing [field notes]	Recording [in particular, the use of technologies such as digital audio-visual voice and video recording as well as field notes]
Solitary data collection and analysis	Data session groups [meetings where data is presented to researchers who understand the research goals. Therefore, the record of what is recorded may be seen as more "objective" than field notes alone and enhance data analysis perspectives particularly of recorded data].
Open [the boundaries of field emerge during fieldwork]	Focused [restricted to certain aspects of the field]
Researcher explores issue through entire communities or cultural groups/people as a whole	Researcher explores a distinct issue or shared experience in cultures/sub-cultures within specific settings (Cruz & Higginbottom, 2013; De Chesnay, 2015)
Social fields [concerned with social groups, institutions and events]	Communicative activities [concerned with actions, interactions and social situations]
Participant role	Background knowledge [the researcher has the background knowledge, that is, the emic perspective of the specific issues, situations and actions in order to perform the study activities]
Subjective understanding	Conservation
Notes	Notes and transcripts [observation supported by technologies]
Coding	Coding and sequential analysis

Focused ethnography is increasingly recognised as a relevant methodology within nursing research (Cruz & Higginbottom, 2013). It is suitable for use in health care research because it provides "pragmatic and efficient ways to capture data on a specific topic of importance to individual clinicians or clinical specialties, and to determine ways to improve care and care processes" (Higginbottom et al., 2013, p. 1). Roper and Shapiro (2000) have identified three main uses of focused ethnography by nurse researchers. These include:

1. To find out how people from various cultures incorporate health beliefs and practices into their lives

2. To understand the meaning that members of a subculture or group assign to their experiences to help plan the provision of nursing care

3. To study the practice of nursing as a cultural phenomenon. (Roper & Shapiro, 2000, pp. 7-9)

These three reasons for conducting a focused ethnography resonate with my own aims in conducting this study. I sought to find out how CFHNs incorporated their beliefs about the FPM into their clinical practice with parents and children; and "understand" (Lather, 2006) the issues and factors which influenced CFHNs to work in the FPM with parents. Therefore, it was appropriate to use an interpretive paradigm such as focused ethnography which enabled exploration of a bounded, cultural group (Mayan, 2009) such as CFHNs. Further, although I intended to explore macro issues such as power and language (Muir-Cochrane, 2000), this was not purely for the goal of emancipation but rather, to enhance mine and others understanding of the issues under investigation. Understanding of issues such as power and constraining factors affecting nursing practice by me and the participants is integral to emancipation.

I also chose a focused ethnography rather than conventional or critical ethnography as the most appropriate methodology for a number of other reasons. First, my study had a narrowly defined research question and culture requiring examination (Polit & Tatano Beck, 2008). Second, my study met the other descriptors of a focused ethnography identified in Table 1 above. Lastly, the use of a focused ethnographic methodology allowed me to use my "insider and background knowledge and previous experience" (Wall, 2015, p. 5) of working for many years within the CFHN specialty. As the researcher of this study, I was in an outsider role with this specific cultural group of nurses and mothers. However, my significant insider knowledge of the clinical specialty and NSW Health service meant that I had a background understanding of CFHN work processes, policies, clinical issues

and in particular, the use of the FPM by CFHNs with mothers attending the service. This background and insider understanding assisted me in narrowing the focus and delineation of my research question and study.

Higginbottom et al. (2013) have provided methodological guidance for researchers wishing to conduct a focused ethnography. The research question/s in a focused ethnography commonly centre on "describing experiences within cultural contexts or specific groups/sub-groups" (Higginbottom et al., 2013, p. 4). They are generally "first-level questions" which are focused on the "what", for example, what are the characteristics, factors, beliefs of a specific population in a particular setting or who have a certain condition (Higginbottom et al., 2013, p. 4). This is consistent with my primary research question identified in Section 3.3.1 (p. 46).

Similar to conventional ethnography, purposive sampling is the commonly used sampling technique in a focused ethnography (Higginbottom et al., 2013). Additional strategies such snowballing are used where necessary and key participants are invited to participate in order to facilitate access to the study group (Higginbottom et al., 2013). The sample size is generally reached when data saturation occurs, that is, no new information is obtained from additional participants (Guest, Bunce, & Johnson, 2006).

The data collection in a focused ethnography, like conventional ethnography, incorporates interviews, field observations and notes, a range of documents including the researcher's reflective journal (Higginbottom et al., 2013). Interviews are generally semi-structured and are tape or digitally recorded and transcribed verbatim where consent has been provided (Higginbottom et al., 2013). The "observer-as-participant" role is typically undertaken by the researcher in the field because it is less time intensive in the field than "participant-as-observer" (Higginbottom et al., 2013, p. 5). This type of observer role is also suited to environments where full and active participation is not permitted, for example, hospital wards or clinics (Higginbottom et al., 2013). Videorecording equipment such as cameras, tape or digital recorders and video recorders are commonly used data collection techniques which support and enrich the field observations undertaken in a focused ethnography (Higginbottom et al., 2013; Knoblauch, 2005). The researcher uses field notes and reflective journals to assist with contextualisation of data particularly those related to non-verbal communications (Higginbottom et al., 2013).

Data analysis within a focused ethnography requires the researcher to "engage in an iterative, cyclic, and self-reflective process" as initial interpretations are questioned, data is continually revisited, and new insights inform future data collection and analysis

(Higginbottom et al., 2013). In addition, (and common to all research), the authors state the focus of data analysis should be identification of the answers to the specific research question and development of concrete recommendations (Higginbottom et al., 2013).

Rigour in qualitative research can be established through researcher reflexivity and adherence to a clear methodological framework (Higginbottom et al., 2013). The veracity of a focused ethnography may be evaluated by the criteria identified in Table 1: Comparison between Conventional and Focused Ethnography, (p. 51). Similar to other qualitative research, Higginbottom et al. (2013) state that rigour in a focused ethnography may be assessed using the commonly used criteria identified by Lincoln and Guba (1985) of credibility, transferability, confirmability, and dependability. I also chose to follow this process to ensure study rigour. Data collection methods that support "triangulation" with multiple means of data collection to compare, contrast and confirm findings assists with maintenance of rigour within the study (Higginbottom et al., 2013). Sufficient description of the setting, participants and study environment must be provided to enable depth of understanding of the research context (Higginbottom et al., 2013). Details of these descriptions are provided in the study design which immediately follows discussion of the conceptual framework further in this chapter. First, I provide further detail on my position as researcher, my assumptions prior to entering the field and use of reflexive approaches within the study.

3.4.1 Reflexivity and the Researcher's Position

It is essential to discuss the researcher's stance when conducting a qualitative inquiry (Madison, 2012). Positionality refers to the acknowledgement and reflexivity of the researcher regarding his/her own "power, privilege, and biases" (Madison, 2012, p. 8). It means that ethnographers are responsible for reflecting on their own position [including assumptions] in relation to the research and participants, their authority and their "moral responsibility relative to representation and interpretation" (Madison, 2012, p. 8). This is especially relevant in a focused ethnography which is "often performed within the researcher's own working environment….[therefore], the concept of reflexivity is crucial during interpretation of the data and when drawing conclusions" (Higginbottom et al., 2013, p. 7). Similarly, transparent ethical processes, respect for participant dignity, and the fully informed consent of both practitioners and patients/clients is required (Higginbottom et al., 2013). In view of Madison's (2012) and Higginbottom et al. (2013) recommendations, I now turn to my position as doctoral researcher and my own history of power, privilege, gender, racial identity and perspectives that may influence this study.

Reflexivity relates to the degree of influence that the researcher exerts, either intentionally or unintentionally, on the research findings (Jootun, McGhee, & Marland, 2009). This is crucial in nursing research, such as focused ethnography where the researcher may know the participants (Higginbottom et al., 2013). Jootun et al. (2009, p. 42) state that reflecting on the "process of one's research and trying to understand how one's own values and views may influence the findings adds credibility to the research and should be part of any method of qualitative enquiry". This research required me to think, question and reflect on my assumptions, beliefs and position as a researcher at various stages of the study. My knowledge, assumptions and beliefs prior to entering the field included:

- My understandings about the role of the CFHN based on fifteen years practising in the specialty. This included understandings and beliefs about how the profession operated within the structure of the public health system of NSW, what CFHNs valued and what standards of professional practice should look like.

- An understanding that the FPM that had been introduced into the CFHN workforce was a model of care that seemed beyond reproach; and, that very little planning or resources had come with its introduction to sustain its practice.

- Holding somewhat polarised views about the implementation of the FPM in practice. That is, I realised I had created a simplistic good/bad binary. I believed that CFHNs who demonstrated an ability to work in the FPM with parents were "good" nurses or had "good" practice; and those nurses unable to do this and who acted in an expert model with parents demonstrated "bad" or poorer nursing practice. Lack of awareness of binary thinking can oversimplify issues, is erroneously judgemental and may lead to an inability to look more broadly at the situation.

- That I would recognise during participant observation what constituted working in the FPM with parents. I held these views because of the belief that I had an in-depth understanding of the FPM. I held this view because in 2002, I was one of twelve clinicians selected in NSW to undertake the initial FPM facilitator training group taught by Hilton Davis, the lead author of the original model (Davis & Day, 2010; Davis et al., 2002). Thereafter, I was one of three FPM group facilitator trainers in the NSW LHD where I was employed. I was responsible for providing the FPM training with my two colleagues for a number of years to CFHN and paediatric nursing staff. As part of my CNC role, I was also responsible for undertaking centre based and home visiting practice development assessments of

new staff during their consultations with parents as part of their orientation to the service. This included assessment of nurses' general clinical skill as well as ensuring that that they understood the tenets of the FPM and could demonstrate this in their practice with parents.

- That recent change to CFHN practice areas may be problematic and impede the ability of these nurses to work in the FPM with parents. These changes included additional health screenings of infants, assessments of maternal psychosocial well-being, increased use of technology for medical record keeping, and performance indicators for UHHVs of newborns. I held concerns that the way these additional practices were introduced may be unhelpful to nurses and counterproductive to their ability to work in the FPM with parents. I realised that I held initial assumptions about what the factors were that would influence the CFHN's ability to work in the FPM with parents and that this may bias my data collection, analysis and ultimately the findings.

- That based on my knowledge of the CFHN service and of parenting groups I would know how best to recruit participants into the study.

- An awareness of my position of power relative to nurse participants. This awareness was due to my CNC role in the nursing specialty and health organisation. To clarify, my use of the term "power" throughout this thesis is consistent with Foucault's (1982) assertion that power is not owned but is exercised at all levels of social relations. This view is in opposition to Western notions of power as binary. However, I considered this issue to have little impact because participants were to be recruited outside the LHD where I was employed. Further, by the time of data collection I was in my new role as an academic with the university. Both mothers and nurses were advised during information sessions about my CFHN background and the restriction of my role to a doctoral researcher while conducting the study.

Recognition of my assumptions, values and biases, and my position as researcher within the study has helped to highlight potential for power imbalance and was essential prior to entering the field as well as in the overall context of the research. This is because in ethnography the researcher is the major instrument in data collection (Fetterman, 2010; Lipson, 1991).

Before I entered the field, I had what I considered was considerable expertise and understanding of what constituted "good" CFHN practice and how nurses should

demonstrate working in the FPM with parents. I assumed I had a thorough understanding of the FPM from being a FPM group facilitator and my subsequent immersion in delivering the training to CFHNs in my LHD. I had worked as a CFHN CNC and had conducted many nursing orientation programs and supervision of nurses' clinical practice with parents, infants and children on home visits and in centres. I had also been responsible for reviewing instances of nurses' practice where there were concerns of competency and safe practice. However, I was aware that I held a degree of uncertainty and scepticism about how possible it really was for CFHNs to work in the FPM given the many changes and demands placed on them. These included health policy requirements and the expectations of their managers as well as the varying needs of parents. I had had numerous conversations with CFHN colleagues where I worked (not the location of this study) and was aware that my concerns were shared by others.

Despite the defence of my choice of focused ethnographic methodology, I found it challenging to enact in my own specialty area of CFHN practice. I was required continually to examine my assumptions about CFHN practice, my biases, viewpoints and superficial understandings of participant responses, actions and the systems that were contributing to these. I was aware prior to entering the field that I may have been perceived as an expert nurse by some participating CFHNs and as evaluating their interview responses and nursing practice and viewing it in a favourable/unfavourable light (Cudmore & Sondermeyer, 2007; Field, 1991; Roberts, 2007; Simmons, 2007). The nurse manager and mothers may also have framed their responses during interviews based on their knowledge of my work role. In using ethnographic methods of data collection including open-ended interview techniques, clarifying the aims of the study and working in partnership with participants I endeavoured to reduce this potential aspect of study bias. Also, because the data collection occurred outside my own health district, none of the nurses were accountable to me for clinical or management issues and this was clarified in the inclusion criteria (Dowse et al., 2014) of my ethics submission.

My role in the research was an informed observer-as-participant (Higginbottom et al., 2013). My level of participation at the Child and Family Health Centre new parent groups and consultations was limited to joining in during informal conversation and chatting, helping mothers by holding the infant/child occasionally as appropriate but refraining from giving advice and helping in a professional nursing capacity. The limitation to this, however, was the requirement to remain cognisant of my role as a mandatory reporter should child protection issues arise or be observed with a mother or if there were serious concerns regarding nursing practice. I took an ancillary role to the nurse leading the

consultation with the mother(s) and endeavoured to be as unobtrusive as possible. For example, if asked a question by a mother I deferred to the facilitating nurse while remaining in a supportive role.

As a CFHN "insider" acting as a research "outsider", I found it was difficult at times to remain within the boundaries of my researcher role (Dowse et al., 2014). The CFHN participants may also have at times, blurred the boundaries of my roles during the study. For example, "despite not knowing the nurses personally, a number asked for my opinion on their interactions with parents during their follow up interviews" (Dowse et al., 2014, p. 35). The tenuous issue of the power inherent in my researcher role was present during both data collection and analysis phases of the study. I attempted to redress this issue by transparency of consent and re-confirmation of consent particularly regarding the use of participants' video recorded material (Dowse et al., 2014). I was also acutely aware of my power in applying a critical lens during data collection and analysis, especially in relation to nurse participants' clinical practice. Similar to Simmons (2007) and Cudmore and Sondermeyer (2007), I experienced conflict with regard to a sense of betrayal of the trust placed in me by participants and not wishing to portray them negatively in the research findings (Dowse et al., 2014).

There are reported advantages and disadvantages, however, to researching in your own culture (Cudmore & Sondermeyer, 2007; Field, 1991; Simmons, 2007). One advantage is that it may be easier to gain entry into the setting when seen as a nurse by the participating mothers and as a CFHN by the participating nurses and managers. Field (1991) stresses though that it is essential to make clear one's role as a researcher and determine and clarify with participants the level of one's participation during consultation with families. Lather (1991, p. 84) suggests that a researcher needs to ask themselves a number of reflexive questions regarding positionality in ones' research work. These are:

- Did I encourage ambivalence and multiplicity?
- Did I impose order and structure?
- Did I police boundaries?
- Did I confront my own evasions and doubts?

In summary, my professional and personal experiences had shaped the initial assumptions, beliefs, values and knowledge I held prior to entering the field for this study. However, just as my views had evolved over time as a result of experience, my continued personal, professional growth and change over the ensuing years it took to complete this study required me to reconsider some of my preliminary views. In particular, reflecting on

participants' views and my observations of nurses' practice led me to realise that I was somewhat arrogant about my assumed knowledge and understanding of CFHN practice and the FPM. I hadn't thought that I would learn so much from participants and from being required to continually reflect on practice.

This conflict regarding my research positionality helped me realise I needed to develop a greater capacity for reflexivity (Davies & Gannon, 2006) and mindfulness (White, 2014) in order to "acknowledge my position and respond appropriately (Dowse et al., 2014, p. 35). Tusaie and Edds (2009) state that reflexivity and mindfulness are similar though interdependent concepts both involving self-awareness. Mindfulness, however, also requires one to be non-judgemental and to pay attention on purpose, to the present moment (Frazer & Stathas, 2015; Kabat-Zinn, 1994, 2013; Tusaie & Edds, 2009; White, 2014). During the course of this study I enrolled in an eight–week mindfulness-based stress reduction (MBSR) course (Kabat-Zinn, 2013). The learning from this transformative course and my ongoing yoga and mindfulness practice were critical strategies in my development of reflexivity during the conduct of my research (Dowse et al., 2014). In addition, regular research supervision sessions and use of a study diary and fieldwork journal "assisted in keeping track of my responses and reflections" (Dowse et al., 2014, p. 36).

The next section presents the conceptual framework followed by the study design. The study design provides detail on participant recruitment, setting, and methods of data collection, analysis and rigour as well as the ethical considerations arising from the research.

3.5 CONCEPTUAL FRAMEWORK

The conceptual framework adapted for my study was carefully chosen to facilitate a systematic macro to micro exploration of the factors influencing, and the nature of their impact, on the CFHN's ability to work in the FPM with parents. I selected the *Ecological Model of Human Development* (Bronfenbrenner, 1979) to adapt as the research framework because its design enables a methodical exploration of factors that may influence CFHNs working in the FPM with families. In particular, the model is appropriate because of its focus on the impact of context and the ecological system in explaining how human development occurs (Rosa & Tudge, 2013). The authors explain:

> Bioecological theory in its current or mature form specifies that researchers should study the settings in which a developing individual spends time and

> the relations with others in the same setting, the personal characteristics of the individual (and those with whom he or she typically interacts) (Rosa & Tudge, 2013, p. 244)

Urie Bronfenbrenner's theory of human development evolved over four decades (Tudge, Morkpova, Hatfield, & Karnik, 2009). Tudge et al. (2009) have, therefore, stated the importance of being explicit about which version of Bronfenbrenner's model is used to base research. I selected the earlier, Bronfenbrenner's (1979) *Ecology of Human Development* version of the theory as the basis of this study's conceptual framework because of its simplicity in being able to organise and analyse the data, and reconceptualise the findings in a systematic macro to micro approach. Bronfenbrenner's (1979) version of the *Ecology of Human Development* is particularly relevant because the same model underpins understandings of the demands of contemporary parenting and children's development in the Family Partnership Model (Davis & Day, 2010; Davis et al., 2002; Day et al., 2015). Bronfenbrenner's model has also been widely influential in research and in shaping public health policy in relation to development theory that have benefited the well-being of children (Cornell University College of Human Ecology, 2014).

The diagrammatic representation of the conceptual framework for the study uses as its foundation Bronfenbrenner's (1979) well-known, original model of "nested....concentric structures, each one contained within the next" to outline the relationship between the "ecological environment" and factors that may influence parents and impact on their ability to work in the FPM with the CFHN (p. 22). (See Figure 2: Conceptual Framework for the Study adapted from Bronfenbrenner (1979)). A description follows of the various systems in the model.

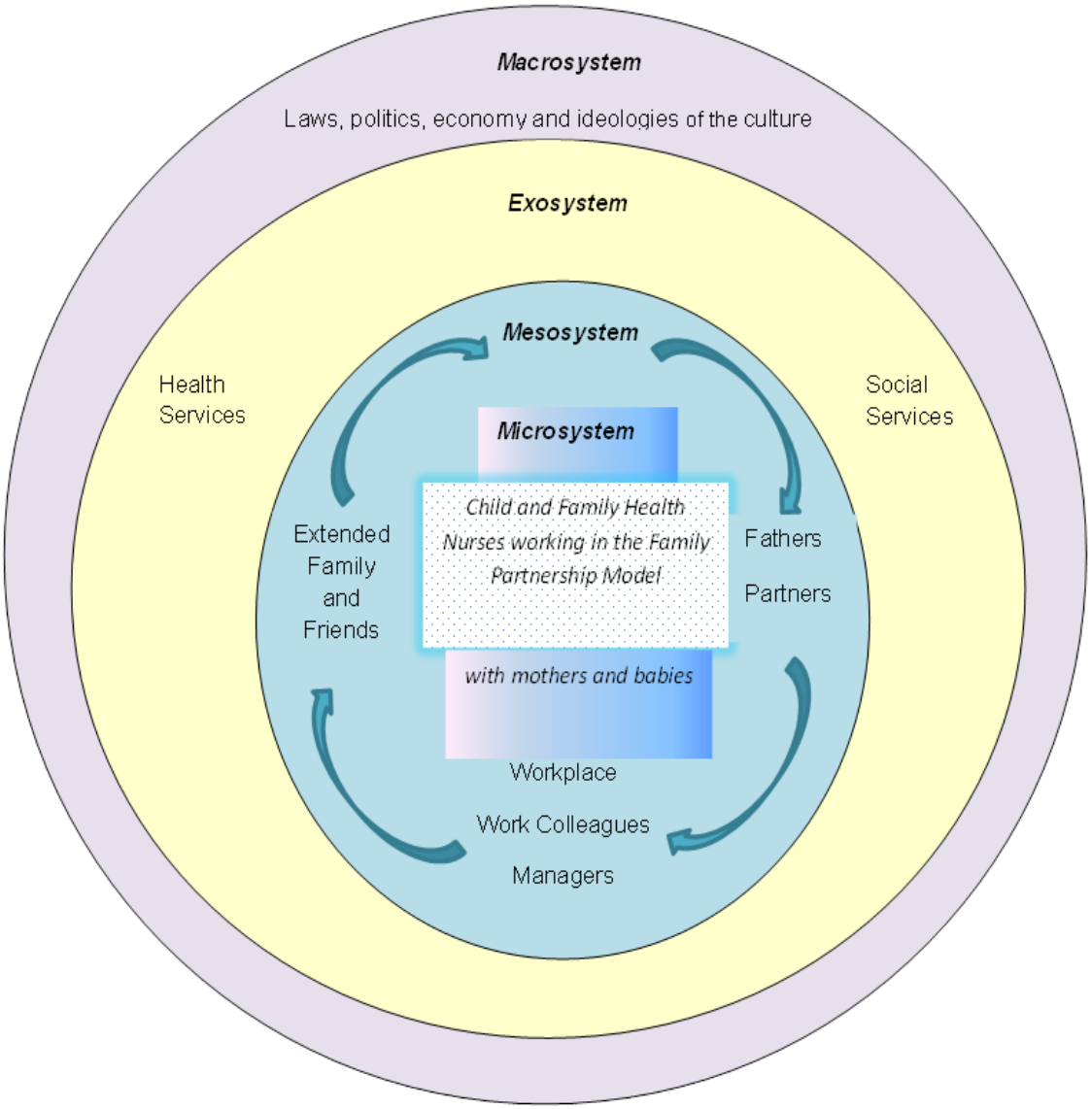

Figure 2: Conceptual Framework for the Study adapted from Bronfenbrenner (1979)

The environment in Bronfenbrenner's ecological model consists of four concentric, interconnected structures (Bronfenbrenner, 1979). The centre of the ecological model is known as the microsystem (Bronfenbrenner, 1979). The microsystem is defined as the:

> most proximal setting, with particular physical characteristics, in which a person is situated, such as the home, child care, playground, and place of work, and in which the developing person can interact in a face-to face ways with others. The setting is one in which activities and interpersonal roles and relation engaged in over time are the constituent elements. (Rosa & Tudge, 2013, p. 246)

In the conceptual framework for the study, the microsystem refers to the immediate environment within which the CFHN and the parent/baby is co-located and interacts. This is because the CFHN and the factors influencing their ability to work in the FPM with parents is the focus of my study. However, as no fathers volunteered to participate, only mothers/babies feature in the microsystem with the CFHN.

The mesosystem is the next concentric structure of the ecological model (Bronfenbrenner, 1979). The mesosystem is described as:

> The interrelations among two or more settings in which the developing person actively participates (such as, for a child, the relations among home, school, and neighbourhood peer group; for an adult, among family, work, and social life). A mesosystem is thus a system of microsystems. (1979, p. 25)

In the conceptual framework for the study, the mesosystem refers to the immediate environments or settings that the child, their family and the CFHN is located and interacts. For example, the CFHN's immediate workplace and colleagues with whom she regularly interacts on an interpersonal level comprise a mesosystem.

The exosystem is the third, concentric structure within the model and refers to the:

> The ecological system in which the developing person of interest is not situated and thus does not participate actively within it, but nevertheless experiences its [indirect] influences…such as when what occurs in a parent's workplace has a follow-on effect within the home. (Rosa & Tudge, 2013, p. 247)

In the context of this study, the exosystem is where policies are developed and implemented (Rosa & Tudge, 2013), for example, that exert influence on the CFHN's role in their work with parents and children.

The outer circle of the ecological model is known as the macrosystem and refers to the overarching belief system or ideology of a culture or subculture (Rosa & Tudge, 2013). This incorporates the political, economic, social and educational systems as well as the laws, customs, and values of the society in which in the developing individual lives (Bronfenbrenner, 1979; Rosa & Tudge, 2013)

Bronfenbrenner's (1979) ecological model situates the developing child within the central microsystem. The centrality and dependency of the child within the family means that the parents have a primary ethical responsibility as caregivers and so are placed at the centre of the microsystem with the child within the family context. In the adaption of Bronfenbrenner's (1979) ecological model for this study's conceptual framework I have placed the CFHN also within this central microsystem and this represents a mesosystem (see Figure 2). The CFHN, parents and child are situated at the centre of the conceptual model because it is their interactions that are the focus of the study. There is an interactive two way flow between the nurse, and mother and child and between the different levels of the ecological model. There are pressures on parents and on the CFHN where each negotiates the development of their respective relationships. All have to negotiate themselves within the context of their respective ecological systems from the home to external systems such as work, the economy and the pressure of finances, the political environment and so on.

3.6 STUDY DESIGN

3.6.1 Recruitment Process

I employed purposive sampling for this study in line with focused ethnographic methodology where participants are required to have specific knowledge (CFHNs that have undertaken FPM training]; and experience, [parents who are attending the CFHN service] (Higginbottom et al., 2013). Patton cited in (Merriam, 1998, p. 61) states that "purposeful sampling is based on the assumption that the investigator wants to discover, understand and gain insight and therefore must select a sample from which the most can be learned". This required the direct participation of CFHNs. CFHN managers were sought for recruitment in order to investigate their views of the factors that may influence nurses' ability to work in the FPM such as the culture in which practice takes place. Recruitment of

parents was required in order to observe the interactions that occur during CFHNs' consultations with them and seek clarification from the parents via semi-structured interviews. The inclusion criteria ultimately developed was as follows:

1. Consenting CFHNs currently working in a permanent or contract basis in the NSW public health system from the LHD in which the study focuses who had completed FPM education. This ensured that all nurse participants had had formal education in the use and implementation of the same education program in relation to working in the FPM with parents.

2. Consenting CFHN managers currently working in the same health service in which the study focuses who had participated in education related to the FPM or had knowledge of this model of practice.

3. Consenting English speaking parents with infants/children 0-5 years attending CFHN services in the areas in which the study focuses.

I chose to recruit participants outside my own LHD to avoid possible ethical implications arising from my dual roles of researcher and Child and Family Health Clinical Nurse Consultant (Dowse et al., 2014). Additionally, I wished to undertake recruitment in a Health District where CFHNs worked in regional and metropolitan areas which might provide access to a greater diversity of client families.

In 2011, during the data collection phase of this study, the NSW Health Service was divided into (17) Area Health Services. Following a major NSW Health restructure in 2012 (Local Health District and Boards) Act 2011, the metropolitan and regional services were reorganised into fifteen distinct entities and renamed Local Health Districts (NSW Health, 2014). Therefore, at the time of data collection, there were four discrete geographically located CFHN teams within the one metropolitan Area Health Service selected for recruitment. The term Local Health District (LHD) is used from hereon when referring to the location of study setting.

I obtained a written letter of authorisation for the study to proceed from the Area Director, Child and Family Health of the LHD in which the study was conducted [Appendix A]. This approval was granted on the proviso that I was flexible with interview schedules with nurses' clinical work to take precedence. I was also requested to take responsibility for recruitment of parents.

There was approximately twenty-five (25) CFHN staff and one nurse manager in each of the four teams. To facilitate recruitment I contacted each of the four nurse managers and

arranged to attend a nursing meeting or inservice education program in each of the four teams. At each of these four sessions I introduced myself and gave a short presentation about the study, copies of which were distributed to the nurses present. Additional copies of the presentation were left with the nurse manager for staff who were absent on the day of my presentation. Child and Family Health Nurse Information Statements (Appendix B) and Child and Family Health Nurse Consent forms (Appendix C) with stamped envelopes addressed to the researcher were left for nurses to complete if they were interested in participating. Similarly, I provided a copy for the Nurse Manager at each session of the Child and Family Health Nurse Manager Information Statement (Appendix D) and Child and Family Health Nurse Manager Consent Form (Appendix E). Over a period of several months I received completed consent forms from (n=9) nurses and (n=1) nurse manager. These nine nurses comprised three nurses each from three teams and one nurse unit manager of one of these teams. There were no nurses or managers from the fourth team. This is further discussed in the next chapter (see Figure 3, p. 61).

I attended early parenting groups at the recruited nurses' Centres in order to present the study information and recruit one or more parents to link with each of the nine nurses. The rationale behind linking a parent with a participating nurse was to ensure that this nurse conducted the child health check consultation (NSW Kids and Families, 2013), that I was to video record (Dowse et al., 2014). I attended twelve parenting group sessions overall. At each of these twelve parent groups I provided copies of the Parent Information Statement (Appendix F) and Parent Consent Form (Appendix G). I also provided a Research Flyer (Appendix H) advertising the study to nurses at each centre to attach to their waiting room notice boards for parents to view. Nine (n=9) parents (all mothers with infants aged between five and nine weeks) were subsequently recruited to the study.

These nine mothers included three mothers/babies from each of the same three teams as the participating nine nurses. This was a purposive recruitment decision so that a mother/baby, where possible, could be linked with her participating CFHN in order for me to observe and video record the baby's child health check consultation. This number of nurse and parent participants enabled sufficient data to be obtained from interviews and participant observation to reach saturation consistent with focused ethnographic methods (Higginbottom et al., 2013). Data saturation was reached when no recurring themes emerged during data analysis.

3.6.1.1 Recruitment issues

Only one nurse manager volunteered to participate in the study. The nurse manager was highly committed to working in the FPM. As no other nurse managers volunteered to participate it wasn't possible to obtain other nurse managers views on the study topic. Further, despite wishing to attract both parents to participate in the study only mothers volunteered. Therefore, the views of fathers are not included in this research.

3.6.2 Setting

3.6.2.1 Interviews

The settings for the interviews conducted during this study were chosen to suit the convenience of participants and to minimise interruption to their schedules. I presumed prior to data collection commencing, that interviews would be conducted in three main sites: the parents' homes, the nurses' Child and Family Health Centre, and the nurse manager's office. Most first interviews and all second interviews with nurse participants were conducted in their office at their child and family health centre. Two nurses, however, chose to have their first interview at their home on their day off from work; another nurse chose to meet me in her local park because there were renovations taking place at her home. The nurse manager selected her office for me to conduct her sole interview. Seven of the nine mothers elected to have their interview at the Child and Family Health Centre either immediately after their baby's child health check consultation with the nurse or after their next parent group session the following week. I conducted interviews with the remaining two mothers at their home during the week following their child health check consultation.

3.6.2.2 Observations of Child Health Check Consultations

All nine occasions of participant observation of mothers/infants and their CFHN took place at a Child and Family Health Centre when the babies were scheduled for their six-eight week child health check consultation.

3.7 DATA COLLECTION

3.7.1 Semi-Structured Interviews Procedure

Interviews with the nurses, managers and mothers were used to gather information and were held in a semi-structured format. The questions used were mostly open-ended and

unstructured when opening or following a line of discussion, and close-ended during confirmation periods (Fetterman, 2010; Tham, 2003). I posed questions that were simple so that ideas could be focused; that were non-dichotomous; were neutral rather than having loaded meaning; and, avoided inferring cause and effect. The research question, aims of the study and the conceptual framework were used to guide the nature of the interview questions. Interviews commenced following receipt of permission to proceed, exchange of pleasantries, agreeing on duration and a recap of the study and my background. I used brief Interview Prompts (Appendices I-L) to help guide discussions if the interviewee (or I) lost focus and to help keep to the topic of the study. For instance, I asked nurses for examples of "how they would describe the culture of the organisation or cultural aspects that might influence practice". I asked parents for instances of where they "felt listened to by the nurse during their consultation".

First interviews were conducted with the nine CFHN participants prior to their child health check consultation with participating mothers/babies that I was to attend as part of participant observation. In first interviews with nurses I sought information about their understanding of the FPM and their views regarding the factors influencing, and the nature of the impact, on their ability to work in the FPM with parents. Second interviews with each of the nine nurses were held subsequent to their video recorded consultation with their linked mother/infant, in order to seek clarification on particular matters I observed during participant observation. This second interview was facilitated by the use of recall and direct feedback from the nurse from watching her videorecorded consultation and helped to clarify aspects of the interactions that occurred. This is in keeping with an emphasis on the iterative, focused ethnographic techniques of data collection.

One semi-structured interview was held with the CFHN manager in her office at her workplace. The interview sought to obtain the manager's understanding of the FPM and her views of the factors in the workplace culture that influenced the ability of CFHNs to work with parents using a partnership approach.

I conducted one semi-structured interview with each of the nine mothers following the completion of their videorecorded consultation with the CFHN. This interview was held as soon as possible after the consultation to reduce potential problems with recall, and generally occurred within one week of the consultation. The interview purpose was to obtain mothers' views regarding their relationship and interaction with the CFHN during the consultation. For example, I asked for instances where they felt listened to, were asked about their health goals or perceived being treated as equals by the nurse.

3.7.2 Participant Interview Validation

Twenty-eight interviews were conducted in total. These ranged from twenty to eighty minutes duration and provided rich, descriptive verbatim data from the participants' perspective. All interviews were digitally audiotaped with participants' permission. The audiotaped data was transcribed and all participants invited to review their unedited interview transcript and to make changes or deletions as they wish. Most declined this offer except for four nurses who requested the transcripts of their first interviews and two mothers who requested their interview transcripts. These were posted to these participants with a stamped addressed envelope for its return within two weeks of receipt, with explanation that they were free to edit it as required and return it with any changes. Neither of the mothers requested changes to be made. One nurse, however, requested changes to her interview transcript and these were minor and related to spelling or punctuation errors. All participants (except one mother who declined) requested, and received a copy of the summary of the findings (Appendix M). Relevant excerpts from interviews are provided in the findings (Chapter 4) to illustrate participants' views and experiences.

The issues I encountered while conducting interviews included occasionally being hasty in pre-empting participant responses or jumping in to prematurely finish participants' sentences. I occasionally asked questions about topics not raised by participants that were based on my insider knowledge of the CFHN service. For example, I asked nurses and parents' about their experiences of the first home visit and the initial health assessments conducted.

3.7.3 Field Notes

Fieldwork is a hallmark of ethnographic research and consists of the researcher entering the research setting and conducting the study (Fetterman, 2010). In this study the "field" included the various locations of the research setting identified in Section 3.6.2. Field notes were made either during or after interviews or consultations at the Child and Family Health Centre. I also made notes about what occurred during the recruitment process and my reflections and impressions following each interview that was conducted because the data collection process proved quite complex (Dowse et al., 2014). Data consisted of conversations and interactions between the nurse and her clients (the mother and infant), processes observed in the home or Centre, and the use of participants' verbal and non-verbal cues.

3.7.4 Participant Observation Including the Use of Video Recording

Field data consisted of interviews and participant observation including video recordings of child health check consultations conducted by participant nurses and their linked mothers/infants. Participant observation is characteristic of ethnographic research and "crucial to effective fieldwork" (Fetterman, 2010, p. 37). Participant observation in this study consisted of my attendance at each of nine child health check consultations in an informed "observer-as-participant" role. This meant that I could assist if requested by the nurse or mother, for example, to hold the baby, but refrain from joining in conversations. I located myself seated in a part of the consultation room usually away from participants' direct eye contact where possible. My purpose in doing this was to be as unobtrusive as possible and respectful of participants' right to conduct their work and help seeking without interruption from me. Despite having written consent, I re-sought verbal permission from both nurses and mothers before entering the consultation room and setting up the small tripod to affix my digital Sony ™ camcorder where I could audio visually record the interactions between participants. All nurses and mothers agreed for me to proceed with observation, and with recording. Once the camera was recording, I could redirect it should participants move, for example, to conduct the child health check on the examination bench. I was also able to observe interactions and conversations myself without having to view through the recorder during the whole consultation.

In total, I videorecorded nine child health check consultations. These recordings ranged from thirty to sixty minutes duration. I also recorded conversations held between nurses and mothers separately on a digital audio recorder to enable a transcription of the consultation to be conducted. This transcription aided my later analysis when viewing the video recorded data.

The video recordings were a vital component of the data collected for this study. Observations of video recordings during the consultations between participants enabled me to closely study the nature of the relationship that developed between nurses and mothers; to examine these interactions in depth; and to clarify aspects of these interactions with nurses during their second interview. An additional advantage was that nurses appreciated the opportunity to view and reflect on their clinical practice. Research involving video recordings of CFHN practice interaction with parents has previously been conducted in the Australian context (Grant & Luxford, 2009; Hopwood, 2014b). It has also been used in qualitative research that evaluated FPM training in health visitor practice in

the UK (Bidmead & Cowley, 2005b). The video recordings of consultations "aided my participant observation and reflection through being able to subsequently review in detail the nurse-parent-child interactions scene by scene" (Dowse et al., 2014, p. 36). This process, in addition to reflexivity, assisted me in making "the familiar unfamiliar" (Edvardsson & Street, 2007, p. 24).

3.7.5 Researcher Study Diary

I completed a number of researcher study diaries over the several years it took to complete this research. These provide a written account of my questions and deliberations regarding the conceptualisation of the study and the methodological issues, reflections and insights that occurred for me throughout the course of the study.

The diary also provides an account of my regular meetings with my research supervisors. These meetings were digitally audio recorded and I made notes in the diary from these recordings to indicate the direction I needed to take at each phase of the study. For example, they record our discussions about the most appropriate methodology to use to answer the research question and recommendations of further reading to undertake.

3.8 DATA ANALYSIS METHODS

3.8.1 Preparation of data

The data collected from interview audio recording were stored as MP4 computer files on my computer and external hard drive. Each of these devices were password protected. Each of the interview audio recordings were labelled and sent to a qualified transcriber for verbatim transcription. These were returned to me as a Microsoft Word ™ file. Each nurse, mother and baby were allocated a pseudonym. The interview transcripts were reviewed and verified against the audio file as they were received. Video recordings were likewise downloaded and saved to my computer and external hard drive.

I initially had commenced entering all unedited transcript and audio data files into N Vivo™ Version 9 (a qualitative data software program developed by QSR International) to assist with management of data during analysis. However, I quickly found this process disengaged me from the data and did not provide me with the reflexivity I needed for immersion and the iterative and inductive nature of qualitative inquiry. If anything, it fostered within me a deep aversion to pursuing any analysis at all.

Therefore, following discussion with my research supervisors, I stopped using N Vivo 9™ as *"too distracting and de-energising*". On reflection, as I progressed with organisation of the data it became apparent that the mechanistic N Vivo™ Version9 process of data management did not suit my way of thinking when conducting thematic analysis. Thereafter, I created Microsoft Word ™ tables to organise each iterative phase of the analysis as it moved from whole chunks of transcript and documents into emerging patterns and themes. Table 2 below provides detail on the transcription notation codes developed during analysis as well as the numbering system used in each chapter and identification of the major themes and subthemes in Chapter 4 -Findings.

Table 2: Transcription Notation Codes

Symbol	Meaning
Participants' voices	Italicised font used to indicate participants' speech
…	Break in transcription within the sentence.
….	Break in transcription of more than one sentence
( )	Researcher's comments and participants' pauses, gestures or expressions are added within brackets
< >	De-identified person or place
<u>a</u>	Underlined for speaker emphasis
What were	Italicised, bolded text represents the researcher's speech
Field notes and researcher diary entries	Italicised data from researcher's field notes or researcher diary entries
Comic sans	Researcher assumptions
Numbering System	Meaning
5.4 CHAPTER 1/THEME 1	Main chapter heading or Theme
5.4.1 Working With Others	Sub-theme
5.4.1.1 Working with Colleagues	Sub-heading
<u>Working with interprofessional teams</u>	Highlighted point within a sub-heading

3.8.2 Thematic Analysis Methods

Thematic analysis methods informed by Braun and Clarke (2006) and Vaismoradi, Turunen, and Bondas (2013) were used for all data items collected during field study. Thematic analysis is a "method for identifying, analysing and reporting patterns (themes) within [and across] data… [and can be used] to interpret various aspects of the research topic" (Braun & Clarke, 2006, p. 79). Thematic analysis also has the capacity to depict "reality" while retaining the capacity to expose what's hidden beneath surface (Braun & Clarke, 2006, p. 81). All thematic analysis was undertaken by me and discussions with my supervisors took place to clarify and agree on developing themes. The phases of thematic analysis adapted for my study from Braun and Clarke (2006, p. 87) are outlined in Table 3 below.

Table 3: Phases of Thematic Analysis

Phase	Description of the process
1.Familiarising yourself with your data:	Transcribing data, reading and re-reading the data, noting down initial ideas.
2.Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3.Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4.Reviewing themes:	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5.Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6.Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back to the research question and literature, producing a scholarly report of the analysis.

3.8.3 Thematic Analysis Phases

Phase 1: Familiarising myself with the data:

Data analysis occurred concurrently with data collection or as soon as transcripts were received from the transcriber. I began this initial analysis phase by first noting participants' characteristics and basic demographic information. I read each nurse's whole transcript in order of interviews conducted with nurses. I used the overarching research question and the interview prompts to broadly summarise and categorise each nurse's response to the individual prompts. I included verbatim quotes with identifying page numbers from the original transcript to link to the relevant respondent.

Example excerpt:

Data extract: ***CFHN 1st Interview prompts***
Ask the nurse about his/her experience of working in partnership with parents
"…because of the nature of the work, it's quite…because it's …sitting and hearing families' distress or… listening is quite an exhausting job." (Monica[3], 1st Int. p.23)

On each hard and soft copy transcript I made notes in red font of phrases and themes I noted within the transcript and wrote myself reflective questions and memos in my study diary as I went. I linked these ideas and memos with the relevant field notes collected during or after interviews or observations. I identified on the transcripts in coloured pen where nurses' responses answered questions posed related to the research prompts. Participants' responses and my preliminary ideas were transferred to a Microsoft Word ™ document as I began to organise and sort the data into groupings of similar features. Appendix N provides more detailed excerpts of the first three analysis phases.

Phase 2: Generating initial codes:

The generation of initial codes emerged as I worked through interview transcripts. I began to organise the data by cutting and pasting excerpts of transcripts under "groupings", for example, culture, influence of manager, influence of colleagues, influence of parents, technology, and interview prompts. I continued to use red font to highlight my own emphasis, voice, thoughts or words as they occurred in response to the data.

[3] Pseudonyms used for all participants.

Example Excerpt:

Transcript excerpt:	Coded for	My Reflections
"A *first visit is very hard* to be *…it's very hard to use partnership. There's lot of pressure to get information and get out of there for your next visit. So I've found … some visits that it's too stressful to use."* [Monica, 1st Int., P9).	Meeting UHHV targets Get information Stressful and hard to work in partnership on some first visits	Monica talks about the FPM as a set of skills that can be *turned on and off* when needed, e.g. hard to use FPM during UHHV as too much content to cover and questions to ask parents.

I developed and alphabetically organised Microsoft Word™ document called *Summary Table of Emerging Themes - CFHNs' First Interviews* (see-Appendix N). This document tabled the emerging factors influencing, and the nature of the impact (divided into positive/less positive) from nurses' first interviews. The left column listed the influencing factors identified by the participants. The table also includes brief discussion and participants' recommendations as well as my reflections on the points made by the CFHNs or my response to their comments (in red font).

Next I grouped each video graphed consultation of the CFHN and mother/baby; the CFHN's second interview transcript; and, the mother's interview transcript as one data set for analysis. The rationale for grouping this data set was because the focus of nurses' second interviews and parent interviews were each related to their videoed consultation. I systematically grouped each subsequent CFHN and mother/baby set for each of the nine nurse-mother/baby linkages. This analysis approach assisted with ordering the analysis of this large amount of complex interview and video graphed data.

I carefully viewed each of the nurse-mother/baby child health check consultation recorded videos. I read and made notes on the accompanying transcript of each videoed consultation and its digital recording. I also made notes while reviewing each video regarding participants' position, gaze, interactions relative to each other, and tone of speech, whether the consultation seemed rushed, & the general environment. These notes provided depth and clarification of aspects of the consultation and were useful in conjunction to the field notes I collected at the time of participant observation. Serendipitously, this systematic process enabled me to see where congruency and/or discordance were present in the interview data of nurses' initial and follow-up interviews

and their observed clinical practice, and, the views of the mothers about the nurse and the CFHN service.

Example Excerpt:

<table>
<tr><td colspan="2">Researcher Notes: Videoed Consultation of Neroli and Lisa (mother) and Baby Poppy / Neroli's Second Interview</td></tr>
<tr><td colspan="2">Position: Neroli is tall. She notes during her second interview that although her seat is at its lowest point she is still not at same eye level as the mother but sits a bit taller.

Body language: Neroli leans in frequently; Neroli and Lisa often have legs crossed in synchrony. Neroli has hands loose and relaxed in her lap, notes that she is often nodding in agreement or encouragement of parent. Lisa had to stand to rock and console Poppy for quite some time in the beginning of the hour consult and after baby had been examined. This was not stressful and Poppy was relaxed once breastfed. (The video was turned off briefly at Lisa's request while latching the baby).</td></tr>
<tr><td colspan="2">Nurse / Mother Follow-up Interview Question:

Describe nature of the relationship developed with the nurse/mother during the consultation</td></tr>
<tr><td>Neroli:

"We have a relationship yet are still strangers; yet they trust us and here [watches video] Lisa has truly shared [not filtered her information]; it was a true reflection." [Neroli]</td><td>Lisa

"I get along very well with Neroli. She's very supportive and I can open up comfortably with her. She helped me through when I had mastitis with my last baby. I've stuck with her as much as I could." [Lisa]</td></tr>
</table>

I analysed the nurse unit manager's interview transcript last. This helped me to get a sense of the interplay between the CFHNs' responses and rationale for management views, processes and decisions.

Phase 3: Searching for themes

Once I began to have a sense of the whole data picture, and initial coding into potential themes was completed, I gathered and grouped all data relevant to each potential theme. This was achieved by synthesising the coding conducted of nurses' initial and follow-up interviews with mothers' responses and the video graphed consultations. The NUM's responses and field notes were also included at this step. The resultant document from Phase 3 analysis was titled "*Data Synthesis Table"* (see excerpt below and Appendix N). This synthesis process assisted me to gather and mesh all data into broad themes related to answering the research question.

The *Data Synthesis Table* consists of several columns with a common theme and sub-theme informing the relevant coded extracts to be entered into each column. Participants' coded extracts were broadly categorised into positive (shaded columns) and less positive responses. One column was used for me to add my reflections, thoughts and comments in **red** font. Mother's responses are depicted in **blue** font. I subsequently wrote notes and drew mind maps and diagrams throughout the margins of this document as the level of my analysis and reflexivity deepened.

Factors Influencing	Nature of Impact				CFHNs' & Mothers' Views & Recommendations	My Reflections
	Nurse 1st interview NUM interview **POSITIVE**	Nurse 2nd Interview & **Mothers' Interview** (blue font) **POSITIVE**	Nurse 1st interview NUM interview **LESS POSITIVE**	Nurse 2nd Interview & **Mothers' Interview** (blue font) **LESS POSITIVE**	CFHN 1st First interviews; CFHN 2nd interviews Mothers' Recommendations	(red font)
Subtheme: **Challenges of Meeting Role Requirements** UHHV Maternal Psychosocial screening Workloads Health budgets	*"I think working in a person's home is actually easier to adopt this model …we are a guest…I think we have more power potentially"* [in the clinic]. [Neroli] *"It's a* ***bit like a squishy ball****. You squish on one side and it pops out the other side almost."* [Neroli] ***METAPHOR*** *"The first visit and the psychosocial questions. I use them as a rationale and to premise the relationship with the parent."* [Annie]	*"Doing the EDS & DV scales is helpful"* [Angela] *"The home visit is good and helps establish the relationship"* [Virginia] *"I found the first home visit really good."* [Dani] *"The first home visit was good. I was happy with the overall service including breastfeeding support."* [Millie] Millie's views of the psychosocial screening*: "It's not a problem; it's good that the nurses bring it up."* [Millie]	*"It's hard to work in partnership on the first visit"* [Monica] *'Psychosocial screening can initially be a barrier with inexperience."* [Neroli] *"…maybe the budget? So you're always just a bit short 'cause I don't know any centre that's perfectly happy."* [Sandy] *"The volume of work is the difference and partnership can't be 'ticked'"* [Sandy]	*"No home visit until 4 weeks postpartum and we had no communication from the CFHN service."* [Susan] *'The questions on the first home visit are confronting. I felt uncomfortable with them."* [Susan] *"The first home visit questions are more like a checklist. They didn't bother me. It was good it was at home."* [Juanita]	Susan suggested to me that nurses need to get to know the mother first and ask questions in a more conversational style	Monica describes the FPM as a set of skills that can be *turned on and off* when needed. E.g. hard to use them during UHHV as too much content to cover and questions to ask parents. Neroli's 'Squishy ball' metaphor is comparing the team and manager support with broader health policy requirements and limited health budget. Susan experienced discomfort with UHHV questions. Some nurses asking the maternal psychosocial questions like a checklist.

Example Excerpt: ***Data Synthesis Table***

Phase 4: Reviewing themes:

Phase 4 involved the refinement of major themes and sub-themes drawn from across the whole data set and the drafting of a thematic map. There were numerous iterations of this stage of the analysis process. The final thematic map of the study findings is depicted in the next chapter in Figure 4: Study Findings Themes and Sub-Themes (p. 96).

Phase 5: Defining and naming themes:

Phase 5 consisted of distilling the analysis down to four major themes, each having a number of subthemes. This was the most challenging and time consuming aspect of my whole study. The lengthy analysis process provided me with invaluable lessons in the development of patience. This phase could not be rushed. It required a deep level of reflexivity and many consultations with my research supervisors. It also helped me to cultivate mindfulness so that I could sit with the "not knowing". Eventually, I recognised the crystallisation of the final themes and subthemes and the overall story of the analysis. An example of the categorisation of the resulting first major theme and associated sub-themes (drawn partly from the data from the above *Data Synthesis Table*), is provided below.

Example Excerpt of final named themes and sub-themes:

Theme 1	**THE CFHN WORK ENVIRONMENT AND CULTURE**
Sub-themes	*a. Working with others* *b. The workplace* *c. The challenges of working in partnership and meeting role requirements* *d. The sustainability of the FPM*

The final themes and sub-themes arising from data analysis are identified and discussed in detail in the next chapter.

Phase 6: Producing the report

In Chapter 4, I present my research findings in relation to the research question and study aims. The themes and subthemes are supported by selected data extracts providing rich descriptions and examples that portray the emic perspective. This is followed by Chapter 5, where I discuss the findings and relate them back to the literature and research question. The research report concludes with the clinical implications and recommendations for further research.

3.9 RIGOUR

Higginbottom et al. (2013), state the rigour with which a focused ethnography is conducted can be evaluated against the criteria listed in Table 1: Comparison between Conventional and Focused Ethnography (Section 3.4, p. 51). However, assessments of rigour within qualitative studies are most commonly performed using the criteria of credibility, transferability, confirmability and dependability proposed by Lincoln and Guba (1985).

Credibility of this study was achieved through the opportunity that was provided for each participant to verify their interview transcript/s as well as the summary of the findings (Appendix M) that was sent to each participant. The reader will be able to determine credibility from the extent to which the findings make sense for them as an accurate representation of data and participants (Mayan, 2009). Triangulation of data can also assist in enhancing a study's credibility (Mayan, 2009). Triangulation, or "testing of one source of information against another" (Fetterman, 2010, p. 94), can help to compare, contrast and confirm findings. In this study, triangulation of data and analysis was facilitated by my use of multiple information sources including semi-structured interviews, participant observation and videoed recordings of child health check consultations. In addition, I investigated the research topic from the CFHNs', nurse manager and mothers' perspectives and was able to compare and contrast these viewpoints.

In terms of transferability, this was achieved by providing a sufficiently rich description of the setting, participants and methods used to conduct this study. It is anticipated that the reader will be able to assess the applicability of the findings being transferred to other like settings (Mayan, 2009). The confirmability of this study may be judged by whether the findings are logical (Mayan, 2009). The reader may determine confirmability from my provision of sufficient description and rationale for the methods used to recruit and collect data and conducting analysis concurrently.

Dependability was attained through my detailed explanation of data collection and analysis methods. It was enabled by my reflections, thoughts and ideas generated in my study diaries and from discussions with my research supervisors. These diaries provide a comprehensive account of methods from the development of the research question and methodology selected to recruitment, data collection and analysis.

Finally, Mayan (2009), suggests reflexivity is the most important researcher strategy to employ to ensure rigour is maintained throughout the study process. As a doctoral

student, my ability to become a reflexive researcher developed over the course of the study and from the influence and counsel of my research supervisors (see Section 3.4.1). In addition, my decisions in relation to the conduct of this study were rigorously evaluated during my candidature confirmation process and by the University and Local Health District Human Research Ethics Committees.

3.10 ETHICAL CONSIDERATIONS

This research was approved by the LHD Human Research Ethics Committee (HREC) [Approval Number: 1003-088M; where the study was situated and registered with The University of Newcastle HREC [Reference Number: H-2010-1181] following my peer review and confirmation of candidature. Throughout the study, I endeavoured to address issues of sensitivity to participants' privacy and any possible emotional outcomes associated with the experience of study participation. The following procedures and protocols were followed to ensure that ethical principles and due diligence was observed in relation to the rights of research participants and their protection from harm (Mayan, 2009).

3.10.1 Voluntary Participants

Participants were not coerced into joining this study. Following ethics approval and authorisation for the study to proceed (Appendix A), I advised the CFHNs and their managers about the study in the months preceding the commencement of data collection. At each of the information sessions I presented to the four nursing teams I provided copies of Child and Family Health Nurse Information Statements (Appendix B), Child and Family Health Nurse Consent forms (Appendix C), a CFHN Manager Information Statement (Appendix D), and, a CFHN Manager Consent Form (Appendix E). CFHNs and managers interested in participating in the study were invited to sign the consent forms and to return to me in the stamped addressed envelope provided.

All nurses and CFHN managers in each respective team were invited to participate in the study. Nurses and managers who consented to participate were not accountable to me as I was not employed by the LHD in which the study was conducted.

I attended early parenting groups in order to recruit a parent to link with each nurse. At these groups I provided brief information about the study and left Parent Information Statements (Appendix F) and Parent Consent Forms (Appendix G) with reply paid envelopes addressed to me. Parents interested in participating in the study were asked to sign their Consent Form and supply their contact details so that I could contact them if

they required more information about the study, and to arrange the parent's interview following the consultation with the CFHN.

3.10.2 Valid Consent

The requirement for legal consent requires that participants must be fully informed regarding what they are being asked to do and its voluntary nature, the likely consequences from participation, their right to freely withdraw and their right to refuse without penalty (Mayan, 2009). CFHNs, their managers and eligible parents were invited to voluntarily participate in this study. Written information was provided to participants outlining the research aims, methods, and expectations of participants. The Information Statements invited the reader to seek more information prior to consenting by phoning the researcher at the contact numbers provided. Participants were advised that they had the right to withdraw from the study at any time without any negative consequences. A Withdrawal from Research Form (Appendix O) was available for participants should this be required. It was noted on this form, however, that interview data could only be withdrawn before analysis took place as the data wouldn't be able to be identified after this. No participants in the study took up this option to withdraw from the research. Written consent was obtained from all participants.

A Visitor Information Statement (Appendix P) and Visitor Consent Form (Appendix Q) were available should someone unexpectedly enter the room during participant observation while a video recording of the consultation between the nurse and mother/child was being conducted or during the semi-structured interviews. Again, this option wasn't required because all videoed consultations between the mother, their infant and the nurse occurred uninterrupted at the Child and Family Health Centre; likewise, none of the interviews were interrupted or had visitors present.

Consent in relation to the use of video recordings of participants' voice and image was conducted in two steps. There was an initial consent obtained to videorecord the consultation. At the conclusion of the recorded consultation, a re-consent was sought from participants for their confirmation that the videorecording could be used in the manner outlined in the Information Statements and Consent Forms. All participants re-consented to the use of their voice and image except one mother who withdrew consent for her video to be made public. The mother was concerned about identifying information discussed about her partner during the consultation. Likewise, the nurse conducting the consultation withdrew her consent in order to uphold this mother's wishes. Consent was maintained, however, for use of their videorecorded data within my research study.

3.10.3 Confidentiality and Anonymity

During the period of the study all data was stored on a password protected file on my computer. No one else had access to these passwords. A data storage list was maintained. Participant's contact details and consent forms were stored in a locked filing cabinet in the researcher's office. Only members of the research team (my research supervisors) had access to electronic and document data (including video recordings). I had employed a transcriber who had access to interview data only and was also bound by confidentiality not to disclose information about participants or their data.

Care was taken to ensure that participants' privacy and the information they disclosed was protected at all times by the use of pseudonyms or coded names. Participants could also request access to their own data should they wish to review or retract information. Only the above mentioned withdrawal of consent to use video recorded data from one CFHN and mother during her CFHN consultation occurred during the study. Publications and/or conferences arising from this research will not include any identifying data about participants. The proviso to this is that participants' voices and/or images may be identifiable if used in professional conference presentations or posters. However, the consent process ensured that participants were aware that this may occur and is discussed further below.

Anonymity implies that the participant's identity is protected and no connection by the researcher and transcriber can be revealed towards the participants. Participants were informed that the transcriber would not have access to their names or identifying details, and would be asked to keep all information confidential. Transcripts were coded and interviewees asked not to use their real names. Any recognisable data such as the respondent's name will be destroyed at the completion of the study.

Care was taken to minimise the identification of CFHN participants' in the data collection of video/audio recordings that may be presented at future conferences and/or workshops. This care taken is in view of the possible risk to the professional reputation of the nurse should he/she be identified by colleagues or managers. The identification of mothers, infants in the video recordings was able to be minimised in accordance with their wishes and consent. The consent form had a specific opt-in tick-box for participants to agree to their image/voice being used in the manner suggested. Options included pixelating or otherwise distorting/blurring identifying images. As mentioned, participants were reminded of their right to review the video once it was taken (and edited where necessary) and at that point to request that their contribution be edited or removed.

Further, I asked participants to reaffirm their consent that the recordings may be used in the manner outlined, for example to analyse data or should the need arise to use the video images and voices for the purpose of a conference or workshop. None of the participants requested to withdraw their permission or edit their video consultations. The exception to this was the aforementioned nurse and mother who requested their recorded video consultation not be used in conferences or other public venues. I was granted permission, however, to use their video recorded data as part of the data analysis. In summary, participants were offered the opportunity to:

- View their video image/voice and:
- Withdraw and delete their video image/voice;
- Have their video images and voice edited prior to use;
- Have their video images pixelated prior to use.

3.10.4 Storage of data

Data will be kept at the The University of Newcastle, Faculty of Health and Medicine, School of Nursing and Midwifery for five (5) years following the completion of the study. Digitally audiotaped interviews, Microsoft ™ word documents and video recordings will be stored on USBs in the safe at the School of Nursing and Midwifery. Access to these data will only be available to those people involved in this study. All data, including video recordings used for conferences, will be destroyed 5 years following completion of the study; electronic data will be deleted from the computer system; and participants' contact details and consent forms will be destroyed following The University of Newcastle procedures for shredding of sensitive documents.

3.10.5 Participant Care

Assistance was available to CFHN participants through their regular workplace clinical supervision and/or the LHD employee assistance program if they experienced distress from issues that were the focus of the study. The nurse manager was also able to be consulted if, during the course of the study, concerns arose regarding a nurse's clinical practice. None of the nurse participants experienced physical risk during the study and none requested support from issues arising from the study. However, one nurse participant during interview discussed issues related to feelings of distress from challenges arising in the workplace that had occurred to such an extent she had considering resigning. The interview was stopped temporarily and the nurse offered

options for her support such as clinical supervision or counselling. However, the nurse indicated that her current manager was very supportive and that things were improving such that she was able to continue the interview.

As this research may have included respondents' experiences that may be emotional, an environment that was familiar and safe for the mother(s) was necessary for the interview. Sources of support were available to be offered if mother(s) raised any underlying issues of concern during their interview. These included their GP and/or other relevant government and non-government agencies. The manager of the CFHN service could also be contacted regarding this issue. Options for mothers' further support were able to be discussed with them should this be needed.

During the study, observations were made at times of the interactions that occurred during the interviews held at the parents' or nurses' home. If at any time during the study participants' reported incidences of illegal behaviour or I held a concern for the safety, wellbeing and welfare for an infant or child participating in the study, then I was obliged to report this information to community services or the police. The manager of the CFHN service was also to be contacted if any of these issues arose. The Information Statements provided to prospective participants highlighted this requirement. However, no incidents of this nature occurred during the study.

3.11 SUMMARY

This chapter has presented the rationale for the selection of focused ethnography as the appropriate methodology used in my study. It has also provided detail on the conceptual model I adapted for this study, namely, Bronfenbrenner's (1979) *Ecological Model Of Human Development* as well as the methods used to conduct the study. This included the development of the research question, data collection and analysis methods and the ethical considerations that arose within the study. The next chapter presents the study findings.

Chapter 4 FINDINGS

4.1 INTRODUCTION

This chapter commences with a demographic description of the participating nurses, nurse manager, mothers and their babies. These descriptions are provided to orientate the reader to the varied relationships, characteristics and context of the participants. Table 4 (p.89), provides identification of the pairings of participant CFHNs and their respective participant mothers/babies that occurred for the video-graphed consultations. The CFHNs are also identified according to the geographical team that they work within. Next presented are the study findings including the major themes and sub-themes emerging from the data. Verbatim exemplars from the data are provided to highlight the participants' (emic) views, attitudes and behaviours (Creswell, 2013, p. 96). The study findings include my observations and reflections as well as my assumptions and understandings from my previous CFHN role; that is, the researcher's (etic) views (Creswell, 2013, p. 96).

4.2 THE PARTICIPANTS AND SETTING

Nineteen participants volunteered for this study. This included one nurse unit manager, nine CFHNs, and, nine mothers with nine babies aged between five and nine weeks. All participants were Caucasian. The mothers were recruited from parenting groups facilitated by their participating CFHN or a CFHN colleague. Although fathers were present at some of these groups none volunteered to participate in this study. All the husbands of the participating mothers had returned to work by the study's data collection phase. Therefore, none of the fathers were present during the videoed CFHN consultation with their partner and baby. Only one father was home at the time of my interview with the mothers. However, he had made prior arrangements with his wife to take their baby for a walk in the pram after my arrival. This was to enable his wife to be interviewed without interruption. Due to the total absence of fathers' views in this study, the parent participants are hereon referred to as mothers.

Each of the four CFHN teams in the LHD where the study was situated had its own Nurse Unit Manager (NUM) or Nurse Manager. The different title of manager reflects a classification and ranking within the NSW Public Health System Nurses' and Midwives' (State) Award 2011(NSW Health, 2011b). All nine participating CFHNs and the participating NUM worked in metropolitan Centres within the LHD. Three nurses each

volunteered from three of the CFHN teams. The participant NUM also came from one of these teams. There were no participants from the fourth CFHN team in the LHD. The mothers linked with participating nurses also lived in the same metropolitan LHD. However, one family had just recently moved to the LHD and, another was shortly relocating to a rural township 150km away in a different LHD. The nurses and manager from the three teams within the LHD as well as the linking arrangement of nurses and mothers/babies are indicated in Figure 3 below. Pseudonyms were used in place of all participants' real names.

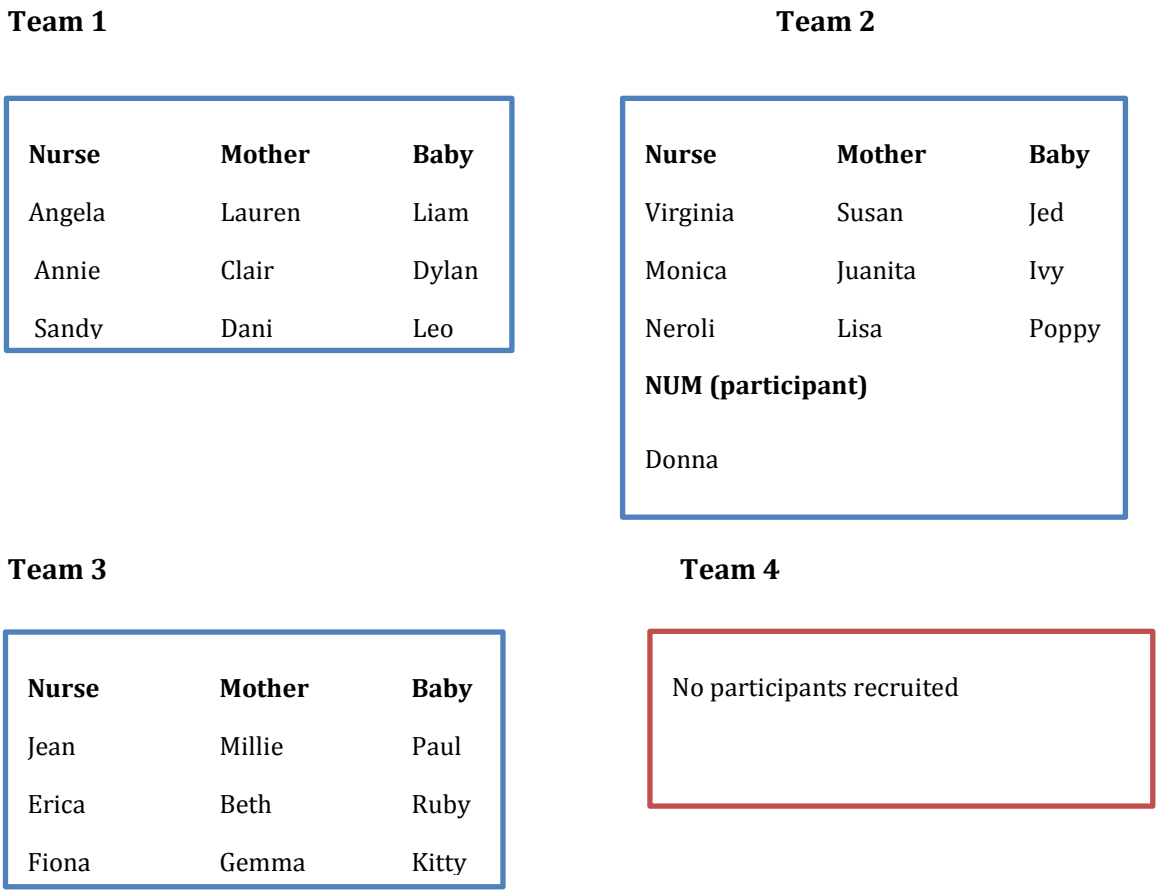

Figure 3: Participants and teams from the NSW Health LHD where study conducted

Prior to working in CFHN, six nurses were midwives, one nurse was a health visitor, one specialised in paediatric nursing and one worked as a community nurse. Four of these CFHNs held tertiary qualifications though only one nurse held a Master's qualification. Five nurses were born in Australia and four were born either in the United Kingdom or another English speaking country and all migrated to Australia as adults. All of the participating CFHNs worked part time, predominantly four days per week. The NUM worked full time. All CFHNs and the NUM had completed the initial FPM training program.

The NUM and two CFHNs from the same team as the NUM had successfully completed additional training to become FPM Group Facilitator Trainers. Although I did not specifically asked their age, all nurses appeared to be middle aged ranging between early forties to early sixties. I did not ask the nurse participants about their marital status or whether they had children themselves.

All mothers were married and currently living with their husbands. Six mothers had been employed before the birth of their first baby and were on maternity leave at the time of their interview. One mother was currently undertaking an undergraduate degree at university. The remaining two mothers were not currently working outside the home. One of these mothers had a toddler and the other had a preschool child in addition to their newborn for whom they were the main caregivers. One mother was aged in her mid-late twenties; seven mothers were aged in their early thirties and one mother was aged 37. Four mothers held tertiary qualifications, one mother was completing the final year of her university undergraduate degree, and one mother held TAFE vocational training qualifications in child care. One mother had held a senior role in the public service but did not report having formal university or other training qualifications.

With regard to their choice of interview setting, five CFHNs elected to have their first interview at their clinic and one CFHN at the local Family Care Cottage. Two CFHNs requested to have their first interview in their home and one asked me to meet her in a local park as renovations were occurring at her residence. All of the video-graphed consultations with the CFHNs and mothers/babies and second interviews with CFHNs were held at their respective child health centres. The NUM was interviewed once only in her office.

Six mothers elected to have their interviews at the Child and Family Health Centre either following a parent group session or directly after their video-graphed consultation with their CFHN. This arrangement proved for these mothers to be the most time efficient and least intrusive to participate in the study given their responsibilities as mothers of very young babies. A nearby office or private sitting room where the door could be closed was located within the CFHN Centre to ensure the mothers' privacy for these interviews. Three mothers, however, preferred that I conduct their interview in the comfort of their home. Apart from the mothers' babies, on no occasion was any other person present for the interviews. Only myself, the CFHN and linked mother/baby were present at the video-graphed consultations.

The tabulated description of the participants (Table 4) is next presented and indicates the linking between each CFHN and mother/baby. Pseudonyms have been used in place of participants' real names.

Table 4: The Participants

Descriptions of the linked CFHNs and mothers/babies and the participating Nurse Unit Manager (NUM)				
Child and Family Health Nurse	**Years in CFHN**	**Team**	**Mothers and babies**	No. of children
Angela Angela, a middle-aged woman, worked part time (4 days/week) at her Child and Family Health Centre (CFHC). Angela was a midwife prior to undertaking her CFHN education. Angela has a Master of Nursing specialising in CFHN and completed the initial FPM training three years ago. Angela's manner was one of a confident and experienced CFHN. Her garrulous conversational style and loud voice made Angela appear extroverted and many of her statements reflected stances that were either "black or white".	11	Team 1	**Lauren and baby Liam (aged 5 weeks)** Lauren was a young, married woman aged in her mid-thirties. Her healthy, fully breastfed infant son Liam was aged four weeks at the time of the child health check consultation. Liam is Lauren's first baby. Lauren had a very quiet manner and appeared to be a quietly confident and patient person. She stated that she was enjoying motherhood and found the CFHN service to be a great resource. Lauren worked in a public service position requiring a high level of responsibility and personal risk and was currently on maternity leave for several months. Lauren was married and said that within two weeks she and her husband (not present today) were relocating to a rural region 150 kilometres away to be closer to her extended family.	1
Annie Annie, a middle-aged woman, was born in the UK. Annie commenced work as a sick children's nurse at 18 years of age and specialised in paediatric nursing. Unlike many CFHNs, Annie did not hold a midwifery qualification. Annie came to Australia in 1982 and worked in a children's hospital. Later, she commenced working as a school health nurse in 1987 and completed the CFHN certificate at the NSW College of Nursing in 1989. Annie had been working in CFHN since that time including	21	Team 1	**Clair and baby Dylan (aged 6 weeks)** Clair, aged in her early to mid-twenties, is the youngest study participant. Clair was a child care worker by profession and Dylan is her first baby. Clair was married and said her husband was very supportive. They currently lived upstairs with her in laws. Clair struck me as a very practical, pragmatic woman who had an easy, relaxed manner especially for such a young, first time mother.	1

four years at the local secondary level family day stay service. Annie worked four days per week predominantly in CFHN where she said most of her work was with infants less than 6 month old of age. Annie said that she was initially more child oriented in her practice from her paediatric background. Annie held clinical nurse specialist (CNS) status within her CFHN service. Annie completed her FPM training in 2005.				
Sandy Sandy, a middle-aged woman, presented as a bright, attentive, and very quickly spoken person. Sandy, born overseas, migrated to Australia in 1984. She commenced working in CFHN in 1997 following the completion of a Graduate Diploma in CFHN. However, she had been working in her local community in nursing since 1994 apart from a four year gap during 1997 – 2001 for the birth of her children. Sandy currently worked part time in CFHN and completed the FPM training in 2007.	14	Team 1	**Dani and baby Leo (aged 6 weeks)** Dani, a first time mother, was aged in her early thirties. Dani presented as very well groomed and relaxed. Dani was married. Her husband was unable to be present during her interview or child health consultation due to work commitments. Dani said that she was a qualified social worker and was on maternity leave from the local health service where she was employed. Dani said she enjoyed being a mother to her new baby Leo.	1
Virginia Virginia, a middle-aged woman, had worked in CFHN since 1996. She now worked four days per week in universal services as well as in the local CFHN Family Care Cottage. Virginia was very enthusiastic about the FPM and was one of three FPM group facilitators in her team.	15	Team 2	**Susan and baby Jed (aged 9 weeks)** Susan, an articulate and educated woman, was aged in her early to mid-thirties. Susan was a school teacher who appeared confident, well groomed, relaxed and confident. Susan was married. Her husband was unable to be present for her interview or child health consultation due to work commitments. Jed was her first baby boy, fully breastfed, well and now aged nine weeks.	1
Monica Monica was a middle-aged CFHN from the United Kingdom. Her professional background included being a midwife for eleven years, seven of which were in the early discharge midwifery program. This role involved Monica providing midwifery care in the home to women and babies discharged early from hospital. Monica stated that she has been working as a CFHN for about six years, having completed	6	Team 2	**Juanita and baby Ivy (aged 5 weeks)** Juanita was a slightly older first time mother aged 37 years. Juanita is married and previously worked in a laboratory prior to the birth of her first baby Ivy now aged five weeks. Ivy is fully breastfed and seemed quite content during the consultation. Juanita and her husband (not present at consultation) had only moved to the area at 38 weeks gestation. Juanita said that she didn't know anyone living in the area before moving	1

the CFHN certificate in 2005. She completed the FPM training five years ago.				
Neroli Neroli was an Australian woman aged in her late forties-early fifties. Neroli had ten years' experience as a CFHN and currently worked part time. Previously, Neroli had worked as a midwife as well as in the university sector in early childhood teaching and developing aged care courses. Neroli undertook the FPM training in 2003. She was very experienced working in the model as she had also qualified as a FPM group facilitator in 2007, facilitated one group annually and had clinical supervision using the FPM approach.	10	Team 2	**Lisa and baby Poppy (aged 8 weeks)** Lisa was aged in her early 30's and described herself as a stay at home mother of a toddler and new baby. Lisa attended her consultation with her second baby, Poppy now aged 8 weeks. Lisa had made her appointment purposively to see the same CFHN, Neroli whom she had also seen with her first child. Lisa said that she had built a rapport early on in consultations with Neroli with her with firstborn. She said that Neroli had a knack for remembering client names, was very bubbly and easy going and seemed caring and concerned.	2
Jean Jean, a middle-aged woman had worked in CFHN for 20 years. In this time Jean said that she had seen lots of changes in practice. Jean usually worked four days per week. Jean presented as looking tired as her interview was held at the end of her workday. Despite this, Jean was keen to participate and said that she completed her FPM training in 2005.	20	Team 3	**Millie and baby Paul (aged 8 weeks)** Millie presented as a confident and relaxed young mother aged in her early 30s. She was attending the consultation with her second baby boy, Paul aged eight weeks. Millie also had a three year old pre-schooler whom her husband was caring for at home.	2
Erica Erica was a middle-aged woman born in the United Kingdom. Erica said that she originally trained as a registered nurse in the UK in 1980 but had now lived in Australia a long time. Erica said that she had a background in health visiting from the UK prior to working in CFHN. Erica completed the FPM training in 2006. Erica stated that the FPM was a way of working she was always interested in, and doing the FP training consolidated what she already thought was the way to engage families.	10	Team 3	**Beth and baby Ruby (aged 8 weeks)** Beth was aged in her early thirties and was completing the final year of an undergraduate degree. Beth said she very much enjoyed her first baby Ruby's antics and enjoyed attending the CFHN service. Beth made a point of saying that despite the structure of the CFHN service it was almost a casual approach which she said was a nice refreshing change.	1

Fiona Fiona, a middle-aged woman, completed her registered nursing certificate in 1979. Fiona was also a qualified midwife and neonatal intensive care nurse. Fiona said that she specialised in neonatal intensive care nursing from 1991 and practised in Western Australia for six years. Once married with children Fiona stopped shift work and completed the CFHN certificate course in 2001. Fiona currently worked on a permanent part time basis. Fiona completed the FPM training in 2003 and was pleased that she had been accepted to undertake the FPM group facilitator's course in 2012.	10	Team 3	**Gemma and baby Kitty (aged 5 weeks)** Gemma appeared a very confident young woman aged in her early 30's. Gemma was a qualified allied health professional and had a very bubbly personality and laughed a lot. Gemma noted that people can easily boost or detract from a new mother's confidence in their parenting with a comment or look. Gemma was pleased that so far the CFHN service had been very supportive of her parenting choices with her first baby Kitty aged just five weeks.	1
Nurse Unit Manager - Donna Donna was a woman aged approximately in her late thirties to early forties. Donna had been in her current NUM role with the CFHN service for the past twelve years. Donna had worked as a CFHN prior to her current appointment and also for three to four years as a CFHN working specifically with adolescent parents. Donna participated in one of the original FPM group facilitator training programs with Hilton Davis and has facilitated numerous training programs over the years. In recent years, Donna had offered clinical supervision to staff facilitating the FPM group. This clinical supervision has been offered since the FPM training began in the area.	Team 2 12 years as CFHN NUM			

4.3 THEMES EMERGING FROM AGGREGATED DATA[4]

I found that four themes emerged following my analysis of data collected to seek a response to my research question:

> *"What are the factors influencing, and the nature of their impact, on the child and family health nurse's ability to work in partnership with parents, as described in the Family Partnership Model?"*

The identified themes are titled "Theme 1 The CFHN Work Environment and Culture"; "Theme 2 Managing the Body: CFHN Body Work and Partnership Practice"; "Theme 3 A Mindful Space"; and, "Theme 4 The Mothers' Evaluation of CFHN Care". These themes are a complex, interconnected network of social practices that operate through partnership. The first three themes ("Theme 1 The CFHN Work Environment and Culture"; "Theme 2 Managing the Body: CFHN Body Work and Partnership Practice"; and "Theme 3 A Mindful Space") capture the participants' views, experiences and my observations of the CFHNs and NUM. The fourth theme stems from the views of the mothers and my observation of them during their video recorded child health checks and, therefore, this theme is called: "Theme 4 The Mothers' Evaluation of CFHN Care".

Sub-themes emerged in each of the four themes and findings related to each of these are located under the relevant theme. The sub-themes arose from data that captured various components or aspects of the theme that were discussed or raised frequently, and which assist in elaborating on particular elements of the theme. Sub-headings are used to organise the findings within each sub-theme. The transcription notation codes including organisation of themes, sub-themes and sub-headings are identified in Table 2: Transcription Notation Codes (Section 3.8.1 p. 68). Verbatim data is used throughout this chapter to illustrate the emic views and experiences of the study participants. The identified themes and sub-themes are listed as follows in Table 5: Study Findings Themes and Sub-Themes:

[4] Aggregated data sources included interviews, participant observation, video recordings and field notes.

Table 5: Study Findings Themes and Sub-Themes

Theme 1 THE CFHN WORK ENVIRONMENT AND CULTURE	Sub-themes: a) Working with others b) The workplace c) The challenges of working in partnership and meeting role requirements d) The sustainability of the FPM
Theme 2 MANAGING THE BODY: CFHN BODY WORK AND PARTNERSHIP PRACTICE	Sub-themes: a) Conceptualising and integrating partnership into practice b) The reality of the embodied CFHN
Theme 3 A MINDFUL SPACE	Sub-themes: a) Being present in the moment: A mindfulness discourse b) Reflective practice c) Being mindful of self
Theme 4 THE MOTHERS' EVALUATION OF CFHN CARE	Sub-themes: a) Positive experience b) First develop rapport c) Modern technology: Enhancing parent-nurse partnerships

The four themes, their related sub-themes and their relationships with each other which emerged from my analysis of the aggregated data are diagrammatically represented below in Figure 4: Study Findings Themes and Sub-Themes. This diagram demonstrates the most important finding identified by my study. This new finding identifies there is a central "space" for *mindful partnership*[5] between the challenges of the CFHN work environment and the management of the body, in the context of family partnership work with mothers. The overlapping areas indicate that these spheres of work intersect within what I term "A Mindful Space". This "mindful space" is the space where the CFHN recognises and cultivates an embodied mindful partnership practice when working with mothers/babies. This "mindful space" enables the CFHN to be grounded and present with awareness in both mind and body, non-judgementally when working with each mother/baby. My findings identify that an ability to cultivate this "mindful space" provides the CFHN with the spaciousness, inner resources and capacity to work with both personal and work-

[5] The term *mindful partnership* refers to the CFHN using the skills or practice of mindfulness when working in the FPM with parents. This practice supports the "cultivation and maintenance of the [parent's] experience of therapeutic presence" (Geller & Greenberg, 2012, p. 181) when with the nurse.

based challenges and respond more effectively to provide a therapeutic presence in partnership with mothers/babies.

The study findings also identify the various significant organisational processes and factors within CFHNs' and manager's work environment that positively influenced or detracted from their ability to work in the FPM with mothers (see Theme 1- The CFHN Work Environment and Culture). I observed the challenges present and the CFHNs identified numerous issues and some solutions central to "Theme 2 - Managing the Body: CFHN Body Work and Partnership Practice" when working with mothers. The third theme identified is "A Mindful Space". This theme identifies new knowledge of specific ways of being and activities that enable a "mindful space" for the CFHN to pause and reflect so that they may be able to provide an attuned presence, awareness and non-judgemental partnership based approach with mothers. Finally, the mothers in this study generally reported positive experiences with the CFHNs they had encountered (see Theme 4 – The Mothers' Evaluation of CFHN Care). They provide insight into their experiences of their interactions with CFHNs and have provided important recommendations to improve these relationships and communication processes with the CFHN service.

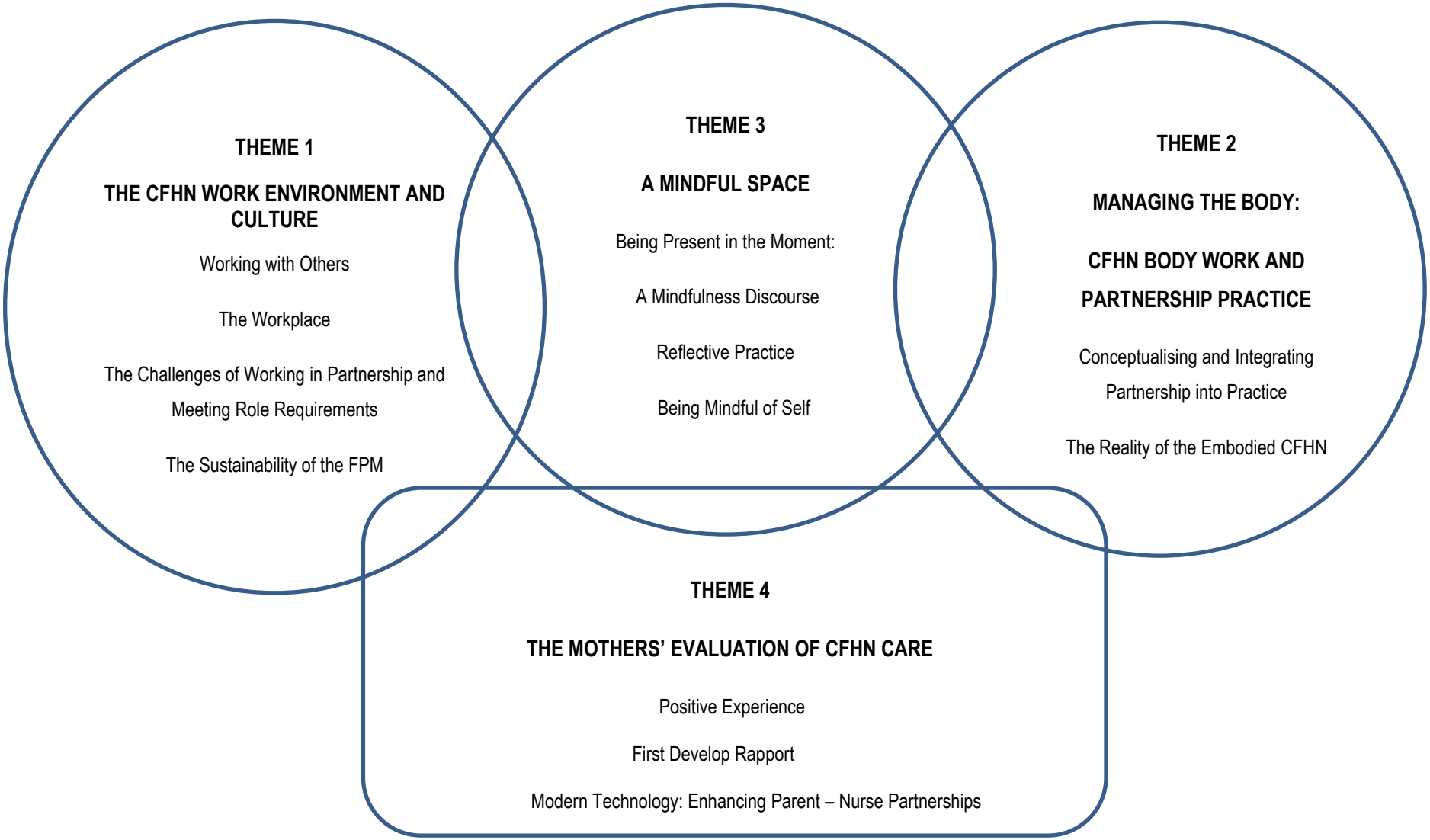

Figure 4: Study Findings Themes and Sub-Themes

4.4 THEME 1 –THE CFHN WORK ENVIRONMENT AND CULTURE

The first theme discussed is the "The CFHN Work Environment and Culture". A number of factors related to the CFHNs' daily work environment and the organisational culture and processes were identified particularly during the first interviews with CFHNs and the NUM. The nurses reported that at times these factors had the capacity to be a source of support; or conversely, an impediment to working in the FPM with mothers. These factors became the emergent sub-themes of THEME 1 and included: "Working with Others"; "The Workplace"; "The Challenges of Working in Partnership and Meeting Role Requirements"; and, "The Sustainability of the FPM".

The people, processes, culture and work environments that the CFHNs faced daily emerged during data analysis as key influencing factors that impacted their ability to work in the FPM with mothers. The nurse participants in this study were a relatively homogenous group regarding age, ethnicity, and professional experience. They had all worked in CFHN practice between six and twenty-one years. It's therefore not surprising that the nurses reported similar core aspects of their work environment as influencing their way of working with mothers. Despite identifying similar core work aspects, it emerged during data analysis that individual nurses had contrasting things to say about them. Some of these differences may be attributed to the environment, organisational processes and cultural influence of the particular teams and manager that they worked with. Differences may also have resulted from individual participant's cultural backgrounds and work experiences as our past experiences can influence individuals' current interpretations and perspectives.

4.4.1 Sub-theme 1 Working with Others

The first sub-theme within the CFHN work environment that the CFHNs and NUM reported influenced their ability to work in the FPM with mother is "Working With Others". The "others" referred to in this sub-theme consists of three key groups organised and discussed below under the sub-headings: "working with colleagues"; "working with managers"; and, "working with parents". Key points discussed within each sub-heading are identified as underlined text.

In using the sub-theme titled "Working With Others", I'm conscious that it could be viewed by the reader as inferring the construction of binaries such as "us" and "them"; "good

nurse colleague" and "bad nurse colleague". To clarify the use of this term, I refer to the work of Michelle Fine (1998) on "working the hyphen".

> Working the hyphen means creating occasions for researchers and informants to discuss what is, and is not, 'happening between', within the negotiated relations of whose story is being told, why, to whom, with what interpretations, and whose story is being shadowed, why, for whom, and with what consequence. (Fine, 1998, p. 135)

"Working the hyphen", that is, examining the "space" in the relationship between the nurse and others: colleagues; managers; and, parents/babies, is pivotal within this account of the findings of a study based on partnership between nurses and mothers. Examining this "space" also enables analysis and reflection on my relationship and interactions with participants. The detailed presentation of findings related to this "space" occurs in Theme 3 – A Mindful Space.

4.4.1.1 Working with Colleagues

The term "colleagues" used in this study refers to participant nurses' CFHN co-workers. It also refers to allied health and staff from other agencies that they had dealings with when working with families. The influencing ability of colleagues was described by the nurses as having either positive or negative attributes. These attributes are sub-titled: "Supportive team members", "A competing discourse with colleagues" and "Working with interprofessional teams". The support provided by team members included a sense of feeling strengthened by working with like-minded team members. However, this was not the case for all and a few CFHNs reported needing to use subversive behaviours to protect the mothers and babies in their care. This protection involved shielding their mothers/babies from CFHN colleagues who held strong views about certain clinical areas, such as breastfeeding. These colleagues had been known to provide information and care to parents they knew conflicted with that provided by the CFHN participant. Hence, there was a lack of "collegiality" and instead a competing discourse with some CFHN colleagues. A lack of consistent information and care by CFHNs may potentially confuse and upset some mothers. CFHN participants also described a desire to avoid conflict with colleagues who used their power and influence to their advantage in team meetings with the nurse unit manager.

Supportive team members

Eight CFHN participants spoke of the positive influence of colleagues on their ability to work in the FPM with mothers. This positive influence stemmed from working with supportive CFHN team members who were described as collegial and flexible. Working with supportive nurse colleagues provided a welcome buttress for CFHNs particularly when feeling overloaded or needing someone to debrief with. They could be approached if the nurse needed to debrief or if help was needed with one's workload. Neroli gave examples of "*colleagues swap*[ping] *workloads to help each other"* and said that her colleagues "*encouraged each other to use the* (family partnership) *model ourselves"*. Jean, from another team also said that her team members were excellent in "*sharing the* [different] *work roles"*. Annie, who had worked in her service for twenty-one years, acknowledged that she had *"a lot of very close friends in the team…the team's been like my family member"*.

Erica stated that her "*colleagues are brilliant… (we) often come back and unburden….it can just be so great to run it past a colleague….that's the first line of defence if you like"*. The metaphor "*first line of defence"* was used by Erica to describe how her colleagues could be used to unburden or debrief when she was upset by something that had happened in the work environment or when she was unsure if she had done the right thing clinically with a mother/baby. Metaphors are powerful linguistic tools that enhance our insight and depth of understanding of a situation (Junker, 2011). Erica's phrase "*line of defence"* invokes images of war and the existence of forces that may be harmful. I didn't question Erica further about her meaning so it's unclear whether the "*defence"* was against self-harm, retribution or work overload. The phrase "*line of defence"* in this context, however, suggests the protection of "self" by sharing something upsetting with "safe" people or seeking a second opinion from trusted colleagues. Erica added that it was helpful working with CFHN colleagues who were likeminded and generally agreed on how things should be done at work.

> *I think working with the colleagues you know, that are of similar like-mindedness and also, you know, build a very similar rapport to the way you do, makes following on with clients easier.* (Erica)

Erica followed this statement with the example of breastfeeding support. Stating "*we do breastfeeding support here and we all have a similar attitude towards it"*, Erica explained that she and her nursing colleagues endeavoured to support breastfeeding mothers but

would be no less helpful to "*someone not* [breast] *feeding".* This shared attitude was felt to benefit mothers in that nurses understood and could then more easily follow on with the management and care plan for the mother/baby where needed, for example, during periods where their colleagues were on leave. However, Erica also stated that it was helpful to be able to *"shuffle people if I think that her* [another CFHN's] *style might suit the client better"*. Erica stated that some mothers preferred nurses who had a more directive style. Erica described herself as a "*terrible softy…and not very good at being directive"*. This indicated to me that although Erica and her nursing colleagues generally shared similar understandings and attitudes to care, their style of delivery differed from more directive (expert) to less directive (partnership style) approaches such as espoused in the FPM.

Two nurses, Jean and Neroli, stated that they felt that most CFHNs wanted to work in the FPM nowadays and that this approach was embedded within the culture of their service. This was emphasised particularly by Neroli whose NUM was also a FPM group facilitator who reinforced the model with her staff. Neroli stated: "*that relationship's* (with the parent) *not just with me as one person….the family partnership model, it's with us as a service"*. Neroli followed this up by saying that in her team, the FPM commenced with the very first client phone call. Neroli's statements suggest that the nurses in her team are required to be "team players"; all using the FPM to underpin practice as a "shared organisational practice" (Rossiter et al., 2011, p. 29). Being a team player may also indicate a requirement by CFHNs to conform to the accepted standards and norms of the team.

A competing discourse with colleagues

The supportive, collegial CFHN work environment just described was not experienced by all nurse participants. Two CFHNs reported having worked with what they described as unsupportive or undermining CFHN colleagues. The causes of conflict with their CFHN colleagues stemmed from competing ideas about a) who the "partner" is within the professional relationship; and b) nurses being constrained in their ability to work in the FPM by others' beliefs about organisational policy or by colleagues with a different interpretation of organisational "rules" [meaning government health policy or clinical guidelines]. While these difficult incidents were reported by just two CFHN participants, they were significant in that they caused them to experience substantial work based stress. This section "A competing discourse with colleagues" explores their views of this experience and its impact on their ability to work in partnership with mothers.

Angela discussed as an example her use of the National Health and Medical Research Council (NHMRC) clinical guidelines on infant feeding (National Health and Medical Research Council, 2012) in clinical practice with breastfeeding mothers. This government document guides CFHN practice and information for parents in relation to breastfeeding and introduction to solids. Angela's conflict centred on the dilemma she experienced of being required to advise mothers to follow the NHMRC clinical guidelines (which she calls *"the rules")* regarding delay of introduction of solids to infants until they are around six months old (National Health and Medical Research Council, 2012, p. 85). Angela, herself a qualified lactation consultant identified that this delay in the introduction of solids or complementary (formula) feeds was not necessarily in the best interest of some mothers and babies. Further, some mothers wanted to introduce infant formula or solid foods before their baby was six months of age. Angela's dilemma centred on who was her "lead professional partner" in this situation; the mother or her CFHN organisation and responsibility to comply with policy and guidelines? Angela, [quietly dropping her voice and leaning forward toward me], added that when she didn't follow clinical guidelines in relation to breastfeeding, in this instance the National Health and Medical Research Council (NHMRC) Infant Feeding Guidelines (National Health and Medical Research Council, 2012), she was:

> *…really conscious of what I say to the families, and this sounds <u>really terrible</u>,* (her emphasis) *doesn't get heard by my colleagues who I'm working with, particularly the ones who might go and tell tales to somebody else.* [Angela]

Angela perceived she worked with some colleagues who acted as censors that monitored and reported nurses' practice if not in accordance with accepted NSW Health or NHMRC guidelines pertinent to CFHN. She expressed a "fear discourse" if she perceived her colleagues had overheard some of her conversations with mothers. Angela stated that she had found a *"sneaky way of managing"* the predicament where she felt she needed to advise mothers to introduce complementary formula feeds to supplement their exclusively breastfed babies.

> *I've sort of worked out a sneaky way of managing it but it's actually not really* (pause) (or) *well, I've worked out how to manage that now without getting into trouble. What I basically say to the Mums* (is) *"Well you need to give them some calories" and I send them to the doctor and between when they've left me and got to the GP and come back to me they've made a decision about giving complementary feeds*. [Angela]

Angela's professional assessment discourse in these instances was that the babies were not gaining sufficient weight for an expected timeframe and required supplementary feeds. Angela's sense was that there was a need to operate from a subversive or "*sneaky"* discourse when providing certain types of care and information to mothers in order to work in partnership with them. Angela's *"sneaky"* discourse indicates her sense of constraint from her colleagues' opinions and judgement. However, she upholds her belief that the FPM requires her to prioritise her partnership with the mother over the "rules" (government health policies and guidelines) of the organisation. Further, Angela's "*sneaky"* practice is unlikely to assist her or her colleagues to change the status quo regarding breastfeeding practice and discourses but is instead self-serving in an environment where nurses are expected to uphold dominant institutional interests and beliefs. It was a struggle for Angela to publicly back her own professional judgement within a workplace culture where some CFHN colleagues appeared to prioritise the institution's policies and guidelines over experience.

A "peer culture that acts similarly and that supports reflection and change" is a recognised organisational requirement which supports FPM practitioners (Davis & Day, 2010, p. 270). Angela's examples suggest, however, that CFHNs do not always work in partnership with one another. Angela said that if some of her CFHN colleagues happened to provide subsequent care of a mother/baby she had seen they *"might attempt to subvert it* (the care plan)" by altering the original plan she had developed with the mother. Professionals often have different opinions and clients' needs may differ between visits. However, I inferred from Angela's statement that she felt her nursing colleagues' intention in altering the care plan she developed with the mother/s was to undermine her professional judgement in favour of care planning in accordance with policy and guidelines and with the nurse's preferred practice. Annie identified similar experiences to Angela and stated that:

> *Nurse colleagues with strongly held views and beliefs* (about), *for example breastfeeding, they don't hear what mothers are saying. So I've got to mirror the guidance that I give to my parents with what I feel they may get from my colleagues. …and them* (parents) *feeling so torn because it's so different*. [Annie]

Annie said that her role in this instance was to "*hold them* [the parent] *while they struggle with that* [competing discourse]". Continuing with the example of providing parents with breastfeeding information, Angela said there were "*two sets of rules. I've got a family partnership set of rules and I've got the rules* (government health policies and clinical

guidelines), *related to breastfeeding"*. I understood from Angela's last statement that for her, working in the FPM with mothers was in conflict with taking a more expert and advice giving role that following *"the rules"* (government health policies and clinical guidelines), about breastfeeding to the letter may create.

These organisational "rules" also conflicted with Angela's view below that CFHNs were accountable for their own professional practice or that they could practice autonomously in the FPM with mothers.

> *I'm working with that family* (meaning mother and child) *and that's my assessment as a professional…* (there's) *an inability to be…completely autonomous. We're part of a bigger organisation which is fine, but in family partnership we're really supposed to be regarded as quite autonomous with the family, because the family are autonomous, right? 'Cause they are an individual unit that has its own abilities and inabilities and if we reflect on those abilities and their* (the families') *abilities to understand their children, then, you know, that autonomy, really I'm not respecting that if I am telling them what the "rules" are.* (Angela)

Angela expressed concern that in team meetings, some colleagues with particular views were more strategic in ensuring that their voices were heard and able to present "*how it should be".* Similarly, Virginia stated:

> *I think nursing's been traditionally a hierarchical system. And I think there's still um… some horizontal violence or bullying that goes on. I do. I think it's kind of a fear of retribution. If I say too much what will happen?* [Virginia]

These statements implied that Angela and Virginia perceived unequal power relations, competing discourses and differing perceptions of ways to achieve goals or maintain the status quo among their CFHN colleagues. Angela stated that her CFHN colleagues in her clinical supervision group had also expressed a conflict regarding working in partnership with parents and following *"the rules"* and resorted to using subversive methods to survive this discordance. Angela said the implied message from her CFHN clinical supervision colleagues was that in relation to following rules:

> *As practitioners, we work out ways of subverting them* (the rules) *in order to live with ourselves in our own perception of our role as child and family health nurses working in partnership with families.* [Angela]

Angela disclosed that she considered this professional issue so important that she had considered resigning:

> *It's actually one of the reasons why I would consider stopping working like, going to another career not as a child and family health nurse because you just get really tired of trying to* (pause) *do the right thing by the parents and by the rules of the organisation. And sometimes it gets to a point where the conflict is too great that your own principles about family partnership, given what you're working with, conflict with the principles of what the organisation says we have to do and, there's no like meeting point in the middle…. The conflict is, it's tiring. <u>It's exhausting.</u>* (Angela's emphasis)

Angela clearly held significant concerns regarding the causes of nurses' competing discourses, that is, between acting according to, or adopting FPM principles and following "*the rules"* of the organisation. However, she did not mention at interview or appear to consider addressing it with her organisational manager/s to work towards changing the *"rules"*. I inferred from Angela's silence that she perceived it was outside her role or scope of influence to effect change in decision making about policy and guidelines in her team. The participating NUM in this study did not herself mention a conflict for CFHNs between following organisational guidelines and working in the FPM with mothers.

Although most CFHN participants interviewed found their CFHN colleagues to be supportive, Angela and Annie found the censoring and judgemental discourses of some of their CFHN co-workers to be quite stressful. It was difficult in these circumstances for them to be able to work in partnership with their colleagues, and in turn, with their client mothers/babies. They reported instead using subversive practices at times to meet mothers' needs and follow FPM principles. This type of care provision was considered to be in conflict with organisational demands and regulations. It appeared that Angela and Annie chose in these instances to work outside organisation rules based on government health policy but rather chose to fore-front their professional opinion.

<u>Working with interprofessional teams</u>

Two CFHNs, Jean and Erica identified how working with the broader interprofessional team influenced and impacted on their ability to work in partnership with mothers. Jean described the positive influence of these interprofessional relationships on her ability to work in partnership with parents while Erica had less positive comments to make. These nurses' views of the positive and less positive factors on CFHNs' ability to work in

partnership with parents that emanate from working with interprofessional teams are outlined below in this section.

Jean stated that working with her general nursing colleagues and the broader health team contributed positively to working in partnership as it helped her to *"put a lid on judgement calls"* that may get in the way of working in the FPM with mothers. I asked Jean to expand on what she meant by "*judgement calls"*. Jean stated that she was referring to her own personal values and beliefs that "*can sometimes get in the way…of working in partnership with parents,* (and) *with families. I have to question them sometimes"*. Jean explained that having worked with many different health workers from different domains in the past had helped her to develop insight and other ways of thinking that enabled her to be less judgemental when working with mothers. Being non-judgemental is a core quality required by the CFHN when working in partnership with parents (Davis & Day, 2010).

In relation to the wider support of the interprofessional team, Erica used two metaphors to describe her CFHN role and the difficulty of referring families onto secondary level services. Firstly, Erica described her role as being "*a listening post and then a sign post"*. Her role was to listen and then if the parent's needs could better be met by an outside service, to act as *"sign post"* to link the parent with that service. In her follow-up interview, Erica expressed the difficulty and frustration she felt when referrals were not accepted by the nominated service or the service unfairly discontinued its service to the parent. This difficulty of referral or withdrawal of service to vulnerable families was identified by Erica as adversely impacting on her ability to work in partnership with them. As a primary health level community CFHN she was unable to meet the significant needs of these vulnerable families without additional intervention from secondary level support services and the interprofessional team. In the second metaphor Erica used she had a picture of herself: *"standing here with a handful of balloons* (each balloon representing a different service)*…the parent comes along and you're asking the parent, 'Which of these balloons* (do you want)*?' you know".*

Erica stated that the difficulty for CFHNs was that they weren't able to find exactly the right "*balloon"* to match the needs of the mother. In addition, referring on to secondary services was difficult and the inflexible intake and exclusion criteria of some of these services were upsetting for her particularly when working with vulnerable mothers with complex needs. This lack of willingness of services to take clients was problematic as these families may derive benefit from the extra support. Some services, however, would not accept these referrals.

> *If people are living in a hazardous situation where there might have been history of domestic violence or something like that, services won't go there. So sometimes you feel like the people who need the most can't have them because they've made themselves ineligible.* [Erica]

There were also practical barriers to interprofessional services providing home visits. Erica gave two examples of mothers she was scheduled to visit the day of the interview where there were practical barriers to referrals for the support of these new mothers being accepted by secondary services.

> *So this morning I went to visit somebody who lives up fifty-five steps and on a driveway like this* (uses hands to indicate a steep incline). *This afternoon I'm* [going] *visiting* [to] *someone with twins who lives up fifty-five steps and no handrail. This is my third home visit to this mum with twins and she lives up all these stairs. She had a C-*[caesarean] *section, the twins were premmie* [premature]*, she's got a physical disorder that gives her pain in her joints and so on and although despite efforts to get home help into her house, starting with her stay in hospital a month ago,* [she] *still doesn't have anyone helping her. So to me, I'm going to visit this woman until I know she's got something else* (professional person or service) *going on. Someone* (from referral service) *won't visit at home at a house like that but I do but I'm pretty tired at the end.* [Erica]

Erica voiced the frustration and anguish of mothers being *"unfairly dropped"* by referral services; and, the impact this had on her as a primary health level CFHN whose main workplace performance indicator was the provision of UHHVs to parents with newborns within fourteen days of birth (NSW Department of Health, 2009). Her anguish was also for the families as this lack of secondary service acceptance of referrals and support might result in deleterious consequences for them.

> *And then we have scenarios like ...where she* (mother) *couldn't make a couple of appointments with <name of service>...and you're thinking, 'No!' Because that means we've got them* [the client] *back again and because we don't have the time that means they don't get the service that they need. So...but it causes ...it's a lot of anguish for you when you go to the trouble of trying to sort out referrals and do things like that and I think particularly...she was unfairly dropped by the service because you know,* (there's) *enormously difficult steps*

to negotiate and she has arthritis. They made her come to them. So naturally, carrying twins with a medical condition and dealing with all that she was going to miss a couple of appointments. She wasn't cut any slack… 'these are the rules and we're going to stick with it'. And I think 'No, that's not how you run a service'. So that kind of attitude upsets me.

And quite often the whole business of getting people back again and we think, right, we're only a preliminary service. Our job is to send on the people who need sending on. Second level service and...situation going downhill and in the end DOCS (Department of Family and Community Services) *is involved and you think all that could have been perhaps averted if they had the help they needed early on…..I'd really like if we had more hours so we could* [keep the client]*...rather than handing it off to someone else. ...or straining because of the demands ...*(But) *we have to get out and see these people for the first home visit* [UHHV]*. That is the ...key indicator that we have to do the home visit within fourteen days.... And so if you do ...the first* (home visit) *time and sort out services for them, you don't have the time to go back week after week.* (Erica)

Erica also wished CFHNs had a better collaboration with GPs and the Department of Family and Community Services (FACS), previously known as the Department of Community Services (DOCS). In her wish for better collaboration Erica was comparing her current work environment with where she had worked previously.

I think it might be partly (that) *I was lucky where I worked. It was possible to have meetings where we would all sit down and have inputs about difficult clients and so someone would be like the designated team leader. And so you had much more of an idea about what's going on in families* (lives) *from other people's perspectives. So* (it was) *much more coordinated and I sort of miss that feeling here that we don't really have that sort of relationship with the GPs or with DOCS, for example. I think we're trying to work on it from the last changes…they're trying to make DOCS …a bit closer in relationship but it's still got a long way to go. Everybody's so guarded in what they say* (about clients' privacy and sharing of sensitive information)*. That makes it difficult.* [Erica]

Erica did not elaborate on what she meant by the statement "*Everybody's so guarded in what they say".* This statement could imply that professionals were mindful of their legal requirements under privacy legislation especially in relation to third party and sensitive

information (Office of the Australian Information Commissioner, 2015). It may also suggest, however, that professionals providing child and family services "do not communicate well" and that tensions exist "around professional boundaries" (Schmied et al., 2015, pp. 163, 167).

4.4.1.2 Working with Managers

Each CFHN team had their own Nurse Manager. Although all four nurse managers from the LHD were invited, only one Nurse Unit Manager (NUM), Donna, consented to participate in this study. Donna was the NUM of Virginia, Neroli and Monica's CFHN team. The six remaining nurse participants were from two other geographically based teams, each with three nurses apiece (see Figure 3, p.86). The Nurse Managers of the different teams from which nurse participants were drawn were reported by their nurses as having different perspectives on the FPM. All CFHN participants identified the influence, and the nature of the impact of their respective managers on their ability to work in the FPM with mothers. The nurse manager's style in relation to the FPM was reported to be a particularly significant influencing factor and is discussed further below under the subheadings: "Manager's leadership supportive of the FPM", and, "Manager's leadership style unsupportive of the FPM

Nurse participants from two of the three teams reported having long term stability of more than ten years with the same nurse manager. Seven of the nine CFHN participants reported that they found their nurse managers to be a positive influence on their ability to work in partnership. However, two CFHNs from the third team reported that they had a new nurse unit manager. These nurses were cautious when discussing during interview about this new NUM's ability to support them to work in partnership with mothers. This cautiousness discourse may well have stemmed from having a previous nurse manager whom one nurse reported as exhibiting bullying behaviours.

<u>Manager's leadership supportive of the FPM</u>

Virginia summed up her team's sentiment of her NUM's positive contribution stating:

> *We're really fortunate. Our manager really supports family partnership…I think if your management has an understanding of it* [FPM] *and are supportive….all the other things can flow on.* [Virginia]

In addition, Neroli, who worked in the same team as Virginia and Monica, stated that their NUM Donna:

> *…supports* (the) *family partnership model 100% and subtly works with staff in the FPM by encouraging us to be very self-reflective and to use the model as a base.* [Neroli]

However, despite their NUM's positive contribution to working in the FPM, Monica and Neroli also stated that at times it was frustrating, challenging and even confronting when Donna used the FPM practices of exploration and reflection in interactions with them. In her first interview, Neroli discussed how it could be confronting when Donna, her manager, worked in the FPM with her:

> ***So,*** (Donna uses) ***exploratory questions?*** *Yeah, and very Socratic*[6] *type questions as well and not fix-it type questions.* ***Okay. Not directive as such which is not always what you would normally expect from a manager?*** *No, and in fact sometimes I think that Socratic questioning can be quite confronting 'cause it really is quite challenging to say 'Well okay, what did this mean for the family? What did it mean for you and how could you do it differently?' Rather than saying 'Well, here's a solution. Go ahead with that solution'.* [Neroli]

Monica and Neroli could see parallels here with mothers' frustration when they came to the clinic wanting answers and as the nurse; you reflected their questions back to them.

> *Funny, sometimes it can be annoying... I can see why* [it] *frustrates parents sometimes when you want an answer and get handed back a question* [by Donna, the NUM] *who uses family partnership skills.* (Monica)

This experience with Donna gave Monica, in particular, insight as to why mothers got cross with her at times when she attempted to work in the FPM with them. This "annoyance" was the only critique of the FPM reported by any of the participants during the data collection phase of this study. The nurse participants and NUM appeared to have readily accepted that FPM was part of routine CFHN practice and policy. Indeed, the nurse participants in this study spoke of being committed to incorporating the FPM into their practice. Many said they were using their interviews with me as opportunities to reflect on their capacity for discursive partnership practice with mothers/babies. There were no other challenges or criticisms made about the FPM or this way of working with parents.

[6] This 'Socratic' style of questioning is used by facilitators in the FPM training program. It "involves constantly asking …questions, listening, and trying to understand (the) answers, exploring these and inviting participants to consider alternative views as necessary" (Davis & Day, 2010, p. 267).

Erica described her nurse manager as being also supportive. She stated that her manager shared the same FPM philosophy about the CFHN job as her nurses and that this was enormously helpful. Erica said her manager looked at both sides if there were complaints, wasn't rule bound and had a sense of humour.

Manager's leadership style unsupportive of the FPM

Sandy's team had a new nursing unit manager. In appraising her NUM's contribution to working in the FPM Sandy operated from a cautious discourse. She stated that things with her new NUM were *"so far, so good…* [but] *I don't want to rock the boat* [laughs]". Sandy, in not wanting to "*rock the boat"* suggests that she is not game to test or challenge her new NUM in case there are adverse consequences. Annie reported that her previous NUM had been more adversarial and there had been workplace bullying of nursing staff in the two years prior to the appointment of the current NUM. Annie stated that "*I had huge issues with bullying happening"* and that during this time had considered "*moving on"*. Annie saw the irony of this situation saying that the manager's goal for her CFHN team was for them to work in the FPM with mothers. However, Annie stated "*the interesting thing is that they* [the managers] *don't work in partnership with their colleagues"*.

Annie's statement that she had considered *"moving on"* implied that she had thought of resigning from her CFHN position. This suggests that she experienced her workplace environment as difficult or stressful from having an adversarial manager and from witnessing and being subject to workplace bullying from her. Her manager's behaviour undermined the implementation of FPM and suggests that there were double standards in the workplace regarding the application of the FPM: one for CFHN staff; and one for managers. Davis and Day (2010) state:

> …the incongruence between management action and the notion of partnership…(suggests) that those in power could ignore the model while at the same time expecting everyone else to obey their orders and to work in partnership. (p. 264).

Donna, (NUM), also said that the nurse manager's leadership style was a contributor to CFHNs' ability to work in the FPM with mothers.

> *If a manager's style isn't understanding of the model, that could be something that's more difficult to negotiate round …as well as being* [and if you are]*the lone voice in a group of people that don't understand* [then] *that's harder to*

> *challenge your colleagues …or challenge your managers…and management about trying to work in that way.* [Donna]

Donna stated that conflict had arisen in her CFHN team where staff had been less able to incorporate the FPM into their practice. Donna said she would follow things up with these staff if she was uncomfortable in relation to their practice and ability to work in partnership with parents. Donna acknowledged that "*Those* [nurses] *that have really struggled with the model have chosen to leave".*

In the above two examples, we see Annie's desire to work in the FPM with mothers but her difficulty in doing so due to her previous NUM's leadership style and Annie's experience of workplace bullying. In contrast, Donna, who was committed to FPM being implemented by her team, saw those nurses that really struggled with incorporating the FPM into practice choose to leave.

> *Staff haven't managed to move along and as that continuum,* (that is, the) *distance between* (those nurses struggling to incorporate the FPM and) *others* [who have succeeded in this] *has got further apart, they have left. It's been an interesting journey with a couple of people particularly. They have chosen to leave.* [Donna]

An outcome for mothers that may occur as a result of these nurse resignations is that it also limits any "choice" they may have in terms of CFHN models of care. Some CFHNs have a longstanding investment in working in the "Expert Model" from their prior education and workplace history (Davis & Day, 2010, p. 76). From Donna's responses, it appears that the culture of her work team has made it untenable for these CFHNs to continue working there if they are unable to forgo the Expert Model and demonstrate a commitment to FPM ideology and practice. Donna said that the conflict that arose in her team from staff being unable to work in the FPM with mothers was more evident in recent years since the FPM had been embedded into CFHN practice and policy. Donna compared this to the years prior to the introduction of the FPM in the NSW CFHN service (pre 2001), when it was less obvious if people weren't using partnership approaches because it was less well identified and articulated. As an example, Donna said she had made changes to CFHN staff facilitating certain parenting group sessions. She also changed how the groups were run so that they functioned in a more partnership approach with participants compared to traditional parenting group programme styles where the nurses operate more as expert information deliverers. However, Donna stated these changes to group facilitation meant that a section

of the parents attending these groups were no longer getting their perceived needs for expert information and advice met. Donna revealed she had received a number of complaints from a section of local parents from the area about the changes made to how the groups were now run.

> *Look there's a group of people* (parents) *out there that for whatever reason they want someone* (the CFHN) *to fix things for them. They think that's what's going to help them the best and we have a population that seems to have a high percentage of those clients.* ***Is that right?*** *And I have …have complaints from that population about the way we run our groups… because it's parent led and, you know, "The nurse doesn't tell us what to do…". I had one nurse there that was particularly good at being needy*[7] *with them you know, so I think that particular group appreciated her style. So, therefore, when we changed that, and there were people* (nurses) *there who worked in partnership, they* (parents) *were not so comfortable with that for whatever reason that is. It was a huge change. I had complaints about that* (from parents) *at the time …when they had the change. So even though now it is the best way for families to work through their parenting issues, some families aren't ready to go there either for whatever reason. If we don't meet their needs they* (parents) *do get a little bit frustrated for whatever reason yeah…and if you try to meet everybody's needs, you just wouldn't really do it.* [Donna]

In stating "*if you try to meet everybody's needs you just wouldn't really do it*" I understood that Donna was referring to the known limitations of using the Expert Model approach when working with parents (Davis & Day, 2010, pp. 78-79). In a work environment and culture that requires evidence for practice, Donna manages her CFHN staff in a style that reinforces their use of the FPM when working with parents. Its efficacy for helping parents has a stronger evidence base than approaches such as the Expert Model (Davis & Day, 2010). Therefore, to permit her CFHNs to continue using an expert model to meet certain parents' needs would not be supporting evidence based practice.

[7] The phrase *"being needy"* refers in this context to the CFHN creating relationships with participants in her parent group that reinforce the nurse's power on the grounds of her greater knowledge and expertise and that reinforce the roles of the help-seeking, vulnerable and compliant parent. This creates a CFHN –parent relationship where the nurse is affirmed by being "needed" by the parent. It does not help the parent to develop their own sense of competence and self-efficacy in relation to problem solving concerns with the care of their child/ren or other relationships and problems (Davis & Day, 2010).

The example provided above by Donna indicates the proactive influence the manager can have on ensuring that CFHNs use the FPM when working with parents. In this instance, the NUM changed the CFHN facilitators of the regular parenting group to ensure the group facilitation style was parent led, and the nurses worked in the FPM with attending parents. The nurse who had previously facilitated the parenting groups had not been using a FPM group facilitation style. The group had been nurse rather than parent led and gave parents expert advice and information. This nurse was presumably displaced from facilitating this group and given additional support and/or clinical supervision to address her lack of partnership facilitation skills. Donna emphasised that "*There's an answer for every* (nurse) *query if you go back to the* (partnership) *model. Nurses who don't follow the model in this service will be challenged by me".*

I asked Donna whether the change in facilitation style "*impact*[s] *on their* (parents) *returning to the service?"* Donna answered: *"No, not really"*. It's unknown whether the CFHNs who were unable to facilitate the parenting group in a parent led partnership style were also the nursing staff that Donna said chose to leave the service.

Donna stated she didn't believe that environmental factors should stop a nurse from working in the FPM whatever they might be. Donna stated the *"service is supported by health policy and management structures above* [her] *including the medical service director who is comfortable and understanding of the* [partnership] *way to work with families"*. In addition, Donna referred to the culture of her service stating that a partnership approach had been used for some time within the organisation:

> *The culture of working with families in that way … you know, respectful way and listening and so on has been the culture here for a long time. So my experience from working here is that the culture isn't an issue.* [Donna]

Donna clearly aimed to work in the FPM with the CFHN staff in her team. This was very much appreciated by the nurse participants in this study even if interactions with her when she used FPM skills were reported to be annoying at times. Donna also stated CFHNs would be challenged by her if they did not practice according to the FPM. Challenging is a critical component of the helping process in the FPM (Davis & Day, 2010). The difference in the roles of nurses versus parents though is that the NUM, via her position, holds the authority and ability to exercise power ensuring that CFHNs practice in the FPM according to health policy. Disciplinary action may ensue if nurses don't comply. Parents, however, can choose to attend CFHN services or go elsewhere for support. There remain,

nonetheless, some families and CFHN staff who don't want to or are unable to work in this approach.

The leadership style of the CFHNs' manager clearly had an influential role for these nurse participants on their ability to work in the FPM with mothers and their options to use other models of practice. This influence ranged from being a positive role model and support for staff in the use of the FPM to one that was negative and conflicted with working in partnership through the use of bullying behaviours. Donna was a strong advocate for the FPM. It is unknown whether the other three CFHN managers within the service shared similar or conflicting viewpoints.

4.4.1.3 Working with Parents

Not surprisingly, a factor that all CFHN participants including the NUM identified as influential was the parents' willingness and ability to share in the work of partnership. The parent is the other significant partner in the professional relationship with the CFHN. The nurses spoke of the positive and less positive factors that mothers brought with them that influenced this relationship and how they addressed some of the more challenging issues. These positive and less positive factors that influence working in partnership with parents are discussed below within this sub-heading of "*Working with Parents"*.

Beginning with positive factors, nurses spoke of the personal rewards and positive feedback they received from mothers that kept them motivated to work in the FPM with them. Annie expressed this as:

> *I do see that when I talk to mothers and I ask them what they feel or what they're doing and I praise them for what they're doing, that they just…it's like stroking a cat. You get them purring in a second, you know, and that for me is hugely rewarding.* [Annie]

In contrast to Annie's consideration of resigning from managerial bullying, here she stated *"The thing that stops me leaving… is the mothers. I love the job. I really love the job and the kids. Thanks from the Mums is why you hang in there".* (Annie's emphasis). Annie also stated that the reward of the mothers' feedback was hugely influential to her working in the FPM with them.

Erica stated that CFHNs were lucky in that they worked with mainly motivated mothers. This was perceived as making it easier to work in the FPM with them.

> *I think we're very lucky that we're working with people who are so motivated. There's no one more motivated that a mum with a new baby….people are very receptive…they will listen perhaps more than they used to ….So you're both headed for the same goal as it were. You're not trying to persuade somebody.* (Erica)

The mothers themselves were perceived to bring a lot to the partnership relationship as Neroli stated they:

> *…help us to work in the model as well* [through] *…recognition of what the mother brings to the consult: intelligence; knowledge of her baby; her own goals; and information from her support people.* [Neroli]

Neroli added that *"confident parents make it easier to work in partnership"* rather than operating from an expert discourse. Annie used the metaphor: "*We're just polishing the edges"* to describe the CFHN role with confident parents. For Annie, this metaphor conveyed that the CFHN had only to support and guide the "*easy and amenable"* parent to help them grow in their parenting confidence and competence. Overall, the mothers in this study were reported by the nurses as being easy to work with. For example, Erica spoke of one of her parents Beth as being "*very open…. she* [her consultation with baby Ruby] *was very easy to do.* [Beth asked] *Straight forward questions and you know,* [it was] *just simple".* Not all mothers, however, were reported as being willing or able to work in the FPM with CFHNs. These less positive factors that parents bring with them that impede the CFHN's ability to work in partnership with them are discussed next.

The group of parents that the CFHNs in this study found most difficult to work in the FPM with were those who came to consultations wanting the CFHN to give them the answers to solve their parenting difficulties. This common situation was challenging for the nurses because the FPM recommends working towards solutions in partnership with the parent rather than providing expert advice. Neroli stated that "n*ot all clients were happy to work in the* [family partnership] *model; so many want a solution"*. Monica surmised that this desire for solutions was due to the parents' preconceived idea of the role of the CFHN. It could also be conjectured that very tired, sleep deprived and frustrated parents with a crying newborn may want their CFHN to provide them with a quick fix to solve their problems.

A further factor that negatively influenced working in the FPM was trying to work with parents who became angry when attempting to work in partnership with them. During her

first interview, Sandy spoke at some length of scenarios with clients she had encountered where the client became angry and defensive and she found herself getting angry in return.

> *How easy the consult goes [and the ability to work in partnership] depends on the comfort of the client in answering questions. They may just get angry and be challenged and go on* (the) *defensive and you get angry back. It's hard to find your way back to working in partnership. Where do you find that link?* [Sandy]

Sandy reported she did not have answers or know quite how to manage the situation with clients who operated from an anger or defensive discourse. The parents' discomfort and anger may in part be a response to not getting the answers or responses from the CFHN that they were seeking. This somewhat parallels the "*annoyance"* and confrontation experienced by Neroli and Monica reported in Section 4.4.1.2 (p. 108) when Donna responded to their queries by "*handing* (them) *back a* (their) *question"*. In these situations, however, it appears that both Sandy and Donna were exercising a degree of professional power by choosing to withhold knowledge, albeit with well-meant intentions and in line with FPM principles.

Jean said she had found that mothers who wanted to be given answers tended to gravitate toward CFHNs who were more prescriptive in their approach. In contrast to Donna (NUM) who said she would challenge CFHNs not working in the FPM with mothers, Jean stated that mothers' preferences should be respected; and that a nurse's personality or presentation when working with clients should not be discounted.

Virginia and Erica spoke of mothers who were difficult to engage as being harder to work with in partnership. Erica suggested that sometimes the mother was testing the CFHN and that trust, patience and time was needed to engage and work with them. Erica compared this with the scenario of when you go yourself to see a new GP. As the new client, you are also testing and judging whether the doctor is trustworthy. This difficulty in engagement was attributed to mothers' past experiences which made them less predisposed to trust CFHNs who were perceived as authority figures.

Erica said that some clients *"regard us as 'the welfare'. You know, they've got this attitude…not telling you the truth".* Erica, an experienced health visitor and CFHN, understood this issue as a constraint to working in the FPM explaining the difficulty in

relationship building when "*parents' own history of authority figures can get in the way and may take years to break down if at all*".

Virginia was circumspect about this group of mothers. Her experience and insight had helped her realise that it was not possible to "*befriend them all….you're here to do the best you can* (for the parent/baby/situation)". I understood this phrase to mean that despite Virginia's best efforts *("do*(ing) *the best you can")*, she realised it was unrealistic to believe she could engage with and help all mothers. The use of the word *"befriend"* could be viewed to identify a partnership approach toward the mothers. This word could also indicate that Virginia may have unwittingly held a subtly patronising attitude toward parents who were deemed in need of support rather than one based on the FPM. From Virginia's statement, however, it appears that she was able to stand back from her own experience of working with mothers and accept that it was not possible to "*befriend them all"*.

Three CFHNs reported they found it challenging to work in the FPM where they disagreed with the lifestyle or parenting choices of the parent. Angela said she found it difficult to challenge some of these choices without sounding judgemental. Jean said there were also risks in making assumptions about the client based on their appearance. Neroli summed this up in her follow-up interview saying of such instances that "*those skills of family partnership and the qualities are mandatory*". Neroli explained that it was easy for her to show respect for mothers such as Lisa who are easy to engage and are observed to be managing well with their children but:

> *You have to work harder at where you're coming from for the families that you may disagree with their parenting choices or their lifestyle choices*. *And I think for those really complex families that's when those skills of family partnership and the qualities are mandatory….'cause you might be the first person to totally respect that person and that family. And what a gift and what power that has for them to then go and believe in themselves even little bits at a time.* [Neroli]

Examples of parenting choices the nurse may disagree with include the mother's choice to not immunise their child or to bed share (co-sleep) with their infant. CFHNs may not agree with these parenting choices because they conflict with their own beliefs as well as current health policies, guidelines and messages about health prevention and safety for children (Australian Government Department of Health, 2013; SIDS and Kids, 2014). Neroli did not

elaborate on what she meant by parents' "*lifestyle choices",* however, these choices could be wide ranging. They may include (but are not limited to) same sex couples who are also parents; parents who use recreational drugs; or cultural practices of families from culturally and linguistically diverse backgrounds (CALD). None of these lifestyle choices were known to be relevant to the mothers participating in my study.

Neroli's statement indicated that CFHNs in these instance had to work extra hard to put aside their own judgements and "othering" (Fine, 1998), in order to be able to engage and be respectful of the family's choices. This is a challenging situation for the nurse as she also is encouraged to display genuineness; one of the helper qualities espoused in the FPM (Davis & Day, 2010). The FPM authors state "If parents detect any indications that helpers are not genuine, then they will not trust them or open up to them in ways that facilitate the helping process" (Davis & Day, 2010, p. 116). Neroli saw this action of showing respect for families in these situations as empowering for them.

Monica stated in her first interview that when both parents present at a consultation they may, at times, have conflicting agendas they each want affirmed by the CFHN. She identified a further scenario where grandparents from different cultural backgrounds may have parenting ideas that are out-dated, inappropriate, and/or unsafe; for example, swaddling or overwrapping. Monica stated in these instances she does not use family partnership skills but instead gives a factual answer to tactfully help the parent or grandparent to modify their parenting practice.

> *So they're coming along …maybe one parent wants you to tell the other parent what they're supposed* (to do)*…**Yes** (Monica laughs). Or, you know, 'I told you (pretends mother speaking to their partner/mother) that Monica says the baby shouldn't sleep on their tummy!' Now here's my husband or here's my mother… (laughs) … and here's the nurse. 'Can you please tell my mother the baby shouldn't sleep on their tummy?' **How do you manage that?** Well, in that situation, when it's something as concrete as that, I think trying to do family partnership would probably incite a bit of…anger. It's usually easier to say, 'SIDS recommendations are not to sleep babies on their tummies'.* [Monica]

I perceived from Monica's professional judgement of these situations described above, that she had concluded that further exploration of the parenting concern using a FPM approach with the partner/grandmother would be unhelpful. She may not have met the partner/grandmother previously and therefore not had an opportunity to establish a

relationship on which to base further exploration of the issues. It may lead to the partner/grandmother becoming defensive of their stance or to feel embarrassed by having their outdated knowledge exposed. This is a challenging situation for a CFHN. The CFHN must take care to be impartial to avoid seeming to side with the mother with whom the nurse may have an established relationship. The nurse needs to also advocate and ensure the safety and well-being of the baby is paramount.

The requirement for interpreters, particularly phone interpreters was a practical communication factor found to negatively influence working in partnership with mothers requiring these services. Fiona said the language barrier and use of a third party interpreter detracted from building a relationship with mothers.

> *I think with the interpreters there are a couple that we don't have languages where we can get people* (interpreters)…. *So we've had a couple that we've had to do phone interpretations for and that is difficult building that relationship with the mum when there is the language barrier. They still come back so we must do something but …I don't ever feel that it's…as strong a relationship as…**If you spoke their native language?** Yes.* [Fiona]

The mother's baby or child was reported to contribute to or detract from the ease with which they could work in partnership. Fiona, in her follow-up interview while reviewing the video of her consultation with Gemma and Kitty stated:

> *I suppose if the babies aren't responsive you aren't so responsive. You might distress the mum if you keep going so changing this could be sort of* [be]*…not a barrier but …what's the word I'm looking for? Just a bit of a problem or a concern if you've got a mum that's stressed or distressed about what you're doing to the baby while you're examining the baby. It can be difficult. Often you might need to give the baby back to mum, calm both of them down and start again. And sometimes that can be a barrier* [to working in the FPM] [but] *that didn't happen in this case* [during the videoed consultation]. [Fiona]

I perceived that the barrier to partnership referred to by Fiona is that the baby and his/her well-being is the main interest of the mother and therefore it is stressful for a mother to have her baby upset by Fiona's physical examination. This may diminish the mother's willingness to engage in further discussion while consoling her crying baby.

Jean identified in her follow-up interview that it was important to talk to the baby and get "*permission"* from the baby to examine them. This parallels the corollary of working in partnership approaches for the parent and child.

> *I really think it's important to talk to the child.* ***Yes.*** *And he's not just an object to be examined. So I try to gain a little bit of…approval like: 'Yes, it's okay. You can examine my hips'…* ***So in terms of almost getting permission from the baby?*** *Yeah, as well …and to treat him like a little person. He is a person. He's lying there, he's a person and we're talking about him and he might only be a few weeks old but he's still a little person.* [Jean]

Jean was the only nurse to mention or allude to working in the FPM with the baby. From analysis of the data, the baby in most instances had not been discussed as an individual in his/her own right deserving of respect and the same courtesies that are extended to adults. This may be in part, because the focus of the study was on the factors influencing and the nature of the impact on nurses' ability to work in the FPM with parents; therefore, the babies were not the focus of study. Jean, however, may have expressly recognised the centrality of the child's well-being as the mother's principle interest. Therefore, settling the baby and ensuring she "gets on with" the baby serves both the interest of the mother and the nurse, who wants to be able to assess the well-being of the child.

Some nurse participants, for example, Virginia and Annie, spoke for the baby during their consultations, for example, "*Thank you Mummy".* The statement from Jean above, however, was different in that she stopped the playback of the video recording to specifically discuss this point. I surmised that Jean, rather than being mother or baby focussed, displayed an ability to work in partnership with both the mother and child. Jean had assessed and accommodated the central importance of the child to the mother and perhaps that access to the mother to some extent depended on her relationship with the baby/child. Working in the FPM with both the mother and baby may assist Jean to complete the maternal and infant assessments that are required of her by the health institution. She modelled a partnership approach for the parent with her baby during the consultation that was a corollary of the nurse working in partnership with the mother.

Four CFHN participants alluded to broader issues that may constrain parents and adversely impact on their ability to work in partnership. Jean stated that:

> *Society puts enormous amount of pressure on women in general, on relationships, on families….There's lots of things that impact on people you*

know, the economy, the world news, events …things like that, just stressful living. [Jean]

Jean recognised the wider influence that society, the environment, economy, politics and the government, and international events played in the lives of women and on mothers. She also recognised that these issues could influence mothers' receptiveness to care from the CFHN and their readiness and availability to work in partnership. Nurse participants acknowledged that these societal impacts and stressors were different for each mother/child.

Annie and Angela identified beliefs within society about what constitutes "good mothering" and can unnecessarily burden women. Mothers may put pressure on themselves to meet arbitrary standards of "good mothering" that may not necessarily fit with their own or their baby's needs. There were no specific comments made by the CFHN participants about how these influences and pressures may affect the well-being of fathers.

I perceived a lot of mothers (are) *exhausted.* ***Okay****. Because society has this message that you shouldn't let babies cry. And that a good mother has her baby close to her chest and doesn't desert them by leaving them to cry.* ***Is… that what the mothers are telling you or that's what you're perceiving*** **(sic)** ***they believe?*** *That's what I'm perceiving* (sic) *that they believe society says they should do. And certainly a lot of the mothers… a lot of my colleagues who are very passionate about their breastfeeding, also have the ethos that the baby should have access to the breast whenever.* [Annie]

Annie's descriptions of society's messages about "good" mothers allude to the binaries present regarding whether to let babies cry and about mothers' breastfeeding behaviours that are present in Western societies today. In this instance, a "good" mother doesn't let her baby cry and gives him/her unfettered access to the breast; a "bad" mother allows her baby to self-soothe (cry), perhaps in its crib, which may be seen as more restrictive of her baby's breastfeeding pattern (Aston, 2008). Mothers also get messages from society about "where" it is socially acceptable to breastfeed their babies (Stearns, 2013). This discourse is indicative of the emotive and strongly held beliefs and values that both parents and CFHNs may hold regarding parenting behaviours such as infant sleeping and feeding. Parents' with strongly held beliefs and values about parenting practices may resist any challenges to these beliefs by the CFHN. Thus, the receptiveness of the parent to work in

partnership with the nurse may be reduced as a consequence. These beliefs and values are additionally challenged by further sets of policy "rules" and guidelines that govern the CFHNs' clinical practice as discussed in Section 4.4.1.1. (p. 98).

Annie and Angela also identified problems arising from parents ascribing popular parenting books and/or parenting relevant websites with incontrovertible ways to manage their child.

> *You meet that same sort of challenge when it comes to dealing with the Tizzie Hall's[8] and those sorts of books' cause the mothers will be given them. And other parents will tell them, this book was my bible and if you follow it you won't have the problem.* [Annie]

Annie has identified that problems may occur for mothers if they measure their success at child-rearing by how well their baby fits in with the feeding and/or sleeping routine prescribed in a book such as *Save our Sleep* (Hall, 2009). Mothers are also influenced by the well-meaning advice on these topics they receive from family, friends, other parents, health professionals, the media, and the internet. Mothers' sense of self-efficacy and competence with their baby may also be adversely affected and this may be compounded by sleep deprivation or other issues with their baby that is still not addressed. While the CFHN can work in partnership with mothers to help to explore and address these concerns; this may be much more difficult when mothers have invested and established tightly held beliefs about correct ways of managing children's behaviour and where these have been derived from a book.

In this sub-heading "*Working with Parents"*, various supports, challenges and specific issues were identified that mothers bring with them to the professional relationship with their CFHN. Likewise, throughout this sub-theme of *WORKING WITH OTHERS,* nurse participants reported the satisfactions, frustrations and for some on occasion, sense of frustration that arose for them when working with their colleagues and/or their managers. These factors, when compounded in the work environment, had the capacity to significantly support or detract from their ability to work in the FPM with mothers and babies.

[8] Tizzie Hall's *Save our Sleep* (Hall, 2009) is a very popular book that provides parents with children from birth to two years with strict sleeping and feeding guidelines that if followed, promise to help the baby sleep through the night from birth.

4.4.2 Sub-theme 2 The Workplace

THE WORKPLACE of the CFHN is the second sub-theme identified during data analysis that supports the first main theme: CFHN WORK ENVIRONMENT AND CULTURE. During thematic coding of this subtheme, two main components emerged which became the sub-headings organised within this sub-theme; namely, "*The Physical Environment/Landscape"* and "*Look at me': computer and technology systems"* discourse*.*

4.4.2.1 The Physical Environment/Landscape

Six nurses said that their physical work environment and space contributed to or detracted from working in the FPM with parents. It was very noticeable to me that there were varying levels of maintenance of the buildings and interior furnishings among the seven CFHN centres that I visited. For example, in one centre:

Field Notes*: I observed that there was peeling paint on the walls, the chairs were shabby and the physical space of the consultation room was quite small (Ethnographic Observation, 2011).*

Neroli pointed out that her consultation room was small and the parent group room could not fit prams comfortably. This was problematic as parents of small infants often bring their prams to settle their babies. The small space of the rooms in some centres, location of hand washing facilities, power supply and internet access for the nurses' desktop computers, the office desk (often L shaped), nurses' five point swivel chair as well as parent chairs, toddler scales and children's toys meant that there was little scope to alter the configuration of the office space and furnishings. Jean and Fiona, both based in a different geographical team to Neroli, spoke positively, however, about their centres. Indeed Fiona said her: "*centre is nice. The parking is easy so we get a lot of out of area people. The reception staff are pleasant to the women*".

Field Notes: *I observed that the CFHN centres in Team 2* (see Figure 3, p. 86) *were quite newly built and furnished in comparison to Neroli's centre. The building, waiting area and consultation rooms were all well-lit, freshly painted, the chairs were comfortable and the air conditioning operating (Ethnographic Observation, 2011).*

Jean added that good administration and reception services were important as they were often the first point of contact for parent clients. This made the entry for mothers to CFHN services pleasant and easy to navigate which might be a factor that helps to keep them coming back. The presence of modern, comfortable furnishings such as the chairs in the

consultation room added to the relaxed, welcoming atmosphere. It was important for Jean to *"work in an adequate physical environment that enables staff and client parents to be relaxed and staff to feel professional".*

Study Diary*: I reflected when focusing on the physical environment of the work place, that none of the CFHN participants in this study had made specific reference to having culturally welcoming signs or posters for Aboriginal parents or for families born outside of Australia. Nor was specific reference made to engaging more fathers to attend CFHN services with their partners. I knew from my previous CFHN role that the great majority of the nurses' client families were Caucasian and that the main attending parent was the mother. I had not asked nurse participants questions about factors influencing working in partnership with specific groups of parents. (Researcher Study Diary, 2011)*

During their follow-up interviews, all of the nurses watched the playback of their video graphed consultation with their linked mother/baby. For three of the CFHN participants, watching themselves on the video heightened their awareness of the physical space, seating and limitations of their consultation rooms. Virginia, Neroli and Erica all said that they would like to alter the height of their office chair in relation to height of the chairs provided for the parents. Awareness of the height of chairs in relation to mothers' chairs indicates an awareness of the symbolic power of the professional which the nurses were trying to ameliorate. I understood by their statements that the nurses wanted to tangibly equalise the power balance to promote partnership by sitting at the same level as the mothers. Neroli, for example, said that she would like to change her seat height and room set up. She would like to move the chairs away from the wall for mothers to be able to place them where they were comfortable rather than have them in a prescribed spot. Virginia and Erica also said they would be more aware of their seat height in relation to parents in future. Erica said watching the video playback of her consultation with mother Beth and baby Ruby made her aware that she needed to watch the height of her chair and computer usage in future as she was already taller than most of the mothers attending her centre. Beth, in fact, was the only mother that made reference during her interview to the physical space of the consultation room or the seating arrangements which may indicate that it was not of key interest to parents. Beth spoke positively of the space, seat height and relationship building technique that Erica used as follows:

> *At same height, same eye contact, plenty of room, not straight down to business; despite the structure it's almost a casual approach* (which) *is a nice refreshing change.* [Beth]

From the above descriptions, the nurses appeared mindful of the physical space of their consultation room and its potential contribution to working in partnership with mothers. The nurses generally were also very aware of the limitations present in creating a more comfortable and welcoming environment for mothers and children. The influence and impact of computer use and information technology on the CFHNs ability to work in partnership with mothers is next presented under the sub-heading *"'Look at me': computers and technology system".*

4.4.2.2 "Look at me": Computers and Information Technology Systems

For the CFHNs in this study, watching the playback of their video recorded consultations during their follow-up interviews enabled them to reflect on the configuration of their consultation room and in particular, their computer usage and seating arrangements. At some stage during their interviews, all nine CFHNs referred to their computers and communication and information technology (ICT) systems as factors which influenced their ability to work in the FPM with parents. In addition, six of the nine mothers made recommendations about the CFHN service's use of ICT; these are discussed in THEME 4 – Mothers' Evaluation of CFHN Care. The CFHN participants reported a vexed relationship with their computers and ICT systems. There was a binary operating and some resistance expressed by the CFHN participants regarding their use of computer technology; its use was seen as both good and bad. It was good in that it helped with ease of access to client records but bad because it created additional work demands. These issues are discussed further below.

A positive feature identified of having an ICT system was that a mother/infant client may be unknown to a particular centre but the CFHN could still easily retrieve their electronic file.

> *I think the computer system is good because they* (mother/baby) *can turn up anywhere at any time and you don't have to go looking for* (hard copy) *files….I don't have to worry about that. I just ask for the date of their birth and their surname and if they're not in the system it takes me five minutes for it, we just start again. And there's none of that 'Oh well, you don't belong here thing'. So that's actually fantastic.* [Angela]

This was compared to the previous paper medical filing system where the mother's/baby's hard copy medical record would be held in the CFHN centre where they were first registered. This made their history unavailable if they presented at another

centre, apart from that recorded in the infant's Personal Health Record [Blue Book]. Previously, the paper based medical records hindered continuity of information and care as well as client choice of attendance at their preferred CFHN centre. Jean stated that the current ready access to the client file "*supplements you and helps you understand the client*" and this contributed positively to working in partnership with them.

Further, Jean, said she was looking forward to having client appointments scheduled electronically. Jean was the only nurse, however, who stated that she found that the electronic medical files and the improved networking system provided better-quality access and communication with workers from multidisciplinary teams. Examples of the services Jean mentioned included the child protection focussed Child Well-Being Units and Family and Community Services Department (FACS).

> *The networking system,* (improved access and) *communication with other workers working in multidisciplinary teams, Community Services Department* (FACS), *child well-being units, documentation, looking up client information on IT, computers …that's good! It supplements you and helps you understand the client.* [Jean]

Less positive aspects of the introduction of the computer and electronic record keeping were also identified by nurse participants. Angela, for example, said that she couldn't touch type and thought that most of her CFHN peers couldn't either. This meant that CFHNs found difficulty in documenting contemporaneously during the appointment compared to when they had a paper based file. Angela did not mention whether she or any of her CFHN colleagues had considered learning to touch type or if they had requested continuing education in this area.

Fiona explained that the extra time it now took to document on the computer was a negative impact on working in partnership with parents' because it created more work and reduced the appointment time available for the CFHN to discuss mothers' issues.

*In building that relationship you know, we have to spend 10 minutes, 15 minutes for some people after each client, you know, so that shortens your actual…**Do you mean on the computer? Entering data?** Entering data and just doing most things on the computer is slower than just writing it….I like the computer but I think it creates a lot more work. And if you're not a fast typist you know, that's another barrier too because that means, you know, you're condensing… So you're face to face with the mum's shortened because you know that you're going to need X amount of time to do the documentation.* [Fiona]

The nurses' consultation appointment times had not been increased to compensate for the extra time it now took for them to complete their computer based documentation. Nurses such as Fiona expressed frustration at the amount of time this now took from their consultations with parents and their ability to work in partnership with them. Monica further identified that the community CFHN electronic record keeping system was not compatible with hospital medical records. This meant that there was duplication of documentation by CFHNs because they were required to document in two medical record keeping systems. This duplication created extra work and stress for busy CFHNs.

Fiona also found the computer system cumbersome and said that files between community health services and hospitals were not necessarily linked. Fiona revealed that the introduction of the Electronic Medical Record (EMR) was a recent administrative change added to the CFHN role. It enabled the service to know where clients accessed the service and how many times they had attended. Fiona further reported that "they" also wanted the CFHN IT system eventually linked with GP practices. In using the pronoun "they", I understood that Fiona was referring to the senior managers of the CFHN service, the LHD and within the corporate structure of NSW Health who were likely to be the major benefactor from these innovations. There were also clear benefits for CFHNs to eventually work within an organisation that had an integrated primary health and hospital IT system. No mention during interviews, however, was made by Fiona or other nurse participants of the increased surveillance and electronic record keeping of parental/child attendance that was occurring at these services. There was criticism by most CFHN participants though of the increased work and documentation that technological change had brought to their role that detracted from working in the FPM with mothers. From their discussions, however, it appeared that the CFHN participants had accepted that these technological changes were now the status quo and could not be resisted or challenged.

Four nurses were critical of their use of the computer while watching the playback of their video graphed consultations during their follow-up interviews. When viewing her computer use on the video recorded consultation during her follow-up interview Annie stated *"That's what's lovely about home visits; not having computers"*. Annie said using the desk computer in the clinic "*tends to take you away* (from the mother); ….*you have to turn away to do it"* which implied the depersonalising nature of its use. She compared this to hand written notes that could be kept on her lap while still facing the mother during a home visit.

Erica expressed that she *"hated fiddling with the* [infant's] *Personal Health Record or spending too much time on the computer screen and not looking at the mother"*. Erica repeatedly reiterated her hatred for paperwork later in her follow-up interview while watching her video recorded consultation and said she also hated when her GP looked at the computer rather than at her.

> *I just hate the paperwork. Writing... at least I'm not on the computer. I try to do that as little as possible. I hate it myself: I go and see the GP and he looks at the computer. "Look at me! I'm the patient!"* (her emphasis) *I hate that.* [Erica]

Angela stated while watching her video recorded footage during her follow-up interview that she had felt "*disconnected"* from Lauren during their consultation while she was typing onto the computer and rushing to complete her work. In this space Angela was driven by a discourse of busyness and getting the job done. She said that this was *"where it's not really family partnership"* inferring that the *"disconnection"* created by typing and turning away from the parent had impacted negatively on the relationship.

> *So this is where it gets difficult ...and disconnected with the mother. I do it all the time but it's probably not um…I could possibly say, 'Excuse me while I just type this...' You know, because it is... I mean I'm in such a rush....you know, I just want to pack in so much information. That's where it's not really family partnership. I packed a lot of information into that and you wonder if they're actually absorbing any of it. Because I talk so quickly…..* [views more of the recording] *Wow! So in 10 minutes I've done all that! Maybe I can slow down a little bit.* [Angela]

Study Diary: *I reflected after this interview that the use of the video playback had helped Angela to gain insight into her physical behaviour and interactions with Lauren and that she may be able to slow down a little in future consultations and negotiate her computer use with the parent. (Researcher Study Diary, 2011)*

Fiona was also concerned while watching her video play back during her follow-up interview that she had turned to the computer to log in at the beginning of the consultation. She said she would not normally turn away from the client to look at the computer. However, Fiona's computer had been standing idle while she was in the waiting room chatting with Gemma while Gemma was finishing breastfeeding her baby prior to the consultation. Fiona's computer had automatically "logged her out". She had not had the

opportunity to re login and locate and open the mother/infant's electronic medical records before entering the consultation room with Gemma.

During my observation of the CFHNs' consultations with their linked mothers/babies I was able to observe the different ways CFHNs used the computer and physical space in their consultation rooms. I was also able to further analyse this usage when reviewing the video graphed recordings of these consultations:

Field notes: *Virginia took great care with asking permission from Susan, her parent client, to turn away to enter data onto the computer. Virginia also took care to explain to Susan what was actually documented, how her information was secured on the computer and if it was okay to proceed. Neroli did not use the computer at all during her consultation with Lisa and I presume chose to enter her data following the consultation. Annie had her back to Clair when she sat at the computer to enter data while Clair was standing at the examination bench opposite dressing baby Dylan following his examination. Annie then purposefully asked Clair to sit beside her and appeared to try to bring herself in to line with Clair so that she sat in an open, interested posture and didn't use the computer again during the consultation. Sandy and Angela however, appeared much keener to enter data on the computer throughout their consultations. They both frequently turned away from their client to do so without explanation or apology. (Ethnographic Observations 2011-2012)*

Sandy commented that although she found using the computer interrupted the flow of the consultation with parents that *"Using computers during the consult* (was) *not really an issue for the age group of clients"*. None of the mothers interviewed, in fact, raised any concerns about the nurses' computer use during their consultations with them. Rather, six of the nine mothers interviewed recommended that the CFHN service should improve their ICT services for parents. The mothers did not appear at all resistant to computer technology; instead they encouraged its use by the CFHN Service. I noted a dichotomy here in the discursive use of ICT by the nurses versus the mothers. The mothers' recommendations for improvements to CFHN communication services are discussed toward the end of this chapter in THEME 4 –The Mothers' Evaluations of CFHN Care

The routine workplace activities of CFHNs within the universal primary health service include, but are not limited to, UHHV which includes the completion of the maternal psychosocial assessment and meeting associated performance targets (NSW Department of Health, 2009). These activities, and the CFHNs' perceptions of time, featured prominently in the analysis of nurses' interviews and are presented below in Sub-theme 3:

The Challenges of Working in Partnership and Meeting Role Requirements. The parent's experience and recommendations regarding the first home visit and maternal psychosocial assessment are presented in THEME 4: The Mothers' Evaluation of CFHN Care.

4.4.3 The Challenges of Working in Partnership and Meeting Role Requirements

The challenge of working in partnership and meeting role requirements is the third sub-theme identified during data analysis that supports the first main theme: THE CFHN WORK ENVIRONMENT AND CULTURE. During thematic analysis of this subtheme, three main components emerged which became the sub-headings organised within this sub-theme; namely, "*The challenges of a partnership approach in the context of UHHV"; "Conducting the maternal psychosocial assessment"; and, "Perceptions of time".* These three factors were found to be significantly influential in terms of their generally adverse impact on nurses' ability to work in partnership with mothers.

4.4.3.1 The Challenges of a Partnership Approach in the Context of UHHV

The CFHN participants in this study had mixed views about the Universal Health Home Visit (UHHV) (NSW Department of Health, 2009) and its contribution to their ability to work in partnership with mothers. Beginning with the factors that nurses reported as positive influences, Neroli revealed that there were advantages to conducting this first visit with a family in their home. She felt it was easier to work in partnership with parents in the home because the nurse was the *"guest"* in the home. Furthermore, Neroli advised that the CFHN potentially could exercise more power in the clinic than the mother which could make the relationship less partnership based: "*I think working in a person's home is actually easier to adopt this model …we are a guest…I think we* [exercise] *have more power potentially in the clinic".* I inferred from Neroli's statement an acknowledgement of the tension present in the relationship between the CFHN and mother. The balance of power between the two is tenuous with power shared "with" the mothers always on the tipping point of the CFHN exercising power "over" the mothers (Aston et al., 2006).

Annie stated that she used the UHHV, which contained the maternal psychosocial assessment, as a premise and rationale with which to base the relationship with the mother. Annie explained to them that she asked the maternal psychosocial assessment questions because she was seeking information: "*a picture of their past that might*

influence them [in how] *to then parent"*. Annie also said her rationale was to help them *"be the best parents they can be".* Annie's phrase *"to be the best parents they can be"* could be construed as value laden and condescending; inferring that they were not already at their best and were in need of help from the CFHN to become better mothers/fathers. However, I understood from Annie's demeanour and earnestness that she was rather seeking to support mothers the best way she could within the parameters of the completion of her assessment tasks. Similar to Annie, Angela and Virginia also stated that the UHHV was good for establishing the relationship with the mother. They identified that completing the Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden, & Sagovsky, 1987) and domestic violence screening (NSW Department of Health, 2009) with the mother was helpful with this.

At the service level, Jean expressed that there was more organisational control over CFHN workloads since the advent of the UHHV. Jean explained the CFHN role was "*a lot more…controlled…client-wise, pressure of work,* (and in) *pressure of seeing people"*. This sense of her work being more controlled by policy and her service administration was construed as a positive: "*It's just a more sensible way of working".* There were clearer service parameters established regarding the number of home visits and centre based appointments to be booked per day. In addition, Jean said that her service *"administration seem to be a little more sensitive to the needs of the staff"* and this positively contributed to working in the FPM with mothers. For example, Jean stated that:

> *There are times now that are set aside that you can reflect and touch base with people by phoning or asking them back in for another interview or offering them another encounter if you're suspicious…and referral pathways* (are) *a lot clearer nowadays.* [Jean]

I inferred from Jean's use of the word *"suspicious"* in the context of offering further appointments to mean that she had some appointment flexibility in place to follow up a mother/baby if she held clinical concerns about their well-being. However, despite Jean feeling that the controlled environment arising from the universal services provided by CFHN was supportive of working in partnership, she stressed that nurses needed to remain available to the mothers. Jean stated this wouldn't happen:

> *…if you've got a service and a bureaucracy that dictates you've got to see this many and that many and roll over and do things quickly; you can't offer that.*

And that doesn't sound like…that doesn't happen here? *It has in the past. I think there's been lots of changes in child health over the last few years.* [Jean]

Overall, in Jean's estimation, the demands upon her at work were more controlled since the commencement of UHHV and her perception was that her managers were less dictatorial regarding how many clients were to be seen. Jean was the only nurse to voice these views. Six CFHN participants, in contrast, identified the significant challenges that existed with meeting: NSW Health performance targets related to conducting the UHHV on babies within two weeks of birth (NSW Department of Health, 2009); juggling the other demands of the CFHN role; and, also trying to work in the FPM with mothers. There were apparent contradictory discourses from the health institute operating that created competing and conflicting role requirements of the CFHN. Monica, for example, said that the factors that were negative influences on working in partnership included needing to meet UHHV targets because: "*We have to do a certain number of visits… which impacts on trying to do your job the best way you think you can because you're up against trying to collect information"* (from the mother within a limited timeframe).

Sandy spoke of a number of challenging issues related to CFHN service performance targets and tasks. She said that it was very hard not to be task focussed when the service was *"'task focussed'. We need to get outcomes and we need to count the outcomes and we need to give them to our accountants".* The *NSW Health Maternal & Child Health Primary Health Care Policy* states: "Specific data on UHHV performance is requested by NSW Department of Health on a quarterly basis". (NSW Department of Health, 2009, p. 33)

The outcomes referred to by Sandy were the numbers of UHHV conducted within two weeks of birth by her CFHN team. These numbers required computer entry, calculation as a percentage of the number of newborns in the LHD, and quarterly submission to NSW Health; hence Sandy's use of the phrase "*give them to our accountants"*. Although the figures are not given to "accountants' in reality, they are accessed by or sent to designated positions within the LHD responsible for these calculations, reporting and compliance with NSW Health policy directives. The Chief Executive (CE) of the LHD is charged with ensuring compliance with this policy implementation and meeting performance targets for UHHV (NSW Department of Health, 2009). Therefore, pressure to achieve UHHV performance indicators is exerted downward through the management tiers from NSW Health to the Chief Executive of the LHD, local service managers, nurse managers and finally to the CFHN who is the frontline worker.

Discordance was voiced by Neroli between the research evidence supporting the relationship focused role of the CFHN with mothers; and, the requirements of the broader health policies of NSW Health that focused on occasions of service. Neroli identified that NSW Health policies had "*a big influence"* on how CFHNs worked and that this influence was in conflict with their ability to work in partnership with parents:

> *I think the broader health policies have a big influence on how we work because at the end of the day they're still after the occasions of service and doing our home visits within the first two weeks and <u>not</u> recognising that yes, you can go and do a home visit but it can just be a home visit…**Yes** …versus a more meaningful consultation. So we can go in and just do all that tick box stuff and weigh a baby and we could churn out five or six babies but are we actually empowering these families to be the best parents they can be by ticking boxes? So I think yes, the bigger umbrella of the health service and NSW Health…and the things like* [CFHNs] *wasting time on having cars serviced and cleaning cars and, you know all the paperwork we have to chase up and do. So yeah, there's big influences on how we actually work from the bigger* NSW Ministry of Health]*…and the expectations, and how do we quantify what we do? How do we know what the outcome is of years of what we do until the child is actually an adult? So, you know, we've got lots of great research on the benefits of home visiting and sustained home visiting, the importance of the relationship and um…the importance of…. if we look at the research on postnatal depression screening and the importance of the child and family health nurse and the importance of the skills such as listening, empathy and all the lovely skills of family partnership. So there's lots of research to support what we do but then are we supported from the bigger healthcare service and the answer would be <u>no</u>.* [Neroli]

Similar to Annie's earlier statement in this section, Neroli's question "*are we… empowering these families to be the best parents they can be?*" is somewhat value laden. This paternalistic discourse suggests that parents are without power and in need of the CFHN to help them be *"the best parents they can".* This is contradictory to the strengths based focus of the FPM. However, Neroli's tone and demeanour, like Annie's, was earnest. She expressed frustration at the discrepancy between the ideal of working in the FPM in meaningful consultations with parents; versus checking tick boxes that could count activity but not measure quality or the impact of the CFHN role in the lives of children and

mothers. She also voiced a lack of support for the CFHN role from the *"bigger umbrella of the health service and NSW Health".*

Neroli's view of discordance with health structures and the FPM contrasted with her NUM, Donna's view of the same issue. Donna, in 4.4.1.2 (p.108) had stated: "*The service is supported* (to work in partnership) *by health policy and management structures"* and this environmental support enhanced CFHNs' ability to work in partnership with mothers. Donna, however, was perhaps invested in positively representing the organisation and therefore less likely to be openly critical of NSW Health structures given her nurse unit manager status and role.

Resource issues as a result of meeting UHHV performance targets were identified by three nurses as factors that influenced their ability to work in the FPM. Neroli identified that it would help reduce workload stress if there were "*More staff and cars to be able to keep numbers up and pressure off*". In reference to keeping numbers up, I understood Neroli to be referring to meeting UHHV performance targets. Keeping the *"pressure off"* I perceived denoted keeping the stress off oneself and one's colleagues by meeting targets and avoiding having reminders from managers that targets were not being met. There was a constant juggle by CFHNs to coordinate their time and workloads to meet these demands within resource tight budgets. Thus, the workplace environment was described by Neroli as a *"bit like a squishy ball*. *You squish it on one side and it pops out the other".* In using this metaphor, Neroli was comparing the CFHN support present from her team and manager with the requirements of the LHD and NSW Health. Her metaphor, "*the squishy ball"*, implied that if one area of CFHN practice was constrained by a reduced budget or by an increase in the CFHN workload or work demands, then the CFHN could do less in another area or that the nursing care of families would be compromised. For example Sandy describes nurses being pushed for time to sit and talk with their client mothers:

> *All you want is some time to sit down with the client, whatever the issues are….but I think most of the time…there isn't enough time…and maybe the budget, you're always just a bit short 'cause I don't think there's any centre that's perfectly happy.* [Sandy]

CFHN participants acknowledged there were stressors present for their nurse managers between supporting their nursing staff, meeting UHHV performance targets for Families NSW (FNSW) and NSW Health, and the requirement to follow health policies. Monica stated "*There is a clash for her* (NUM) *between supporting nurses and meeting targets for*

FNSW, broader health policies and occasions of service". Neroli stated that despite the negative influence to working in partnership from the "*bigger umbrella of the health service"*, at their CFHN team level, her NUM did her best to *"create an environment where she encourages us to work to the best of our ability and that is using the family partnership model".*

Fiona, Jean and Sandy spoke about the amount of change in recent years since the UHHV policy was introduced and the increased volume of work within the CFHN service. This was identified as a practice constraint by Fiona who stated *"There's lots of change you know? There's lots of new projects coming in, lots of new people happening and I think sometimes people feel less valued on a personal level* (by the organisation)". Each new introduction of a practice change was for Fiona *"another thing we have to do. Therefore that'll cut down our time"* (to work in partnership with the parents/babies).

4.4.3.2 Conducting the maternal psychosocial assessment

A recurring pejorative phrase used by some nurse participants in their interviews in relation to their role was their having to "*tick boxes or checklists"*. This phrase referred to the amount of maternal and infant surveillance and screening required within the CFHN role by health policy at the time of interview. This was perceived by some nurse participants to negatively influence their ability to work in the FPM with mothers. This view contrasted with the views of other nurses such as Annie, Virginia and Angela, that assessments such as the EPDS (Cox et al., 1987) and domestic violence screening were helpful in establishing the relationship with mothers on the first home visit. For example, Sandy expressed consternation and frustration when she reviewed the video playback of her consultation with Dani and Leo at her follow-up interview stating:

> *I can't believe it! Tick, tick, tick, ticking all the boxes that's what I'm doing there.* ***It doesn't sound like you like doing that?*** *Oh well, you know, what I'm saying, it's just...this isn't partnership. This is a process that has to be done. So we have to tick it and it's really task oriented. So it's very hard to be* [in]*...this business of partnership.* [Sandy]

Also taking a less positive viewpoint, Monica said that using family partnership on the first home visit is sometimes just not an option because of:

> *…having to collect all the psychosocial history* (maternal psychosocial assessment), *having a very prescribed amount of information that we have to*

> *get from a family. I feel that impacts quite a bit on family partnership because you have very little time to build a relationship before you're asking very personal questions quite directly. And then you don't have time to ask…to maybe explore that information.* [Monica]

Asking the maternal psychosocial assessment questions at the UHHV was also identified as a barrier to working in partnership with mothers for inexperienced CFHN staff. Neroli said less experienced CFHNs were quite *"stilted before they know the* [maternal psychosocial assessment] *questions and confident with asking more open ended questions".* Neroli stated that this awkwardness improves as the new CFHN gains confidence and experience. Instead of reading from the checklist on the assessment form and asking closed ended questions the nurse can begin to ask more open ended questions in a flowing conversational style.

During my observations of the nurse-mother/baby consultations recorded in my field notes I detected considerable variation in the approach of the nurse participants in asking the maternal psychosocial assessment questions and the EPDS (Cox et al., 1987). In my field notes I observed:

Angela turn again to the computer, and with her back to Lauren, commenced asking the maternal psychosocial assessment questions (NSW Department of Health, 2009). Angela used closed rather than open ended questions. She did not provide Lauren with an explanation for them or seek Lauren's permission to proceed with them. Angela kept her back to Lauren the whole time the questions were asked while typing the responses onto the computer. Angela's use of closed ended questioning allowed for yes/no responses only, and having her back to Lauren during the assessment did not demonstrate engagement with Lauren where she could detect non-verbal cues that might indicate signs of discomfort or where follow-up of responses might be needed. (Ethnographic Observation, 2011)

This contrasted with my observations of Virginia who:

…invited Susan to complete the EPDS, explained its use and reassured Susan that she could refuse. Susan agreed and the EPDS scale was presented to Susan in a paper format. Virginia slowly and carefully explained to Susan how to complete the tool and asked for permission to go through the responses with Susan. Virginia offered to hold Jed while Susan completed the EPDS. Virginia thanked Susan for completing the EPDS and obtained permission to turn away from Susan while she quickly scored it. Virginia again checked if it was okay to spend a few minutes going through Susan's responses and score, alluding back to the agreed time of

finishing the appointment at the beginning of the consultation. Virginia carefully went through each response with Susan not accepting them on face value. Susan was given space to respond to each question in more depth especially if there was a positive response. At the end of the EPDS review, she asked Susan "Do you want to ask me anything else about that?" to which she declined. (Ethnographic Observation, 2011)

The above two excerpts of field notes were my observations of experienced CFHNs both of whom I assumed were aiming to work in the FPM with the mothers. However, their ability to engage and be present with them appeared markedly divergent. In the first example, Angela appeared disconnected from Lauren during the assessment. Angela made the same assessment of herself in her follow-up interview while watching the video recording of the consultation. Angela had stated this was because she felt rushed and that there was lack of time to complete her computer entry afterwards. Angela also said it was because "*she hated asking the* (maternal psychosocial assessment) *questions"*. (Angela's discomfort in asking these questions is explored further in Theme 2 - MANAGING THE BODY: CFHN BODYWORK AND PARTNERSHIP PRACTICE.) In the second example, Virginia gained Susan's permission to conduct the EPDS (Cox et al., 1987) and remained present with her stepwise through each part of its completion and subsequent discussion of responses.

The nurse's skill and comfort in asking the maternal psychosocial assessment questions including the EPDS, was identified during data analysis as a factor that could influence her ability to work in the FPM with the mother. This is significant as this assessment generally occurs at the UHHV if not completed antenatally by midwifery staff (NSW Department of Health, 2009). The UHHV is also usually the first face to face contact between the CFHN, parent(s) and their newborn baby. Due to the personal and intrusive content of some of the assessment questions, if these are not asked using the requisite sensitivity to the parents' verbal and non-verbal cues, the CFHN may miss vital signs regarding issues that need to be further explored (Rollans et al., 2013). The CFHN may also not recognise the mothers' discomfort with the questions being asked. Mothers, therefore, may also be less likely to disclose issues of concern. This could mean unnecessary delays occur for them in accessing support for important issues such as postnatal depression that can adversely affect the health and well-being of themselves, their baby and partner. The mothers' views of the impact of being asked the maternal psychosocial assessment questions either at the UHHV or at the six-eight week child health check consultation in the CFHN Centre are discussed in THEME 4 –THE MOTHERS' EVALUATION OF CFHN CARE.

In addition to completion of the maternal psychosocial assessment, it was identified as vital to focus on the well-being of the newborn baby early in the UHHV. Monica stated in her first interview *'"it's not very good when you get to the end of the visit and then you weigh the baby and* [realise], *'Oh my goodness! It's lost weight! Oooohh!'"* Prioritising the assessment of the newborn and completion of his/her one-four week child health check as well as needing to complete the mother's assessment within a prescribed, limited timeframe may lead to the CFHN being more directive and task focussed during the UHHV rather than partnership focussed.

4.4.3.3 Perceptions of time

Within sub-theme 4.4.3: The Challenges of Working in Partnership and Meeting Role Requirements, a recurring sub-theme that arose during analysis of the first interviews of seven CFHN participants as well as the NUM was the influence of time on their ability to work in the FPM with mothers. Time was identified as an issue not only at the UHHV but in other areas of CFHN practice such as follow-up child health check consultations at the centre. Despite working in the same LHD at the time of the first interviews, it became apparent that there was a substantial difference in the amount of time allocated for clinic based child health check consultations within the three teams. Neroli, Virginia and Monica, all from Team 2, reported having one hour clinic based appointments routinely scheduled for the six week and six month child health checks (NSW Kids and Families, 2013). Nurse participants from the other two teams had just thirty minutes allocated for these same appointments. This reduced the consultation time available by half for them to get to know the mother/child and their needs as well as meeting the requirements and tasks of the CFHN role. The reason for the discrepancy in appointment time allocation among the three teams is unknown and was not discussed by any of the participants.

> *Our normal clinic appointments are half an hour and what we've chosen to do at* (our) *Centre is have five half hour appointments and then break at 12 o'clock for doing any you know, extra work. So if you have an hour with a woman when you're only allocated half an hour, it puts all the other mums out.* [Fiona]

Monica, from Team 3, on the other hand said they had one hour appointments for the six week and six months child health checks. Monica stated that the FPM was supported by having a:

> *…good amount of time allocated for babies who come back for their six week check and don't feel pressured to just tick the boxes.* (You can) *…take a breath and say, "tell me how the last six weeks have been for you".* [Monica]

Jean, an experienced CFHN, who also had thirty minute appointments, in contrast to Fiona thought this was sufficient. For example, Jean said of her allotted time for appointments *"To have time to sit with people…I think half an hour's pretty generous".* Jean, also appreciated that time was available in work hours for me to interview her saying *"Time for reflection at work in work time is pretty precious".* Although I didn't query Jean further on why she thought the time allocation for appointments was generous; it may be that she perceived that it was generous in comparison with the standard fifteen minute appointments that individuals routinely have with their GP. Jean's experience may also be a factor which influences her efficiency in conducting consultations with mothers/babies. Fiona stated that time "*was more of a factor during clinic visits; home visits are fine"*. Home visits, particularly the UHHV, usually have a more flexible timeframe and a minimum one hour time allocation compared to centre visits.

Fiona stated that in relation to time, working in the FPM had *"actually helped me to streamline my practice".* Fiona said that she used to try to fix parents' problems but now she focused on the most important thing to the mother at the time of consultation. Monica stated, the CFHN in partnership with the mother "*negotiates the time and client priorities for the consultation*". These views were shared by Donna (NUM) who argued that time was not a *"barrier"* to CFHNs working in partnership with parents. Donna explained: "*If you work in the model you negotiate how much of what you do, for example, the checklist, in partnership with the family…. There's an answer for every* (nurse) *query if you go back to the model".* Donna said that the word *"barrier"* was a fallacy and used as a label by CFHNs for "*this is too hard",* or "'*I don't want to go there"* and that it was a "*loaded word''*. Donna stated:

> *I've heard it* (used) *in seminars and so on and research articles I've read, that they* [nurse researchers] *legitimise I suppose that concept of a barrier and that it's* a*n external thing to an individual. If you use this word* [barrier] *then you don't fully understand what working in partnership means.* [Donna]

Donna's view was that the use of the word "*barrier*" indicated a nurse's lack of understanding of the concept of partnership. Her view and somewhat dismissive attitude may have dissuaded her nursing staff from complaining about any actual difficulties

present in their roles and workplace that constrained their partnership practice with mothers. This view may also shift blame for not working in partnership onto the individual rather than the institution. In stating that some CFHNs "*legitimise…that concept of a barrier",* for example "*time*" as a barrier, as '*an external thing to an individual"*, suggests that Donna perceived it was the CFHN's individual problem or fault for not sufficiently integrating the FPM into practice with mothers rather than a legitimate concern. There were very tangible differences in the time allocated for child health check consultations between the teams. Team 2 had the advantage of one hour over the other teams' half hour. This time disparity was in conjunction with the impact of data entry onto computers and consequent reduction of time available for discussion with mothers during consultations, and, the increased amount of surveillance and screening that occurred within each appointment.

Neroli revealed that there was a perception held by some CFHNs that working in partnership took time. However, she pointed out in her first interview that not using the model took more time. Neroli held this view because if CFHNs did not fully explore client issues and goals, they may give advice and information to mothers that was misdirected or not required. As a consequence, the mothers may not comply with the recommendations and; may need to return for further advice; or, they may decide not to return to the CFHN service. The mothers also have less opportunity to practice problem solving for future concerns that may eventuate with their child.

> *A lot of people see family partnership model as taking time. Yes. Not recognising that fixing it, I think it's 40 or 50 percent of people don't comply anyway, so that actually takes more time.* [Neroli]

For Neroli and her NUM Donna, time was not considered a barrier to working in partnership. In their team (Team 2) however, they had allocated the longer one hour consultation time for the six week and six month child health check. Annie, who in contrast had thirty minutes for the same consultations, stated that *"Time constraints affect good partnership; you have to <u>shut</u> the mother down more if you're aware there's more to do before she goes"*. Annie's statement implied to me that the limited time she had for her consultations meant she needed to be more directive with mothers and less partnership focused. It implies a tension between prioritising partnerships with getting the tasks of the role completed within the time available. Having either the CFHN or mothers perceiving a sense of time constraints may also work against the development of a partnership in the early stages of forming the relationship.

CFHNs such as Sandy who had thirty minutes for a visit said at her follow-up interview that she was aware of time passing during the consultation *"when exploring important issues with the mother"*. This time factor appeared to distract Sandy during the consultation.

Field notes: *I observed Sandy to briefly leave the consultation room twice without explanation to Dani* [mother] *for her absence. Sandy was possibly preoccupied by the fact that mothers and babies were assembling outside for their weekly group session that she was to facilitate. She appeared distracted by this and not always focussed on the needs of Dani and baby Leo. (Ethnographic Observation, 2011).*

At her follow-up interview, I asked Sandy for her reflections on her consultation with Dani. Sandy stated that she *"didn't feel like she did a very good interview* (consultation) *as she felt task focussed and rushed".*

> *It was too much stuff in a short time. I felt rushed.* ***What would you have done differently if you had…?*** *If I'd realised I probably would have allocated more time.* ***I see****. I could explore and be more mindful and more present. I felt like I was having to keep on task. I was really task orientated rather than like...just being able to pan it out as I would have liked to.* [Sandy]

This sense of time passing and a need to rush had a potentially negative contribution on the development of a partnership based relationship between Dani and Sandy. Sandy construed "time" as impacting on her ability for mindfulness when with Dani. I asked Dani during her interview about the nature of the relationship formed with Sandy during her consultation. Dani stated that she *"didn't know if a relationship as such developed between herself and Sandy"*. Dani had also thought the consultation had lasted fifteen minutes whereas it was a thirty minute consultation. However, she said that Sandy was "*open for her to go off the track despite having a checklist to follow*". Dani also stated that she thought that there must have been research done on the numerous questions that were asked during the consultation.

Virginia had one hour for her consultation with Susan and baby Jed whereas Sandy had thirty minutes with Dani and baby Leo. Dani's views of her consultation with Sandy contrasts with Susan's perceptions of her first meeting with Virginia (from Team 2) and the relationship they established. Despite not having met Virginia previously, following their initial consultation for Jed's six week child health check, Susan stated at interview that she felt like they had an established relationship and it was not like a first meeting.

Susan said she thought that the consultation felt like it was "*all about you"* and that Virginia's main focus was her and Jed's well-being.

Angela, like Sandy, stated in her follow-up interview that she had limited time and a sense of rushing through her thirty minute consultation with Lauren and Liam. This sense of rushing or having to "*shut*" down the conversation as Annie mentioned, indicates a difficulty for some CFHNs to be present in the moment with their mothers/babies due to the structural limits on the time available for their clinic consultations; the nurses' need to complete their checklists and tasks; and a general *"sense of rushing"* or limited time to complete their necessary work.

Participants perceived the time available and consultation structure of CFHN appointments to contrast markedly with other health professional groups that also have a relationship focussed approach with clients. In contrast with CFHNs, Neroli stated that:

> *If we think about … allied health services like psychologists and social workers, they have time to reflect between each client.* ***Yes.*** *We don't have that.* ***They have a …break, don't they?*** *Whereas we see nine or ten clients in a day.* ***On a centre day?*** *On a centre day. So you know, that's like well…****Intense.*** *Yeah, so there isn't that opportunity. How can you remember what you said or didn't say or how someone responded or didn't respond at 8.30 in the morning versus 4.30 in the afternoon?* [Neroli]

Neroli identified that these allied health groups have in built time between consultations for reflection. This enabled the professional to regroup before meeting the next client. In contrast, parent/infant CFHN clinic appointment structures were reported to be usually booked one following the other with scheduled breaks for morning tea and lunch. This could create the "*rushing"* discourse reported by Angela [who had thirty minute appointments] as the CFHN is aware of mothers/babies queuing in the waiting room if the allocated time for a consultation is exceeded. There are also competing demands on the CFHN during consultations as there are infant examinations and maternal and infant screening checklists to complete, data to be entered onto the computer, all the while aiming to work in the FPM with the mother. Neroli's observations raises questions about how and why some health professional groups appear to have more power over determining their professional role in comparison to the CFHN service.

Erica voiced her frustration regarding her perception of insufficient time within nurses' workloads and tight budgetary resourcing of the service to engage in a more holistic

practice in partnership with mothers. She identified this issue as adversely impacting on the time available for CFHNs to provide of follow up services to families assessed as needing extra assistance. Instead, these families generally had to be referred on to other services as the CFHN needed to focus on UHHV of newborns. Erica recommended that CFHNs should have more hours "*allocated for follow-up of families"* rather than referring them on to these services. Erica linked this recommendation with role satisfaction and with her view that CFHNs were an extremely skilled and knowledgeable workforce in relation to working with families. With the focus on meeting UHHV performance targets, CFHNs reported having less time available for the follow up of families with identified health or parenting issues that required more intensive intervention. Erica also said if they had more time that home visiting was very valuable compared to sitting in the clinic and that it was well worth spending that time with the parent.

> *We sometimes feel like lots of government money is dished out to new services offered by this group or that group and we're supposed to pass people over to them. And I sometimes think it would be so nice if we were just given more money and more time to do it ourselves. Because we have so much training and …sometimes we have so many new babies that we can't …follow people up as much as we'd like to and that's a real* (pauses) *…that we lose people that we perhaps only see them once or twice and then we might not see them again.* [Erica]

Erica's statement "*it would be so nice if we were just given more money and more time to do it ourselves"* indicates somewhat wishful thinking. In the current neoliberal economic landscape, the Government is increasingly outsourcing services to providers such as non-government organisations (NGOs) (Alston & Dietsch, 2008). Current health policy identifies CFHNs such as Erica and the other nurse participants in this study, as working from the universal, primary health platform (NSW Department of Health, 2009). The intention of this policy is that CFHNs' working at the universal program level, identify parents deemed as vulnerable via assessment and refer to support services as required (NSW Department of Health, 2009). Short term active follow up of these families is possible but not to the extent practised by CFHNs prior to the commencement of UHHV and consequent restructuring and constraints of their role (Grant, 2012; Kruske et al., 2006).

Angela was the only CFHN who identified a "*Lack of time to do research"* in the CFHN role. She was also the only CFHN participant to hold a postgraduate Master's degree in CFHN.

This additional tertiary study may have heightened her interest in clinical research that perhaps her colleagues didn't share or mention during interview. There were no reports by nurse participants of CFHN led research activities in their teams at the time of the interviews.

4.4.4 The Sustainability of the FPM

A further sub-theme of THEME 1 – The CFHN Work Environment and Culture comprises concerns identified by CFHN participants about the sustainability of the FPM. CFHNs identified these concerns as influencing factors that impacted on their ability to work in partnership with mothers. Nurse participants such as Neroli stated that "*More support is needed for the sustainability of the FPM* (because) *most of the staff don't get to revisit* (the) *model regularly* [through further education]*"*. Two CFHNs in this study, Neroli and Virginia, as well as Donna (their NUM) had been formally trained as FPM group facilitators. This afforded them the opportunity to formally revisit the model once or twice a year when facilitating FPM training groups. Donna was able to also revisit the FPM by providing clinical supervision to the CFHN FPM training facilitators.

Fiona, from a different CFHN team, indicated that she had only just received permission to undertake the FPM group facilitator training the next year. Fiona stated that until recently in her team, apart from the CFHN Clinical Nurse Consultant, CFHN staff had not been granted permission to undertake the FPM facilitator training. Instead, allied health staff such as social workers undertook the training and facilitated the FPM group training. For the CFHNs in Fiona's team, this lack of access to advanced training and supervision in the FPM over several years was a structural factor adversely affecting nurses' ability to formally revisit the FPM on a regular basis. It also limited professional education opportunities and the necessary support to develop FPM expertise and partnership champions within this team of nurses.

Following their initial FPM training some years earlier, the remaining six CFHN in this study were dependent on themselves, their colleagues, managers and workplace supports to sustain practising in a FPM approach with parents. This next section presents findings in relation to the sustainability of FPM practice as a key factor influencing the ability of CFHNs to work in partnership with parents.

4.4.4.1 Supportive mechanisms for CFHNs to work in the FPM

When asked about workplace facilities that contributed to working in partnership, seven of the nine CFHNs (included nurses from each of three teams) in this study reported that access to regular clinical supervision contributed positively to this. One of these seven nurses [from Team 3], however, reported that she did not currently receive regular supervision. The six nurses who did receive monthly group clinical supervision found it provided an important opportunity to reflect on practice. Fiona described workplace supports such as clinical supervision, staff counselling and talking to your manager relieved personal and workplace related stressors that impacted adversely on working in partnership.

> *The busyness of the centre or the complexity of the clients may impact on how well you work in partnership…. It doesn't matter how many days a week you work you can have supervision* (and) s*taff counselling may help support distressed nursing colleagues to be able to offer clients one hundred percent. We all have lives outside of work that may be causing these feelings and you can talk to your manager because maybe there can be something that can, you know, happen in the workplace that may alleviate some of that stress initially so that you feel that you are offering one hundred percent which is what most people want to do.* [Fiona]

Annie expressed that clinical supervision provided reassurance that she had done the right thing in relation to the management of a client.

> *It has the capacity to be* [helpful for working in the FPM]….*more often than not it's just reassuring that I've done the right thing…I learn a lot off* (sic) *other people's scenarios.* [Annie]

CFHN participants from Team 3 had access to their CFHN clinical nurse consultant for clinical supervision. Erica found this a very helpful opportunity to *"to run things past her and debrief about clients".* The other two teams in this study, however, did not have a clinical nurse consultant position allocated to provide clinical leadership and support to the CFHN workforce.

Six of the nine CFHN participants at their follow-up interviews commented positively on the use of the video for reviewing their consultation with their client mother/baby. They identified that the review of their video was valuable as a reflective tool as it helped

demonstrate the subtleties of partnership and the nuances of the consultation. It appeared to me from their responses that this was the first opportunity they'd had to review a video recording of themselves in consultation with a mother and baby. Some CFHN participants identified that the future use of video recordings of themselves in practice with mothers/babies could be a valuable teaching and learning tool as well as an aid to enhance clinical supervision sessions.

> *So I think partnership is a wonderful way to work but you're working and perhaps the subtleties of the work are demonstrated by the actual videoing because there's a lot of subtleties.* [Virginia]

By stating "*there's lots of subtleties"*, Virginia was referring to the often unnoticed, unconscious or automatic responses the nurse may make, for example, to the mother's non-verbal cues, synchronisation of body movement with the mother, how the seats are arranged and so on. Watching the replay of their whole consultation with the participant mother/baby and being able to stop it, rewind and focus on aspects of their consultation enabled the CFHN participants to closely examine their embodied practice. Sandy stated that the use of the video at occasional consultations could be a very valuable teaching tool.

> *It's excellent. I wish we'd do it more often. We should do it all the time because like ...and we could have ... we should have our supervisor with us to say: 'What are you thinking jumping in like that? Because...radical tangent! and...it's got nothing to do* (with what the parent said) *'...shut up!...What did she say? Are you paying attention?'.... I think a video process is like... it's a fantastic teaching tool*.' [Sandy]

Sandy suggested that having her clinical supervisor present for the review of the videotape would be more effective in challenging her to reflect on aspects of her practice observed on the replay. For example, stopping and discussing the videoed interaction if Sandy had interrupted the parent or redirected the conversation on another tangent. Sandy also suggested the videos could be helpful to:

> *…pick up specific examples and really practice them and put them onto the screen … so* (people) *can actually physically see. Those are some good examples of that. I think that would be really cool. This is a great tool. I'm sure actors could do that…And the thing is, the more people critique practice the better it gets. I think that we all need critiquing and you get much better. And if you're open to learning it's good, yeah.* [Sandy]

The use of the video, therefore, could be used to develop and sustain practice by providing more depth to a clinical supervision discussion. Two CFHNs, however, wished to place a caveat on the use of the video as a reflective tool. This caveat was that the recording and review of the videotape should only occur in confidence, one on one with a clinical supervisor.

> ***Is it a useful thing to do for child and family health?*** *I think it is but I think it would be useful only if you did it with another clinical supervisor, not other colleagues watching you ...to avoid feeling judged.* [Angela]

Further, Monica stated that she found her review of the tape somewhat difficult as it made her realise at times the other directions a consultation could go or what she may have missed in (mother) Juanita's cues. I asked her:

> ***How are you finding reviewing the tape?*** *It's really hard because first of all when you're in a consult, you're listening to the client and you're trying to listen to the information, hear what they're saying and... you know, give information if that's what they're asking for or try and hear the unseen... the unheard stuff ...So that's quite hard but this is like looking and thinking: 'Oh, now I'm hearing it all over again. Did I say...? ... Was she saying something else with that?'* [Monica]

The difficulty that Monica expressed was that when she was with the parent she was listening and thinking concurrently, giving information and "*trying to hear the unseen";* the unspoken message. Monica was referring to the cues to realise the important "unsaid" message of the parent was also important. The review of the videotape revealed to Monica, like Virginia, the subtleties of working in the FPM and the vigilance that was required of the CFHN during interactions and communication when in consultation with a mother/baby. The use of this video by Monica in a clinical supervision session with a trusted colleague could potentially be a valuable learning opportunity for her to further explore her practice concerns about the consultation.

Jean was the only nurse to identify the use of the video as tool to provide evidence of the well-being of the baby at the time of consultation. In Jean's consultation with Millie and baby Paul, the infant was not observed to focus his vision on his mother until the end of thirty minute consultation.

> *That was reassuring for me… when he started watching her 'cause he was not making eye contact. When I saw him doing that with her towards the end, I felt relieved….And also it's on video and…a record.* [Jean]

An eight week old infant that does not make eye contact can indicate a visual or neurological problem. It was reassuring for Jean that she was able to see Paul focus toward the end of the consultation and again on the replay of the video as evidence of his ability to focus on objects.

In contrast to clinical supervision, however, Monica said that she preferred her team's monthly education update to sustain partnership practice because:

> *In group supervision with six to seven nurses in the group…there's often not enough personal opportunity. Once a month we have full dedicated day meeting with updates and you actually get to just focus on yourself as a nurse… it's wonderful.* [Monica]

Regular access to clinical supervision is recommended for all CFHNs in order to reflect on practice and for structured professional support and development (NSW Department of Health, 2009). NSW Health staff have access to free counselling via the Employee Assistance Programs if they face personal and/or workplace challenges that are adversely impacting their work. Regular access to team meetings and education days provide opportunities for collegial support and for CFHNs to keep up to date clinically. For example, when asked at first interview what would help CFHNs to better work in partnership with families Sandy suggested that her service:

> *…revisit partnership…like an inservice again for the basic principles of partnership. I mean those things wouldn't go astray 'cause it's good practice because everyone goes rusty….and because you forget. You just forget…and before you know it you've gone in boots and all.* [Sandy]

Sandy identified herself as a nurse who liked to "fix" things. Going in *"boots and all"* was a metaphor used by Sandy that referred to her forgetting her FPM principles and reverting to her previous "fix it" or expert approach when working with parents. The expert discourse sits in contrast to working in the FPM with parents (Davis & Day, 2010; Davis et al., 2002; Day et al., 2015). The findings related to nurse participant views of the use of the expert approach in this study are explored in Theme 2 – MANAGING THE BODY: CFHN BODY WORK AND PARTNERSHIP PRACTICE.

Donna identified a number of supports she had implemented for her nursing staff that also helped to embed and sustain the FPM in nurses' practice. These included clinical supervision and case discussion for all CFHN staff; coffee club with Donna and one-on-one supervision for new CFHN staff; and, interview processes that ascertained the CFHN candidate's philosophy of working in the FPM prior to employment. Coffee club referred to an informal regular meeting that Donna had established to support new staff.

> *So they meet with me every 6 weeks… well roughly 6 weeks. We just have a half an hour in the morning and we have a coffee… (and) yeah… just sort of nut out anything that comes up. So obviously it gives me another opportunity to plant that partnership seed.* [Donna]

4.4.4.2 Validation of practice: "Communication is hard to measure"

Two nurses identified the issue of external validation of their practice when asked during interviews for ideas and solutions to issues they may have raised in relation to sustaining the FPM. These nurses were concerned that it was hard to validate and have evidence for their practice and for working in partnership with mothers. Working in partnership was not so easily ticked off as data entry and its communication focus is difficult to measure.

> *I think that we do need to have in place things that validate what we do every day. And it's hard to measure the relationship that you form* (with parents) *so I think this is a way of helping us measure that relationship because you've now got strategies to go well 'Yes, it's working 'cause you're coming back' or, 'I never saw you again so it didn't work', you know? I suppose, I don't know, I'm not explaining myself very well. So many things we do in child and family health are difficult to measure because a lot of it is communicating. And that is something that is hard to measure and I think the results are whether people come back, whether people give you thank you cards or whether they …their evaluations on the group that you do. 'Yes.' You know 'We liked it.' 'No, we didn't.'* [Fiona]

Fiona acknowledged that the FPM gives CFHNs the tools to evaluate their individual practice with mothers/babies: "*But having it* (family partnership) *does validate it I think and it gives you more information and tools to actually use… so that we've got measures to evaluate our own practice I suppose".*

Sandy asserted that data entry allowed for a credibility base for the CFHN service to verify the activities that nurses daily performed in their jobs.

> *I think we've reinvented ourselves in a way our practice…the use of computer. You can make numbers and you can give them to people that need to count them to actually prove who we are and that we don't do nothing….As frustrating as data entry is, it allows a credibility base I think.* [Sandy]

Sandy's comments allude to the reinvention of CFHN practice through the use of technology. However, Sandy also identified, like Fiona that partnership was difficult to quantify and measure: *"Partnership is not written up, you know what I mean? It is not ticked off, it's not boxed. I suppose it's a qualitative analysis"*. These two nurses recognised that it was important for the CFHN service to be able to prove that the service they offered was valuable. Their need to prove the value of their CFHN practice indicated to me that these nurses experienced a degree of vulnerability about the future of their roles. There was a need to account and provide a credible basis to the health bureaucracy for their existence and continued work with mothers and children. This was able to occur to some extent, via the collection and entry of data into software that could count and measure their activities against a standard or performance target. The nurses identified that it was more difficult to externally measure their performance regarding working in the FPM with mothers. As Fiona identified, however, CFHNs could gauge this in their individual practice if the parents returned for subsequent care with their infants/children.

I reflected on my own CFHN background and could see there were erosions into the CFHN role in NSW that could be contributing to a discourse of vulnerability. Providers such as GP practice nurses, pharmacy nurses and other health providers were now performing child health screenings that was once the sole domain of the CFHN, GP and paediatrician. At the universal level of CFHN practice, the nurses' role had shifted from broadly providing care to mothers with children from birth to age five to one that focused on the under one's and particularly the provision of home visits to parents with newborns.

4.4.5 Summary of Theme 1

The first theme, "THE CFHN WORK ENVIRONMENT AND CULTURE" presents findings that relate to the culture and work situation that influence and impact on CFHNs' ability to work in the FPM with mothers. In each of the subthemes of Theme 1, factors are identified that nurses found to be supportive or unsupportive influences on this ability.

People that CFHNs encounter and interact with in the work environment form the "other" half of the professional relationship with the nurse. The three key groups of "others" identified in the findings include the CFHNs' colleagues, managers and client parents/infants. Nurses described how individuals in these groups could imbue them with a sense of support and personal gratification or conversely, be a source of stress that detracted from their ability to work in the FPM with mothers. Nurses, for example, identified work environments where colleagues and/or managers exerted powerful, controlling influences that required them to resort to using subversive strategies in their clinical practice. What the mother/child brought with them to the professional relationship with the CFHN was identified, not surprisingly, as factors highly influential to the nurses' ability to be able to work in the FPM with them.

The physical workplace of the CFHN centres and their use of computers influenced their capacity to be present with the mother during the consultation. Nurses reported feeling constrained by limitations to office layouts including the location of the computer, the comfort of the chairs available for parents and whether there was air conditioning on the premises. Despite the benefit of having client records at their fingertips, nurses voiced frustration at the amount of data that was now required to be entered onto computers. This requirement shortened the time available for discussions with the mother as data entry needed to be factored into appointment times. Some nurses mentioned the distraction from working in the FPM with the mother when they had competing demands of knowing that assessment tasks required completion and that time was passing. It was also identified that there was a significant difference in the time allocated for appointments across the three CFHN teams in the one LHD although there was no rationale for this thirty minutes time difference. These differences appeared to have a significant bearing on nurses' job satisfaction overall; and were impacting factors identified as influential to whether or not they felt it possible to put partnership into practice with mothers.

Challenges were reported by all nurse participants in meeting their role requirements whilst keeping a partnership focused approach with mothers. Nurses identified discordance with the performance targets and policies set by NSW Health while being expected to work in the FPM with parents. Only the NUM supported these policies as being advantageous to CFHNs' ability to work in partnership with parents. At the time of the interviews, nurses found the amount of screening and assessments required, particularly at the UHHV, to be challenging when a rapport was not yet established with the mother.

Some nurse participants were able to recognise these challenges and had adjusted their clinical practice accordingly. Others identified difficulties working in partnerships with so many checklists to complete. Nurses recognised that data entry was necessary for external validations of the worth of the CFHN service. However, family partnership, which is a relationship based communication approach with parents, was identified by two CFHNs in the study as unable to be calculated by external measures. These factors associated with the nurses' changed and expanded role as a result of policy changes regarding UHHV and increased assessment requirements, were overall reported as influences that adversely impacted on their ability to work in partnership with mothers.

Sustainability issues were revealed regarding working in the FPM with mothers when there were few chances to revisit the model once the initial training was completed. For the CFHNs in this study, the initial training had been completed more than four years earlier. All nurses identified that clinical supervision, team meetings and access to education helped to reinforce their family partnership practice. However, there were reported limitations with clinical supervision as a support mechanism. While reported as valuable in affirming practice, its limitation was that it was generally a group session for one hour, once per month that in some instances, also incorporated case review. Hence, this one hour timeframe was difficult for nurses to discuss individual client or workplace issues when there was limited time and airspace to share with colleagues. Likewise, there were competing demands for education timeslots at education inservice sessions. Some CFHN participants, said that it was easy for them to slip back into "fix it" or expert modes of practice and forget their partnership skills when feeling rushed and time pressured when working with mothers. Despite these partnership practice "lapses", overall, the CFHN participants in this study endeavoured to the best of their ability to work in the FPM with their linked mothers/babies. However, the gaps present in the education and support structures of the CFHN workforce to sustain working in the FPM made this difficult for most of the nurses and, therefore, are identified as factors adversely influencing their ability to work in the FPM with mothers.

Theme I has focused on findings related to the influence of the various factors within the CFHN work environment and culture and the impact these have on nurses' ability to work in the FPM with mothers. Theme 2–MANAGING THE BODY: CFHN BODY WORK AND PARTNERSHIP PRACTICE expands on these and presents findings related to the CFHN participants' embodied experiences and bodywork when negotiating their work environments.

4.5 THEME 2 - MANAGING THE BODY: CFHN BODY WORK AND PARTNERSHIP PRACTICE

In Theme 2, findings are discussed regarding the various ways CFHN participants experienced and managed their body in relation to working in the FPM with mothers within the challenges of the work environment, that is, their embodied practice. To begin, I will reprise concepts and terms related to the "body" and "practice" to contextualise their use in this section. First, humans both "'have 'a body' as well as an awareness of 'being' a body" (Draper, 2014, p. 2237). Draper (2014) states "The term 'the body' implies a thing, an object; some kind of material entity. In contrast, embodiment….is the experience of living in and through our bodies (pp. 2236-2237)".

Therefore, the body is essential to the conduct of our everyday affairs as they occur "in and through our bodies" (Draper, 2014, p. 2237). It follows that the body is central to "patients [and parents'/babies] experiences and in nursing practice" (Sakalys, 2006, p. 17).

Second, nursing is a profession that takes the body as "its immediate site of [paid] labour, involving intimate…touch or close proximity" (Wolkowitz, 2002, p. 497). The CFHN profession has a predominantly communication based role with mothers; that is, one that is generally "hands off" except when it may be necessary to assist a mother with a breastfeed, or touch is used, for example, to convey empathy. However, the CFHN routinely conducts body based examinations on infants and children (NSW Kids and Families, 2013). The term "body work", as used in the context of this study, refers to the "exchange of body related services for a wage and the performance of physical and emotional labor[9] (sic) in this exchange" (Kang, 2003, p. 826). Further, body work entails an:

> interaction between bodies and the (self) disciplining of one's own body…The closer the work with the body the [greater] need for regulation of one's own body and the more fine-tuned the embodied discipline. (Wainwright, Marandet, & Rizvi, 2011, p. 221)

Gimlin (2007) has neatly summarised the forms of body work discussed that apply to the findings of this study. These include "a notion of body work as:

[9] *Emotional labor* refers to the 'management of feelings to create a publicly observable facial and bodily display; it is sold for a wage and therefore has exchange value' (Hochschild, 2012, p. 7).

(i) the work performed on one's own body,

(ii) paid labor [sic] carried out on the bodies of others,

(iii) the management of embodied emotional experience and display, and

(iv) the production or modification of bodies through work." (p. 353)

The related concepts of emotion work, and body work[10] and nurse participants' subjective and objective embodied experiences emerged from data analysis as key factors influencing their ability to work in the FPM with mothers. The CFHN participants in this study had all undertaken an initial FPM training program within their workplace. This was followed, as identified in the findings of this study, by the regulation and disciplining of their bodies in order to hold and display the correct concepts, speech, and behaviour in relation to the FPM with their colleagues, managers and parents. Sakalys (2006) states that there has been a "subdued" focus on the body in "nursing's grand theories and caring theories" (p. 17). In particular, Sakalys (2006) states that caring theories have predominantly "focused on the nurse-parent relationship" to the exclusion of constructs related to the body "as a fundamental condition of the person" (p. 17). Therefore, the salience of embodiment and body work, including emotion work, to CFHN practice, especially their communication work with mothers, is featured here as findings that are new insights into the analysis of factors influencing their ability to work in the FPM with parents.

Third, nurse participants' descriptions and my observations of their embodied "practice" during interviews, when in consultation with mothers/babies and from their video recordings, varied across a range of standards that describe the FPM (Davis & Day, 2010). This range entailed nurses who appeared to wholly embrace and embody the tenets of the FPM in their descriptions of its concepts, and in their language and behaviours during body work with mothers and infants. Other nurse participants verbalised or demonstrated elements of what is known as the "expert model". The concept of the "expert model" in this study includes nurse participants' use of such terms as the "fix it", "medical" or "hospital based [nurse] training model" and is considered the antithesis of a partnership approach with parents. A key shortcoming of the expert model is that it does not "put parents at the centre of the helping process and, therefore, neglect[s] their obvious expertise and power" (Davis & Day, 2010, p. 79). The expert model instead privileges the "superior expertise", knowledge and power of the health professional (Davis & Day, 2010, p. 89).

[10] Note: Body labour is known as 'body work' and Emotional labour as 'emotion work' in this study as a better fit within the Australian lexicon.

The embodiment of partnership concepts and practice by the nurse appear central to the development of partnership based engagement and relationships with mothers. Ray describes these "interpersonal or relational experiences between the nurse and the patient", or in my study, the mothers and babies, as embodied engagement (Ray, 2006, p. 108). In this study, I took the view that the mind and body are "inextricably linked as a result of the mind's location within the body" (Shilling, 2003, p. 12). This view, therefore, precludes Cartesian notions of a "mind/body dichotomy" (Shilling, 2003, p. 8) when discussing the embodied practices of CFHNs. This view parallels my preference to also avoid the creation of a body work/emotion work dichotomy in the context of this study.

In order to regulate their bodies when in consultations with mothers, CFHNs in this study undertook emotion work in order to "manage and manipulate their emotions" to perform the work of partnership (Shilling, 2003, p. 104). Therefore, the mind, and the emotional and psychological body is included when referring herein to CFHNs' embodied practice and body work. Due to the factors influencing the CFHNs' subjective experience of their body, for example, from fatigue and menopausal symptoms, not all nurses in this study appeared able to effectively regulate their emotional or physical body to comply with their expressed desire to work in the FPM with mothers. This was despite the nurses' best intentions to do so.

The findings in Theme 2 portray the influencing factors related to the CFHN participants' embodied experience and body work in relation to their partnership practice with mothers/babies. The following sub-themes demonstrate the nurses' range of conceptualisation of the FPM and the challenges they encountered in managing their bodies in order to implement it with mothers in their clinical practice. Two sub-themes of Theme 2 are presented below: "Conceptualising and Integrating Partnership into Practice", and, "The Reality of the Embodied CFHN".

4.5.1 Conceptualising and Integrating Partnership into Practice

This subtheme presents findings related to the various ways the CFHN participants discussed their conceptualisation and integration of the FPM into their embodied practice with mothers and is organised under the sub-headings "*'Understandings of the FPM: 'I'm supposed to be doing Family Partnership'"; "Letting go (of power base)"; "Attending to listening and use of verbal and non-verbal cues"; and, "Being worthy of working in partnership with parents: Professional experience and growth".* The degree to which nurses

in the study understood and had integrated the concepts underpinning the FPM appeared to correlate with their embodied practice and body work with mothers/babies during consultations as well as with their discussions during interviews.

4.5.1.1 Understandings of the FPM: "I'm supposed to be doing Family Partnership"

Nurse participants in this study were highly motivated to work in the FPM with mothers and valued the opportunity this study offered them to reflect on the FPM and their clinical practice. During their first interviews, all CFHN participants were able to describe their understanding of the FPM and what the model entailed (see Figure 1, page 2). The nurses broadly understood it as a model and a framework to use when working with families; were able to describe the requisite helper qualities and skills; and, that it "*takes away from that idea of you* (CFHN) *being the expert"*.

Neroli, Virginia and their NUM (Donna) mentioned that for them, using the FPM was a core, personal philosophy and belief because they believed that the FPM worked. As previously identified, Donna was a FPM group facilitator and used the tenets of the model in her interactions with her staff. Donna stated that she was: "*probably unique…I mean our other managers are in the same boat".* I asked Donna what she meant by the metaphor "*in the same boat".* Donna replied that she had completed "*the same* (FPM) *course (with)… managers in our other areas".* Donna explained, however, that she was unique as she had followed up after her initial FPM training course by establishing correspondence with one of the authors of the FPM and trainers of her course. She said she had also established a mentoring relationship with a FPM facilitator trainer from NSW who provided *"support and guidance …afterwards which I found very valuable".* This uniqueness compared to her peer CFHN managers, was that Donna had taken further steps to embed the FPM into her management style and communication and interactions with her nursing staff. Thus, Donna's embodied conceptualisation and integration of the FPM was a key influencing factor that helped to imbue partnership within the culture of her nursing team as described in 4.4.1.2 (p. 108). Further, although Donna as NUM, did not have direct physical contact with mothers and children, it appeared that she was invested in the discipline and regulation of her own body through training, supervision and support in order to model the FPM with her nursing staff.

Neroli and Virginia also had had the benefit of undertaking the FPM Facilitator Training program. This afforded them the opportunity to revisit the FPM on a regular basis by running FPM training groups and receiving clinical supervision from Donna. Neroli and Virginia realised they had an advantage over other CFHN staff members in their team in being able to regularly revisit the FPM. This regular return to the model assisted with the clarity of their conceptualisation and integration of the model into their embodied practice with mothers. From the analysis of their interviews, observation of their consultations, and, from their linked mothers' interviews, I identified Neroli and Virginia's capacity for self–reflection and being respectfully mindful when with their mothers/babies. This set them apart from the other nurse participants in this study on a continuum of embodied ability to work in the FPM.

Donna summed up this capacity of nurses to understand, integrate and embody the FPM into practice by saying that *"people are on a continuum of the model really of how well they work in partnership and how well they understand it"*. Some of the CFHN nurses in Donna's team were reported as sitting toward one end of this range of FPM practice ability. They were described by Neroli as being less respectful of the FPM and lacking a willingness to modify their approach and consider incorporating it into their clinical practice with mothers.

> *Not everybody has this same, how can I put it? Not belief but, the same respect for family partnership model and the same willingness to think about 'How can I incorporate this into my practice?' and at times, reflect back about the model.* [Neroli]

Those CFHNs reported to be less respectful of the FPM could be viewed as sitting at the opposite pole of a continuum of bodily ability and commitment to embody partnership practice with mothers to Neroli and Virginia. These nurses, according to Neroli and Donna, were less willing to regulate their bodies by reflecting on or conceptualising the model thereby integrating it into their embodied practice with parents.

It is unclear why these CFHNs resisted or rejected opportunities or did not incorporate or embrace the FPM as underpinning all of their nursing practice. Being aware of its requirement in NSW Health policy (NSW Department of Health, 2009) and their NUM's endorsement of it, these nurses were perhaps mindful of not entirely rejecting the FPM. Or, they may have possibly given some consideration to partnership but recognised that not all mothers wanted to be considered as partners, that is, some wanted answers.

Nurses who declined to share this commitment to the FPM were at risk of being held to account by their NUM for not sharing in her ethos for embodied partnership practice. As Donna stated "*Nurses who don't follow the model in this service will be challenged by me".* Therefore, in view of the organisation's interests and goals, these nurses put themselves at a likely disadvantage to their colleagues who shared their NUM's views. They were likely to be thought "less of" if the workplace hierarchy considered partnership so positively and essential for CFHNs to demonstrate its tenets in their speech and behaviour with mothers.

The continuum of how well CFHN participants conceptualised the FPM and incorporated it into their embodied practice was evident in the regulation of their bodies during my observations of their child health checks with their linked mothers/babies. It was also evident in nurses' follow-up interviews where they reviewed the video recording of their consultation. This video recording enabled them to be aware of and appraise their own embodied practice. For example, when reviewing her consultation with Lauren and Liam, Angela stated:

> *There's a lot in there. There's counselling, there's family partnership, there's...checking on growth and development, observing him...there's a huge amount of stuff going on there.* [Angela]

In Angela's brief reflection on her consultation with Lauren and Liam she has distinguished the FPM from other aspects of clinical practice rather than as a fundamental, embodied way of working or model of care. Monica, in her first interview, also appeared to separate working in partnership with mothers from other aspects of care stating that there was a time and a place for using the FPM with them.

> *So, having an awareness that there is a time and a place to use the partnership model. Sometimes people come to you because they do want you to be the expert but once again, it's about having to find that out.* ***Yeah.*** *Sometimes it's…they're angry because they don't want to hear the answer that's really happening. Like they don't want …with a new baby that's not sleeping, they don't want to hear that this is going to go on for some months and that this is actually normal new baby stuff. They don't want to hear that.* [Monica]

Angela and Monica's comments indicate they hold a somewhat disjointed view of partnership, that is, one that is more a part of the nurse's "toolkit" to use with the right client and at the right "time and place". Rather than underpinning the nurse's embodied practice approach with parents,, this conceptualisation of partnership conflicts with the

intent of the FPM (Davis & Day, 2010), NSW Department of Health (2009) policy and the NSW CFHN Professional Practice Framework (NSW Health, 2011a). This variation in the conceptualisation of the FPM by the CFHN is a key influencing factor that impacts on their embodied partnership practice with mothers. On review of her video recorded consultation at her follow up interview, Monica stated that she was aware that she was "*supposed to be doing family partnership'*.

> *At this part in the consult, Juanita was going on and on and on about this baby. And I think that I do remember sitting there thinking: 'I would like to move this along a little faster but I'm supposed to be doing family partnership!' What's the family partnership in this?* [Monica]

Monica attributed her feelings of guilt and heightened awareness of needing to "*do family partnership discourse"* to my presence at her consultation observing and videotaping her interactions with Juanita and baby Ivy as part of my study. Monica's statement indicates her "managed feelings" and behaviour as she persevered with the body and emotion work necessary for to demonstrate an embodied partnership approach during her consultation with Juanita (Hochschild, 2012, p. 13). Monica's statement sat in contrast to her having conceptualised, internalised and integrated the FPM as wholly underpinning her everyday embodied practice with mothers. Monica's guilt that she was "*supposed to be doing family partnership",* however, suggests she knew that it was "wrong" to consider not fore-fronting partnership with mothers at all times but she chose to do otherwise when she felt it necessary. This view contrasted with Virginia and Neroli who described the FPM as a core belief and philosophy that underpinned their whole CFHN discursive practice with mothers.

I identified from Angela and Monica's comments of their observations of their video recorded consultations with the mothers and babies, a dualism in their "body-self relationship" with regards to working in partnership (Sakalys, 2006, p. 17). They were critical of their "object body" as seen on the video recording; "that (body) which can be known by a third-person observer...a passive object to be seen/observed/manipulated" (Sakalys, 2006, p. 17). Their "subject body" that is "the body that is experienced" (Sakalys, 2006) expressed a degree of failure of their object body to demonstrate partnership practice with their mother/baby to an idealised, arbitrary standard (p. 17).

I asked the CFHN participants in this study at their follow-up interviews about the nature of the relationship established with their participant mothers at their consultations. Fiona

said that she felt she had been able to build a relationship with mother Gemma but didn't think she used a lot of family partnership skills. Similar to Monica and Angela, Fiona's statement appeared to demonstrate a lack of understanding of the stages of helping in the FPM and a sense that she had not sufficiently managed or regulated her body to work in partnership with Gemma. She felt her embodied practice to be lacking.

> *With just reflecting on the consultation, I really don't know if I used a lot of family partnership skills. I felt I built a relationship but when I went home I was sort of thinking, 'Oh I didn't comment on something….' I don't know if I used a lot of those skills consciously. Maybe I could have done this better …by um…not so much asking, 'Is there anything further I can help you with today?' maybe phrasing that differently.* [Fiona]

Fiona and some of the other nurse participants appeared to conceptualise the FPM as a tool or set of strategies that needed to be consciously employed when working with parents rather than an overarching way of working. This indicated to me that these CFHNs may be less experienced or confident of working in the FPM with mothers; may have had less opportunity to fully understand it; yet, they are conscious of trying to emulate and embody its tenets in their body work with mothers and children. Also, although not voiced, they may not consider or agree with it as being a "comprehensive" way of practicing. Monica stated that she had been influenced by my presence with the video camera; possibly feeling herself under surveillance, given the topic of my study featured the factors influencing the ability of the CFHN to work in the FPM with parents. Nurse participants were also aware I was once a CFHN Clinical Nurse Consultant. These factors may have consequently heightened Monica's awareness of needing to demonstrate embodied partnership work in her speech and behaviour with mother Juanita.

4.5.1.2 "Letting go" (of power base)

A facet of body management expressed by all nurse participants during interviews was their need to let go of previous ways of working with mothers when integrating the FPM into practice. The majority of CFHN participants in this study had their nursing identities forged in traditional, hierarchical, hospital based training systems consistent with the "expert model". Nursing identity and body practices formed when working as "doers" in a hospital based medical model as well as some nurses' personal traits of wanting to "fix things" have to be unlearned in order to work in partnership with parents (Kruske et al., 2006). As Grosz (1994) states, the body is "marked by the history and specificity of its

existence" (p. 142). Therefore, the nature of our human subjectivity is formed through the history of our experiences as they occur "in and through our bodies" (Draper, 2014, p. 2237).

Donna identified in her interview the difficulty some CFHNs have in consciously adopting a partnership approach rather than a "*fix it"* [I can do] approach with parents.

> *Nursing staff who struggle to work in partnership with families tend to have a greater neediness to feel important and have people to depend on them... to have power and control; needing to be in control, the 'fix-it' sort of model. Their measure of success is how much they fix the client, the number of contacts from the client, how many clients tell them they're wonderful*. [Donna]

Donna's pejorative views of nursing staff who "*struggle to* [regulate their bodies to] *work in partnership"* could be construed as being full of assumptions and value laden. She considers these nurses as "needy" in multiple ways and perceives these as negative attributes in the body and emotion work required by CFHNs to work in partnership with parents. The problems associated of working in a "*fix it"* model versus the FPM are also described by Virginia.

> *I think it's easier to work as an expert but it's not easier for the family and their wellbeing in the long term.* ***What's your experience of what happens…if you work in that expert model?*** *Well, I think you're giving them a temporary fix and it doesn't always work anyway and they haven't been heard…. there's no respect in being the expert.* [Virginia]

These issues of the expert model being a temporary solution for client problems and lacking respect are clearly identified in the FPM texts (Davis & Day, 2010; Davis et al., 2002) and the associated training program (Davis et al., 2009). A number of CFHN participants in this study expressed the challenge of "*letting go"* of the expert model and its associated power base; their assumed "*authority"* when trying to instead, embody working in the FPM with mothers. These nurses presumed that when working in the FPM, it meant they had to let go of their own power base. However, in the management world, there is a perception held that to give away power is to gain power (Marquis & Huston, 2006).

> *I think that it's challenging always not to be the expert….It's very easy, particularly when you've been in the service as long as I have, to fall into a…a*

> *mode where you're the authority.* ***Yes****. And I think you have to pull yourself back from that because you're actually much more valuable to them if you let them be the specialist in their baby and you give them guidelines but accept that they have the right to refuse your advice and to go their own way.* ***Uh huh****. …I know that there's times that I can be a little bit forgetful of that need to back off being the expert …****Yes.*** *…and see myself more as walking alongside them.* [Annie]

Annie has described the tension present in trying to regulate her body to respond to mothers in partnership rather than as the "*authority"*. In stating "*you're actually much more valuable to them if you let them be the specialist in their baby"'* indicates her awareness of the tenuous balance of power present during consultations with mothers and their babies. However Annie's use of the words *"let them be the specialist in their baby*" suggests that she considers herself "allowing" them, rather than herself, to be the expert in their babies' care. This suggests that the nurse holds the balance of knowledge and power in these situations and can choose to what degree to share this with mothers (Aston, 2008; Grant & Luxford, 2008). Annie also does not mention here what she gains when she *"let*[s] *them be the specialist*", for example, learning more about their situation, their perspectives, their approaches to child care that may be helpful to her body work with them by taking these into consideration. Annie's discussion has, however, featured the personal rewards and satisfaction she experienced from working in the FPM with mothers such as thankyou cards and mothers who returned happily saying an intervention had worked for their situation and baby.

Erica described in strong terms the controlling effect of the use of the expert model with mothers by some of her CFHN nurse colleagues in infant care practices such as breastfeeding: "*I don't like to be one of these breastfeeding Nazis. You give options for how they want to proceed".* Breastfeeding is a dyadic, embodied maternal practice with emotive cultural and professional meanings and practices attached (Stearns, 2013). Breastfeeding is dyadic in that it involves the mother/child as well as the mother/provider, in this case, the CFHN (Stearns, 2013). Breastfeeding as an embodied practice is a contested area of both CFHN and maternal/infant body work in which some nurses' experience difficulty "*letting go"* of their expert practices. The CFHN has to work hard at not embodying herself in dominating ways.

Annie identified that *"Mothers* [who] *see you as the expert"* reinforced nurses' embodiment of the expert model.

> *With unconfident parents there's more risk you'll take on the expert role of information giver and disempower the parent; there's a grey area in the middle*. [Annie]

The CFHN participants in this study identified that the FPM was a helpful framework to use when working with families and that it increased their awareness of the problems associated with working in the expert model. Monica stated it *"opened my eyes ...to what I was doing and to try and move away from telling parents what they should be doing".* Despite this desire for a partnership oriented practice, however, some of the examples and language used in conceptualisations of partnership and the actions taken identified during interviews appeared to place some of these nurses more at the expert model pole of the partnership continuum. For example, Monica indicated that using family partnership on the first home visit was sometimes "*just not an option"*; and, that *"there is a time and a place for using the FPM with parents".*

Angela describes below how she had managed a weaning and sleep issue in partnership with a previous mother with a thirteen month old baby:

> *She said 'So what do I do?' And I said, 'No, no. Let's not talk to him about* (it)*', 'cause she talks to him at night. Like we're going to have a feed or whatever… I said 'No, no, no', and I said 'What you're going to do is you're going to tell him what you want him to do'. 'Cause I worked out the baby: you're gonna say… 'You're gonna have dinner and have a bath and then you're going to go to bed' and you talk to him and so, by working in partnership with her which took (pause) three appointments,…* ***Yeah.*** *…they think they have to have a structure. She still loved breastfeeding and did sort of want to wean but really the problem was sleep.* [Angela]

This excerpt of practice from Angela describes her *"telling"* the mother what she needs to do to settle her baby. The phrase "*Cause I worked out the baby*" indicates that Angela may have felt that she held a greater understanding of the baby than did the mother. This implied to me that Angela had embodied an expert model of dominating power played out in the interaction with the mother rather than the partnership model of shared power.

In another example, Annie had acknowledged that the body work of partnership was a challenge for her. Annie, stated: *"one of the things you need to do then is you need to teach the parents the skills to make the judgement call themselves".* This sentence indicates the use of a pedagogical discourse by Annie in needing to "*teach the parents".* This subtle

language variance shifts the emphasis from "working with" the mother in a partnership orientation to a more expert knowing what's best for them. However, the above sentence contrasts with a later statement by Annie, where she said she encouraged mothers to choose from a range of strategy options and to come back and challenge [CFHNs] on it if they don't solve the problem at hand: "*I want you to be able to take what we give you and make it into a solution for the problem and if you can't, then come back and challenge us on it".*

Analysis of the language used during interactions appeared to uncover the nurse's unconscious, embodied control of the consultation and this was despite a wish to work in the FPM with the mother. I asked Sandy in her follow up interview:

> ***What were the factors that influenced you to work in partnership and whether the mother contributed?***' *I just allowed the discussion to happen and things that she was raising…like an open conversation ...and she was seeking information and I was trying to allow her to... to see all the other factors and to think what ...what else could have been an issue and I didn't want to jump in and say, 'cause you sort of fix it. So you have to try and make her think and she did quite nicely I thought.* [Sandy]

Use of the word "*allowed"* is a subtle language shift that indicates Sandy had charge of and directed the conversation with Dani during this consultation. This is a shift from a FPM approach where the conversation is parent led and there are agreed goals for the outcome of the consultation (Davis & Day, 2010).

Annie expressed confusion about the body work required in relation to the role of CFHN and professional expertise as opposed to mothers' expertise when working in partnership with them. In the following interview excerpt, Annie frankly discussed this confusion concerning the meaning of "expert" and "expertise" in the context of family partnership and her nursing role status at performance appraisal with her nurse unit manager.

> *It's challenging always not to be the expert …and there's certainly some elements probably in all health services where um…if you're given a title, with that comes the idea that that comes with an expertise….And there's some element that you have to show like I've got my appraisal….It's next Monday and I've got to show why I'm worthy of the CNS* (Clinical Nurse Specialist) *and why I'm worthy of this and why I'm worthy of that… On the one hand, I'm not supposed to… I've got to stop…I've got to prove I'm an expert and on the other*

hand I've got to stop myself being the expert and guide people and sometimes there's a grey area and the black meshes into the white and it's really hard to keep the two very distinctly defined. [Annie]

Annie's CNS status had given her symbolic evidence of her expert CFHN knowledge and position within the work place hierarchy. Her confusion appeared related to her status as "expert" and her view that she had to physically stop herself from "*being the expert*" in order to work in partnership with mothers and babies. CFHN knowledge and expertise, however, are needed to prudently distinguish when to work in the FPM with the mother leading, trusting her to know when to raise concerns about herself or her baby; and, when a more directive, CFHN clinical intervention is required. In the following example, Annie, a very experienced former paediatric nurse with considerable expertise in the assessment and care of sick children, revealed this difficulty in using her nursing expertise. The example involved a young mother who lacked confidence and had a history of poor mental health as a child. The mother was regularly attending Annie's weekly parenting group with her new baby. Annie had recognised that this young woman was struggling with her ability to mother but said she misread how much she could leave her to ask for help.

Her baby didn't do very well and ended up hospitalised because of failure to thrive. And I felt one of the reasons I think I failed to pick it up was that I was so …in the back of my mind, ….had a really big message from colleagues that we mustn't weigh babies, that we must convince mothers that they've got to look for wet nappies and they've got to see good feeding and ...if the mothers were reporting all of that then you don't need to [weigh the babies]*... I had no reason to undress the baby and weigh it and so the whole thing* [the baby's well-being, growth and development] *got slipped because she was attending but not really* [attending consultations] *if you know what I mean.* ***Yes.*** *So I was physically seeing her but never seeing the baby undressed and...in retrospect, I felt that I failed her a lot and part of the reason that I failed her was I was so focused on my family partnership skills... I wasn't ticking the boxes that I would have done in the expert mode like weighing the baby every week and filling in forms.* ***Yep. So tipped the balance one way?*** *And so I made some significant errors ... which I deeply regret in handling that case ...and I still struggle a bit with that sort of area of building the mother's confidence without taking over.* [Annie]

Annie's retelling of the incident was a regretful discourse. She acknowledged the significant clinical errors she made and deeply regretted her management of the above case. This discourse was juxtaposed with a continued bewilderment about the role CFHN expertise played in undertaking the body work of partnership based relationships with mothers. She described this situation as her failure to identify a baby that was failing to thrive even though she saw this mother/baby pair each week at her Centre's parenting group. She said despite this, she still struggled with building mothers' confidence without taking over and working as the expert professional ticking the boxes. This example portrays the tension present for CFHNs and the body and emotion work required when trying to empower mothers by trusting them to know when to ask questions and ask for help and, when to intervene using nursing knowledge and expertise. Providing infant screening and surveillance is core business for CFHNs but there may remain misperceptions for some nurses in the application of their clinical expertise when working in the FPM with mothers and children. CFHN professionals may need to negotiate the re-visioning of power relations between themselves and mothers. None of the other nurse participants openly discussed whether they also experienced this blurring of professional nursing responsibilities in the context of employing nursing expertise while endeavouring to work in partnership with parents.

In a sense, what Annie has described is "body boundary work" (Draper, 2014, p. 2240) in which the boundaries have become blurred. The locus of front line CFHNs' work is the body. In Annie's example, the work of partnership was privileged over her nursing skills of looking, touching, examination and assessment. This privileging of partnership created a "boundary" around the baby's body and attribution of maternal expertise regarding her baby's body and well-being which was lacking in this instance.

An important distinction discussed that may also be drawn from Annie's example is the role of the CFHN compared to the role of psychologists (whom developed the FPM model) when working in partnership with parents. CFHNs, along with other professional groups, use their physical body in their assessment and intervention role with babies and children and to lesser degree, the mother. Nurses' look, listen, touch, measure, assess, and manipulate the baby's body at developmental child health checks and other consultations (Australian Health Ministers Advisory Council, 2011; NSW Kids and Families, 2013). CFHNs also have a mandatory role in advocating for the well-being and welfare of the child (Australian Health Ministers Advisory Council, 2011; NSW Parliamentary Counsel's Office,

1998). In comparison, psychologists as a rule do not regularly conduct physical examinations on infants and children or mothers.

The expert model paradigm was challenging for some CFHN participants to forgo and they struggled to regulate their bodies appropriately in order to work in a partnership approach with parents and children. Confusion was present regarding the deployment of nursing expertise and finding the right balance of complementary expertise from the mother when there were blurred body boundaries. Annie's above example indicates that she had misunderstood how her CFHN expertise and physical assessment skills complemented her ability to work in partnership with mothers/babies. Harnessing her clinical expertise Annie had misunderstood to be "working in the expert model". This misunderstanding resulted in adverse outcomes for the baby and mother attending her parenting group. This was reported by one nurse in this study. It may also be an unspoken issue for other CFHNs when aiming to work in partnership with mothers and babies

4.5.1.3 Attending to listening and use of verbal and non-verbal language cues

CFHNs in this study spoke of the close attention they needed to give to the body work of managing the two way flow and use of language, both verbal and non-verbal by mothers in order to work in partnership with them. They needed to be able to listen well and be aware of their own embodied physical responses such as facial expressions and gestures in their interactions. CFHNs were required to regulate their physical and emotional bodies in order to demonstrate working in partnership with mothers.

In relation to the use of verbal and non-verbal cues, Annie and Erica stated that the feedback they received from mothers' reactions was a huge factor that influenced their partnership work with them. This feedback could result from observing a mother's facial expression, or when mothers returned [to Annie] after a consultation and said *"you really heard what I was saying and you really helped me"*. The mother's reaction and expression could also tell Annie when she needed to physically and/or verbally *"back off"* if she was being too directive with them. Thus, CFHNs' require highly attuned skills in being able to "read bodies".

Erica stated in her follow-up interview while reviewing her video-recorded consultation, that she had been looking closely at Beth (mother) for cues that may indicate something was *"not quite right*".

> *Beth is one of those people that makes light about everything so you have to be careful that you do pick up if something's not quite right. She will try to gloss over things. ...but so far I haven't picked up that there's anything that's really disturbing her that I'm aware but she's one of those jolly people that will try and minimise things when perhaps she should be a bit more up front about ...So you're always going to be looking harder at her when she's saying, 'It's all fine'.* (and asking) '*Is it really fine?'* [Erica]

Field notes: *I reflected on Erica's assessment of Beth following her interview. It takes an experienced, knowledgeable CFHN skilled in reading body language to discern these subtle cues "that something may not be quite right" with a parent and be able to explore issues effectively. Erica had to manage her body in order to maintain an interested, focused attention on Beth to identify and respond to these cues. (Ethnographic Observation, 2011).*

Monica provided an example of this expertise in reading mothers' body language in the excerpt below. Prompted while watching the video playback of her consultation with Juanita and Ivy during her second interview, Monica said that Juanita's body language influenced her responses during her consultations:

> *…and her body language too. You can see that she did feel uncomfortable because her body stiffened up and she also, when she was talking about...being quite protective of the baby, putting her hand on her baby.* [Monica]

In this instance, Monica said she observed the mother's body "*stiffening up"* and "*putting a* [protective] *hand on her baby"* when Juanita was recounting an event where her baby Ivy was potentially exposed to a communicable disease. Juanita's body language prompted Monica to expand on this issue with Juanita as she was able to observe bodily, the discomfort the situation had created for the mother. When I later interviewed Juanita she agreed about this and, in parallel fashion, said that the cues she received from Monica's body language and prompting encouraged her to expand on the issue that was bothering her.

The importance of reading bodies, and the body and emotion work in the CFHN's facial expressions and non-verbal feedback was highlighted to me in the follow-up interview I held with Jean. Jean was reviewing her video recorded consultation with mother Millie and baby Paul. Jean stated that *"she was really able to see her own facial expression and saw the*

effect of her <name of medical condition[11] that caused paralysis of facial muscles> *that she had as a young woman"*. Judy said she was *"jealous of others* (like me) *who had wide smiles"* as she had limited physical ability to use the muscles of her face and smile.

Field notes: *I assumed that Jean was tired or was less able to engage with Millie than some of the other CFHN participants as she did not seem to smile much during the consultation. There was a lack of physical animation in her face. I was really shocked at Jean's admission. I had not realised what was missing from her communications with Millie. Indeed Millie, (whom I interviewed immediately after the consult), was very happy with her meeting with Jean and said she really thought that she had been listened to. Jean spoke of CFHN colleagues who have also at times made assumptions and said "that she did not seem to be enjoying herself" at team functions if they did not know about her illness history. I was embarrassed by my assumptions and the ill-founded judgements I had formed about Jean's practice based on her physical appearance and cues. (Ethnographic Observations, 2011).*

Jean's assessment of her overall video replay, however, was that she wouldn't have changed anything about her practice with Millie and baby Paul. Jean's assessment of her "object body" was that it had physical limitations outside her control but that she listened and tried to be respectful; two significant components of working in the FPM. Indeed, Jean's appearance and facial expression did not impede the mother's (Millie's) very positive perception of her consultation.

Study Diary: *I agree with Jean's summation of her partnership practice now that I understand the communication hindrance resulting from her limited facial expression. I realise that Jean has skills and qualities on par with Neroli and Virginia on a partnership continuum. It makes so much sense to me now that I know what it was I couldn't quite work out; why this nurse's embodied communication style seemed so passive. (Researcher Study Diary, 2011)*

Four CFHN participants spoke more generally of the cues and feedback they received from parents. Fiona said that the different ages and cultures of mothers actively influenced her body work in trying to establish partnership with them by knowing the sort of relationship building and communication that may be required. Fiona said that she would watch how mothers would come into her office and might change her posture, use of language, and where she sat in response. For example, Fiona said she might choose to sit on the floor with an adolescent mother of a toddler. Fiona's descriptions indicate the

[11] The medical condition is not identified to protect participant anonymity

variety of ways she regulated herself to undertake the synchronised body work necessary to aid her establishment of a partnership based relationship with mothers.

Virginia spoke of the "*power of listening"* for effective communication with mothers when working in the FPM.

> *And we mean effective communication and effective listening. Not just doing you know, a bit of head nodding and kind of, you know, playing with your fingernails, or looking at your clock or flipping the paperwork. Listening is a lot of skills and a lot of …intense concentration.* ***Yes.*** *A lot of non-verbal skills.* [Virginia]

This active listening requires the CFHN's body to be constantly attuned to the mother. This occurs through her physical attention and "*intense concentration"* to collect the verbal and non-verbal cues given by mothers. This concentration, attentive listening and responding is hard body work. It requires the CFHN to regulate her own body for the duration of each consultation for every mother/baby when working in partnership. There are also numerous concurrent bodily activities and tasks of the CFHN to also keep abreast of when working in partnership. Jean has summarised some of these activities that she focuses on when working with parents:

> *Language, the way we speak to people, for example, 'What can I help you with today?' Asking upfront for the client's agenda, stops us thinking we have to tick all the boxes, being careful to listen, checking self ….* [Jean].

Nurses were objectively analysing their embodied practice when viewing their video recorded consultations. They appeared aware (but not always to demonstrate it at the time of consultation) that how they manage their body including their listening and language skills, are critical components of working in the FPM with mothers even though they may not have verbalised this in partnership terms. Maintaining the intensely focussed communication work of partnership proves to be challenging for CFHNs. These challenges are compounded if there are distractions present for the CFHN. The findings related to "coping with distractions" are presented in subtheme 4.5.2 The Reality of the Embodied CFHN (p. 173).

4.5.1.4 'Being worthy' of working with parents: Professional experience and growth

Nurse participants stated that it was personally important to keep up to date with clinical knowledge and their own professional development needs in order to best help their client families. Although not articulated, the nurse participants in my view were alluding to their bodies "as a project" (Shilling, 2003, p. 4). Shilling (2003) states:

> There is a tendency for the body to be seen (by the modern individual) as an entity which is in the process of becoming; a *project* which should be worked at and accomplished as part of an *individual's* self-identity. (p. 4) (Author's emphasis)

In this study, the CFHNs stated they were committed to attending conferences and workplace inservice sessions in order to become more accomplished CFHNs. The nurses in this study identified at interview that knowledge and experience contributed positively to incorporating the FPM into their embodied practice. One nurse, Virginia, also mentioned that *"we all need to work in evidence based practice. We need to keep current".* Virginia understood that keeping practice evidence based and up to date complemented other aspects of the body work associated with partnership work with mothers, such as having a reflective practice. Annie, Jean and Sandy described how the FPM training was integral to their professional growth trajectory (their bodies as "projects") and embodied identity as CFHNs.

> *I think it's* (FPM) *emerged as you go through your different…I have to say, training and studying…. I think it has evolved with being in the* (CFHN) *career and …yeah, experiencing it…. You come to realise that some interventions have better outcomes when you sit back and think about it.* [Jean]

> *"I've grown heaps and heaps within the service. The challenges that the service has thrown me over the years as a person, as a clinician… I was nothing like I am now in the capacity to help people and I guess that gives you a sense of allegiance* [and] *I have a huge belief that I've been taught right."* [Annie]

For Annie, undertaking the FPM training was akin with being *"taught right".* It enabled her professional practice to develop and increase her *"capacity to help people"*

Experience in the CFHN role contributed to nurses being able to work in partnership with mothers in a number of ways. Annie used the expression "*being in a comfortable*

environment or territory" to describe how discussing issues with mothers such as infant sleep, settling and wrapping were areas of *"core business"* for CFHNs that contributed positively to working in partnership. Virginia said that experience was also needed to remain working within professional "body boundaries" (Draper, 2014) and to know when an episode of care was completed as well as the importance of referral and moving on. Virginia was clear on her embodied professional role with clients stating: *"I'm not a mother substitute or great Aunty".*

CFHN participants Jean and Neroli stated that a broad education was needed to effectively inculcate embodied partnership work with mothers, not just medical understandings alone. Jean stated that understandings of sociology, anthropology and history were valuable for working in the FPM with mothers. Neroli agreed but leaned toward nursing education providing a greater depth in psychology and sociology content for all nurses because: "*I think it helps you understand people".* Being able to understand people, Neroli stated, was essential for CFHNs in order to be able to work effectively in partnership with mothers.

Jean and Sandy stated that it was important for CFHNs to have regular education and practice updates via inservice sessions in order to be confident in their clinical practice. Erica said that conference attendance where current relevant information was provided contributed positively to keeping motivated and interested in the CFHN role. Annie stated that for her, it was important keep her clinical practice up to date in order to be "*be worthy of working in partnership with clients'*. When I asked what she meant by *'being worthy"* Annie explained that she needed to be worthy or deserving of the respect and trust shown to her by parents to provide guidance and support with their precious new baby. In Annie's words:

> *Parents come to us for support because they need to be told that everything's going okay for reassurance. …So it's important if I'm going to work in partnership with them that I'm worthy of working in partnership with them. 'Cause if I can't meet the needs that they've come to me for then I'm not the right person in the job. Yeah**? Uh huh**. So the fact that …the job won't let me become stale … that it gives me ongoing education, that it guides me… to challenge myself so I grow … with the mothers that …that's part of a partnership. I mean part of my …you know … if you sign a contract in a partnership you both bring things to the role. Now my parents bring their baby …and their knowledge. If I'm going to accept that degree of respect that they've*

> *given me that they trust me with the most important thing in their lives, then I have to step up to the plate and be worthy of that trust.* [Annie]

In this section, the data analysis indicates the nurse participants equated ongoing clinical education and development as a key professional responsibility of the individual CFHN; and, one that contributed positively to their ability to work in partnership with mothers. Their bodies were "projects" (Shilling, 2003, p. 4) to be continuously worked at, improved (through education/professional development) and disciplined [through self, peer and managerial surveillance and regulation] in order to be CFHNs "*worthy"* of the trust of mothers with their babies. It gives an indication of the roles and expectations the "partners" in the partnership play in these encounters. The parents come to the CFHN professional with an expectation that they (the nurse) have the requisite knowledge to help them. The parents contribute the love, support and knowledge from being with their baby; while the CFHN is expected to bring her up-to-date "clinical" knowledge to the consultation as one attribute of body work in order to be *"worthy"* of the parents investing their trust in the partnership relationship with the nurse.

4.5.2 The Reality of the Embodied CFHN

4.5.2.1 Keeping the body alert

The CFHNs in this study identified the presence of distractions either of a workplace nature or emanating from within themselves, which adversely influenced their ability to work in the FPM with mothers. These distractions made it harder for the CFHNs to manage and regulate their bodies in order to work in partnership. Neroli described some of the internal and external distractions experienced and how these could detract from her "*being in the here and now*'" with the mother.

> *So once a distraction has occurred then it's harder to be in the here and now of where the person and their story actually is.* ***Aha****. …and the distractions can be internal 'cause you're hungry. Distractions can be somebody knocks on the door and they want something or distractions can be: this client's arrived 10 minutes late and you're thinking, 'OK. Now we've got 20 minutes left of a thirty minute appointment'.* ***Yes.*** *Or the distractions can be that the baby just doesn't want to be there for that day or the toddler doesn't want to be there or the… you know, whatever doesn't want to be there. Or maybe the mum feels that she*

> *has to be there and she's been told to come from another staff member and thinking: 'Why am I here?'* [Neroli]

Sandy described her sense of feeling rushed; task orientated and "*drowned"* in general work and information in both her interviews

> *I mean I think the basic issues are one does get task focused and there are a lot of tasks. You do get drowned in a lot of information that you need to disseminate and deal with and sometimes…'* ***To the parent?****' No, with general work… work stuff so that your mindfulness might not be there 'cause you're trying to deal with all this stuff and the phone calls and blah, blah, blah.* [Sandy]

Sandy's use of the expression *"You do get drowned"* implied to me that her embodied emotional experience was one of sinking or going under; unable to stay afloat with her CFHN workload. Sandy was aware that her physical and emotional sensations were distractions that prevented her from being fully engaged and mindfully present with mothers and their babies during consultations. Sandy's reflections on her consultation with Dani and Leo in her follow-up interview reinforced that she had felt rushed and this distracted her from being mindfully present and adversely affected her ability to work in partnership with them.

Field notes: *Sandy is aware of how she would like to practice with parents. However, her perception of time constraints and competing service demands means for her that she must complete her "checklist" of maternal and infant assessments within the consultation. Dani's maternal psychosocial assessment had not been completed at the UHHV which meant that it needed to be completed at this six-eight week child health check consultation at the clinic. The other competing demand for Sandy was hearing the arrival of mothers in the waiting room for their parenting group session that Sandy was later to facilitate.* [This also occurred today at my follow-up interview with Sandy where she doesn't have much time yet is trying to accommodate my interview]. *The nurses at the centre purposefully schedule the baby checks before and after the parent group sessions to make it easier for mothers to have a one-stop shop visit. Sandy said she would like to have been more mindful and present during her consultation with Dani. However, this is an actual slowed down, conscious state of being where you are focused on the task, person or situation at hand. I don't think I observed this especially when Sandy abruptly, albeit briefly, left the room on two occasions. Both Sandy and Dani's subsequent interviews correlate with this observation: that she was unable*

to be mindfully present and there appeared to be a lack of bodily synchronicity between them. (Ethnographic Observations, 2011).

Other key distractions that were discerned from analysis of the aggregated data that adversely impacted on nurses' ability to work in partnership with parents are presented as the sub-headings below. These include "*Feeling disconnected or not in a good headspace", "Tiredness",* having *"Too many clients back to back"*; and, *"Ageing and menopausal bodily discourses".*

4.5.2.2 Feeling disconnected or not in a good headspace

Angela, during her first interview, communicated significant insight into her own personal issues including her mental health state that could adversely impact on her working in partnership with parents. Angela's conversation and tone indicated that there were issues from her past, some of which that may be unresolved, that impacted adversely at times with the body and emotion work of engagement with parents when conducting assessments. Angela stated:

> *The other thing that can hinder it* (working in partnership) *is your own mental health state. If you're not in a good mental health state then you're not going to be tuned in to focus on other people….Or if you* (the CFHN) *haven't processed ...you know, if you've had a difficult family history or...even I think if...relationship with men isn't that...you can tend to dismiss their* (fathers') *contribution or make assumptions about them.* [Angela]

Angela's difficulty in remaining alert and attuned to the parent was played out during her subsequent consultation with Lauren and Leo. She appeared to find it difficult to remain fully present and engaged with Lauren during the maternal psychosocial assessment component of Leo's child health check. Asking these questions appeared to cause Angela discomfort and posed a challenge for her to regulate her embodied responses in order to demonstrate working in partnership with Lauren and Liam.

Field notes**:** *I observed Angela physically turn her back to Lauren and Liam, face the computer screen and commence typing while asking the sensitive maternal psychosocial assessment questions. Angela asked the questions in a blunt, close ended format without pausing for further clarification or eye contact with Lauren. (Ethnographic Observation, 2011).*

During her follow-up interview while watching her video recording of the consultation, Angela revealed her feelings of disconnection and difficulty in asking Lauren the maternal psychosocial assessment questions. Angela admitted she "*hated asking those questions*" and implied that it was her own personal issues that interfered with her ability to ask them of the mothers. After watching her "object body" (Sakalys, 2006) asking Lauren the maternal psychosocial assessment on her video recorded consultation Angela reflected:

> *I hate asking those questions. I absolutely hate them. That's why I brush over them. I just hate them.* ***What…?*** (Angela continues to speak) *I don't know whether it's my own stuff or whether I just don't know whether I would just manage what the answer would be but it's hard for me to ask those questions. And although I mean we need to ask them, I just hate asking them and in fact recently I've been in a bit of trouble because I wasn't asking them at all at the home visit. And of course that means you can't do the psychosocial assessment is not really complete. So … I started to ask them but I still brush over them because …it's not...no. It's just my stuff really.* ***OK.*** *Really. Yeah. So that's not partnership really.*
>
> ***What do you mean by that?*** *Because it's not really...it's my stuff getting in the way of... you know, like if it was partnership then you would want to know...you would give them an opportunity to give you an answer that meant that you could offer them the services.* (Angela continues to watch the video).
>
> *And again, that's disconnection. See? I'm not even looking at her. You're still disconnected but by facing the computer and not facing them.* [Angela]

I gathered from Angela's account that she engages in significant emotion work (Hochschild, 2012) each time she asks mothers these questions during consultations. She must try to manage her feelings in order to "create the facial and bodily displays expected from employees" (Hochschild, 2012, p. 7); in this instance, ideally a CFHN who is demonstrating engagement, interest and empathy and is facing the mother. She repeatedly stated "*I hate asking those questions*" yet she must ask them of mothers at work on a daily basis. The discourses that appear to be operating in Angela's excerpt from her transcript are a "distressed" discourse, a "subordinate" discourse, and a "guilty" discourse. Organisationally, she is voicing the contrasting tensions within which she is trying to work and provide support to mothers. Angela states she experiences significant distress whenever she has to ask the maternal psychosocial assessment questions. She must

comply with policy and her manager's request that she completes this assessment thus a "subordinate" discourse is operating as Angela is unable to exercise control or power over this situation. Finally, a "guilty" discourse is operating as Angela admits to still "*brush*(ing) *over"* the questions which is "*not partnership really"*. Angela was unable to undertake the necessary body and emotion work (Hochschild, 2012); that is, the requisite facial or bodily displays that indicate engagement and partnership work with Lauren. She turned both her face and body away from Lauren and typed onto the computer during this part of the consultation.

Study Diary: *I reflect that Angela was vulnerable here in relation to personal vicarious trauma by not feeling equipped or supported to ask these assessment questions that she must ask daily in her practice. The NUM has used her authority and disciplinary power with Angela ("I've been in a bit of trouble") to ensure she asks mothers the maternal assessment questions at the UHHV. I think that Angela may be typing onto the computer during the consultation because:*

- *She can turn away from Lauren to better manage and avoid her physical and emotional discomfort;*
- *She hates asking the maternal psychosocial assessment questions so disconnects from the parent as a defence mechanism; (you are less likely to engage if you're not making eye contact);*
- *Angela said she is unable to make alternate seating arrangements due to the spatial constraints and where power points/cords are situated in her consultation room;*
- *She feels rushed and feels there's a lack of time to type responses on the computer after the consultation; Angela also said she is unable to touch type. (Researcher Study Diary, 2011)*

Angela's history and the structural forces at play are influential to her sense of personal agency to affect positive change in this situation. Angela justified her actions in this instance with Lauren, however, by saying that *"It's okay. We've developed a relationship because I've done the home visit".*

Donna (NUM) stated during interview the crux for CFHNs to be able to work in partnership with parents was how well they were able to cope with change and the emotions, thoughts and feelings that accompanied it. In addition, Donna stated: *"The nurse's personal makeup, emotional stability, well-being and life experiences significantly impact on their ability to work in partnership".* However, Donna did not expand on this or

discuss how as a manager she provided support to her staff that were experiencing difficulties with adjusting to change.

Neroli said that "*Not being in a good headspace hinders being with the client"*. Neroli said she tries to ensure that any problems or concerns she may *"have actually stays out the door so that I can truly be with a client"*. Neroli recognised, like Angela, that the nurse's own mental health state could negatively affect partnership practice. This was because a poor "*headspace"* could potentially impair engagement processes and the body work required for emotional and physical attunement with parents. Neroli stated she actively tries to disengage from any of her own personal issues in order to be "*truly with"* parents. This indicates that Neroli prepares herself to be "present" when in consultation with mothers and children.

Erica, in her first interview, stated that her personal history leaned her more toward the needs of the child rather than the mother during consultations. Although this may not be a "distraction" as such, it is an orientation of practice that stems from events that occurred in her past; her embodied experiences. This orientation may influence nurses' partnership focus during consultations regarding whose needs are paramount at the time; the mothers or the child's.

> *A lot of it depends on your personal philosophy I think. If you're very liberal then…you tend to…shift onto that side …and kind of …if you like the sensation of being on the child's side whereas some people are on Mum's side and feel that she needs the kid in a routine so she can cope. …. I'm not very good at that. I have to say, I'm not very good at being very directive… I'm a terrible softy but …I think that's partly as well comes from my history as a little kid …when you've been abused yourself you tend to be very sympathetic towards the needs of children and not want them to suffer at all.* [Erica]

Erica's account alludes to somewhat of a dichotomy for CFHNs: being on either the mother's or the child's side during consultations; an "us or them" discourse. Fathers/partners are not mentioned. Annie described a similar orientation to Erica in being child oriented and attributed this to her paediatric nursing background. Erica's excerpt above alludes to a personal history of abuse as a child that has influenced her child focussed practice orientation. Erica's embodied practice was imbued with sympathy for the needs of the child based on her own subjective experience. Erica did not have to ask Beth the maternal psychosocial assessment as this had been completed at her UHHV. I

was, therefore, unable to observe whether Erica's past impacted on her ability to conduct this assessment. However, Erica did not raise this aspect of practice as a concern during either of her interviews.

4.5.2.3 Tiredness

Physical feelings of tiredness and work overload were perceived by nurse participants to contribute to workplace burnout and were identified as factors that negatively affected their ability to work in the FPM with mothers. Monica describes these feelings of burnout as follows:

> *When you feel burnout, your energy tank empties out from not enough self-care …you don't want to know about problems, you have less empathy, you get irritated, feel resentment. …you're just trying to get through the day as best you can and finding that it does take a toll. You don't really want to participate in Family Partnership. You get a headache, tired and burned out quickly.* [Monica]

This physical and emotional fatigue and lack of energy was an issue for Monica particularly at the end of the day. In her follow-up interview Monica stated:

> *Probably the biggest thing for me is having the energy to do it really. At the end of the day,...it's much harder to ...you might still try to work in partnership but it's much harder to listen when you're tired because it takes a lot of energy…at the end of the day I think I listen a lot less with tiredness*. [Monica]

Monica also stated that noise was a physical distraction and was compounded by the responsibility she commonly held of whole day supervision of students and new staff members. There was no dedicated CFHN role or clinical nurse consultant to undertake this task in her team. This necessitated Monica to focus not only on the needs of mothers and children during consultations but also to support and teach supernumerary students or new staff throughout the day leaving little time for personal space and reflection.

> *I actually just thought of one* (factor that influences working in partnership with parents)… *New staff and supporting new staff and trying to be… to use family partnership with new staff which can be hard. And then… doing it with clients and then we also had quite a few student nurses, early child and family health students, also coming in. So that impacts too because …you've got…got another agenda to achieve in that visit as well. So that …that can be*

quite…that can be quite stressful….There is no quiet time. ***Ahh.*** *….There is no thinking time.* [Monica]

In addition, "*the end of the day"* was stated by Monica and similarly by other nurse participants, as when *"the tricky ones often come along"*. This expression meant that mothers with more complex needs may have appointments scheduled late or "routine" clients presented with unexpected complex issues. This was problematic as Monica said nurses "*often have less energy than the beginning"* of the day when their bodies were more likely to succumb to fatigue. Monica also used the metaphor "*the heaviness of the clients"* to indicate complexity of needs and implied she expended a great deal of personal energy in her body work with the weighty or needy issues of these mothers and their children. I implied from this metaphor that Monica felt physically and emotionally weighed down by the needs of these parents. She indicated the resulting drain on her energy also adversely affected her capacity for the emotion work required to work in partnership with them.

Monica clearly identified that for her, the CFHN role was emotionally and mentally draining. Further, she stated that working in partnership required a lot of energy. Monica said, like Neroli, that you needed to be "*in a good place yourself*" to work in partnership with mothers. This inability to do so at times lead Monica to express guilt that she was not conforming her embodied self to the idealised standard required of the FPM.

Because of the nature of the work, …because it's …sitting and hearing families' distress… Listening is quite an exhausting job. …I found there is …sometimes you can't really understand why you've got so exhausted doing this job. It's not like you run around the medical wards and made fifteen beds and showered twenty patients. So you think, 'Why am I so tired?' …I think it's important to acknowledge… for myself that… it is (an) *emotionally and mentally very draining job….family partnership takes a lot of energy….* ***So you need to be in a good place yourself****? I feel like… guilty that I don't use it* [the FPM] *as much as I should.* [Monica]

The FPM requires the CFHN to consider and attend to the personhood of "the other", that is, the well-being and possible support needs of the parent(s) and child(ren), as well as her own personal needs. It presupposes that the nurse is able to share and give of herself through bodily displays of the qualities of respect, genuineness, quiet enthusiasm and empathy when in consultation with parents and children (Davis & Day, 2010). Being genuine suggests that the CFHN be consistent in their approach and to act naturally and

not in a "mechanical or artificially deliberate way" (Davis & Day, 2010, p. 115). Being genuine with mothers means the nurse can share with them at times if they are experiencing distractions from fatigue, ill-health or other problems during a consultation. These self-disclosures should be used only when it is considered of benefit to the mother so as to help them understand the change in the nurse's presentation or attention (Davis & Day, 2010, p. 116). However, the FPM also recommends that helpers leave their own problems "outside the helping situation so they do not interfere with it" (Davis & Day, 2010, p. 121). The helper, or CFHN as it is in this instance, should demonstrate personal integrity, emotional strength and be able to tolerate the distress that may come from listening to others' problems. It's understandable that CFHNs such as Monica express a guilt discourse when unable to meet the standards of partnership espoused in the FPM. For example, should Monica be more genuine with a parent regarding her fatigue at the end of the day or demonstrate a more concerted effort for alertness and emotional strength? Endeavouring to work in partnership practice with every family throughout the whole work day, day after day appeared to be exacting a physical and emotional toll, particularly when Monica was feeling overly burdened and/or depleted. Mothers, likewise, may have little to share and be harder to engage in partnership if they too are worn out from lack of sleep or other concerns.

Continued exposure to stressors at work such as those described previously by Angela (asking the psychosocial questions daily, undermining colleagues), Monica (fatigue and feeling overburdened), Sandy (stressed by competing demands and time constraints), Annie (struggle with deployment of expertise when working within the FPM, previous reported bullying by manager), Erica (fatigue & menopausal hot flushes); can potentially lead to the "modification of [their] bodies through work" (Gimlin, 2007, p. 353). This modification of the body occurs as "psychosocial experiences become embodied" resulting in adverse physical or emotional consequences such as high blood pressure, changes to the immune response and mood changes such depression (Gimlin, 2007, pp. 363-364).

Sandy said in her first interview that there were *"Not many full time staff in the service".* Sandy thought *"most staff worked part time because the job's exhausting".* Virginia also stated that tiredness and work overload could contribute to the burnout of CFHN staff. Burnout symptoms are recognised factors that adversely impact on nurses and other workers. In this instance, it affects the CFHN having the bodily energy available to be emotionally engaged and attuned in partnership with mothers.

4.5.2.4 Too many clients back to back

Monica stated that "*having too many clients back to back"* added to her feelings of distraction and the ability to be mindfully present in partnership with mothers.

> *The other thing I find as another factor* [which influences our ability to work in the FPM is] *if we have too many clients back to back. There's always a new client to meet and find out what they want and where they want to go with that and then move onto the next one….* [However] *…we* [nurses in the clinic] *do look after each other because we've got an awareness of that.* [Monica]

For Monica, this situation meant there was little time for reflective practice or for her to re-energise and focus on the next mother's needs due to other agendas to complete during and after each consultation. This was compounded when Monica was also required to supervise students or new staff members as mentioned previously. This situation impacted adversely on her energy levels and ability to concentrate and thus her capacity to work in the FPM with mothers.

The changing role of the CFHN and the requirement to work in partnership with mothers did not necessarily equate with a concurrent change in client appointment and other work role scheduling. This was despite some CFHNs in this study reporting a level of autonomy in the control of their diaries and appointments. CFHN "Occasions of Service" (OOS) quotas and pressure to meet UHHV performance targets were factors that reduced appointment scheduling flexibility.

Back to back consultations and having prescribed work tasks and assessment tools to use during consultations lead Angela to state in her interview "*There's stuff we have to say every time. It's just a bit neurotic, you know, like we're machines".* The phrase "*it's just a bit neurotic"* indicated to me that Angela thought the process of saying the same or similar things every time to every parent was "crazy". The metaphor of the CFHN being like a "*machine"* suggested that Angela was likening the role to one that could be performed by robots. The nurses and parents were part of a production or assembly line with the nurse saying the same "*stuff we have to say every time"* to every mother. Further, the individual CFHN body was imminently replaceable and "controlled by forces beyond their reach" (Shilling, 2003, p. 45). Working like a machine suggests a dehumanising discourse operating that is at odds with a "humanised" embodied partnership practice. Although I did not pursue this metaphor with Angela at the time, it may indicate that Angela felt there

was less flexibility to respond in partnership to mothers' immediate issues with such a prescribed role.

4.5.2.5 Ageing and menopausal bodily discourses of the CFHN

One nurse, Erica, in her first interview cited her age and menopausal symptoms as factors adversely impacting on her ability to work in partnership with parents. Menopause is an embodied, gendered experience that for Erica caused "multiple disruptions" (Boughton, 2002, p. 423). Erica said that it was:

> *Just my age. Probably a personal point of view just, you know, menopausal hot flushes in the middle of the night waking you up for two or three hours and you feel like a wet rag when you come into work and it's so hard to have that energy to give out to other people when you're just feeling a bit kind of…So if you have you know, two or three difficult clients on a day like that it's… by the time you get to the last one you're just going.... That's a personal thing. We all have our off days I suppose but menopause can be a bit of a nightmare. There's so many of us in this service are around that stage. And you don't think very clearly….I just hate it when I'm not up to par. I really hate feeling like I'm not doing a great job*. [Erica]

Erica said that menopausal symptoms, hot flushes, disrupted her sleep so that her body felt like a "*wet rag"* on arrival to work in the morning. This metaphor implied to me she felt wrung out and limp as she had no energy and was not ready for the day's work. Menopausal symptoms, like pregnancy and breastfeeding, are aspects of women's embodied experiences that may be at odds with the demands of the workplace (Gatrell, 2007; Hausman, 2013). As Erica indicates, her CFHN colleagues and all nurse participants in this study, were middle aged and around the stage of experiencing symptoms related to perimenopause, ageing and midlife changes. Only Erica, however, specifically cited menopause as a factor that negatively influenced her ability to work in the FPM. However, five other CFHN participants in this study mentioned being fatigued, irritable, distracted and overloaded at times in their work roles. It could be conjectured that the nurses, in addition to work place stressors, were also experiencing symptoms synonymous with commonly experienced peri-menopausal symptoms (Newhart, 2013) and the ageing process.

4.5.3 Summary of Theme 2

The second theme, 'MANAGING THE BODY: CFHN BODY WORK AND PARTNERSHIP PRACTICE' details the findings regarding the various ways the CFHN participants experienced and regulated their bodies within the challenges of the work environment in order to conform to body work necessary to demonstrate partnership. The findings portrayed the factors challenging CFHN participants to holistically conceptualise, integrate and implement an embodied FPM practice given the constraints of their work landscape; of their own understandings of the FPM; and; their own bodies' available physical, emotional and psychological energy to implement the FPM with mothers and their children.

Theme 2, therefore, has focused on the findings related to the factors found to influence CFHNs' embodied experiences and the body and emotion work required of them to implement the FPM in their work with parents. These factors included nurse participants':

- range of conceptualisations of the FPM that impacted on its integration into their embodied clinical practice with parents;
- experience of the significant body and emotion work required to *"let go"* of their power base and use of the "expert model" as well as knowing how best to deploy their professional expertise in partnership with parents;
- knowing how best to effect the necessary bodily displays, stance and presence required with parents that denote partnership qualities and the standard of skills in listening and use of verbal and non-verbal cues;
- work performed on their own bodies via inservice and conference attendance to maintain up to date with their professional education in order to be *"worthy"* of working in the FPM with mothers;
- body and emotion work required to cope with distractions such as physical tiredness, not being in a "*good headspace"*, feelings of overwork from too many *"back to back clients"* with no space for rest and reflection, and, from symptoms related to ageing and menopause; and,
- experience of the impact of a continuous flow of families on their ability to provide a mindful practice.

These nurse participants appeared to try their best to regulate and discipline their bodies and emotions in order to work in the FPM with mothers. The next section, Theme 3 - A MINDFUL SPACE discusses findings specific to how some of the CFHN participants managed to overcome these physical, emotional and work based challenges that adversely impact their embodied partnership practice with mothers. Being mindful of their embodied presence and responses when in consultation with mothers/babies enabled the CFHN to be more readily available to work in partnership with them.

4.6 THEME 3 - A MINDFUL SPACE

The third theme identified in the findings of this study is 'A MINDFUL SPACE'. This theme identifies specific ways of being and activities that enable a "space" for the CFHN to pause and reflect so that they are able to provide a more attuned, partnership based response to mothers. Three sub-themes of Theme 3 are discussed below: "Being Present in the Moment: A Mindfulness Discourse", "Reflective Practice', and, "Being Mindful of Self". Each of these subthemes has overlapping features with the other subthemes in this section. For example, reflective practice helps the CFHN to recognise when she may need more self-care activities to restore energy to more readily be in the moment in partnership with a mother/baby. However, the findings have been categorised into the three subthemes to provide a more succinct and easier flow for the reader.

4.6.1 Being Present in the Moment: A Mindfulness Discourse

Two CFHN participants in this study discussed the need to give mothers their undivided attention when in consultation with them. Neroli used the metaphor of *"the little kid that needs to leave their worries on the worry tree as they come into school"* to compare with how she approaches coming to work so that she is ready to be present both in body and mind with her client mothers and babies. By attempting to leave her worries outside the consultation room, Neroli appears to be describing the quality of "emotional strength" and the emotion work required by practitioners of the FPM (Davis & Day, 2010, p. 121). Virginia said she tried to *"stop and stocktake, and has a self-protective strategy*" that she uses before seeing the next parent/child. Virginia stated that she tried to leave things in one home before moving onto another, in order to give mothers her undivided attention. Both of these nurses' comments appear to be describing their aim of preparing themselves to be present in the moment before meeting each new mother.

Neroli and Virginia stated they demonstrated being present with mothers through stillness. Neroli stated stillness portrayed advanced empathy and unconditional positive regard toward the parent. These two attributes are identified as essential qualities when working in partnership with parents (Davis & Day, 2010). Virginia, like Neroli, spoke of being in the moment as central to showing unconditional positive regard when working with mothers and their children.

> *One of the most important things that always stays in my mind is unconditional positive regard…. I really try and go in and think: 'I'll be with them in the moment,' because we all do bring things in our own head with us. And I try and for each house I visit, house after house, so I'll try and leave behind what happened in the last house. I mean I process it with clinical supervision but so that I give…it's my undivided attention for the time that I'm there. 'You're special. I'm here to try and listen and to try and help us make sense of what's happening for you and ask you what you might like'.* [Virginia]

Angela recognised the importance of physical stillness and speaking quietly for her own future practice when she reviewed her video recorded consultation at her follow-up interview. Angela identified how this might help her in future to be present in the moment to work in partnership with mothers.

> *I possibly could have been stiller...I need to sit still in the chair…. It's really good. I think I'll continue to make sure I remember that….It's calming for me and I think it'd be calming for the mothers 'cause you're not...you're focussed on them but you're not dropping things and moving around….. You can hear I'm quite loud. Maybe if I speak more quietly* (and) *…talk more slowly. I think I might talk more slowly.* ***So you might slow down a bit?*** *Slow down. It's exhausting talking at that rate, yeah. It's also not very good for my mental health I think because it impacts on my anxiety.* [Angela]

Angela recognised from her video replay that she could regulate her body more with mothers. She could, for example, adjust her activity and rate of speech to calm herself and thereby become more focused on the mother/baby. Fundamental to both Neroli and Virginia's practice when working in partnership was to align their nursing agenda with the expressed needs of the mothers. Virginia stated:

> *Stick with her agenda and then marry them together* (your agenda and the mothers)…*making sure its client focussed; it's partnership with the client leading.* [Virginia]

Angela also identified the importance of remaining *"on track"* with the parents. She stated while reviewing her video recorded consultation at follow-up interview, that it required self-discipline to do this and to not let yourself be distracted by "*your own stuff*".

> *It's a big discipline to remain on track and not to go off track. I knew...I had the* (mother's) *story. Yeah. Self-discipline. To remain... and not to bring your own… stuff.* [Angela]

Angela's identification of "*self-discipline"* as requisite to being "*on track"*, that is, being present with the mother, was analogous to me to the nurse being completely focused and mindful of self and of her responses. It also parallels the statement by Wainwright et al. (2011) "the closer the work with the body [in touch or proximity] the [greater] need for regulation of one's own body and the more fine-tuned the embodied discipline" (p. 221) required by the nurse. It is a challenging task for anyone to be able to remain present in the moment when communicating with others; and one that requires continued practice and vigilance (Huston, Garland, & Farb, 2011; Razzaque et al., 2013). Neroli and Virginia displayed the most aptitude regarding this mindful ability to be present with mothers/babies. However, it appeared this was more difficult to sustain for Angela and the remainder of the CFHN participants. This is not surprising as it difficult for most individuals not to be distracted by internal stimuli such as hunger, anxiety or by external pressures and challenges such as those posed by the CFHN work environment as described in Theme 2.

Study Diary: *While analysing the data I reflected on the difficulty CFHN participants identified, and that I observed during consultations, regarding their ability to be "present in the moment" in partnership with the mothers/babies. There were so many competing demands and challenges for them to juggle both personally and within the work environment. Yet Neroli and Virginia understood the importance of being present and aware and managed as best they could to do this. I began to wonder if there was something missing from the FPM and within the workplace. I considered that the FPM may have limitations and there are already known limitations regarding its implementation and sustainability within the NSW Health CFHN Service (Fowler, Rossiter, et al., 2012; Rossiter et al., 2011). The Mindfulness Based Stress Reduction (MBSR) (Kabat-Zinn, 2013) course I undertook in 2012*

and my regular Ashtanga yoga practice over the past twelve years caused me to reflect on how important mindfulness and the breath were to remaining calm, focused and aware. Could mindfulness be integrated into the FPM/workplace to help aid nurses' self-care and therefore, the care of their client families? Could this provide the "space" for nurses to be able to be present to work in partnership with mothers despite the constraints and pressures of the workplace? I was also aware that a suggestion to incorporate mindfulness practice into the FPM/workplace, could be construed as the individual responsibility of nurses' to undertake more "training" to improve themselves and their partnership practice, while not addressing the extant structural issues with the broader service system. (Researcher Study Diary, 2011)

Overall, I concluded that mindfulness in practice had the capacity to provide therapeutic benefits for both nurses and mothers, and aid nurses' ability to work in partnership.

4.6.2 Reflective Practice

I asked the CFHN participants during first interviews for their views on the factors that positively influenced their ability to work in the FPM with mothers. A recurring sub-theme that arose was their ability to have time for reflection. Three nurses in particular spoke of the importance of reflection in their workday; to be able to take time to pause and reflect. Reflective practice is recommended as a means of sustaining FPM practice and developing as FPM practitioners (Davis & Day, 2010, pp. 268-269). Reflective practice is also pertinent to be discussed here as the second sub-theme of Theme 3 - A MINDFUL SPACE because mindfulness has been described as a "logical extension of the concept of reflective practice" (Irving, Dobkin, & Park, 2009, p. 61) .

Virginia and Neroli, who were well grounded in the theory and practice of the FPM through their FPM group facilitation skills and knowledge, said they did their best to pause and remind themselves regularly about their work purpose. Neroli stated she would frequently reflect and question her motivations for work: *"We all have life experience outside our work life but we have to remember: why are we coming to work and what's the purpose of what we're there for?*" They practised pausing to reflect on how best they could prepare themselves to be in the moment with their client mothers and babies. Virginia stated that it was important to be mindful of what her motivations were for continuing to work with the mother/family and to know when an episode of care was completed or when the mother/baby needed to be referred on to secondary services.

Jean spoke of being appreciative that in her workplace there was "*some time in work hours to reflect*". Jean stated that she valued the time she had to see me for interview during work hours. Having time during work to reflect enabled Jean to take time to think about her practice, think about which mothers/babies she had seen and provide some follow up in order to touch base with them.

> *I think too …giving people some time in work hours to reflect on…**Nurses?** Yes, nurses to reflect on their practice of who* [sic] *they saw last week so you can recall and give a phone call, a follow up phone call just to um…yeah just I suppose…I don't like the word 'check on people' but just to touch base. **With the mothers?** Yeah, with the mothers, the parents, the families and just to say you know, 'I'm thinking of you or last week when we saw each other,… how are you feeling this week?' To follow up on people, not just to see them once…. **Yes**. A human touch I think is important.* [Jean]

Jean appeared to me to be using reflection in order to think about whom she had seen and to take the time to provide compassionate follow-up of mothers who may be in need of extra support. Jean also spoke of her discomfort with the practice of surveillance of parents stating "I don't like the word 'check on people'". Jean used reflection to be aware of her own beliefs and judgements to ensure they didn't conflict with her ability to work in partnership with parents. Hence, Jean was mindful of her language use and the construction of a surveillance discourse of power and control.

Sandy, too spoke of the importance of reflection but candidly stated that it was not always so easy to do in practice. Sandy gave reasons for not being able to take time to reflect such as being too busy and having too many tasks to be completed.

> ***So it sounds like though that you do reflect on what you do?** I do but* [I] *don't always do it. Because I mean…I do but not always. I try to … but… you're busy.* [Sandy]

From discussions with CFHN participants it appeared most found there was little time in the work place for reflection when busy in *"back to back"* consultations with mothers and babies. However, nurses such as Neroli, Virginia and Jean spoke of being able to make "space" for reflection in their workday. It is less clear whether the CFHNs who were less experienced in the FPM were also able to find space for reflection, though Sandy's comments suggest this was difficult.

Sandy alluded to the importance of mindfulness to her working in partnership with mothers during her follow-up interview. Again though, Sandy admitted that this was hard to do in practice and that it was very easy to get *"lost"* fixing things and being busy with tasks. This appeared to be a concern for Sandy but she thought it might be the case in any workplace role when "*you're juggling a few balls at a time"*.

> *I think it's so important to be mindful and it's so easy to be lost fixing it, you know? It's really hard because you've got tasks and they have to be done, you know? You just have to get stuck into the tasks and...I think the tasks are where you get stuck.* [Sandy]

Having perspective about the purpose and limitations of her CFHN role was identified by Virginia as an important aspect of her reflection on practice. Virginia discussed the realistic limitations of the power of the CFHN's intervention in the lives of mothers and children. Virginia understood that it was her role to help the mother "*rehearse"* what they might do about an issue but ultimately it was the mother's life and journey. It was also vital for her to continue to reflect on the purpose of her work with the parent and recognise when the work was completed.

> *I think it's keeping it in perspective. It's their life; it's their journey* [the mother's]. *And I remember a psychologist sharing with me once that perhaps when we go in there it's the rehearsal for what they might do later. But they do the performance. They're living the life.* ***What does that mean?*** *…they're the ones doing the performance. I don't have to own their problems. I don't…they're their problems and I can be there with them but it's their journey in life. And whether they choose to go one way or the other is what they choose to do…. 'We want a really good rehearsal and let's do the best we can!' …I don't own their life. It's their life….and that's when I talk about that professional boundary. You need to be really clear and you need to be clear with yourself. 'What am I doing here? What is my role here? Is the work complete?'* [Virginia]

Virginia's reflective practice clearly enabled her to have a clear perspective about the input, responsibility, limitations and boundaries of her CFHN role with mothers when working in partnership with them.

It is notable that the three nurses (Neroli, Virginia and Jean) who spoke of regularly using reflective practice were also the CFHNs who appeared to be at the more experienced or advanced end of a continuum of FPM practice. Their ability to reflect helped them to

mindfully provide the partnership focused "space" for their embodied responses to their participant mothers/babies that I observed during their consultations (despite Jean's physical limitations). Nurses such as Sandy, understood the importance of reflection but had not yet been able to integrate this into her everyday embodied practice. This may be a significant contributing factor that could explain why her responses were observed to be less partnership oriented during her consultation with Dani and Leo. The role of the nurse unit manager and broader organisational responsibility for identification and responding to nurses' difficulty in finding space for reflection was not articulated by nurse participants in this study. The integrity of CFHN clinical practice which includes partnership practice and developing helpful relationships with mothers is challenged if nurses do not have time to pause and reflect on their work.

4.6.3 Being Mindful of Self

Three CFHN participants spoke of self-care activities as being vital in aiding their ability to reflect and practiced self-care and kindness to themselves on a daily basis. These nurses recognised the need to be mindful of self. They looked after themselves well so that they were better prepared for the paid body work of partnership with parents. A self-care discourse was for them a factor important for embodied partnership practice. Neroli, for example, mentioned her need to daily "*debrief myself from the day"*. In doing this Neroli said she walked after work every evening and thought about her day to *"reflect upon it and put it in a safe place"*.

> *One thing I have to do every day is …to almost debrief myself from the day. I actually walk every night and think about my day. Not always but if I have had a day that's been one of those days where there's been clients that are more complex or…, I wasn't comfortable with how that visit went or anything like that. That gives me time… time to think about it and reflect upon it and then put that in a safe place for myself as well. And so the model really helps me do that. I think having that… that framework in the background.* [Neroli]

Erica did something similar to debrief herself after work. Erica stated she did *"other stuff, Pilates, and walk(s) [with] the dogs on the beach to stay sane"*. I asked Neroli during her first interview how she maintained her ability for self-care and to reflect each day. Her answer indicated her use of the qualities of honesty, humility and genuineness in that she understood that she was imperfect, needed to take breaks and be honest with her colleagues and client parents when she wasn't feeling well.

> ***How do you maintain that …ability to reflect?*** *Um… I probably don't. And that's why I do go on holidays and you know, and I'm not perfect. I recognise that you know, and I think the minute we think we're perfect …we really need a new job! (laughs)* ***So there's humility there!*** *Because … at the end of the day, we all have life experience outside our work life but we have to remember: why are we coming to work and what's the purpose of what we're there for? ….and we do also have to be kind to ourselves day to day and also be respectful to our clients and say, 'Look I'm sorry, but today I don't feel one hundred percent well' and say to my colleagues, 'Look I can hear where you're coming from but with respect, I don't choose to agree with what you're saying'.* ***OK.*** *So you know, it's that honesty as well I think.* [Neroli]

Neroli and Virginia both identified the importance of humility when working with mothers and their children. Humility was explained to mean recognition of the limitation of their ability to solve clients' problems and that as individuals they were imperfect. The qualities articulated by Neroli are identified as integral to helpers working in the FPM (Davis & Day, 2010).

Lastly, Monica, who revealed how tired she became and how energy draining she found the CFHN role at times in Section 4.5.2.3 (p.179) identified one self-care strategy that she employed in the work place to help cope.

> *I need to put things in place when I'm starting to feel burnt out so I may look at the diary and see if there's time I can put in where I'm not doing face-to-face clients. I might …be able to catch up on some of the work. That's …that's wishful thinking a lot of that.* [Monica]

Monica spoke of being able to "*catch up on some of the work"* when not *"doing face–to-face clients".* I didn't pursue the meaning of these statements at the time of interview. I presumed, however, that catching up on paper or computer work, or making referrals and phone calls etcetera is considered "work" that can't be done when in consultation with parents and babies. In Sections 4.4.1.1 (p.98) and 4.4.1.2 (p. 108), Monica and other CFHN participants acknowledged they looked to their colleagues and managers to help juggle and share the workload when they were feeling overburdened and tired. Being mindful of self-care activities, though discussed by only a few CFHN participants, were seen as essential to maintaining the necessary energy and "space" to work in partnership with parents.

4.6.4 Summary of Theme 3

Themes 1 and 2 presented findings related to the numerous factors that CFHN participants identified that impacted adversely on their ability to work in partnership with mothers. Theme 1 identified factors within the THE CFHN WORK ENVIRONMENT AND CULTURE. Theme 2 presented findings related to MANAGING THE BODY: BODY WORK AND PARTNERSHIP PRACTICE. In Theme 3: A MINDFUL SPACE, *Being Present in the Moment: A Mindfulness Discourse, Reflective Practices* and *Being Mindful of Self* were identified by approximately one third of the CFHN participants in this study as being integral to working in partnership with parents. The findings in Theme 3 echo the findings related to discipline and regulation of the body discussed in Theme 2; that is, the regulation of emotion and physical activity and providing a mindful presence. However, the nurturing, restorative and therapeutic potential of mindfulness as a component of partnership practice I conjecture outweigh its potential to be viewed as another body work discipline.

Despite the small number of nurse participant responses comprising Theme 3, I believe these findings remain critical to the ability of the nurse to find the "space" for embodied partnership practice with mothers. Neroli and Virginia, who had the most to say about the findings identified in the subthemes of this section, were also the nurses whose practice placed them at the advanced end of the partnership continuum and from whom we can learn. My assertions discussed above in Section 4.6.1 about the potential of the addition of mindfulness to the FPM to aid nurses' ability for self-care and awareness of their embodied responses when with parents is discussed further in the next chapter.

4.7 THEME 4 – THE MOTHERS' EVALUATION OF CFHN CARE

The fourth and final theme identified in the findings of this study is "THE MOTHERS' EVALUATION OF CFHN CARE". This theme portrays the views of the participant mothers about their experience of the relationship and interaction with their participant CFHN and, therefore, fulfils one of the aims of this study. Three sub-themes of Theme 4 are presented below: "Positive Experience", "First Develop Rapport", and, "Modern Technology: Enhancing Parent-Nurse Partnerships".

4.7.1 Positive Experience

At the beginning of their interviews, I asked each of the mothers for their views on their six-eight week child health check consultation held with their linked CFHN. All of the nine mothers stated that their consultation with their CFHN was good and overall a positive experience. They reported feeling comfortable and listened to by their respective CFHN.

The mothers said that their nurse was easy to talk to and that the consultation felt like '*it's about you*'. For example, Millie stated "*I think it's a positive experience because you get the basic baby checks and the opportunity to ...ask if there's anything unusual".* Likewise, Susan stated "*Yeah, I thought it was really good. I think Virginia was lovely and so easy to talk to and um…yeah, I …we covered everything that I wanted to cover".* Lisa explains why her consultations with Neroli always made her feel good afterwards:

> *The reason I feel good afterwards is she talks to me about me as well….I always feel a lot better after I've had the checks to make sure that both of them have been okay….but I think that session that we had last week was more about the mother. And I think Neroli too pays a lot of attention to the mother. It's not just about the baby. She's very focussed on making sure Mum is okay and I think that's why as well I feel good after… 'cause a lot of the time it's not about you when you've got kids. You kind of get put on the back burner in a lot of ways in yourself and what you do as well as your relationships …children always come first.* [Lisa]

Lisa, who had a pre-school aged child in addition to her newborn, said at interview that she had actively sought out an appointment to see Neroli with this new baby as she had seen her with her firstborn. Lisa stated that motherhood *"put her on the backburner".* For Lisa, this meant that her needs were often secondary to her children's or her husband's or the other demands of being a mother and homemaker. Lisa appreciated that Neroli paid a lot of attention to the needs of mothers in addition to the needs of the children and said she always felt better after seeing her.

The parents in this study said that they were able to participate in an open conversation with their CFHN, that she was non-judgemental and displayed empathy and concern for them. Clair was in her mid-twenties and the youngest parent participant in this study. Despite being a full time child care worker before her baby's birth, Clair said it was "*obviously completely different having your own baby* [and] *…it was helpful to be taught things by the nurse and to have my questions answered".*

Some of the mothers compared their six-eight week child health check consultation with the CFHN to a recent visit with their GP or paediatrician. Gemma stated that Fiona "*spoke to me like a human and a person rather than speaking down to me"*. Gemma compared this positive experience with a recent visit to baby Kitty's paediatrician where she had felt belittled by the manner of the doctor. Similarly, Beth, who was an assertive, articulate and educated woman in her mid-thirties stated:

> *We've responded well to this* [CFHN] *model of care. It's not like an authoritarian model. It comes across as if they're talking to you, not at you, whereas at the doctor you sort of walk out a bit dignity poorer, the difference is quite marked.* [Beth]

Field notes: *I observed that both Erica and Beth seemed to enjoy each other's company throughout their consultation. Beth has a quirky sense of humour and made cute jokes about Ruby's baby behaviour. There was a lot of easy banter that occurred. (Ethnographic Observation, 2011)*

Parents such as Millie commented that the overall CFHN service available was *"Great! It's free and it's very thorough"*. Beth similarly stated "*It's great that the centre is open every day and the nurses made it clear that if you're not coping to pick up the phone or go in there; the clinic is a really good thing".*

Despite CFHNs such as Angela, Monica and Sandy being critical of their ability to work in partnership with their participant mother at times during their consultations, overall the mothers in this study reported having positive experiences of care. The mothers appreciated being listened to and spoken to respectfully.

4.7.1.1 "She's more like a trusted advisor"

My second interview prompt with the mothers asked for their views on the nature of the relationship established with their CFHN at their consultation. Five of the mothers stated that it was a professional relationship but friendly. Mothers such as Lisa recognised there were boundaries in the relationship stating:

It's definitely still a professional relationship. I don't see myself going for a coffee with her [Neroli] *or anything. Not that I wouldn't but the relationship hasn't stepped across from a professional one…but it's a comfortable friendship in a way I guess. But at a professional level….A lovely working relationship.* [Lisa]

Beth described the nature of her relationship with Erica as someone who was a "*trusted advisor"*. A trusted advisor is held in high regard in the corporate business world for mentorship and guidance with important matters.

> *It was...more of a trusted advisor relationship that I would use in my corporate life, a trusted advisor...**Are you in business?** Yeah, in IT. And a trusted advisor in that capacity is someone that yes, they're an expert and yes, they're in their ...own field and whatnot but they're not there to run the show. In this case, they're on the one side and you go to them not the other way around….It's not like a confrontation thing and not like a doctor-patient thing and it doesn't come across that way. And you know, she's obviously providing a service of care and health and making sure that Ruby's ticking all the boxes and passes the tests and passes everything and is on track...in that regard. But it doesn't come across as patronising; it doesn't come across that way.* [Beth]

In addition, four mothers described the model of CFHN care they experienced as very non-confrontational, non-hierarchical and supportive. Susan stated that she felt herself and Virginia already "*had an established relationship and it was not like a first meeting"*. Susan felt that she bonded with Virginia because of the way she spoke and because her main focus was Susan and Jed's well-being.

> *I think it was just that I felt like I sort of bonded with her a bit more because she reminded me of mum. **Because of her appearance?** I think it was the way she… she spoke. It wasn't like I was speaking to my GP and just …asking me questions. I think that she was having a conversation but her main focus was our wellbeing.* [Susan]

Lisa identified that receiving positive feedback from Neroli helped their professional relationship. Lisa provided the following example of a situation when Neroli provided her with compassionate, mindful care and concern. This had occurred after the parent group session the previous week. There had been a possibility of Lisa's newborn being diagnosed with a congenital, life limiting illness and Lisa was very distressed. Neroli was able to recognise Lisa's distress, prioritise the urgency and display genuine concern and empathy in the moment: *"I can feel that she empathises with the situation …just by the way that she responds while not minimising the seriousness of situation".* This example exemplified for Lisa the strength of the partnership relationship she had with Neroli.

She [Lisa's baby 'Poppy'] *was tested and she had the gene and then … she was snuffly and that was making her very upset. I thought 'Oh my God, it's a sign that she's got it and blah, blah'. So we were given a one in seven chance and had to wait a week to find out. So in that week I came to the* [parent group] *session on a Thursday and I didn't bring it up the whole session because I didn't want to upset anyone else or put stress on other people but I came down and I saw Neroli afterwards and she had appointments. And her appointment* [mother] *was standing in front of me and I wanted to talk to her* [Neroli] *and she was conscious that she had another appointment as well and then I was standing there and she said 'Can I talk to you afterwards?' And I said, 'Oh you're busy. I know you're busy'. And then I started to get upset and I did burst into tears and …the other girl was lovely and said, 'You go in'.*

So I went in only for five minutes but Neroli took that time and she looked at the other woman and said, 'Are you OK if I do that?' And it was just the concern on her face that I was so upset. And I felt that was genuine concern and she wanted me to come in and I only spent five minutes with her but it just getting it off my chest and I think she's good …a good person to…she's happy to listen. And she didn't say, 'Don't worry, it'll all be OK' because she knew that it was possible that it wasn't going to be OK. But even the way that she just said to me, 'I can understand…' Empathy I think is the word where she was …empathising with me that 'I know why you're upset. I can see why you're upset. If it is going to be…if it is the case [which it's not] *but if it was it's going to change your whole life. Your life and Poppy's life'. And instead of saying, 'Don't worry it'll all be okay' she actually responded to me with 'These are things that you're upset about and I understand that' and that was good in itself. Not going well, 'Don't worry, it'll be all right and nobody knew that'. Nobody knew for sure it'd be alright.* [Lisa]

The scenario demonstrated for Lisa the strength of her relationship with Neroli and that she could trust her to provide an empathic response to her concerns. Neroli, in this scenario appeared to have been able to flexibly employ an attuned, empathic presence responsive to Lisa's need while also being mindful of the other mothers and babies waiting for their appointments.

Neroli was also the only CFHN participant to expressly advise the mother at the beginning of the consultation, to be mindful of what she chose to share while the video camera was

recording. In doing so, Neroli demonstrated empathy, mindfulness of the client's well-being, high level reflection and critical thinking skills all of which would foster the further development of a trusting relationship with Lisa. The video was also turned off for approximately ten minutes during this consultation while Lisa breastfed her baby, Poppy. Again, this occurred following Neroli's prompting and the mother shifted the front of her body away from me and the video camera. As per the requirement for valid consent, I asked all participants at the end of their video-taped consultation for their re-consent to use the recording of their image and voice at possible future presentations. Lisa was the only parent participant who withdrew this consent as she had discussed some personal information about her spousal relationship that she did not want to be made public. Neroli, in turn, withdrew her consent for the use of her video recording in public presentations in order to respect and uphold Lisa's withdrawal of consent. No other nurses or mothers withdrew consent regarding the use of their video recordings. Only two mothers at interview mentioned the presence of the video camera during their consultation. Lisa stated "*I had verbal diarrhoea and I don't know if that was the impact of the camera"*. Susan stated that she "*didn't notice it* [camera] *after a while"* as she was more focused on her conversation with Virginia.

Clair appreciated that the CFHNs were consistent in their advice and information. She stated it was helpful *"having nurses on the same wavelength as each other to tell me similar things".* Clair compared this to the unfavourable, conflicting advice she had received from midwives following Dylan's birth.

Only one mother, Dani, reported being uncertain if a relationship developed during her consultation with Sandy.

> *I don't know if a 'relationship' as such developed 'cause...it's just sort of fifteen, twenty minute sort of consult. But ...I guess sort of knowing Sandy from the other weeks* [at the parent group]*, I've sort of ...all I can say is, I felt comfortable to ask a question...* ***Okay.*** *I ...you know, she... put it out that things are private and confidential and I felt that you know, she was respecting things that I was saying and all those sorts of things.* [Dani]

That Dani did not feel the same sense of relationship with Sandy as other mothers such as Susan did with Virginia may be a result of her response to Sandy's quite rushed and businesslike approach to the consultation. I had observed Sandy asking lots of closed "*checklist"* questions, and her brisk body language gave cues of efficiency and being

somewhat rushed. Sandy also left the room twice during the consultation with out advising Dani or me what she was doing. There was thirty minutes allocated for this consultation compared with the sixty minutes provided for this child health check conducted in Virginia, Neroli and Monica's team. Sandy was also required to complete the maternal psychosocial assessment in addition to the infant examination within the thirty minute appointment as it was not completed at the UHHV. Their consultation in fact lasted forty-three minutes although Dani thought it was just fifteen minutes or so duration.

4.7.2 First Develop Rapport

Analysis of mothers' interviews indicates that they valued the first home visit as it made things easier for them as first time parents. For example, they did not have to leave their house and travel to a CFHN centre at an appointed time with their new baby. The mothers found the home visits comforting and confidence building and Susan, Beth and Lisa all said that the first home visit was good.

> *I think that home visit is really good….I think that helps with the relationship. It gets things started and really encourages people to come to the* [parent group] *sessions… because that's the first encounter that you have. So if you feel very comfortable with that then you will be more inclined to continue on.* [Lisa]

Gemma stated in her interview that she had been feeling anxious and unconfident when newly home with her baby. She said she had needed support and affirmation that she was doing a good job with her baby, Kitty. This anxiety was alleviated by the home visiting CFHN who helped build her confidence as she saw Gemma in her home environment and was affirming of all she was doing with Kitty. Gemma said would have become more anxious and have seen the GP more often if she didn't have the support of the community CFHN nurse.

> *That's my personality as well. Everything I do …I want to know how to do it, you know? I don't want to just fumble through things…..with Kitty. If I was to be left to my own devices every day and didn't have any support then I… I would have a lot of anxiety myself….*[and] *I probably would have been to and from the doctors a little bit more than I have if I didn't have the community nurse…. Yeah, they've been one of the greatest resources that I've had.* [Gemma]

In relation to the maternal psychosocial assessment questions that are asked at the UHHV, Millie said that they were not a problem and that "*it's good that the nurses bring it up*". In contrast, Susan found these questions on the first home visit confronting and they made her feel uncomfortable. Susan suggested that the CFHN needed to get to know the mother to first develop a rapport and to ask them in a more conversational style rather than in a direct question/answer format.

> *I didn't feel like I had that same connection* (with the home visiting CFHN) *but I think it was because I put a wall up …and I think that the questions on that one are a bit different. Like I wasn't expecting the questions in the first visit. The questions about family life and which I had nothing bad to say but um,…it was a bit of a shock when they were asking, you know, 'Have you felt like you want to harm your baby…?', yeah all that. So I wasn't expecting that side of things …so I found last week's one* (consultation with Virginia) *much more… easy….It* (the maternal psychosocial assessment) *was a bit confronting…. I think it was just the realisation that other people might be having some problems… whereas … last week's was more like a conversation and the first one at the home was a bit question and answer…. so maybe for the first one when …when everything's new and you've got a newborn maybe it needs to be a bit more relaxed. You're nervous anyway….* ***So you have made a suggestion that maybe it should be more of a conversation instead? How do you think that could occur?*** *Maybe if you're having a conversation, she still needs to ask the questions but maybe a bit more in passing if it could …other than sitting down and …question and answer and just …you know, 'Are you feeling like this?'* ***So tell me how it occurred?*** *We were sitting down in the sitting room and…it was very like across from each other and just …straight away as soon as we came in. We haven't got to know each other yet. In the beginning to straight away have to be answering questions was a bit daunting.* [Susan]

The development of rapport in the parent-helper relationship is one of the first steps in the FPM (Davis & Day, 2010). However, when the CFHN is inexperienced, task oriented, time poor or not used to working within confined time frames, and, is not mindful of the effect of her approach she may overlook the important steps of engagement and relationship building with the mother and obtaining permission to proceed with the assessment. The result of omitting these steps is that it may inadvertently alienate the mother who may not return for further CFHN support for herself or her baby. Mothers

Juanita and Millie also described the questions on the first home visit as like a checklist. However, they stated that the questions didn't bother them as they were asked casually in a conversational manner unlike Susan's experience, and added it was good to be able to have the visit at home.

> *There was a lot more questions actually on that particular* [first] *home visit. It was going through maybe a checklist. ...but I mean that's fine. They didn't bother me….it was more conversation...It felt like there were more questions that had to be asked..., having to get through them.... ...It's good that that first one* [visit] *was at home…. My partner was there as well…. I didn't really want to take him out for the first few weeks*. [Millie]

Beth suggested that it would be helpful for parents on the first home visit if the CFHN could provide an upfront plan of what needed to done during the home visit. This suggestion is in keeping with stages of the helping process where the goals of the visit should be known and agreed to by both the nurse and the parent/s (Davis & Day, 2010).

> *The only different thing I would have done if I was a home visit person* [CFHN] would *have just been to come in and introduce themselves* (sic) *and say, 'Okay, we're going to do this, this, this and this'....and it was fine how it was because it was all very casual '…and we're going to measure her now and whatnot.' Whereas if they sort of... I suppose I'm the kind of person that likes to have a plan, you know? I like to know what's going on.* [Beth]

A further suggestion made by some of the participant mothers was that continuity of carer would be good in relation to the first home visit and subsequent appointments at the CFHN centre. Dani, in particular, identified that she would have liked continuity from the CFHN that did the first home visit.

> *One thing that does come to mind because I was surprised, the lady* [CFHN] *who came the first time, like I never got to see again. And I guess it hasn't really mattered because Sandy's been able to answer all the questions but I sort of, I really liked her and then I assumed that when I went up to the clinic I'd see her again....just because she sort of did all the checks. And you kind of, if someone does all those sort of checks at home you kind of think 'Oh well, they already know* [baby] *Leo or they've seen him before'.* ***And know your story?*** *And sort of know a bit of the story. I guess I would have liked some contact with*

her again. ***So some continuity…?*** *Yeah or maybe if she did the six week check* or *something or whoever comes the first time does the other one.* [Dani]

4.7.3 Modern Technology: Enhancing Parent-Nurse Partnerships

I asked the mothers at interview for their ideas about issues, concerns or suggestions they might have in relation to developing a more helpful relationship with their CFHN and/or the CFHN Service. Five mothers in this study suggested that the communication system between the CFHN service and parents could be improved, particularly the use of modern information technology systems. For this generation of mothers it was the norm to use the internet and smart phone technology to find information about services and supports, for booking appointments and to connect with others experiencing similar situations via blogs, email, online forums and Facebook™. The next section presents the mothers' suggestions about improving information technology systems and other forms of communication to help in achieving partnership at a distance.

4.7.3.1 I don't read pamphlets: "Use technology more"

Lauren revealed at interview that at her first home visit the CFHN gave her a bundle of unsolicited pamphlets. The problem was that Lauren didn't read pamphlets.

> *They can give you too much information too. I know that's difficult to judge I suppose but I've got the blue book*[12] *and the nurse went through the blue book which is great but then handed me copious amounts of pamphlets which 1) I've never gone through 2) I haven't had the time, and 3) It's just ...I don't know where I put them now because they kept falling out of the blue book so I put them somewhere and I have no idea where I put them. I don't like bits and pieces of paper. I lose them...you've got the internet.* [Lauren]

Both Lauren and Beth suggested that the CFHN Service could use information technology more to keep new mothers informed. For example, Beth suggested the service could implement:

> *…better information facilitation, for example, a website or one page cheat sheet: 'Here's everything you might need to know about local referral services'.*

[12] The "blue book" is a colloquial term used in NSW for the *Child Personal Health Record* (NSW Kids and Families, 2013).

> *Also fortnightly or monthly email notices to groups of Mums regarding anything coming up at the centre or legislative changes etcetera. You could use the enrolment lists based on the baby groups.* [Beth]

Many mothers during pregnancy now download and use specific apps on their smartphones to keep track of the growth of their unborn baby, Lauren said that she read her emails daily and now subscribed to an internet site that gives her:

> *…weekly email updates of where my child is up to and what to expect in the next week and I find that easier because I've got to be on emails anyway. It's just a quick bit of information about what your child should be doing and where they're up to. You've got the internet and most people subscribe to a site.* [Lauren]

Lauren also stated that the mothers from her parenting group sessions at the Child and Family Health Centre emailed each other and like Beth, suggested that perhaps this was something that the CFHNs could organise.

> *I know all the mothers that were there* [at the parent group, *we all emailed each other…and perhaps maybe that's something the clinic could look at 'cause it doesn't cost anything to set up a forum or a website. But just …even have…yeah, a general forum that you could set up where you're all on the internet like where you can do that. … Yeah, and the clinic can set up notices and that sort of thing so…**Rather than ringing, if you've got a question?** Yeah, that's right…and then they could develop apps and things. …So maybe they need to be a bit more advanced in technology and things. …so maybe that's one thing they could do; use technology more, yeah.* [Lauren]

In addition to enhancing communication via improved ICT, mothers suggested that the CFHN service needed to contact new mothers as soon as possible after discharge from hospital maternity services. Susan stated that she did not receive her UHHV until baby Jed was four weeks old and said she had had no communication from CFHN service during this time. Dani stated that she had not been sure how to arrange the CFHN first home visit or even that the service existed prior to having her baby. Dani recommended that parents be informed before their baby's birth that they need to book into the CFHN service early.

Finally, Beth said that mothers currently don't have much knowledge about how long they can attend the CFHN service with their children. In addition, Lisa, a mother of two children

suggested that reminder phone calls from the service would be helpful to encourage parents to have their toddler and pre-schooler child health checks done. This communication could be made more available via local health websites that were tailored to the needs of new mothers. These issues suggest there is a deficit in current ICT services available in CFHN services and it is not easily accessible for parents.

4.7.4 Summary of Theme 4

In Theme 4, the emic views of the mothers' evaluation of care from their CFHN and other aspects of the CFHN service have been identified. The mothers overall, found their consultations with their CFHN to be a positive experience and in most instances, likened this relationship to one that was professional while being friendly. The nurse was considered a *"trusted advisor"* in most instances.

These mothers had concrete suggestions for improvements to the delivery of CFHN care. These suggestions are, therefore, factors likely to be influential to nurses' ability to establish partnership based relationships with other mothers. These suggestions included: ensuring that nurses first develop a rapport at the home visit before asking the maternal psychosocial assessment questions. These questions should also be asked in a conversational manner rather than as direct, closed questions. Further suggestions included that the CFHN service should implement tailored internet based communication processes that mothers could easily access. This could be in the form of email communication, the development of a website and relevant apps for mobile devices to aid in achieving partnership at a distance.

The summary of the research findings from this study is next provided.

4.8 SUMMARY OF RESEARCH FINDINGS

This chapter presented the four dominant themes and related subthemes arising from this qualitative study of the factors that influence, and the nature of the impact, on the CFHN's ability to work in partnership as described in the FPM, with mothers. Semi-structured interview prompts were used to obtain the nurses' and manager's views of these factors. Interviews with mothers enabled an exploration of their experience of their interactions, and the nature of the relationship established with their CFHN at their baby's six-eight week child health check videotaped consultation. Semi-structured interview prompts

were next used to obtain additional depth and insight into participant CFHNs' views of their partnership practice during the consultations with their mother/baby clients through their review and reflection on this video recorded footage.

Nine nurses, one nurse unit manager and nine mothers participated in this study. The CFHNs and NUM shared their often passionate views of the importance of working in partnership with mothers, and how the FPM had influenced them and their clinical practice. The nurses shared their views on both the positive and less positive influencing factors that arose in their work environments and culture and impacted on their ability to work in partnership with mothers. These factors included working with others: their colleagues; their managers; and, the mothers and infants themselves. Nurses spoke of the rapid pace of change to their work roles that had occurred in their workplace over the past decade such as the introduction of UHHV, additional surveillance and screening activities of both the mother and child, and, meeting exacting performance targets. These performance targets and associated policies were, overall, felt to conflict with their ability to work in partnership with mothers. There were challenges identified in meeting the increasing demands of the CFHN role and the simultaneous increased requirement for accountability via data entry and audits of performance targets.

The introduction of computers and ICT systems was viewed by the CFHNs as both a help and hindrance to partnership work with mothers. Data entry onto the computer was slower and the need for duplicate documentation reduced the amount of time available for the CFHN to share conversations with the parent during the consultation. However, these computer databases also provided nurses with ready access to client records and information regardless of which centre the parent/baby had originally attended. This was deemed to assist partnership work by having information about the mother/baby at their fingertips.

The nurses and NUM's views differed regarding whether there were, in fact, barriers present to working in partnership. Some nurses argued that everything could be answered by going back to the FPM. The NUM identified that the use of the word "*barrier"* was an excuse for saying that things were just "*too hard"*. There were, however, tangible differences in the various work environments of these nine nurses. For example, three nurse participants from one team had sixty minutes to perform the six-eight week child health check whereas the remaining six nurses had half this amount of time with just thirty minutes allocated. In addition, some nurses had managers such as Donna who were very supportive of the FPM and modelled it in their own interactions with their staff. Other

nurses reported having more adversarial managers in the past that did not "walk the talk" but instead were reported to have bullied the CFHNs in their team.

Nurses offered constructive comment about enhancing the sustainability of the FPM. The key suggestion was to implement regular inservice education in the workplace that focused on working in the FPM. This was reported to be difficult, especially when there were competing demands for mandatory inservice training as well as education update requirements for other areas of clinical practice. Seven of the nine CFHN participants had had no further education on the FPM since their initial group training some years earlier. This was particularly problematic for nurses who found they got "rusty" and reverted to task focused and expert models of care with the parents and their babies in their care. Two nurses, who were also trained as FPM group facilitators and regularly had the opportunity to revisit the model through the provision of training groups, demonstrated the greatest understanding of the FPM model. Their embodied practice with their respective mothers/babies during their consultations also placed them at the advanced practice end of the partnership continuum. Clinical supervision was frequently mentioned by the CFHNs as a supportive factor for working in the FPM. However, there were limitations to its efficacy for reinforcing the FPM with CFHNs when delivered in a group format for just one hour once per month. The use of videoed consultations was suggested by some nurses as a potentially valuable addition to reflection on practice during clinical supervision that could enhance nurses' partnership skills with parents. Two nurses expressed caution though that this only occurs during individual supervision sessions to avoid the judging gaze of colleagues.

CFHNs identified during interviews a range of conceptual understandings of the FPM. This was partly attributed to the lack of refresher education on the FPM. I observed a corresponding range of integration of the FPM into nurses' embodied practice during their video-taped consultations with mothers/babies despite these CFHN participants expressing a clear commitment to working in the FPM with parents. Nurses readily identified at their follow-up interviews when they had been more task than partnership focused during the consultation held with their participant mother/baby. They expressed frustration and were perplexed as to how to better manage their consultations in order to be more present in partnership with mothers. One CFHN also expressed confusion regarding the deployment of her clinical expertise in the context of working in partnership with parents.

CFHNs discussed the reality of coping with the limitations of their physical bodies and the challenges that this presented for embodied partnership practice with mothers. The nurses in this study were all in the vicinity of being middle aged. They discussed the reality of managing the necessary body and emotion work when trying to work in the FPM with mothers when feeling tired and drained, particularly at the end of the day. One nurse disclosed how her own mental health status and aversion to conducting the maternal psychosocial screening assessment could adversely affect her capacity for partnership causing her to feel "*disconnected*" and another nurse to be *"not in a good head space"* with the mothers at times. Another nurse participant discussed her difficulty dealing with menopausal symptoms and coming to work "*feeling like a wet rag and not up to par"*. It is conjectured that many of the CFHNs in this study may have also been experiencing peri-menopausal symptoms that may at times adversely impact on their ability to work in partnership with mothers. Challenges in regulating the body in response to the stressors within the work environment placed these nurses at risk of experiencing burnout symptoms which adversely impact their ability to work in the FPM with mothers and babies.

Creating "a mindful space" for working in partnership with parents was identified as the third theme of this study. Despite the structural challenges present within the CFHN work environment and the reality of their physical bodies, three of the nine nurse participants were able to demonstrate a high level of reflective practice and ability to be in the present moment in partnership with their client mothers and babies. The FPM does have a strong focus on the importance of reflective practice for clinicians (Davis & Day, 2010; Day et al., 2015). However, having a theoretical model that is infrequently visited through education and/or clinical supervision does not help to embed FPM concepts or integrate it in a sustainable way into individual CFHN's practice. I assert on the basis of findings of this study that what may enable nurses' ability to find the necessary "space" for partnership is the practice of mindfulness. This suggestion does not, however, abrogate the health institution of its responsibilities to provide the necessary leadership and work conditions to support CFHN staff if they wish them to practice the FPM in its entirety with mothers and babies/children. The discussion related to nursing leadership and the health institution will be examined in detail in the next chapter.

None of the three nurses in this study who practiced at the advanced end of the partnership continuum specifically spoke of having a mindfulness practice. They did, however, speak of mindful self-care, reflective practice and skilful workplace habits that

enabled them to refresh and focus between consultations in order to be fully present in the moment with each mother/baby as best they could. I purport that to build sustainability of FPM practice in the CFHN service that the FPM evolve to include a mindfulness component: both as part of its theoretical underpinnings; and, as part of initial and ongoing education and supervision of staff. There is compelling research evidence of the contribution of mindfulness practice to increased concentration and the work performance of staff as well as improved health outcomes for clients (Foureur, Besley, Burton, Yu, & Crisp, 2013; Kabat-Zinn, 2013; Razzaque et al., 2013; Tusaie & Edds, 2009). Partnership work with mothers can help to instil parallel partnership behaviours between mothers and their children (Davis & Day, 2010). Similarly, practising mindful ways of being with mothers may help to instil similar practices for them with their children (Kabat-Zinn & Kabat-Zinn, 1997). It is suggested that the implementation of mindfulness into the FPM and subsequent training programs may also be nurturing for the CFHN. It may enable more CFHNs to give themselves permission to pause and refocus at times throughout their work day; to enable "a mindful space" for themselves as well as a greater capacity to work in partnership with each and every mother and baby as well as their colleagues and managers. This may provide a welcome respite for nurses working within in a continually demanding and changing work environment and culture.

The fourth and final theme presented in this chapter portrayed the mothers' evaluations and experience of CFHN care. This included their interactions with, and the nature of the relationship established with their linked CFHN and the CFHN service in general. Overall, the mothers reported their experiences of their baby's six-eight week child health check consultation with their CFHN as positive. They felt listened to and stated that their nurse made them feel like it was all about them. Only one mother questioned whether a relationship had actually been established with her linked CFHN and queried the amount and purpose of all the questions that were asked.

Similarly, the mothers' experiences of the UHHV were mostly positive except for one whose visiting CFHN had not developed a rapport with her before asking the maternal psychosocial assessment questions. Mothers appreciated the other services offered at the CFHN service including the parent group programs. One of the main recommendations from mothers was that the CFHN Service should improve their communication processes through the implementation of internet based services and technology. This was in keeping with this generation of women who were used to web based communication on mobile devices such as smartphones with each other and expected it from their clinical

providers. The availability of modern ICT systems with mothers could help to achieve partnership with them from a distance.

Chapter 5 presents a discussion of these findings using a focused ethnographic perspective to critique the key concepts identified from data analysis and presents them as new concepts resulting from the study. Issues of power and how it is managed within the FPM features significantly in the discussion. These issues have previously been underreported in the literature (Fowler, Rossiter, et al., 2012; Hopwood, 2014b). In addition, the concepts of body and emotion work and mindfulness are novel in the context of the FPM and CFHN practice and represent new knowledge in this area of research.

Chapter 5 DISCUSSION

5.1 INTRODUCTION

The main purpose of this thesis was to explore CFHNs' and managers' thoughts and/or experiences of the factors influencing the CFHN's ability to work in the family partnership model (FPM) with parents in the practice setting, and the nature of their impact. Although both mothers and fathers were included under the term 'parents' in this study's research question and inclusion criteria only mothers consented to participate. Further, although I advertised widely, only one nurse unit manager consented and participated in the study.

This work is significant because a CFHN's work with a family commonly begins at the crucial time of a woman's major life transition to becoming a mother with its consequent potential for both vulnerability and personal growth (Guest, 2006). Therefore, *how* the CFHN "works" in partnership with the mother and baby has the capacity to influence the development of the mother's confidence and competence in her new role. This study has also explored mothers' experiences of the relationship and interactions with their CFHN and their recommendations for service improvement. It is important to explore mothers' views on these issues because they are the main 'partner' with whom CFHNs work. Obtaining the mothers' views also assisted in answering one half of the research questions, that is, 'the nature of the impact' in the research question. However, fathers' views are notably absent from the findings because no fathers volunteered to participate in the study.

My study identified both positive and negative factors at all levels of Australian society that influence nurses' partnership practice with mothers. It adds new knowledge and importantly, a focused ethnographic perspective regarding the factors influencing, and the nature of their impact, on the CFHNs' ability to work in the FPM with mothers in one LHD in NSW. In this chapter, the study findings are discussed from a focused ethnographic perspective and discussed in relation to the literature and the study's conceptual framework.

My aim in commencing this research several years ago was to understand more broadly how CFHNs negotiate partnership practice with parents in a changing and evolving work landscape. This study has revealed the views of nine child and family health nurses, one nurse unit manager and nine mothers who considered an exploration of the factors influencing FPM practice with parents important enough to participate in this study. I

identified four main themes from analysis of the aggregated data (see Figure 4: Study Findings Themes and Sub-Themes, p. 96). These four themes are tabled below.

Table 6: Outline of Study's Main Themes

Theme 1: The CFHNs' Work Environment and Culture This first theme centred on factors within the CFHNs' workplace that supported or constrained their ability to work in partnership with mothers. These factors included: • the nurse participants' relationships with "others"; their colleagues, managers and their client mothers and babies; • the landscape of the workplace; • the nature of the requirements of their role; and, • issues regarding the sustainability of their family partnership work with mothers.
Theme 2: Managing the Body: CFHN Body Work and Family Partnership Practice This second theme focuses on findings related to the personhood of the nurse participants and their embodied experience of the challenges of working in the FPM with mothers. These challenges included: • the self-regulation and discipline required of their bodies in order to work in the FPM with mothers; and, • the realities of meeting these requirements within the constraints of their work environment.
Theme 3: A Mindful Space The third theme, "A Mindful Space" was revealed as a "space" where some nurse participants demonstrated an exceptional ability to pause, reflect and be mindfully present in the moment with mothers and babies. These nurses appeared to be able to find the necessary "space" for family partnership work with mothers to flourish despite the presence of the organisational and personal constraints identified in the first two themes.
Theme 4: The Mother's Evaluation of CFHN Care Theme 4 captures the views of the nine participating mothers who shared their views of their evaluations and experience of care from their CFHN when working in the FPM. Overall, mothers identified: • positive experiences of their interactions with the CFHNs • recommendations which included improvements in communication both at the level of individual, face to face interactions with CFHNs, and for the CFHN service as a whole via greater use of improved information technology systems.

5.1.1 Methodology and Conceptual Model used to Frame Discussion

I used a focused ethnographic methodology (Cruz & Higginbottom, 2013; De Chesnay, 2015; Knoblauch, 2005; Wall, 2015) for this study. Focused ethnography is used in favour of other ethnographic methods when there is a distinct culture and research question under investigation (Polit & Tatano Beck, 2008), such as the case in my study. Using a focused ethnographic methodology enabled me to use my "insider and background knowledge and previous experience" (Wall, 2015, p. 5) of many years working in the CFHN specialty. As the researcher, I held an outsider role with this particular cultural group of nurses and mothers. However, my insider knowledge of CFHN and NSW Health meant that I had a significant background understanding of CFHN work processes, policies, clinical issues and in particular, the use of the FPM by CFHNs with mothers attending the service. This helped me to narrow the focus and delineate my research question and study. The organisation of the content of this discussion chapter represents my interpretation and reframing of the findings.

The purpose of my reframing, that is, the critical discussion of the findings, is designed to draw attention to the inequities and forces adversely impacting on CFHNs and mothers/babies and thereby affecting opportunities for their ability to work in partnership with each other. This critique, therefore, is not intended to be critical of CFHN participants' and manager's individual clinical and professional practice. My longstanding experience and knowledge of the CFHN service as a whole, is one of nurses' who endeavour to work as best they can with mothers and babies within the constraints of their current workplace environment.

I adapted Bronfenbrenner's (1979) *Ecological Model Of Human Development* as the conceptual framework for this study and the discussion of its findings takes place under each of the levels described in the model. The diagram of the Conceptual Framework has been included in this chapter for ease of reference for the reader (see below: Figure 5: Conceptual Framework for the Study). This model enables a macro to micro level systematic discussion of the factors that have been identified in the findings to influence the CFHN's ability to work in the FPM with mothers and the nature of their impact.

The influences impacting on families and on CFHNs stem from all levels of Australian society. However, the area that predominantly "set[s] the landscape and the structural parameters" (Bambra, 2011b, p. 748) of the nurses' workplace and of peoples' lives is at

the macro level of Bronfenbrenner's (1979) ecological model. My rationale for beginning this discussion with a macro focus is because health, and the health inequalities of individuals and populations are strongly influenced by the political, economic and social institutions at the macro level (Bambra, 2011b). Theme 1 (The CFHN Work Environment and Culture) encapsulates issues relevant to the macro and exosystem levels of Bronfenbrenner's (1979) model, with the sub-theme 'Working with others' also having application at the exo and mesosystem levels. Theme 2 (Managing the Body: CFHN Body Work And Partnership Practice), Theme 3 (A Mindful Space) and Theme 4 (The Mothers' Evaluation of CFHN Care) fall mainly within the micro and mesosystems as they focus predominantly on the self in relation to others.

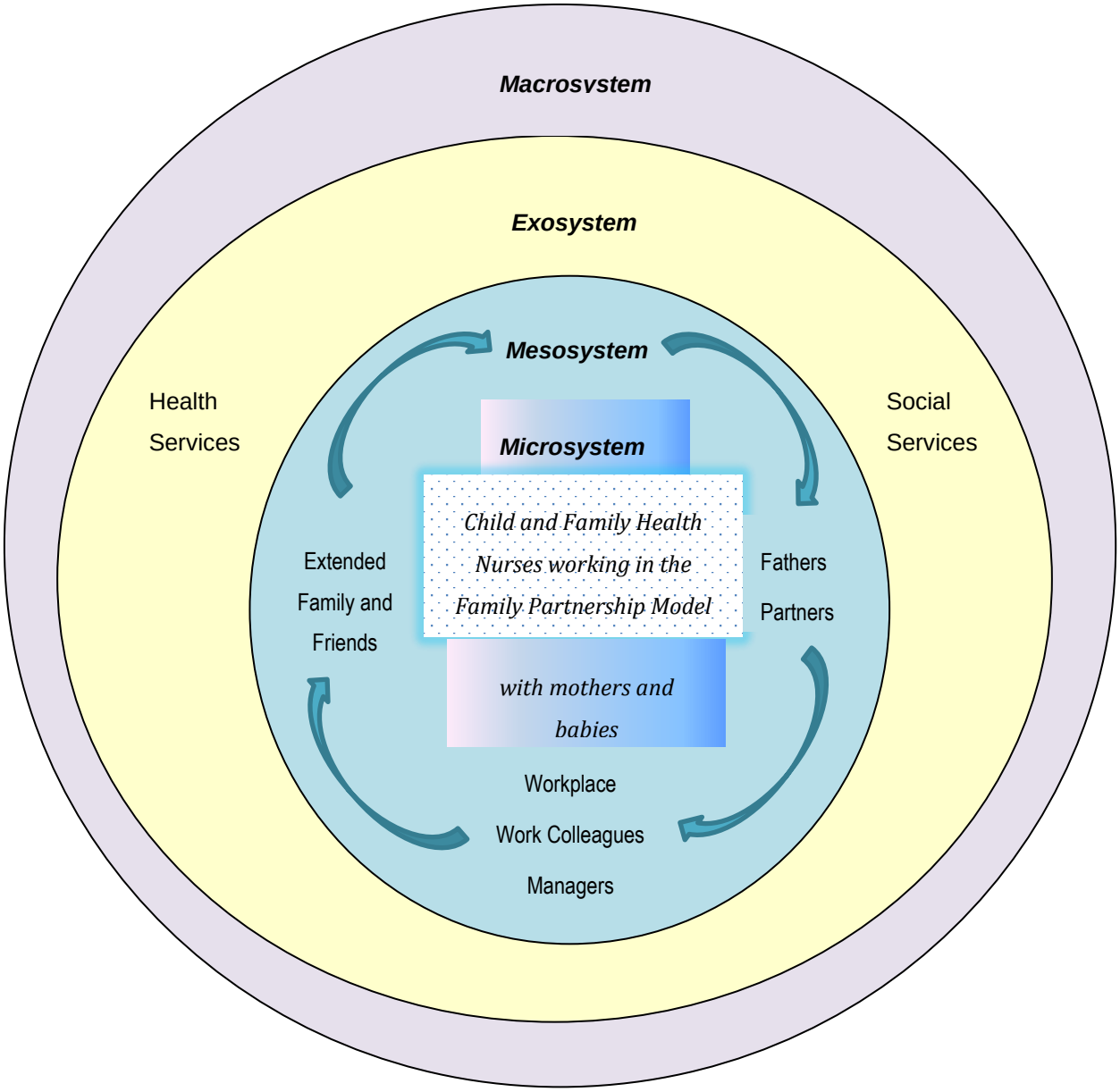

Figure 5: Conceptual Framework for the Study

adapted from Bronfenbrenner (1979)

The following discussion also places the study findings in the context of the literature related to the factors influencing CFHNs to work in partnership with parents. It reveals how the findings sit in relation to previous studies that examined topics similar to those identified by participants. New knowledge is also identified. The significance of the findings is discussed as well as their implications for future CFHN clinical practice, management, policy development and the theoretical framework of the FPM. At the conclusion of the chapter I identify the study's strengths and limitations, re-visit rigour and provide suggestions for future research into this topic and those areas identified as in need of further investigation.

5.2 IMPACTING FACTORS AT THE MACROSYSTEM[13] ON THE CFHN'S ABILITY TO WORK IN THE FPM WITH MOTHERS

In this study, the nature of the organisational culture and events that occurred at the macrosystem were identified as influences that impacted directly or indirectly on the role and function of the CFHN and their interaction with their client mothers, infants and young children. Because of this association, events enacted at the macrosystem such as new laws and policies had the capacity to influence the nature of the interpersonal and intrapersonal relationships of CFHNs and parents at the microsystem. These macrosystem events and associated processes, therefore, had the capacity to support or constrain nurses in their ability to work in the FPM with mothers at the microsystem. Thus, the study findings identified in Theme 1- The CFHN Work Environment and Culture and its subthemes: "the workplace", "the challenges of working in partnership and meeting role requirements" and "the sustainability of the FPM" feature in this macrosystem level of discussion

An overarching impacting factor identified at the macrosystem includes the influence of Australia's neoliberal political economy and culture and its effect on Commonwealth and State government processes such as health budgets, health targets, policy and practice and ultimately peoples' lives. Neoliberal economic policies have been in place in Australia for over the past 30 years (Battin, 2012). Neoliberalism has been the predominant political style for all governments whether Liberal or Labour. Critics such as Navarro (2007) and

[13] In the ecological model, the macrosystem 'consists of the general beliefs, values, customs and laws of the larger society in which all the other levels are embedded' (Siegler, DeLoache, Eisenberg, Saffran, & Leaper, 2014, p. 267).

Bambra (2011b) have pointed to the pervasive influence of neoliberal politics and globalisation on the "steepness of social and economic gradients [as] a key indicator of [poorer] population health and well-being" (Li et al., 2008, p. 66). This effect of neoliberalism in relation to the findings of this study is expanded below as the discussion of the findings proceeds from the macro level of influence and point of intervention to the micro level. The political economy, culture and the nature of government feature prominently in this discussion because its overall structure and function including the legislation enacted at this level, seeps down through the various systems affecting people in society such as nurses, parents and children from the macro to micro level.

5.2.1 The Impact of Neoliberalism on Child and Family Health Nursing

In this section, I begin the discussion with a focus on the Australian political economy as a macrosystem factor that influences society and the public health system. These macrosystem factors ultimately affected the nature of the CFHN Work Environment and Culture (Theme 1) and nurses' ability to work in the FPM with mothers and babies. Nurse participants referred to the *"enormous pressure"* on women and families that stemmed from the economy, the impact of globalisation and societal discourses on mothering. They identified these as factors that may adversely impact on mothers' ability to work in partnership with their CFHN. At the macro level, issues such as the nature of the Australian political economy require closer examination to understand its impact in the context of the factors influencing CFHNs partnership work with mothers and children.

Since the global financial crisis of 2007-09, neoliberal economic rationalism has emerged in Australia where government spending aims to balance or achieve financial surplus in the annual Budget "regardless of how pressing other circumstances may be, and no matter how much social facility may be in deficit" (Battin, 2012, p. 299). In this political economic climate neoliberalism is viewed as a doctrine which holds out relative advantage for the very few (Battin, 2012); and creates greater societal levels of health inequality and disadvantage (Bambra, 2011a; Li et al., 2008; Navarro, 2007). Bambra (2011b) argues that in neoliberal political economies, the kind of work people undertake creates class divisions and plays a central role in the determination of inequality in the distribution of mortality and morbidity. This occurs through exposure to potential physical and psychosocial hazards; exclusion from the labour market and paid work; and, the person's relative position within work-based hierarchies (Bambra, 2011b). These work-based

hierarchies reflect to a degree the broader "societal hierarchies [where] socioeconomic class is determined largely by occupation and work related income" (Bambra, 2011b, p. 746). This is relevant to the discussion of the study findings as the position of the CFHN specialty within the hierarchy of the nursing discipline and health service is discussed in detail in the Exosystem 5.3 (p. 243).

In relation to neoliberal economic policy at the State level, the Australian Medical Association (AMA) identifies that "Funding for the NSW Health Budget comes from three sources:

- the Federal Government;
- retained revenue (that is, money generated by the health department through fees, charges, investments, grants); and
- the NSW Government" (Australian Medical Association NSW, No Date) .

For the first time in 15 years, the AMA reported the NSW State Government came in under budget for health during 2009-10 (Australian Medical Association NSW, No Date). This reference to the 2009-10 NSW State budget is relevant because it was near the time of data collection for this study which occurred in 2011. However, the AMA report noted that one probable cause of this surplus "was the practice of not filling vacant positions" (Australian Medical Association NSW, No Date). The NSW Government budget strategy also anticipates delivering strong surpluses in 2015-16 and in the subsequent three years (NSW Government, 2015). This is relevant to this discussion of neoliberal political economics, budget surpluses and CFHN work because it has been reported that there was a "30% decrease in the number of CFHNs employed in Australia from 6,823 in 2003" (Cowley, Kemp, Day, & Appleton, 2012) to 4,659 in 2011(Australian Institute of Health and Welfare, 2011). This has occurred despite the birth rate increasing in NSW by 16.4% from 2003-2013 (Australian Bureau of Statistics, 2014). Preventive, primary health care such as CFHN services may be targeted for cuts within a neoliberal political economy where State Health budgets aim for a surplus and the policy making process is dominated by powerful vested interests (Sax, 1984). Cuts to preventive health funding were identified by the Council of Social Service of NSW (NCOSS) in the 2014 Australian Federal Budget (Council of Social Service of NSW (NCOSS), 2014). It was reported by NCOSS that the Commonwealth disbanded the *Australian National Preventive Health Agency* and "terminated the *National Partnership Agreement* that funded the *Healthy Children* and *Healthy Workers* programs. These programs were managed in NSW by the Office of Preventive Health" (Council of Social Service of NSW (NCOSS), 2014, p. 5). These funding cuts suggest that market principles are preeminent in health policy decision making.

5.2.1.1 Pressures on CFHN to meet policy expectations within budget

Having fewer CFHNs in the workforce combined with a higher birth rate I believe goes some way to explain why CFHN participants in this study reported feeling under pressure to meet UHHV performance targets during my period of data collection in 2011. Sandy stated that *"you're always just a bit short";* implying that the budget left the service understaffed for the amount of work required to be completed within set timeframes. It's unclear whether in this instance the nurse was referring to her service being understaffed due to positions not being filled and/or because of failure to increase staff to meet increases in the population. Neroli described it (budget constraints affecting clinical practice) as a "*squishy ball"*. This metaphor inferred that when CFHN clinical practice was constrained by a reduced budget and/or less staff, or by an increase in workload (from an increased birth rate and requirement for more UHHV), the CFHN could do less in other areas of clinical practice and/or the nursing care of families was compromised. The pressure experienced by CFHN participants in meeting health policy performance targets was identified as a significant factor that negatively impacted on their ability to work in partnership with mothers. However, none of the CFHNs discussed attempts to resist or challenge with their managers, the connection between budgetary constraint, policy expectations, their feelings of pressure and its impact on their partnership work. As Rudge (2015) states, in the neoliberal world nurses are constrained by "overzealous managerialism and regulation masquerading as professionalism" and, they currently "lack the ability to raise their collective voice to point out the immorality of reductions in health care budgets" (p. 2).

Despite the policy platform in NSW mandating UHHV for all new babies within two weeks of birth (NSW Department of Health, 2009), the budget appears insufficient in some CFHN services to employ enough nurses to achieve this. Results from a recent Australian national survey of universal child and family health services found that a "shortage of CFH nurses limited their capacity to meet policy expectations" with nurses from some districts unable to meet UHHV performance targets within the first month after birth (Schmied et al., 2015, p. 164). This shortage was reported to be due to the number of available funded positions and the "number of qualified nurses prepared to work in certain geographical areas" (Schmied et al., 2015, p. 164). One first time mother in my study reported that her first contact and UHHV from the CFHN had not occurred until her baby was four weeks old. This mother had assumed this late contact was due to poor communication from the service. However, similar to findings identified by Schmied et al. (2015), this delay may be

due to insufficient CFHN numbers and the need for nurses to triage in order of priority which mother/baby dyads receive home visiting. Therefore, nurses in some districts use a prioritisation system where the order of visits is provided based on risks identified on hospital maternal and infant discharge summaries, with well mothers and babies placed at lower priority for the UHHV (Schmied et al., 2015). However, this delay can be problematic for new mothers who are learning to breastfeed and care for their babies should they encounter difficulty in the early days at home after birth.

CFHN participants in my study voiced their criticism of their sense of work constraints in relation to staffing and budget. However, there were no suggestions made as to how they could use their individual or collective agency to influence change in these matters. Varcoe and Rodney (2009), in their research into Canadian hospital based nursing culture, have described how nurses adapted and contributed to the neoliberal corporate workplace by maximising their efficiency through a shared "ideology of scarcity" (p. 125).

> Nurses receive messages about the state of the economy and health care from many sources, ranging from media messages, to managers, coworkers, and patients. Nurses' talk revealed an acceptance of scarcity as the driving force in health care and the driving force that organizes nursing practice. (Varcoe & Rodney, 2009, p. 126)

The Canadian nurses, similar to the nurses in this study and that of Schmied et al. (2015) and Grant (2012), were aware of the "discrepancies between the care they valued and the care they were able to provide" (Varcoe & Rodney, 2009, p. 126). Grant (2012) has described this situation for contemporary CFHNs in South Australia as being "between a rock and a hard place" (p. 9).

5.2.1.2 Constraints on the Development of the CFHN Role under Neoliberalism

Linked to subtheme 4.4.3: "The Challenges of Working in Partnership and Meeting Role Requirements" (p.128), CFHN participants voiced concern about the devolvement of their role and ability to provide primary health level care to mothers and children in the community. This significant constraint on their role was reported to result from them being required to meet UHHV policy expectations within budget which reduced capacity for other areas of clinical practice. The CFHNs' complained they had less ability to provide continuity of care to families and did not have sufficient flexibility to follow up identified vulnerable families after the first home visit since the introduction of UHHV. Being less able to responsively provide continuity of care to mothers and babies constrains CFHNs'

ability to develop and sustain trusting relationships with them based on the FPM. These findings are consistent with the Australian research literature (Grant, 2012; Kruske et al., 2006; Schmied et al., 2011; Schmied et al., 2014). A similar situation has also been reported in the Health Visiting Service in the UK (Cowley et al., 2012; Russell, 2012). The Health Visitor Service in the UK is similar in function to the CFHN Service in Australia (Guest et al., 2013). In the UK, Health Visitor numbers were reported to be decreasing across the country (Russell & Drennan, 2007). The results of three electronic surveys of mothers in the UK during 2006-2008 found they were less inclined to visit their health visitor because they considered the Health Visitor "too busy" (Russell & Drennan, 2007); and, mothers were increasingly more likely to see their GP at an increased expense to the health service for child related issues (Russell, 2012). This has resulted in changes to health visiting policy by the UK government in order to recruit more health visitors where numbers are too low (Russell, 2012). Viewed through a neoliberal lens, the policy change to recruit more health visitors in the UK was perhaps motivated more by potential cost savings to the National Health Service Budget than altruism in providing greater access to health visitors thereby reducing the number of mothers' expensive visits to the GP. Similar, to the CFHN role in Australia, governmental policy changes in the UK affecting health visitors appears to promote efficiencies in care delivery and costs rather than the quality and type of the relationship between the nurse and mother.

The focus of meeting their UHHV requirements and other workload demands has reduced CFHNs' availability to flexibly follow up and provide intensive services to identified vulnerable families and children. Therefore, while NSW Health policy endorses the use of the FPM by CFHNs to form more early partnerships and ensure more families with newborns have an initial entry point into the service; the inconsistency is that there is a reduced capacity to then provide follow on care to those families who may benefit from extra support. This has led to an increased use of referrals to other government and non-government organisations (NGOs) for additional support of these families and was identified by one nurse, [Erica] in this study as adding to the devolvement of the nurses' role since UHHV was introduced. Erica voiced her frustration with the change and potential loss of aspects of what she considered within the realm of the CFHN role and expertise arising from UHHV implementation; the resulting inability to cement a partnership with mothers, and, readily provide follow up services to families who may benefit from extra support.

This devolving of workers' roles and privatisation of health and social services formerly provided by government is consistent with neoliberal economic policies of rationalisation (Alston & Dietsch, 2008). Twigg, Wolkowitz, Cohen, and Nettleton (2011) suggests governmental public authorities open up health and social care to private corporations in expectation of for-profit firms organising public health services more efficiently (p. 181). Organising public health services more efficiently may serve the neoliberal government agenda but it is not necessarily consistent with the clinical practice of CFHN services which focuses on establishing relationships and working in the FPM with parents. The increase of CFHN services' collaboration and partnership with other providers is acknowledged in the *National Framework for Universal Child and Family Health Services* (Australian Health Ministers Advisory Council, 2011). However, the FPM (one of the underpinning principles of this *Framework*), is predominantly implemented within universal CFHN services across Australia; rather than the government and non-government agencies and for profit, private firms with whom CFHN services refer and collaborate regarding the ongoing care of vulnerable families. Therefore, despite CFHNs' investment of time and energy working in the FPM with new families at the UHHV, they may then be required to refer these families on to engage with another service and worker that does not necessarily share the same FPM ethos or clinical expertise.

5.2.1.3 The Impact of Neoliberalism on Public Health Policy affecting CFHN Services

Public policy such as the *NSW Health/Families NSW Supporting Families Early Package – Maternal and Child Health Primary Health Care Policy* which mandates UHHV by CFHNs (NSW Department of Health, 2009), is a mechanism that neoliberal governments can use to their advantage, bypassing "public critical scrutiny or discourse…and without involving the public voice" (Bradshaw, 2015, p. 81). Bradshaw (2015), argues that public policy including policy that affects the nursing profession, should be subject to the same rigorous social and scientific evaluation as research if it is to be considered a reliable basis on which to provide care. In Australia, public health policy is shaped by the Federal system (Tiernan, 2012). Over the last 30 years, the Australian Commonwealth government has become more interventionist in areas of policy that were once the domain of the States and Territories, for example, the national hospitals system (Tiernan, 2012). This has occurred:

> …through the referral of powers or by direct challenges or interventions that effectively bypass the states…[driving an] increasingly centralised agenda

> …to draw (or compel) the states into policy frameworks that establish consistent standards and goals (Tiernan, 2012, p. 256).

An example of one of these policy frameworks relevant to Theme 1- The CFHN Work Environment and Culture is the *National Framework for Universal Child and Family Health Services (Australian Health Ministers Advisory Council, 2011).* The purpose and focus of this document is to articulate a "vision, objectives and principles for universal child and family health services for all Australian children aged zero to eight years and their families" (Australian Health Ministers Advisory Council, 2011, p. 1). Centralisation of public policy agendas such as this brings with it the concept of "deliverology" (Tiernan, 2012, p. 257). Deliverology is a term coined during the reforms of the Blair Government in the UK which describes the techniques and methods required for effective delivery of policy reform that is consistent with neoliberal approaches used by the Australian government today (Tiernan, 2012). These techniques include identifying the responsibility of individuals and groups; setting clear goals and targets; creating performance data to manage performance and measure and review progress with remedial action as needed; and, regular reporting of performance through appointed channels to the relevant minister (Tiernan, 2012, p. 257). One of the benefits described in *The National Framework for Universal Child and Family Health Services* that is consistent with a neoliberal agenda is:

> …progress towards national performance monitoring and the compilation of national population health data for the purposes of comparison across jurisdictions and subpopulations. (Australian Health Ministers Advisory Council, 2011, p. 1)

There are issues at stake, however, in relation to public health policy and the "deliverology" or performance measures developed for the NSW CFHN service by the state neoliberal government. The issues are that they are inconsistent with and adversely impact on nurses' ability to work in the FPM with parents. These issues are discussed in more detail in the next section.

5.2.1.4 Regulation of CFHN Function and Performance: Compliance with Policy Targets

The neoliberal political influence at the NSW Health level I believe is a significant factor impacting on the function and performance of the CFHN Service. This factor links to the Subtheme 4.4.3 The Challenges of Working in Partnership and Meeting Role Requirements (p. 130). The neoliberal agenda has set the performance of the CFHN Service in meeting

UHHV targets as the key CFHN service indicator reported at the State level (NSW Department of Health, 2009). Sandy described this activity as needing *"to get outcomes and we need to count the outcomes and we need to give them to our accountants",* that is, the designated position within the LHD responsible for these calculations, reporting and compliance with this NSW Health policy directive (NSW Department of Health, 2009). One of the key outcomes Sandy referred to was the numbers of UHHVs conducted within two weeks of birth by her CFHN team (NSW Department of Health, 2009). The pressure to achieve the targets for the UHHV performance indicator is exerted downward through the NSW Health management tiers to the Chief Executive (CE) of the LHD, local service managers, nurse managers and finally to the CFHN who is at the frontline home visiting parents and their newborns.

This UHHV performance indicator was reported as problematic for CFHN participants in this study. They identified competing and conflicting role requirements in relation to working in the FPM with mothers that arose from endeavouring to meet these targets. Meeting this universal contact key performance indicator (KPI) alongside the already expanded context of their role (Australian Health Ministers Advisory Council, 2011); has a regulating impact on the governance and function of the CFHN service and is consistent with reports in the literature (and from participants in this study) as a significant factor that creates role tension and conflicts with CFHNs' partnership work with parents (Grant, 2012; Hopwood et al., 2013; Kruske et al., 2006). In essence, working within a neoliberal influenced health system and culture is contrary to organisational values, policies and processes that emphasise CFHNs' working in the FPM with parents.

The findings of my study that continuity of care from the same CFHN at the UHHV and the six-eight week child health check occurred for just two of nine parent participants in this study indicate that it is now unlikely that the CFHN who conducts the initial home visit, assessments and care with the family will be able to provide ongoing continuity of care. One mother, Susan, identified this lack of continuity as a surprise and a concern. Furthermore, Schmied et al. (2011) state that it remains "yet to be demonstrated both in Australia and internationally", that health policies that mandate "universal home visiting and the maternal psychosocial assessment that occurs at this time" actually lead to greater parental "engagement in services and improved outcomes" (p. 114). One issue that may account for the lack of continued parental engagement in services may be related to CFHN service restructure following the introduction of the UHHV. Nevertheless, five mothers in

my study did get to know their CFHN participant in this study from attendance at their centre's weekly group sessions for new parents which the nurse facilitated.

The Australian CFHN literature suggests that continuity of carer in the nurse–parent relationship is essential to partnership practice (Briggs, 2007; Kemp et al., 2006-2007; Kruske et al., 2006; Schmied et al., 2011). Continuity of carer also underpins contemporary, woman-centred, caseload midwifery practice (Sandall et al., 2013) and forefronts the care offered to mothers and babies by the CFHN service. Despite this, the importance of continuity of care by the same CFHN remains "less evident in child health policy documents" compared with the importance placed on continuity of care relationships with the same midwife found in contemporary maternity service frameworks (Schmied et al., 2011, p. 113). CFHNs' ability to work in the FPM with mothers will remain challenged and continuity of care models with mothers unavailable until the mandated compliance with current CFHN performance targets is changed and/or CFHN services have the capacity and capability to redesign care delivery methods. On its own, the FPM theoretical framework does not appear to promote continuity of carer. The authors suggest that the issues of establishing partnership based relationships with parents remain the same whether provided in one or more sessions or by the same worker (Davis & Day, 2010, p. 109). Nevertheless, while the issues of *establishing* partnerships may be the same, the mothers in my study (Theme4-Mothers' Evaluation of CFHN Care) as well as in the literature (Sandall et al., 2013), have clearly identified they want to *maintain* continuity of care relationships during pregnancy, birth and in the postnatal period and beyond.

5.2.1.5 CFHN Practice, Body work and the Neoliberal State

The ability of CFHNs to implement the level and type of care and "hands on" body work[14] with mothers and babies/children is relevant to this macro level discussion of the findings of this study in relation to neoliberalism. This is because the "performance [of bodywork] is shaped by wider social and economic forces and demographic trends" (Twigg et al., 2011, p. 180). Twigg et al. (2011) argue that this body work performed by health

[14] The term "body work" in this study refers to:

- "the work performed on one's own body,
- paid labour carried out on the bodies of others,
- the management of embodied emotional experience and display, and
- the production or modification of bodies through work." (Gimlin, 2007, p. 353)

professionals and social services is "deeply integrated into the wider global political economy dominated by forms of capitalist rationality in the management of resources, including labour" (p. 181). Further, the development and sustainability of relationships between workers and clients, for example, the mother and child, is dependent on a three-way relationship between the worker, their employer and the client with the State holding a major role as fourth party (Twigg et al., 2011, p. 180). The role of the State as the fourth player includes its funding of services and establishment of policies and regulatory standards (Twigg et al., 2011). With regards to the CFHN Service, this means the "establishment of sufficient [nurse] staffing levels to provide UHHV for the Area's [LHDs] population and characteristics" (NSW Department of Health, 2009, pp. 7, 28); that is, the nurse to newborn staffing ratio within each LHD within NSW Health.

The ability of CFHNs to readily engage in body and emotion work with mothers is influenced by their requirement to meet UHHV targets and the available budget to employ sufficient CFHNs to do this. Meeting these targets, in addition to their other workplace demands, was found to create personal conflict for the CFHNs in my study. The performance of the bodywork of CFHNs I observed included the nurses' "hands on" role, for example, during infant screening and surveillance examinations. It also included, however, the invisible, internal "emotion work"(Hochschild, 1983, 2012) they described in order to regulate and discipline their bodies to demonstrate the proper facial and bodily displays of working in the FPM with mothers and babies. This body and emotion work of CFHN is directly linked to Theme 2–Managing the Body: CFHN Body Work and Partnership Practice. Nurses found themselves, as a consequence of conflicting work place demands and values, less physically and emotionally able to work in the FPM with the mothers. This focus on the impact of emotion work on CFHNs in this study is further discussed in the discussion of factors influencing working in the FPM at the microsystem level (Section 5.5.2, p. 284).

5.2.2 The Impact of Governmentality on Child and Family Health Nursing

In this section, the second issue, namely governmentality is introduced in relation to the findings of Theme 1: The CFHN Work Environment and Culture regarding its influence and impact on the CFHN's ability to work in the FPM with mothers. The centralisation of public policy and the increased use of calculations and techniques to measure and report on nurses' performance discussed under neoliberalism (Section 5.2.1, p. 216), is analogous

with the concept of governmentality (Dean, 1994, 2010; Foucault, 1982, 1991, 1994, 2007; Miller & Rose, 1990; Miller & Rose, 2008), as it is practised throughout the tiers of the Australian government and public health system. Governmentality is broadly defined as "the conduct of conduct" (Foucault, 1982, pp. 220-221). Essentially it is a mode of power that involves the maintenance and control of people through policies and processes managed through institutions and bureaucracies (Miller & Rose, 2008; Rose & Miller, 1992). This is achieved in part by the State governments through subtle means whereby individuals internalise social and public health policies and discourses as private endeavours which become daily practices (Perron et al., 2005b).

5.2.2.1 CFHNs and the FPM: Caring Helpers or Agents of the State?

Using the concept of governmentality as a lens, the CFHN workforce can be examined in terms of its role as an "apparatus of security" (Foucault, 2007, pp. 107-108), of Australian neoliberal governments that work at the level of individual families to influence population outcomes (Grant, 2012; Schmied et al., 2011). The purpose of the government, according to Foucault (1991) is "the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc." (p. 100). The government achieves these aims directly or indirectly and "….without the full awareness of the people" (Foucault, 1991, p. 100).

One main way that governmentality is operationalised is by the use of "professional expertise" (Thompson, 2008, p. 78). Professional expertise, Thompson (2008) states, is a "tool used to both govern the conduct of populations, and also that of professional 'experts' themselves" (p. 78). Nurses, such as CFHNs, with their body of knowledge and expertise:

> …are at the flexing point of the state's requirements and of individual and collective aspirations. They occupy a strategic position that allows them to act as instruments of governmentality. Consequently, nurses constitute a fully-fledged political entity making use of disciplinary technologies and responding to state ideologies. (Perron et al., 2005b, p. 536)

On the basis of my findings, (Section: 4.4.3.2, Subtheme Challenges of meeting role requirements – *Conducting the maternal psychosocial assessment,* p. 135), it is evident that the CFHN works as an "agent of the state" (Perron et al., 2005b). This occurs via the CFHN working in the FPM with individual parents and children in order to achieve population

based health policy measures and outcomes (Grant, 2012; Schmied et al., 2011; Shepherd, 2014).

The State confers nurses with "authority" over their patients and clients by virtue of their professional expertise and knowledge (Perron et al., 2005b, p. 537). However, this invested authority, power and expert knowledge did not sit comfortably with some of the CFHN participants' conceptualisations of FPM work with mothers in this study. Consistent with the literature (Fowler, Lee, et al., 2012; Fowler, Rossiter, et al., 2012; Grant, 2012; Hopwood, 2013; Kruske et al., 2006), some nurses in this study voiced role tension and confusion regarding the deployment of their power and clinical expertise in relation to their family partnership work with mothers. For example, Annie, an experienced paediatric and CFHN, regretfully recounted an instance of role tension where confusion about using her clinical expertise vis a vis enacting the FPM resulted in her privileging partnership over her clinical expertise in the care of a mother and infant (see Section: 4.5.1.2., p. 160),

The physical examination of infants is a routine CFHN practice where CFHNs' potentially act as "instruments of governmentality" (Perron et al., 2005b, p. 536). I observed all CFHN participants in this study conducting these infant physical examinations as well as elements of the maternal psychosocial screening assessment. Examination in this instance refers to a:

> …combination of hierarchical surveillance and corrective normalization. Examination evaluates each individual's abilities and knowledge, analyses new learning and behaviours and sanctions the weak, while validating those performances that meet expectations (Perron et al., 2005b, p. 539).

The CFHN routinely conducts multiple assessments and examinations on both mother and child to determine "normal", healthy behaviours, discourage unhealthy lifestyles and parenting practices that "transgress these social tenets" (Perron et al., 2005b, p. 539). Perron et al. (2005b) suggest, that in order to achieve such finely nuanced control over peoples' thoughts and actions:

> The state must come to know them better than they know themselves. An individual must, therefore, open up and confess their deepest secrets. Therapeutic listening techniques are a concrete example of examination. (p. 539)

The FPM may also be viewed as an instrument designed to aid practitioners such as CFHNs' ability to conduct therapeutic listening in order to gain access to parents' "deepest secrets" (Perron et al., 2005b, p. 539) by working in the FPM with them. This is particularly pertinent to the sensitive questions asked in the surveillance tool NSW Health SAFE START *Maternal Psychosocial Assessment Questionnaire* (NSW Department of Health, 2009) (Appendix R). New mothers are asked these surveillance questions by the CFHN at the UHHV or next available clinic appointment. Both nurses and mothers in this study had mixed views about these assessment questions. One nurse, Annie, stated she used the maternal psychosocial assessment as a premise to build the relationship with the mother. She said she used the rationale with mothers that by asking the assessment questions, she was seeking some information, "*a picture of …their past that might influence them to parent" in* order to help them "*be the best the parents they can be".* I suggest, the "normalizing" nature of this routine, universal surveillance activity is in most instances "taken for granted" by mothers as altruistically designed to determine which mother/baby may be in need of help and support rather than an "instrument of social control" (Perron et al., 2005b, p. 541). I didn't ask the CFHNs in this study whether they recognised the power these surveillance questions gave them to make judgements about their clients' (mother's and baby's) care, and to collect data for those whose interests it serves at government level. The nurse participants, themselves, did not articulate a link between the use of the FPM as an aid in these surveillance activities. It is not surprising that CFHNs providing frontline care and support to mothers do not criticise the maternal assessments tools "we" have been taught are designed to identify mothers at risk, for example, of postnatal depression or domestic violence. Similar to Shepherd (2014), in her recent doctoral study into power, care and knowledge in CFHN, it is only my complete immersion in this study that has enabled me to uncover alternate views of the nature of CFHN assessment tools and the altruistic role of the CFHN.

CFHNs in this study did, however, express frustration at the amount of infant and maternal surveillance and screening they were required to undertake and the limited time available to explore and follow up identified issues. They used the pejorative descriptions of their role being consistent with having to "*tick all the boxes … this isn't partnership. This is a process that has to be done"*. The frustration expressed by nurses in this study echoes the "*stupid questions"* critique made by South Australian CFHNs regarding the implementation of structured assessments in Grant's (2012) ethnographic research into intercultural communication in CFHN. The nurses were voicing a dissonance between the information

the State required them to collect and their ability to work (and provide follow up) in the FPM with mothers and babies.

Structured maternal and infant assessments are conducted at specific postnatal stages and milestones of the child (NSW Department of Health, 2009; NSW Kids and Families, 2013). The administration of structured assessment tools has been suggested covertly places the nurse as a surveillance agent of the state (Peckover, 2002; Wilson, 2001, 2003) and at odds with partnership discourse. CFHNs have reported tension or dissonance with the ethical discomfort arising from the "the need to work in partnership with the woman …while responding to the mandate to assess for risk in a structured, population based approach" when asking the maternal psychosocial questions (Rollans et al., 2013, p. 11). Fowler, Rossiter, et al. (2012) suggest this dual role of "inquirer and facilitator" implies a tension for potential asymmetry of power relations between the CFHN and parent that requires careful navigation and negotiation (p. 3312). CFHNs have been reported in response to "conceal the full purpose of the visit", that is, the agenda of maternal assessment with the women by "engagement work: getting that first bit right"; "doing some paperwork; [and] creating comfort" (Rollans et al., 2013, pp. 1, 11). CFHNs also reported that their full surveillance agenda was "cloaked in the baby check"; the baby check being the primary reason the women accepted the UHHV or attended the CFHN centre (Rollans et al., 2013, p. 9; Shepherd, 2011). CFHNs in my study did not identify this same ethical dissonance with the maternal psychosocial assessment reported previously in the literature. However, they were similarly frustrated and experienced the same reported dissonance from being aware of the need to work in a partnership approach with parents and infants and completing task oriented, state mandated surveillance checklists (Grant, 2012; Rollans et al., 2013; Schmied et al., 2015).

The mothers in this study, like their CFHNs, also had varied views regarding the maternal psychosocial assessment questions asked both at the UHHV and six week consultation at the Centre. One mother stated that the sensitive questions asked at the UHHV were not a problem and that *"it's good that the nurses bring it up*". Another mother, Susan, said she found the questions asked on the first home visit confronting and they made her feel uncomfortable because the CFHN had asked the assessment questions more like a checklist before establishing a rapport with her. This mother suggested that it was important for CFHNs to ask these sensitive questions in a more relaxed, conversational approach and to wait until they had got to know one another. However, this getting to know one another takes time that the majority of CFHNs identified as being restricted and

confined. Therefore, it was Susan's evaluation of CFHN care (Theme 4) that led to the development of the Subtheme "*First develop rapport"* (See Section*:* 4.7.2, p. 199). It appears from this mother's comments that she felt the questions were intrusive and unexpected and this resulted in her *"put[ting] a wall up",* that is, she was more guarded and resistant in her responses with the home visiting nurse.

In Susan's example, her sense of being judged was at odds with a partnership approach by the nurse. These tensions present in the CFHN role between acting as a partnership focussed "agent of care" or a surveillance "agent of the state" (Perron et al., 2005b, p. 536) with mothers has been reported in the international literature relating to nurses in roles similar to the CFHN (Mitcheson & Cowley, 2003; Peckover, 2002; Wilson, 2001, 2003). The issue of using the FPM as a strategy to help mothers drop their guard and reveal their "deepest secrets" (Perron et al., 2005b) suggests that the contemporary CFHN has a continued covert professional "policing" role for the State (Peckover, 2002, p. 369). This covert surveillance role of the CFHN and the frustration and/or ethical dissonance that can arise for some nurses as a result; and, the impact of this surveillance on mothers, is a significant influencing factor that may adversely impact on the ability of the CFHN to work in the FPM with mothers.

5.2.2.2 The FPM as a Disciplinary Technology of Government to Manage Populations

During the examining of the findings, I felt conflicted about my views of the FPM as I first encountered it in practice. That is, the view that I held regarding the genuine altruistic intent of the FPM authors, trainers and practitioners who believe it offers a road to securing a partnership approach with parents. This view now contrasted with the more cynical understanding of it being a governmental disciplinary technology and ideology incorporated into NSW Health CFHN policy, staff education programs and practice (NSW Department of Health, 2009). The altruistic intent of "partnership-based agendas" such as the FPM has also begun to be questioned in the literature in relation to CFHN practice (Grant & Luxford, 2008; Hopwood, 2014a, p. 3). However, in my study, there was no critique made of the FPM or its intent made by participants, except reports from two nurses who stated that it "*was annoying"* when the NUM used the Socratic questioning style characteristic of the model with her own staff.

While the FPM *is* designed to assist health professionals such as CFHNs develop skills to improve engagement by families with services (Davis & Day, 2010), increased engagement

of parents and children by CFHNs helps the government achieve population based maternal and infant health surveillance objectives; and promotion, prevention and early intervention in childhood health programs (Australian Health Ministers Advisory Council, 2011; NSW Department of Health, 2009). Two of the listed objectives of the UHHV include:

- "engage families with the child and family service system and to provide support early, within two weeks of birth;
- better determine families' needs for ongoing care by adding depth and context to the assessment by conducting it in the family home and in partnership with the family". (NSW Department of Health, 2009, p. 21)

The FPM was expressly selected by the State as one arm of the training that CFHN are required to undertake in order to implement UHHV and the ongoing maternal and infant assessments and care (NSW Department of Health, 2009). The *SAFE START Psychosocial Assessment and Depression Screening Training* is the other key training component (NSW Department of Health, 2009). Like the outcomes of previous international research in similar contexts mentioned above (Mitcheson & Cowley, 2003; Peckover, 2002; Wilson, 2001, 2003), the findings of this study have helped to defuse for me some of the role tension I have experienced through greater awareness and acknowledgement of these dual roles of the FPM and of CFHNs in NSW.

This discussion of the study findings challenges the view of the CFHN service as politically neutral and provided according to the best interests of parents and children. It is comparable to arguments proposed by Thompson (2008) regarding the role of nursing in relation to governmentality. The FPM, as an instrument of governmentality and disciplinary technology serves a number of purposes. First, the introduction of the FPM into practice by CFHN serves the State at the population level by creating a mechanism aimed to facilitate the engagement of families by the service. Second, higher levels of families engaged with the service enables greater opportunities for surveillance, reporting on the health and well-being of parents and children, and, opportunities to provide promotion of healthful parenting practices and lifestyles. Third, surveillance and detection of problems in parents and children provides greater opportunities for early intervention. Engagement by parents with the CFHN service is crucial as "Neoliberalism depends on self-governance (or in the case of children, governance by parents and similar authorities)" (Clarke, 2013).

Prevention and early intervention for childhood health and development issues are of interest to the government as there is a significant body of literature that outlines the cost benefit ratio of investing in early childhood compared with later intervention strategies (Barker, 1994; Hertzman & Power, 2003; McCain & Mustard, 1999; Mustard, 2010; Perry, 2005). Rose and Miller (1992) have suggested that "government is a problematizing activity" (p. 181). This means that governments create "programmes of government" to address problems and failures in all spheres; social issues, the economy, health, defence and so on (Rose & Miller, 1992, p. 181). In effect, technologies of government facilitate "deliverology" (Tiernan, 2012) and the ability of the State to govern "action at a distance" Latour (1987) cited in (Miller & Rose, 1990, p. 2). The phrase "action at a distance" refers to the indirect means of 'aligning economic, social and personal conduct with socio-political objectives" and relies crucially upon "expertise" (Miller & Rose, 1990, p. 2).

Pregnancy, childhood and parenting are phases of life relevant to this study that are the most intensively governed aspects of human existence (Lowe, Lee, & Macvarish, 2015; Rose, 1989; Weir, 1996), and, therefore, have effectively been "problematised" and "medicalised". One reason attributed to this governance and problematisation is that each of these life phases are associated with "clinical risk" (Weir, 1996, p. 381). Weir (1996, p. 381) states that "Risk calculations in medicine are the product of epidemiological knowledge [and that] clinical risk attaches risk directly to the bodies of persons". For example, Weir (1996) suggests that antenatal care has been progressively "characterised by population based risk techniques with the fetal body as the primary site for the problematisation of risk" (p. 379). Following population based physical and psychosocial screening programmes, pregnant [and postnatal] women are classified into risk groups based on "future oriented" projections of clinical possibilities and probabilities (Weir, 1996, p. 381). Screening of populations, Castel (1991, p. 281) argues, has moved "from dangerousness to risk" whereby surveillance practices remove or minimise future problems through interventions on "modifiable risk factors'' (Weir, 1996, p. 383). Detection of some or a number of risk factors during the surveillance activities of assessment and screening sets off an alert (Castel, 1991, p. 287). This alert may result in a family being visited by a "specialist" with expertise who can confirm or disconfirm the real presence of a danger on the basis of risk factors (Castel, 1991, p. 287).

This assessment of risk continues after the birth with the baby, mother and family all coming under the surveillance and gaze of the CFHN Service. The net surveillance practices of the CFHN service has grown significantly in the years since the beginning of

the 21st century (Australian Health Ministers Advisory Council, 2011). Surveillance and monitoring of child health and family functioning occurs at the individual level between the nurse and parent as well as at the population health level (Australian Institute of Health and Welfare, 2011). The CFHN Service is directed to provide, in partnership with the parents, core services of:

- developmental surveillance and health monitoring of the child;
- maternal psychosocial screening and assessments of family functioning;
- early identification of family need and risk and responding to identified need; and,
- extensive health promotion and social connection activities for parents and children, for example parenting groups (Australian Health Ministers Advisory Council, 2011, pp. 18-19).

Lowe et al. (2015) argue the State is now highly invested in parenting quality in order to optimise children's' brain development (p. 206). Lowe et al. (2015, p. 198) state this "biologising" and surveillance of parenting has arisen from the burgeoning "early years" research (Hertzman & Power, 2003; Keating & Hertzman, 1999; McCain & Mustard, 1999; Mustard, 2010), and the consequent importance placed in policies and programs on "the construction of parenting as a key determinant of brain development and thus the child's future". Parents generally, are already devoted to the creation of nurturing environments for their child. A key role of CFHN work, as identified in the findings of this study, is to work in the FPM with parents, to support them to achieve both the State's and their own individual goals regarding their own health and that of their children; and, detection and early resolution of any parenting issues in order to promote healthy family functioning. This helps the State achieve its aim of maximising the brain development of children and optimising their life chances (Lowe et al., 2015). Yet, I suggest, the ideology of the "prevention of risk" (Castel, 1991, p. 289), and associated increased CFHN surveillance activities of mothers and children are factors influencing at the macro level the ability of the nurse to work in the FPM with parents. Nurses in this study reported their frustration at the amount of prescribed, structured assessments and *"checklists"* requiring completion that detracted from a parent led, partnership agenda. One nurse voiced her moral dilemma and the conflict she experienced in following what she described as "*two sets of rules"*. These were the "*rules"* related to the FPM and those of the organisation. Despite this, the nurses in this study did not identify the FPM as a State directed strategy and disciplinary technology implemented to facilitate the surveillance and support work of CFHNs with parents and children. However, the focused ethnographic analysis and interpretation of

the findings in relation to the literature has assisted me in revealing these less obvious factors and tensions between State government directed surveillance policies, CFHN values and the FPM.

5.2.2.3 CFHN and the FPM: Imperialist Imposition or Necessary Practice Change?

That the FPM was conceived as necessary to implement across the board into NSW CFHN policy and practice in order to improve the nursing care approach of the CFHN with parents and children, implies a deficit in relational care existed that needed rectifying. The FPM was introduced into NSW CFHN Service without evidence of its efficacy in the Australian multicultural context or with the CFHN workforce and families. In 1861, a medical practitioner "initiated the invitation to establish Nightingale nursing in Australia" in order to "change accepted nursing practice"(Godden & Forsyth, 2000, p. 11). English born Lucy Osborn was subsequently recruited to the task. One hundred and forty years later in 2001, the "breath-taking arrogance of imperialism" (Godden & Forsyth, 2000, p. 11) was repeated as another Australian medical practitioner successfully lobbied NSW Health to bring the English authors of the FPM to NSW to once again modify nursing practice; this time, to incorporate the FPM into CFHN and other child health services (Guest et al., 2003). There had, however, been an earlier introduction of the model by child health services in Western Australia in 2001 (Lamont, 2002).

The evidence for the early iteration of the FPM was derived from studies conducted in the UK in paediatric settings and community child mental health services (Davis & Rushton, 1991; Davis & Spurr, 1998). The authorship of original FPM text was developed by two psychologists and one health visitor (Davis et al., 2002). The underpinning framework of the model is based on the work of three psychologists: Rogers (1959); Egan (1990); and Kelly (1955) (Davis & Day, 2010; Davis et al., 2002). Grant and Luxford (2008), both Australian nurse academics with the first author also being a CFHN, have critiqued the theories underpinning the FPM and identified its flaws and/or omissions regarding its application to the South Australian multicultural context and CFHN workforce. They have challenged the contemporary relevance of theories developed by male psychologists post World War II for use in the twenty-first century in Australian multicultural society by CFHNs and families (Grant & Luxford, 2008). Grant and Luxford (2008) argue that:

> As child and family health nurses, we tend not to dislodge our sense of comfort with enduring canons by Kelly, Rogers and Egan as they appeal to

> our sense of equity and fairness through familiar notions of unconditional positive regard and empathy. (p. 315)

However, these "canons", Grant and Luxford (2008) argue, represent a 'rational, white and male, liberal western construct of normality" (p. 315). This "taken for granted" view of normality that is present in the state endorsed FPM may impede CFHNs from taking "account of other world views" (Grant & Luxford, 2008, p. 315) such as those of migrants, Aboriginal or teenage parents. The mothers I interviewed, however, did not identify as migrant or Aboriginal and were not teenagers. Grant and Luxford (2008, p. 315) note it may also impact on nurses' awareness and realisation that the enactment of equity and fairness depends on our understandings of "'self' and 'other' as classed, raced and gendered". There was no critique ventured by any participants in my study regarding the FPM itself, except for reports, previously mentioned, of it "*being annoying"* when the NUM used the techniques with her staff. It appeared there indeed existed a "taken for granted" assumption by CFHN participants that the model could be used in all contexts with all family situations and issues and was "provided according to [the parents'] best interests" (Perron et al., 2005b).

The assumption of its one size fits all approach is implied in NSW Health policy: "at the initial contact the nurse will establish a trusting relationship based on principles of the Family Partnership model" (NSW Department of Health, 2009, p. 22). It is also identified as an underpinning tenet of the *NSW Child and Family Health Nursing Professional Practice Framework 2011-2016* (The Nursing and Midwifery Office, 2011). However, the assumption in the model, which is that all parents want or are willing to work in partnership, finds a sticking point, as identified in this study, when nurses encounter parents in the community who resist partnership approaches. The most commonly reported group was those parents who came to consultations wanting the CFHN to provide them with solutions for their parenting difficulties. Donna, (NUM) identified the presence within the community of "*A group of people out there that for whatever reason they want someone to fix things for them".* The other problematic implied assumption is that the FPM would suit families from all cultures, including that of the Aboriginal people of Australia. This indicates a lack of recognition of differing cultural parenting practices by the State and resonates closely with the findings of Grant and Luxford (2008). The issue of parents resisting CFHNs' partnership approaches is well documented in the literature (Davis & Day, 2010; Rossiter et al., 2011; Wilson, 2001). It is linked to the subtheme

"*Working with Others"* which is further explored at the mesosystem and microsystem levels of this discussion

5.2.3 Society's Discourses[15] on Mothering and Its Impact on the Ability of the CFHN to Work in the FPM

I turn the discussion of the factors identified in this study at the macrosystem that impact on CFHNs and their ability to work in the FPM with mothers to a focus on culture and, in particular, on mainstream Australian societal discourses on mothering. This focus is relevant because culture and the constructs of our discourse shape both nurses' and mothers' thoughts, behaviours and actions. Hence, this section of the discussion is linked to the findings from Theme 1-The CFHN Work Environment and Culture, and in particular it's sub-theme *"Working with Parents*" (See Section 4.4.1.3, p. 114). The societal discourse on what constitutes "good, appropriate" parenting can lead to strongly held beliefs and values by both health professionals and parents (Aston, 2008; Shepherd, 2014). These strongly held beliefs and values were factors identified by two nurses in this study that can influence and interrupt the development of partnership based relationships with mothers. There were no specific comments made by the CFHN participants, however, about how these influences and pressures may affect the well-being and parenting practices of fathers. No fathers volunteered to participate in this study; therefore, their views remain unknown. These "correct" or idealised mothering messages can be conveyed via the media in television programming and advertisements; print media, for example, parenting magazines or celebrity parents featured in women's magazines; as well as the internet and social media (Clarke, 2013). Internalised beliefs and values related to mothering also arise from the socialisation that occurs within one's own family of origin, from friends and communities (Aston, 2008). Aston (2008) suggests that although most of the information on mothering is intended to be helpful, "it can also be hegemonic and oppressive depending on different discourses, stereotypes and myths of motherhood and, therefore, may cause confusion, guilt and uncertainty" (p. 280). One prevailing oppressive, neoliberal societal discourse of contemporary mothers is the "ideology of intensive mothering", that is, mothering that is "child-centered, expert-guided, emotionally absorbing, labour-intensive and financially expensive" (Hays, 1996, p. 8). Hays (1996) argues that "intensive mothering" is a cultural contradiction because while:

[15] The term "discourse" is used within this thesis to refer to cultural, social and/or institutional constructs that include beliefs, values, practices and meaning.

> …the contemporary ideal of intensive mothering involves the subordination of women, it also involves their *opposition* to the logic which subordinates them ... In pursuing a moral concern to establish lasting human connection grounded in unremunerated obligations and commitments, modern-day mothers, to varying degrees, participate in this implicit rejection of the ethos of rationalized market society.' (p 18)

Hays (1996) suggests this ideology places mothers and mothering in direct opposition to the dominant ideology of the self-interested, efficient and profit driven worker of the marketplace, hence the cultural contradiction. Taylor (2011) argues, "intensive mothering", therefore, is a parenting style linked to the capitalist social and gendered structures of class and work. Furthermore, Taylor (2011) argues that this ideology is predominant in white, middle and upper class mothers invested in the "concerted cultivation" (Lareau, 2002, p. 753) of their child's talents. The ideology of "intensive mothering' is pertinent to this discussion of the findings as it may apply to discourses adhered to by the mothers participating in this study, similar to recent findings by Shepherd (2014). The women in my study fit within the classification of white, middle class mothers. Seven of the nine mothers were tertiary educated, professional working women prior to the birth of their babies. The remaining two women had a pre-school aged child as well as their new babies and were not currently in paid employment though both of their partners were described as being in fulltime professional work.

Two nurses in my study identified that messages they perceived mothers received from society regarding arbitrary standards of what "good mothers should do" in regard to child rearing practices, placed unnecessary pressures on the mothers. Mothers invested in these strongly held views, for example, infant feeding and sleeping, were identified to be more likely to resist attempts by the CFHNs to explore or challenge their views when trying to work in partnership with them. Annie provided the following example of societal discourses affecting mothers and nurses regarding infants' access to the breast and infant crying. In this example, Annie perceived that some mothers become exhausted holding to the "intensive mothering" (Hays, 1996) ideology that their baby needs unfettered access to the breast which may adversely impact on their own ability to rest and sleep. This belief of mothers was reported to be reinforced by CFHN colleagues who held similar views regarding breastfeeding. Annie perceived that mothers eager to find solutions to aspects of mothering sometimes become exhausted when seeking to adhere to society's (and sometimes nurses') expectations of "good" mothering practices. Still others strive to follow

and uphold, in an almost cult like fashion, parents' views on these practices documented in a range of texts; Tizzie Hall's (2009) *Save our Sleep: A Parents' Guide Towards Happy, Sleeping Babies from Birth to Two Years* was one text mentioned by a few of the nurses in this study. In this way, sometimes mothers' wishes to prioritise their own or others' perspectives on infant care rather than those put forward by the CFHN working with them, impacts on achieving a partnership between them.

Societal discourses influencing mothers' beliefs and values about the right way to raise their infant can also collide with the policy "rules" and guidelines that govern the CFHNs' clinical practice (Grant & Luxford, 2008). The CFHN or other health professional may weigh into these debates with mothers by providing an "expert scientific evidence" view regarding infant feeding and sleep childrearing practices by following national and State health sets of mandatory policies and clinical guidelines (National Health and Medical Research Council, 2012; NSW Department of Health, 2011; SIDS and Kids, 2014) (Grant & Luxford, 2008; Grant & Luxford, 2011). The CFHN's organisational policy view may also be in contrast with the specific cultural or religious beliefs related to parenting practices held by culturally and linguistically diverse (CALD) groups of parents in the community (Grant & Luxford, 2011). Added to this dilemma for some parents is the well-meant advice provided by friends and family or via social media on these topics (Aston, 2008). Parents may also be exposed to the judging gaze and views of society when out and about with their baby, for example, if breastfeeding in a public space, which may add to their own uncertainty regarding breastfeeding, their parenting capability and their baby's well-being (Stearns, 2013).

Thus, the variety of pressures that mothers may place on themselves, for example, uptake of the "ideology of intensive mothering', and/or those adopted from "expert" books, websites and well-meaning friends and family, may all influence the ability of the CFHN to work in partnership with them. The organisational policies and practices adopted by CFHNs may also strongly influence their own views about correct child rearing practices and, therefore, impact on how well they are able to listen and flexibly work with parents in partnership regarding their concerns on these issues.

5.2.4 Changing Technology: The Impact of the Internet and Social Media on the Ability of the CFHN to Work in the FPM with Parents

One of the key recommendations from the mothers participating in this study (linked to the Subtheme: *Modern Technology: Enhancing Parent–Nurse Partnerships,* p. 202*),* was for the CFHN service to improve its information technology systems in order to improve communication with parents in the community. Although the mothers did not link this with the term "partnership", the use of email, web pages, online discussion forums, apps and social media were seen as opportunities by mothers that may enable the CFHN to enhance nurse-parent partnership at a distance and in the virtual world.

The participation of the parent as equal or lead partners in their care and care of their child is promoted within the FPM (Davis & Day, 2010). Providing information is considered a vital component of such a partnership because informing patients, or in this instance, mothers, about relevant health issues or child rearing practices enables them to be actively involved regarding their care decisions (Hoffman, McKenna, & Bennett, 2008). A number of participant mothers stated they already regularly used the internet to access information about their child's development. Lauren identified that women in her parenting group used email to communicate with each other. She further suggested that the CFHNs "*need to be a bit more advanced in technology and things"* and complained about the unsolicited and unwanted pile of *"copious"* pamphlet based information she received from the CFHN who conducted the UHHV stating: "*I don't like bits and pieces of paper. I lose them...you've got the internet".* It appeared that apart from face to face interactions, the primary health level CFHN service communication systems no longer served the information needs of contemporary, computer savvy parents.

Hoffman et al. (2008) suggest that there is an increasing demand from health consumers such as mothers for evidence-based health information and that practitioners need to be able to communicate this information in clear, appropriate formats. Individuals already have easy access via the internet and "consumer health informatics" to some medical journals and databases, for example Medline Plus and Cochrane (Hoffman et al., 2008, p. 274) as well as a myriad of parenting sites. However, information found on the internet may also be misleading or not current best practice (Hoffman et al., 2008). Hoffman et al. (2008) recommend that:

> rather than being threatened by the potential questioning of an informed patient [mother], health practitioners are encouraged to view this as an advantage, allowing them to involve patients in decision-making more actively…. (p. 274)

This author also recommended that health practitioners evaluate internet sites for appropriate material, readability, quality and accuracy before referring them to individuals (Hoffman et al., 2008).

The age of mothers in this study can be characterised as either from Generation X (1965-1980), or Generation Y (also known as the Millennial generation) (1980-2000) (Hendricks & Cope, 2013). These two cohorts are reported to share attributes with the Gen X group being "comfortable with technology" while the Millennial group is reported to be "technology dependent"; expecting automatic access to information and to be able to multitask (Dols, Landrum, & Wieck, 2010, p. 69). The average age of the CFHN in this study, however, fits more closely with the age of the Baby Boomer generation (1946-1964) who have grown up with much less reliance on internet based information preferring a "personal style of communication" (Dols et al., 2010, p. 69). Despite this, Ridgway et al. (2011) found that Maternal and Child Health Nurses in Victoria had adapted well to computerisation within the workplace.

Angela stated that contemporary mothers created their own "online" chat rooms and Facebook™ groups arising from the parenting group established at the CFHN centre. Angela further stated that "*We* [the CFHNs] *don't think it up* [creating online discussion forums for mothers]. *They do it themselves"*. That is, the CFHN appears to take a "hands off" approach to internet based involvement or facilitation of community parent discussion forums. There appears to date, very little available research, however, that captures Australian parents' views and expectations regarding the use of internet based information and communication by universal CFHN services. Listening and responding to what contemporary, "technology dependent" parents want, and modernising CFHN information technology systems for their use, may help enhance parent-nurse partnerships.

5.2.5 MACROSYSTEM SUMMARY

The macro level of this study is situated on the broad, societal factors found to influence the ability of CFHNs to work in partnership with mothers. The discussion began with a focus on Australia's neoliberal political economy and its policies of economic rationalism

that place a squeeze on public health budgets in the quest for budgetary surpluses. In Australia, there has been a 30% decrease in the number of CFHNs employed (Cowley et al., 2012) despite an increasing birth rate in NSW of 16.4% between 2003 – 2013 (Australian Bureau of Statistics, 2014). Therefore, there are fewer CFHNs available to provide universal home visits to more babies and this shortfall makes it difficult to meet universal home visiting policy expectations. It also means some mothers and babies are left waiting for a number of weeks before receiving their home visit. CFHNs may unwittingly contribute to the neoliberal corporate workplace through a shared acceptance of an 'ideology of scarcity' (Varcoe & Rodney, 2009, p. 126). This "ideology of scarcity" promotes a tolerance by nurses of shortfalls in budget and resources that drives health care and organises nursing practice (Varcoe & Rodney, 2009). Nurse participants expressed criticism that resource constraints and policy expectations resulted in being unable to always provide the care they want for mothers and babies. These are significant factors that adversely impact on their ability for partnership approaches with mothers. However, there were no suggestions offered as to how they could use their individual or collective agency to influence change in these matters.

Nurse participants voiced concern about the devolvement of their role as a consequence of neoliberal policy impacts affecting CFHN Services. The pressure to meet home visiting targets has resulted in an inability to flexibly follow up vulnerable mothers and babies identified through the multiple assessments conducted at the home visit. CFHNs reported an increased use of referrals to other government and non-government organisations (NGOs) for additional support of these families. This was considered by nurses in this study as adding to the devolution of their nursing role since UHHV was introduced.

State health policy has had a significant impact on the regulation of CFHN function and performance in order for services to reach compliance with policy targets for UHHV. This has placed pressure on managers and CFHNs who identified competing and conflicting role requirements in relation to working in the FPM with mothers that arise from endeavouring to meet these targets. The UHHV performance target is not conducive to supporting the ethos of partnership with mothers nor does it promote continuity of carer relationships between nurses and mothers/babies. Lack of continuity of care by the same CFHN from the home visit to the centre based service was also criticised by one mother in this study.

The Foucauldian concept of governmentality has been identified as a significant influencing factor on the CFHNs' ability to work in partnership with mothers in this study.

The CFHN works as an "agent of the state" through the use of partnership approaches with individual mothers and babies in order to achieve population based health policy measures and outcomes. This is achieved through the routinely conducted multiple assessments and examinations of both the mother and baby/child. Further, the FPM is designed to aid the CFHN's ability to conduct therapeutic listening in order to gain access to parents' "deepest secrets". Thus, I propose the paradox, that the FPM with its altruistic relationship and communication focus and intent, is a taken for granted "helping" practice that situates the nurse as a surveillance agent of the state and so hence, the antithesis of partnership.

Governmentality was also operationalised by the use of CFHNs' professional expertise. The FPM may be conceptualised as a governmental technology and ideology incorporated into NSW Health CFHN policy, staff education programs and practice. The FPM was identified as serving the State at the population level by creating a mechanism that facilitated the engagement of families by CFHNs into the service. Higher levels of families engaged with the service provide increased opportunities for surveillance and reporting on the health and well-being of mothers and children and opportunities to provide promotion of healthy lifestyles. The surveillance and detection of problems in mothers and children provides more opportunities for early intervention and potential longer term cost savings to the public health service. Thus, a key role of CFHN work is, through the use of the FPM, to a) support mothers to achieve both the State's and their individual goals regarding their health and that of their children, and b) detection and early resolution of any parenting issues in order to promote healthy family functioning. CFHNs, nevertheless, found that State demands for reporting on the health of families, infants and young children negatively impacted their ability to work in the FPM with mothers. The modern ideologies of risk prevention and associated increased surveillance activities of mothers and children by CFHNs are significant factors influencing at the macro level the ability of the nurse to work in the FPM with parents.

At the macrosystem level are societal discourses on mothering that influence the ability of the CFHN to work in partnership. These discourses are strongly held cultural beliefs and values about what constitutes the binary of good and bad mothering and were identified by nurses in this study as factors that can influence and interrupt the development of partnership based relationships with mothers. One oppressive, neoliberal societal discourse identified that may be relevant to mothers in this study is the "ideology of intensive mothering" (Hays, 1996). Information about mothering is mostly intended to be

helpful; however, it can also become hegemonic and oppressive depending on the different prevailing discourses, stereotypes and myths of motherhood and, therefore, may cause confusion, guilt and uncertainty for mothers. Parents' personal beliefs and values about the right way to raise their infant may conflict with the policy "rules" and guidelines governing CFHN clinical practice as well as individual nurses' own views on mothering practices. Therefore, the pressures that mothers may place on themselves, arising from a variety of motherhood discourses and sources, may influence the ability of the CFHN to work in partnership with them. The health policies and practices adopted by CFHNs may likewise influence their own views about correct parenting practices and, therefore, impact on how well they are able to listen and flexibly work with mothers in partnership regarding their concerns on these issues.

In addition to societal discourses, at the macro level the impact of technologies such as the internet and social media were identified as factors influencing the ability of the CFHN to work in partnership with parents. The age of mothers in this study placed them within the Generation X and Y group cohorts. These groups rely on ready access to technology and social media for their communication and information, for example, smart phones, emails, Facebook™. Mothers in this study made a number of recommendations regarding the modernisation of the CFHN Service information technology systems to enhance nurse-parent partnerships.

5.3 INFLUENCING FACTORS AND THE NATURE OF THEIR IMPACT AT THE EXOSYSTEM[16]

Factors derived from the study findings were found to influence and impact on the CFHNs' ability to work in partnership with mothers at the exosystem level of Australian society. These factors included the historical and contemporary characteristics and structure of the CFHN service. This discussion includes a focus on the visibility, gender, and race and class features of the CFHN role in relation to the body work nurses perform with mothers and babies within a neoliberal landscape. At the exosystem level there is also discussion of the use of power and how it is exercised including the organisation's enforcement of policy and the FPM ideology. The influence of the environment of the workspace including the impact of IT and computer systems and resources such as time are discussed. Finally, the factors found at the exosystem level to be supportive of CFHNs' partnership practice with

[16] In the ecological model, the exosystem comprises 'environmental settings that a person does not directly experience but that can affect the person indirectly' for example, the atmosphere of the work place and leave entitlements (Siegler et al., 2014, p. 368).

mothers such as clinical supervision and education access as well as less supportive factors are discussed. Thus, the factors discussed at the exosystem are mainly informed by Theme 1: The CFHN Work Environment and Culture and in particular, Subthemes 2: "*The Workplace*", and 4: "*The Sustainability of the FPM".*

5.3.1 Characteristics, Structure and Gendered Nature of the CFHN Workforce

5.3.1.1 The nature of pre-and post-registration education of CFHNs and its influence on their ability to work in partnership with parents

A focus on the characteristics, structure and gender of the CFHN workforce is germane to this discussion as aspects of these were identified by nurses in this study as factors influencing their ability to work in the FPM with mothers. The discussion of the structural influences, such as nurse education, on the CFHN workforce outlined herein is limited to those that were reported by nurse participants in this study as impacting on their ability to work in the FPM with mothers. For example, one nurse in this study identified that CFHNs initially trained in a structured, hierarchical hospital based education system rather than the university sector, struggled to move away from traditional, more expert models of care and adopt partnership based approaches with mothers. Kruske et al. (2006) and Bennett (2013) have attributed the age and education of the CFHN workforce as factors that appear to contribute to their ability to adapt to changing policy and practice. Despite the implementation of the FPM into policy (NSW Department of Health, 2009), and all participants undertaking the associated training (Davis et al., 2009), the historical and structural forces in play within CFHN appear to interrupt the ability of some nurses to embody its tenets. This was evident in the interviews of nurses who expressed their challenge in *"letting go*" of the expert model and its power base. I also observed during consultations the practice of some nurse participants who adopted a task focused, nurse led approach with mothers rather than one that clearly demonstrated partnership.

The average age of over fifty percent of the CFHN workforce is reported to be fifty years or older (Australian Institute of Health and Welfare, 2011). Therefore, at least half of these nurses may have completed their initial pre-registration general nurse training via the hospital, apprentice style system. Indeed, the CFHN participants in this study are within or close to this age category. Pre-registration nursing education programs did not begin the transfer to the tertiary sector in Australia until the mid-1980s with the last hospital based course completed in 1993 (Russell, 1990). The traditional, apprenticeship style of nurse

education is reported to have better served the needs of the hospital with the professional education of the nurses seen as secondary (Grant, 2013; Russell, 1990). The focus of nurse education was on disease rather than promoting wellness, and "hospital work dominated nurses" training (Keleher, 2000, p. 260). Having one's professional identity formed, and being socialised within the hierarchical, disease and medically based, expert model of the health and hospital system, is a factor attributed to CFHNs adopting expert rather than partnership approaches in their practice with mothers (Kruske et al., 2006).

Nurses in this study, similar to findings by Kruske et al. (2006), held a range of qualifications but had an overall low level of tertiary educational achievement. One of the nine CFHNs held a Masters qualification (in CFHN); and, another held a Graduate Diploma in CFHN. One further nurse had previously worked in the tertiary sector in early childhood education; however, I did not ask her qualifications for this role. The remainder of the six nurses held post registration certificate level CFHN qualifications gained between six and twenty years ago. This was in addition, however, to their midwifery (five), paediatric (one), health visitor (one), and/or neonatal intensive care (one) certificate qualifications.

The Masters level qualified nurse in this study was the only participant to identify a *"lack of time to do research"* in the contemporary CFHN clinical role. This nurse added that CFHNs "*are not enabled to write"* (publish) and disseminate their vast experience and nursing knowledge and she believed that this reflected the experience of women generally. Apart from the NUM, none of the other CFHN participants in this study mentioned whether there were clinical research activities occurring in their teams. Having minimal experience in research is a finding consistent with a study conducted with CFHNs in NSW by Kruske et al. (2006). Kruske et al. (2006), similar to the findings of this study, state that postgraduate education of nurses currently in the CFHN workforce range from certificate to Masters level qualifications (Kruske et al., 2006). Further, contemporary CFHN education programs vary in their "titles, length, content, clinical exposure and award" across Australia (Kruske & Grant, 2012, p. 200). Kruske and Grant (2012) and Fowler, Schmied, Psaila, Kruske, and Rossiter (2015) have identified the need for the establishment of minimum education standards and qualifications for CFHNs in Australia. This may help to redress concerns of quality and consistency in service provision across jurisdictions for parents and children accessing CFHN services (Kruske & Grant, 2012). In addition, the uptake of Master's level qualifications by nurses has been linked with "professionalising strategies" whereby:

> …the individual *capability* of the master's level nurse enhances the attribution of autonomous skill to the occupation as a whole [and] the master's level nurse is seen to exercise *influence and leadership* and this strengthens the power and status of nursing. (Gerrish, McManus, & Ashworth, 2003, p. 103)

Therefore, a greater uptake of postgraduate education at Master's level by CFHNs may facilitate their ability to bring about change by taking more active leadership roles in policy development and service redesign that affect the profession (Kruske et al., 2006). Undertaking further tertiary education may positively influence the knowledge, skills and analytic and reflective capacity of the CFHN. These may, in turn, be factors that positively influence their ability to work in the FPM through having a greater understanding and ability to instigate agency with practice issues that may impact on their ability to work in partnership with mothers.

One nurse in this study stated the traditional, hierarchical structure found in hospitals also permeated the community health setting where CFHNs worked. Keleher (2003) argues that "hospital centrism" in nursing and nursing organisations in Australia marginalised and situated public and community health nursing services such as CFHN so that they are "historically invisible" and considered of little, if any, significance (p. 50). This positioning of community CFHN as marginalised and invisible was identified by one nurse in this study who stated:

> *We don't really sell ourselves and our expertise to the general community so that people, when I say I'm a child and family health nurse, they think I hold babies all day…. <u>people don't even know we exist</u>.* [Angela's emphasis]

The statement "*people don't even know we exist"* is somewhat consistent with the finding *"no one knows what I do*" by Schmied et al. (2015, p. 165). In the study by Schmied et al. (2015), participants from health professional groups which included CFHNs, providing universal child health services in Australia reported rarely communicating with each other and were unclear as to each other's roles and functions. Angela's statement, however, also referred to mothers within the community; that is a perception of a longstanding invisibility of the role of the CFHN by mothers until they are discharged from hospital with their newborn and receive contact from the CFHN. Angela's perception of the invisibility of the CFHN service by the community was supported by some of the mothers in this study. There comments are reflected in "Theme 4 The Mothers' Evaluations of CFHN Care"

particularly in relation to Sub-Theme 3 Modern Technology: Enhancing parent-nurse partnerships (see Section 4.7.3 p.202). For example, Dani, a social worker and health professional, said she was unsure how to arrange her UHHV and did not know the CFHN service existed prior to the birth of her baby.

5.3.1.2 The historical focus of CFHNs:

In this section of the discussion, I turn the focus to the development of the CFHN service, and nurses' perspective in this study regarding who their "primary" client is and how this is worked in terms of partnership. These issues were identified in interviews with Erica and Annie in this study as influences that impacted on the nature of their relationship with mothers. Rossiter et al. (2011) have described CFHNs changing their practice orientation "from an exclusive focus on the baby, to a focus on the mother" following their initial FPM training (p. 13). The two aforementioned nurses similarly described themselves as being primarily child focussed when consulting with mothers and children. One nurse attributed this to her paediatric background. The other nurse described herself as a *"terrible softy"* when it came to children's perceived needs that stemmed from the personal history of abuse she disclosed that she had suffered as a child. This practice orientation may influence the nurse's understanding and response to a parenting concern, for example, infant feeding, or sleep and settling issues. Privileging the child's well-being over the mother's may influence the nurse's understanding of the issue and her subsequent communication and ability to work in the FPM with both mother and child.

Five of the other nurse participants were midwives prior to their transition to the CFHN service. The foundation of midwifery practice is a relationship between the midwife and a woman that is based on partnership with women (Kirkham, 2010). In midwifery, "being with woman" refers to this "centrality of the midwife–woman relationship and the importance of being alongside the woman in her journey to motherhood" (Skinner, 2010, p. 73). Having a strong affiliation with the mother's perspective may likewise privilege the mother's well-being over the baby's. This can occur, for example, if CFHNs hold western cultural views about the mother's need for rest and sleep when it comes to infant settling (Grant & Luxford, 2008).

CFHN practice that is child or mother centred may also have some impact in terms of explaining the historical development of the service. The early development of the CFHN service in Australia was to address the unacceptably high infant mortality and morbidity rates present in the early twentieth century (Armstrong, 1939; NSW Kids and Families,

2014). As discussed in Section 1.1.1 (p.3), the original child focussed work of the CFHN in NSW evolved over the decades coinciding with changes in society and consequent changes in the emphasis and nomenclature of the nurses' title (NSW Health, 2002; NSW Kids and Families, 2014; O'Connor, 1989). This changing title is reflective of a focus where the child is positioned at the centre of the family and the promotion of the health and well-being of all family members central to the CFHN's role (NSW Health, 2011a; NSW Kids and Families, 2014). Being "mother" or "child" focused, however, may also help explain why Australian fathers remain under involved in CFHN services despite assumptions that the child is just as much the central interest of the father as the mother yet they are still largely excluded (Bennett & Cooke, 2012; Fletcher, Dowse, et al., 2014; Rowe et al., 2013).

5.3.1.3 The Gendered Nature of the CFHN role and its Impact on Working in the FPM with Mothers

In relation to gender, the CFHN workforce is predominantly female with just 1.1% of the Australian CFHN workforce comprised of men (Australian Institute of Health and Welfare, 2011). There is also a smaller proportion of male nurses who identify as CFHNs as the principal area of their main nursing job, for example, compared with mental health (31.9%), critical care and emergency (14.7%) and, management (14.1%) (Australian Institute of Health and Welfare, 2011).

The invisibility and gender, race and class features of the CFHN role was highlighted in my analysis of nurses' body work in Theme 2 Managing the Body: CFHN Bodywork and Partnership Practice (see Section 4.5, p. 153). The universal CFHN workforce is comprised of virtually an all-female, white, middle aged and classed, educated cohort that visits the homes of parents (women and babies). It is, therefore, overall, a feminised workforce role in comparison to other nursing specialities. It's not surprising that the CFHN workforce is so highly feminised given that:

> many of the positive cultural associations of body work, including touch as comforting or healing, are also seen as feminine, drawing on deeply entrenched patterns in relation to motherhood (Twigg et al., 2011, p. 178).

Therefore, it follows that the increased focus of the CFHN in the home of parents and newborns is synonymous with perceptions of the feminised role of nurses as women and holders of knowledge of mothering and infant care. This gendered nature of the work of CFHNs in the home with its feminine performances and identities occurs because as Twigg (2000) states bodywork is:

> …intimately linked with women's bodily lives through motherhood and nurturance. Because [CFHNs who are] women do this work for babies and children, these activities are generalised as female (p. 407).

Further, Twigg et al. (2011) suggest women, as "sexually neutral or safe" are given greater freedom in accessing homes and bodies compared with men (p. 178). This highlights the gendered nature of the CFHN role in the bodywork and care of women and children.

The main focus of the bodywork of CFHNs in NSW, and other states, territories and parts of the Western world (Shepherd, 2014), for over a century has been to "support breastfeeding and infant nutrition", teach "the hygiene of infancy", and, "monitor [infant] growth" (NSW Kids and Families, 2014, p. 2). CFHNs overall have much less physical body work in their clinical roles than general nurses and midwives. The nature of the bodywork performed by CFHNs from my own experience, and from observations of consultations in this study, is largely removed from the "messy" work that nurses perform on the bodies of patients in hospital (Wolf, 2014, p. 150), such as wound dressings and washing people who are incontinent. The feminised and gendered nature of CFHN work, therefore, has remained largely unchanged except that the reduction of infant mortality is no longer a priority (NSW Kids and Families, 2014). Despite such a long history, Angela commented (in Section 5.3.1.2, p. 247), "*when I say I'm a child and family health nurse, they think I hold babies all day…. people don't even know we exist"*. This statement hints at this nurse's view of the broader societal perceptions of the lack of visibility of the CFHN role and its lowly status within the nursing and midwifery profession (Borrow et al., 2011). The comment points to this nurse's perception of her low societal status and sense that the CFHN has little more professional credibility and power than a mother or untrained child care assistant: and, that "caring for children and families is not proper work" (Francis, 1998, p. 2). The intimate and nurturing bodywork performed by CFHN in the homes of parents and behind the closed doors of the CFHN centre help to perpetuate the invisibility of the role and its societal image and rank. The gendered and invisible role of the CFHN both contribute to the factors impacting on their ability to work in the FPM with mothers because of the sense of collective powerlessness it conveys. Despite a long history of acting as "agents of the State" (Perron et al., 2005b), in working with individual families to meet State government population screening and health promotion goals, Grant (2013) argues that contemporary CFHNs have an urgent "need to strengthen [their] position as a nationally relevant specialisation" (p. 9). Grant (2013) argues that if this positioning as a nationally relevant specialisation does not occur:

> The specialisation risks others defining this for them. Further they risk losing their hold in health services through the employment of non-qualified child health nurses, as is the case already in some jurisdictions. The alternative option for workforce planners is the employment of non-professional workers to undertake aspects of the child and family health nurse's role (p. 9).

This sense of urgency occurred following the release of the Australian Government Productivity Commission's *Research Report on the Early Childhood Development Workforce* (Australian Productivity Commission, 2011) and a "national push toward an integrated early childhood workforce" (Grant, 2013, p. 9). In a neoliberal environment of economic rationalism, it is possible that aspects of the CFHN role could be deployed to non-professional workers, similar to the aged care workforce (Lee-Treweek, 1997). If this occurs, I suggest it is likely to be the bodywork conducted by the CFHN that is transferred. Wolf (2014) suggests that this "stratification" of the nursing workforce occurs in settings where greater direct physical care of the body is transferred to lesser trained and paid nurses and care assistants (p. 151). It will be unlikely then that the CFHN will be able to hide "behind the scales" (Shepherd, 2011, p. 142) as an aid to their partnership work with mothers in order for them to confide their "deepest secrets" (Perron et al., 2005b, p. 539). This important "manifest function" and focus on the examination of the growth and development of the child hides the "latent function" of the CFHN's role of surveillance and support of women's emotional health and well-being (Shepherd, 2011, p. 142). The possible removal of aspects of the bodywork performed on infants and children threatens the legitimacy of the CFHNs' work with mothers and, therefore, has a potential impact on their ability to work in partnership with them.

5.3.1.4 The Influence of the Nurse Manager's Leadership Style on the Culture of the CFHN Workplace

One of the key issues identified in the findings of this study at the exosystem in relation to the characteristics and structure of the CFHN workforce, was the influence of the nurse manager's leadership style and the behaviours of both CFHNs and managers that was reflected in the culture of the workplace. These issues are revealed in the findings within the sub-theme "Working with Others" related to *Working with Managers* (Section 4.4.1.2, p. 108). The leadership and management style of the nurse participants' manager/s and their support or otherwise for the FPM, had a significant impact on the culture of nursing practised within their respective teams. Most nurse participants in this study reported

supportive collegial relationships with their peers and managers. However, some CFHN participants spoke of a past nurse manager who had bullied staff and gave descriptions of current colleagues' behaviour that resembled horizontal violence. These issues of workplace bullying from managers and colleagues are discussed in detail in the mesosystem level of this chapter. The leadership of the nurse manager and, the behaviours of both nurses and managers in my study within the respective team cultures were significant in their consequent influence on the ability of nurses to work in the FPM with mothers and/or to use other models of practice. This influence is portrayed in the diagrammatic representation of the "Service Context" in the FPM framework (see Figure 1, page 2) where:

> The management culture, leadership and organisational resources influence practice at all levels of service system alongside the direct supervision and management of individual practitioners. (Davis & Day, 2010, pp. 9, 270)

Contemporary neoliberal public health service structures mitigate against the CFHN manager's ability for shared governance and transformational leadership with staff. "Neoliberal workplaces are characterised by the "the rise of 'individuals' who are in need of a new kind of management, surveillance and control …[and] any questioning of the system is silenced" (Davies, Browne, Gannon, Honan, & Somerville, 2006, p. 62). In the CFHN service, the policy directives and targets to be achieved, for example, the numbers of UHHVs to be completed by the nurse within two weeks of babies' births, are set at the State or macrosystem level (Hopwood et al., 2013; NSW Department of Health, 2009). The CFHN manager is accountable if these targets are not met by nursing staff. Some nurse participants in this study recognised the stress experienced by their manager to produce the right "*statistics*" for reports to NSW Health while being sensitive to asking her nurses to do more.

Thus, a clash exists for both managers and nurses between what is valued by the health service organisation and working in the FPM. The characteristics of this discontinuity has been described by Drucker (2006) as those which differentiate "consonant and dissonant" organisational cultures (pp. 285-286). Consonant cultures exist where the nursing unit or team culture is in harmony with organisational and other professional cultures; dissonant cultures are where the opposite exist and there is incongruence between stated organisational values and behaviours (Drucker, 2006). The characteristics of consonant and dissonant cultures are shown in Table 7.

Table 7: Characteristics of Consonant and Dissonant Cultures

Consonant Culture	Dissonant Culture
Collective spirit	Mismatch between professional and organisational goals
One supraordinate goal	Little staff representation on committees
Frequent staff management interactions	Low staff participation in decision making
Clinical expertise valued	Do not have primary care models
Professional and organisational goals similar across units	Competitive spirit between professional and organisational goals
High cooperation between units	Them-versus-us norm
Primary care model promoting autonomy and independence	Low staff-management interactions
Formal and informal systems to address conflicts	Staff feel undervalued
Match between values and outcomes	Mismatch between values and outcomes
All nurses seen as members of same occupational group	Management seen as outside occupation; double standards for behaviours
All members seen as working toward same goal	Groups feel others not working toward common goal; an us versus them dichotomy
Behaviour norms same for everyone	Myths, stories, symbols not caring or positive

Adapted From Drucker (2006, p. 286)

In this study and in relation to the FPM, some CFHN participants revealed examples of dissonant organisational culture that resembled a:

> …mismatch between professional and organisational goals; a them-versus-us norm; a mismatch between values and outcomes; groups feeling that others are not working toward common goals; and, management seen as an outside occupation with double standards for behaviours. (Drucker, 2006, p. 286)

This clash between what is valued by the organisation and the FPM identified in this study is consistent with similar findings by Hopwood et al. (2013). The managers at each tier of the health service bureaucracy are responsible for ensuring the UHHV targets are met, hence the downward pressure on nurse managers to urge their nurses to *"do more"*. Despite this pressure to achieve targets, however, Donna, the Nurse Unit Manager (NUM) who participated in this study stated her staff was supported to work in the FPM by the broader organisational policies and management structure and that the FPM had been part of their work place culture for some time.

Donna's view that the FPM was supported by both the culture of the workplace and broader organisational context may be in part due to her position within the service and her commitment to the FPM. Donna, a NUM and senior member of the organisation, may

be invested in upholding its image rather than speaking out and challenging senior managers on issues such as resource constraints and policy. Donna too was caught in the downward pressure experienced by the CFHNs of achievement of UHHV targets. However, Donna clearly articulated her very strong personal belief in the value of the FPM and was a trained FPM group facilitator. She also stated that she provided clinical supervision to local FPM group facilitators. Further, it was Donna's CFHN team that was allocated the full hour for the six week and six month child health check consultation. Therefore, Donna had perhaps negotiated a way to facilitate her nurses' ability to work in the FPM with mothers via her support of an adequate allocation of time.

The positive influence of the manager's leadership style on the culture of the workplace and FPM practice has been reported by the authors of the FPM (Davis & Day, 2010; Day et al., 2015). Further, Day et al. (2015) contend that the FPM "needs to be rooted at the heart of service provision…and absorbed into everyday team practice so that it is an expected and routine way of working" (p. 52). Both Donna, and the CFHNs from her team that participated in this study, said she endeavoured to use the tenets of the model in interactions with her nursing staff. Further, each of the three nurses from her team readily conveyed her positive influence on them and on their whole CFHN team to work in the FPM with mothers. The nurses reported this was demonstrated in the manner in which Donna modelled the FPM in her interactions with individual nurses as well as during the conduct of team meetings and case discussions.

This embedding of the FPM at the heart of service provision was a significant hurdle for Donna despite her best efforts to instil the FPM into her nurses' practice consistent with the characteristics of a "consonant" organisational culture (Drucker, 2006). Donna and her medical service director worked to model the FPM with nursing staff and to create a workplace culture which encompassed its values. However, despite having the extra time for CFHN appointments and clear managerial support of the FPM, overall, this did not appear sufficient to me to be able to sustain nurses' partnership practice with mothers. This is because in NSW, what is valued and measured at the State health level in spite of CFHN policy rhetoric pertaining to the FPM (NSW Department of Health, 2009), is the achievement of targets for UHHV; and not the quality of the nurses' interactions with families. As stated in the new edition of the *Family Partnership Model Reflective Practice Handbook:*

> The Model is at risk when it is peripheral and marginal to team and service activity…the Model needs to be consistent with organisational and

> professional values and its practice needs to be integrated into existing service and team systems and approaches. (Day et al., 2015, p. 52)

The role of the nurse manager's leadership and management style in relation to the interpersonal relationships established with CFHNs in this study and its influence on their ability to work in the FPM with mothers, is discussed in the mesosystem level of discussion

5.3.1.5 The Landscape of the Workplace

This section of the discussion at the exosystem is linked to the findings from Theme 1 The CFHN Work Environment and Culture, Sub-theme "*The Workplace*" (Section 4.4.2, p. 123). Six CFHN participants in this study identified the physical landscape of their workplaces as factors influential to their ability to work in the FPM with mothers. At the exosystem level, these physical resources shaped and constrained their capacity to physically demonstrate a partnership approach with families. This issue was most evident in the CFHN Centre where nurses had limited ability to reorganise their consultation rooms. There was considerable disparity in the maintenance of the centres I visited with regard to the furnishings and access to resources such as air conditioning among the facilities of the three teams.

This discussion, therefore, focuses on the landscape of the nurses' workplace at their centres. These workplaces became the main setting for this study. It's acknowledged, however, that nurses spend a considerable amount of their working week visiting parents and children in their homes. Nurse participants such as Neroli have identified in Section 4.4.3.1 (p. 130), the existence of a potential power differential between home and clinic suggesting that the CFHN potentially has more power during consultations in their own centres than at parents' homes where they take on the role of the "*guest"*. In the consultations held in the centres, some CFHNs were observed to reduce this symbolic power differential by reducing their seat height as much as possible to sit at the same head level as the parent. The review of their video-recorded footage sharpened nurses' awareness making them mindful of their use of physical space in their rooms. Three nurse participants said they would like to alter the height of their chair to be able to sit at the same level as the mothers. This indicated their wish to ameliorate the asymmetrical power relations conveyed by the positioning of room furniture. Two of these nurses happened to be very tall women who were perhaps more actively conscious of their height difference and how it may impact on the mothers. Similar to findings by Grant and Luxford (2009),

nurse participants' review of their videorecorded consultations in this study enabled them to "look at their actions, *in the mirror,* (so to speak)" and reflect on aspects of their practice (p. 224). In this instance, watching the replay of their videoed consultation enabled CFHNs to focus and reflect enhancing their embodied awareness of "body geometrics: [which is the] physical relationships of distance and angle" between themselves and the mother and baby (Hopwood, 2014b, p. 202). Nurse participants in this study, consistent with findings by Hopwood (2014b), "noticed relationships between bodies in the video, conveying their sense of how such relationships enact partnership" (p. 202).

Only one parent participant in this study commented on the physical landscape of the room and its influence on the relationship established with the CFHN. This may be because these symbols were of interest to this particular mother who stated she was a fourth year, undergraduate archaeology student; it may, however, not have been of interest to the other mothers. This mother [Beth] spoke positively about the "body geometrics" (Hopwood, 2014b) and the landscape of the consultation room stating she and the CFHN were "*At* [the] *same height, same eye contact, plenty of room, not straight down to business. Despite the structure it's almost a casual approach* (which) *is a nice refreshing change".*

All of the nurses' desks in the consultation rooms were located against the wall and parents'/carers' chairs were situated beside this desk. I observed most nurses to wheel their chairs closer to the mother/baby so they sat at an angle to one another with their heads approximately one metre apart, apparently unconsciously using the recommended distance for comfortable communication (Davis & Day, 2010). The nurses used the corner of their office desk nearest the mother to peruse and document in the baby's Personal Health Record (Blue Book) (NSW Kids and Families, 2013). The landscape of each nurse's clinic room also featured:

- a sink with hand washing and drying facilities;
- office filing cabinets;
- bookshelves with text books and other documentation;
- a large infant examination bench with cupboards located underneath;
- infant and upright toddler scales; a wall mounted height measurement tool;
- children's toys such as blocks, puzzles and books; and, usually;
- a large window that provided a natural light source.

The position of the contents of the room was limited by where the usually "L" shaped office desk and computer best fit to access the power source and internet cabling.

The first of the seven centres I visited was in disrepair with peeling paint and the remains of Blutac™ on the walls where posters had once hung. The chairs were shabby and the physical space of the consulting rooms was quite small. Neroli complained of the smallness of both the consulting room and parent group rooms which left little room to reconfigure furnishings. Research has found a robust association between the lack of control of the office environment and symptoms in workers of "sick building syndrome" (Burge, 2004, p. 188). The symptoms of sick building syndrome (SBS) include general tiredness, headache, mucous membrane symptoms and dry skin (Burge, 2004). There is an increased prevalence SBS in workers who are "female; when exposed to paper and office dust; where there is more use of computers; poor individual control of temperature and light; poor building service maintenance; and poor cleaning or cleanability" (Burge, 2004, p. 187). All nurses in this study were female, were exposed to paper, dust and had an increased daily use of computers. CFHNs from the centre mentioned above also worked in a poorly maintained building. Neroli was critical that the group room was too small to safely fit the parents' prams. This was an inconvenience for some mothers who may wish on arrival for their new baby to remain in the pram if asleep; or to settle their baby in its pram during the group session.

In comparison, two of the CFHN centres of nurse participants from a different team appeared quite newly built, spacious, well-lit, freshly painted with comfortable chairs and air conditioning available. A nurse from one of these centres identified that good administration, reception services and facilities were important as they were often the first point of contact for parent clients. It was important to this nurse to "*work in an adequate physical environment that enables staff and client parents to be relaxed and staff to feel professional".* This nurse appears to be describing the concept of healing spaces which underpin the design of modern health care facilities and have been found to benefit both patients and staff (Ananth, 2008; Huisman, Morales, van Hoof, & Kort, 2012; Sternberg, 2009). Healing spaces are architecturally designed to facilitate light and views of nature, have a pleasant aroma, access to music and art, are safe and reduce exposure to toxic substances (Ananth, 2008). This view is consistent with those of the authors of the FPM who suggest that the consulting room for parents should:

- provide privacy; quietness and ideally be soundproof;
- be free of distractions such as telephone interruptions;
- provide appropriate lighting, inviting and "pleasantly decorated" with adequate space and comfortable chairs;

- have adequate heating (Davis & Day, 2010, p. 94).

Further, because the parents' relationship with the service is known to begin early in the referral process, their ease of contact and the early impressions made from communication with administration staff can influence their future engagement with the service and, therefore, their subsequent relationship developed with the CFHN (Davis & Day, 2010). These factors are important service "marketing" strategies (De la Cuesta, 1994a) which facilitate engagement and partnership with parents and help to keep mothers coming back for care with their babies.

The exact rationale for the variation of appearance and resourcing of the seven CFHCs across what was then the same Local Health District (LHD) is unknown. The nurses' facilities ranged from traditional stand-alone brick CFHC cottages to co-location within community health centres. A nurse from one team who worked in a modern facility said she thought it was because her region, which was in a poorer socioeconomic area, received more political funding from the State Government in order to win votes from the electorate. Conversely, the Centres that appeared the most poorly resourced were located in a wealthy beach side suburb and an upper middle class suburban location. The marked difference between centres in relation to their upkeep and resourcing appeared to me inequitable and unjust.

5.3.1.6 Computer and Information Technology usage in CFHN: Corporate efficiency impacting on nurses' ability to work in the FPM with parents

I observed during my study the dominating focus within CFHNs' consultation rooms of the computer equipment situated on their desks. As mentioned, most nurses physically moved away from their computers to sit closer to and face the mother/baby during the consultation. However, I observed two nurse participants type onto their computer keyboard on and off throughout their consultations, at times with their backs or side facing the mother. This appeared to be a usual practice of these nurses as they did not excuse themselves while they typed or explain to the mother what they were documenting.

This use of the computer appeared to me to interrupt communication; the mother would stop speaking while the nurse typed or would continue to talk without what appeared the full engagement of the nurse in the conversation. This lack of apparent engagement of the CFHN with the mother stemmed from their lack of eye contact or the nurse's full attention while the mother was speaking and is inconsistent with working in the FPM with the

mother (Davis & Day, 2010). This practice of continuing to type while the mother was speaking appeared disrespectful toward the mother; it denoted an unjust power asymmetry where the nurse's completion of work tasks was prioritised over the development of the relationship and respect for the needs and concerns of the mother/baby.

This situation may have been different if the nurse was mindful of the priority of the relationship with the mother and, therefore, felt less pressure to complete computer related information tasks during the consultation. Despite this, however, none of the mothers raised the issue of computer usage by their CFHN during consultations as an issue detracting from their relationship. Sandy explained that for this age group of mothers (Millennial and Gen X), their [CFHNs'] "*computer usage wasn't an issue".* Rather, six of the nine mothers recommended the CFHN service improve their computer technology and communication services for parents. It may also be that individuals, regardless of whether they like it or not, are now conditioned to expect computer usage by their health professional given the focus and frequent use of computers by GPs during consultations. Erica, however, strongly expressed her hatred of this practice saying: "*I hate it myself: I go and see the GP and he looks at the computer. 'Look at me! I'm the patient!'* [her emphasis] *I hate that".* In turn, Erica appeared mindful of her own computer use during her consultation with Beth and baby Ruby during this study.

Overall, the use of computers in the workplace was identified as both a support and a detractor from CFHNs' ability to work in the FPM with mothers. The use of information and communication technology (ICT) in the workplace was welcomed by CFHN staff when it provided quick and easy access to client files in comparison to individual hard copy medical records. One nurse identified that computers and ICT enabled a greater ability to communicate with workers from multidisciplinary health teams as well as external agencies involved in the care of families. However, consistent with the literature (Ridgway et al., 2011; Rossiter et al., 2011), nurses in this study also identified other less positive outcomes from their workplace computer usage. For example, apart from training in the use of electronic medical record keeping, CFHNs reported a lack of education in other helpful computer skills such as touch typing. Ongoing training of nurses in information technology is important because "with the fast pace of change, knowledge and technical skills are quickly outmoded unless they are updated to fit the new technologies" (Bandura, 2006, p. 176). Further, CFHNs can use their human agency to influence the type of technologies used in their service by being open to innovations and proactive regarding

the processes in which their work is performed (Bandura, 2006). Angela stated computer usage slowed down the time it now took for documentation because it took longer to type than hand write. It also meant that what was recorded was "*expressed a bit differently 'cause I'm better at writing than I am at typing".* Undertaking a short touch typing course may have helped Angela better manage the increasing requirements for computer documentation in her role. In terms of medical record keeping it's unclear whether the nurse's change in expression adversely affected the accuracy or coherence of her health record keeping.

The key concern raised by nurse participants regarding their computer usage that adversely impacted on their ability to work with mothers in the FPM was the increased time documentation consumed during each appointment. This was because typing and data entry took longer to complete on the computer and there was incompatibility of some software systems. This resulted in nurses having to duplicate some of their documentation in more than one software program. These activities were a source of frustration for nurse participants because it reduced their face to face consultation time available to develop relationships with mothers and babies and respond to their concerns. Appointment times for consultations had not been increased accordingly to compensate for the extra time it now took CFHNs to complete their computer based documentation.

The incorporation of technology within health care domains such as CFHN is acknowledged as an additional resource demand (Hoffman et al., 2008) both in cost and time. Computer expertise and software knowledge are additional skill sets that require continued updating and practice for this cohort of older nurses. Despite this, Ridgway et al. (2011) report that Maternal and Child Health nurses in Victoria had adapted well to computerisation and had higher ICT confidence when compared to older nurses in the acute sector. Many of the CFHNs in my study likewise appeared to have adapted well to workplace computerisation despite the factors discussed that now placed constraints on their ability to work in the FPM with mothers.

The CFHNs in this study recognised the benefits of having compatible medical record systems with hospitals and other CFHN centres which enabled them to determine where and when clients had presented to services. At the time of data collection, however, there was a lack of standardisation of computer software programs used by CFHNs across the LHDs in NSW. This was also the situation in Victoria prompting Ridgway et al. (2011) to suggest it was time to begin discussions for a centralised, national ICT system. Such a system may assist in providing accurate "population-based child and family health

indicators" that may benefit future clients and communities (Ridgway et al., 2011, p. 127). CFHNs in my study also made positive comments that increased data entry provided a greater visibility and ability to calculate the nature of CFHN work which would help in proving the worth of the role to the organisation.

Ultimately, however, the organisation is the major benefactor of the incorporation of ICT into the CFHN workforce. Consistent with a neoliberal agenda and governmentality, it enables the various tiers of the health service and relevant government department to calculate nurses' activity and outcomes to measure against performance indicators. These technologies are:

> …designed to improve the "efficiency" of nurses' labour and create objective data …thus transferring dominance from the professional judgement of the nurse to that of managers who can claim to "know" based on data. (Varcoe & Rodney, 2009, p. 128)

Consistent with the findings in this study, computerised CFHN technology systems "fail to capture the 'indeterminate work' of nursing…, [and] the data collection and decision making [that is derived] is invisible to nurses" (Varcoe & Rodney, 2009, p. 129). This work, therefore, remains hidden from decision makers because many of its complexities (such as working in the FPM), cannot be easily captured by computer programs.

In Theme 4 The Mothers' Evaluation of CFHN Care Subtheme 3: *Modern Technology: Enhancing parent-nurse partnerships,* mothers reported dissatisfaction with the ICT available from the CFHN service. This may, in part, be a reason in the current computer literate parenting generation why some educated mothers in this study identified they were unaware of what the CFHN service offered before their babies are born. These mothers recommended improvement to CFHN internet based communications such as:

- use of emails and other internet based communication such as smart phone technology, and;
- development of web pages and electronic service directories provided by the CFHN service.

NSW Health has recently developed some internet based applications (apps) for parents. For example the baby's *Personal Health Record (Blue Book)* can now be found as an app on the Apple iTunes ™ store for use by parents in one LHD in NSW (NSW Ministry of Health, 2015). There is also a "*Save the Date"* app for parents to use as a reminder for when their

child's immunisation is next due and comprehensive, evidence based parenting resources available such as the *Raising Children Network* (Raising Children Network, 2015). Overall, the mothers in this study recommended that the CFHN service upgrade its use of internet and web services to meet the needs of technology and social media savvy parents.

5.3.1.7 CFHNs' Perceptions of Time

At the exosystem level, the majority of CFHNs in this study including the NUM identified the influence of time as a factor which impacted on their ability to work in the FPM with mothers. This finding relates to Theme 1-CFHN Work Environment and Culture, Sub-theme 3 "Challenges of meeting role requirements" (Sub-Section 4.4.3.3 "Perceptions of time", p. 138), and is consistent with research literature on barriers to partnership practice in CFHN (Bidmead & Cowley, 2005b; Grant, 2012; Hopwood et al., 2013; Kruske et al., 2006; Rossiter et al., 2011). However, the CFHNs in my study had differing views and perceptions about the influence of time and its impact on their partnership practice with mothers. Similar to the findings of Hopwood et al. (2013), some CFHNs in this study reported using the FPM took less time, while others felt that it took more time.

In contrast to previous published research in CFHN, however, this study revealed during nurses' first interviews that there was a substantial difference in the amount of *actual* time allocated for the routine six-eight week and the six month child health check appointment within the one LHD in NSW. The nurse participants from one team reported having sixty minutes for these appointments while the nurses from the remaining two teams had just thirty minutes allocated. This marked variation in time for the same amount of work seemed to me to be unjust and without basis; one third of the CFHN participants and mothers had an extra thirty minutes to allow partnership to develop. However, none of the nurse participants or the NUM, voiced their criticism of this time differential and it is unknown if nurses from the two teams with shorter appointments were aware of it. No reasons were provided for the time difference. The time differential does, however, advantage the nurses and mothers/babies in one team compared with nurses and parents/babies from the other two teams. It suggests that these CFHN appointment schedules require further investigation to determine the optimum timeframe for the provision of quality care in partnership with mothers/babies, as well as equity in distribution of resources such as time. Despite this significant and unjust time disparity in routinely scheduled appointments, the nurses from the three teams held a variety of viewpoints about the influence of time on their family partnership work with mothers.

It's not surprising that time was not considered a barrier to working in the FPM with the mothers for Donna and the CFHNs from the team where sixty minutes was allocated for the six-eight week child health check appointment. The NUM, Donna, perhaps because of her vested interest and position in the organisational hierarchy, said she believed that time was not a "*barrier*" to CFHNs' working in partnership. Donna's view was that words such as "*barrier"* were "*loaded words"* and was a label and excuse for nurses who consider partnership work as "*too hard''*. Further, she believed that nurses' who use terms such as "*barrier"* don't fully understand the FPM. It was Donna's team that had the longer, sixty minute appointment for child health check consultations. Perhaps, therefore, Donna did not feel her nursing staff had a legitimate argument for practising otherwise than in the FPM with mothers. Donna did not provide a rationale for holding her view about "barriers to partnership". Holding this view might, however, constrain her nurses' ability to speak out about tangible workplace issues that potentially do interrupt partnership practice. It also places the fault unjustly with the individual nurse rather than the consideration of possible structural constraints affecting practice.

In comparison, Sandy, an experienced nurse with the shorter thirty minute appointment stated on reflection of her video recorded consultation that she *"didn't feel like she did a very good interview. It was too much stuff in a short time. I felt rushed".* Annie, another experienced nurse with the shorter appointment timeframe stated that *"Time constraints affect good partnership; you have to 'shut the mother down more if you're aware there's more to do before she goes".* "Shut[ting] *the mother down"* implies a silencing and an unfair discourse where the nurse takes active steps to close or redirect the conversation with the mother in order to complete tasks. This behaviour is similar to findings by Grant (2012) where CFHNs experienced tensions between "problems of time management and duty of care" (p. 7). Task oriented CFHN practice is an identified barrier to providing "psychosocial care" and using effective communication skills that are required for partnership work with parents (Bidmead & Cowley, 2005b, p. 242).

In contrast to Sandy's reflection, however, two different nurses who also had the shorter thirty minute appointment timeframe did not consider time a barrier to working in partnership with mothers. For example, Jean stated "*half an hour's pretty generous"* possibly in comparison to a standard fifteen minute GP appointment. Fiona said that working in the FPM had "*helped …to streamline my* [her] *practice".* In this instance, she explained that the FPM enabled her to now focus on the most pressing concerns of the mother at the consultation rather than trying to fix all her problems. Donna stated that

when working in the FPM with the mother "*you negotiate the time and client priorities for the consultation* [and] *how much of what you do".* Further, using the expert approach with mothers could potentially take more time than working in partnership than with them. In relation to this Neroli explained: *"fixing' it, I think it's 40 or 50 percent of people don't comply anyway, so that actually takes more time"* because mothers may require further support for concerns that were not adequately addressed.

In addition to the significant time differential for appointments noted between the three teams in this study, a further disparity appeared to exist in the way the consultation work of CFHN's is structured in comparison to allied health staff such as social workers and psychologists. Psychologists, such as the authors of the FPM and its underpinning framework (Davis & Day, 2010), have a conversation based therapy intervention with a client that differs from the "hands on" bodywork of the CFHN role. Allied health professionals such as psychologists generally have more time allocated and less surveillance "checklist activities" to perform during their counselling consultations than CFHNs. Like the allied health staff mentioned, CFHNs too have a relationship focussed approach with clients and are now mandated to work in the FPM with parents (NSW Department of Health, 2009). However, even Neroli, who was from the team with the longer sixty minute scheduled child health check appointments, was critical of the lack of time to reflect and regroup between consultations. CFHN appointments with mothers/children are generally scheduled one after the other throughout the eight hour shift apart from meal breaks. This frequency may also occur for health professionals such as psychologists though their formal appointments are generally of longer hour duration and therefore less are scheduled per day.

Given "the effort needed to remain focussed throughout sessions" (Davis & Day, 2010, p. 129), it seems that the CFHN centre based consultations have overall not been re-structured to adequately reflect the intensity of the psychosocial and communication work now required by CFHNs. Nor, it appears, has CFHN work been equitably restructured to reflect the additional workloads of computer documentation and maternal and infant screening checklists while aiming to work in the FPM with mothers. Perceptions of insufficient time appear to contribute to the "*sense of rushing"* discourse identified by some nurses in this study. Further investigation is warranted regarding how and why some health professional groups appear to be able to exercise control and power regarding their appointment structures in comparison to others. If organisations want CFHNs to genuinely implement FPM practice then having sufficient time to reflect on and

be mindful of one's practice is not a luxury but an integral part of the model (Day et al., 2015).

5.3.2 Exosystem Factors that Support and Sustain CFHN Practice:

This section of the discussion relates to the findings of Theme 1 Sub-theme 4: "*The Sustainability of the FPM"* (Section 4.4.4 p. 144).

5.3.2.1 Ongoing FPM Education and Professional Development Opportunities

The ability to revisit the FPM after the initial training was identified by CFHNs as a concern in relation to the sustainability of the FPM in practice. This issue has also been reported in research conducted on issues related to sustaining practice innovation in CFHN (Hopwood et al., 2013; Rossiter et al., 2011). Neroli, considered herself fortunate as most CFHN staff "*don't get to revisit* (the) *model regularly".* Neroli and Virginia, as FPM group facilitators, were able to revisit the principles of the model more frequently which helped to embed it into their own practice. In contrast, the remaining seven CFHN participants had not had further inservice or education in the FPM since their initial group training some years earlier. Day et al. (2015) states it is "absolutely essential" that this type of "train and hope" approach is avoided by service managers where staff are left to do their best to implement the model following initial training (p. 54). It is also unfair on CFHN staff to do this and expect them to be able to develop and sustain their ability to work in the FPM with mothers, and shows inequity in the health care system.

A further structural impediment and injustice identified in this study was that nurses from one team in this study, until recently, were not granted permission to undertake the FPM group facilitator training. This privilege was reported instead to be given to other health professionals such as social workers. These structural factors of lack of access to specific FPM education updates and specialist FPM facilitator training constrain nurses' professional development and the development of expertise in working in the FPM. Further, it restricts the capacity of the organisation to identify FPM "champions" that can help "colleagues to consolidate their understanding of the Model" (Day et al., 2015, p. 54).

In addition to specific education updates in the FPM, most nurse participants identified a commitment to general ongoing, professional development as a complementary individual responsibility. Annie described this responsibility as necessary in order to "*be worthy'* of parents" trust with their new baby. Attending conferences and other clinical practice

updates were reported to both enhance confidence and contribute positively to motivation and interest in the CFHN role.

Nurses in this study, similar to Hopwood et al. (2013), described the FPM as an evolving part of their individual personal and professional growth trajectories. Using Shilling's (2003) depiction of the "body as a project" as described in Section 4.5.1.4, (p.171), the CFHNs' commitment to ongoing professional development appeared analogous with the view of their bodies as "entit[ies] … in the process of becoming…a *project* to be worked at …as part of an *individual's* self-identity" (p. 4). In this case, a commitment to ongoing professional development contributed to their embodied self-identity and self-confidence as CFHNs.

Two CFHN participants identified that access to a broad education would help nurses to effectively embody partnership work with mothers and that medical understandings alone was insufficient. Jean identified studies of sociology, anthropology and history as valuable for working in partnership with parents while Neroli argued for nursing education to provide a greater depth in psychology and sociology content because *"I think it helps you understand people"*. Being able to understand people was seen as essential for the body work required by CFHNs to be able to work in partnership with parents. These suggestions regarding broadening nurse education do not appear to have been previously reported in the CFHN and FPM literature. Fowler, Lee, et al. (2012) however, do state that nurses' educational preparation is vital to the capability of the CFHN workforce to implement co-productive practice with parents. Co-productive practice, similar to descriptors of the FPM, situates parents as equal partners and producers alongside health professionals (Fowler, Lee, et al., 2012).

5.3.2.2 Clinical Supervision and Reflective Practice:

At the exosystem level, clinical supervision was described by most nurse participants as a workplace based support that aided their capacity for self-reflection on practice, dealing with workplace stressors and coping with feelings of burnout and work overload. Reflecting on these issues in regular group clinical supervision was reported to positively aid their ability to work in the FPM with mothers. Attending clinical supervision also helped to reassure nurses regarding their choices in the clinical care of mothers and babies.

These findings are consistent with reports of clinical supervision and reflective practice forums as positive workforce influences that support and sustain CFHNs' partnership

practice (Fowler, Lee, et al., 2012; Rossiter et al., 2011). A focus on reflection in order to effectively implement the FPM is evident with the release of the updated *Family Partnership Model: Reflective Practice Handbook* (Day et al., 2015). Fowler, Lee, et al. (2012) suggest that organisations provide regular opportunities for practice reflection to help CFHNs "challenge the automatic and default position of the 'expert' nurse" (p. 10). A recent literature review that investigated current debates about clinical supervision reported the existence of some confusion resulting from a lack of quantifiable outcomes and resistance to its implementation within some healthcare organisations (Dilworth, Higgins, Parker, Kelly, & Turner, 2013). Despite these limitations, Dilworth et al. (2013) conclude clinical supervision provides a "professionally enriching" environment and forum for shared understandings of health care provision (p. 22). Further, organisations such as Health Workforce Australia (2011) has published a *National Clinical Supervision Support Framework* to guide implementation across health disciplines at a local service level to "expand capacity and capability and cultivate public trust in the education and training of health professionals" (Health Workforce Australia, 2011). Similarly, the NSW Health Education and Training Institute (2013) (HETI), has developed a considerable amount of high quality online and written resources for various health disciplines including "*The Superguide: A Supervision Continuum for Nurses and Midwives",* in order to promote the importance of regular opportunities for critical reflection and critical reasoning.

Notwithstanding the legitimate and altruistic intent of clinical supervision for health professionals such as CFHNs, there remains a feature of its practice that can be considered consistent with governmental technologies associated with the regulation and surveillance of individuals and groups (Freshwater, Fisher, & Walsh, 2015). Freshwater et al. (2015) use the Foucauldian metaphor of the Panopticon to suggest that clinical supervision is a form of government technology acting at a distance whereby group members actively participate in their own self-regulation. Gilbert (2001) argues that clinical supervision and reflection constitute methods of institutional surveillance of staff and it is naïve to suggest otherwise. Further, Gilbert (2001) likens clinical supervision and reflective practice to "rituals of the confessional" that function to produce "ethically self-managing individuals" under the guise of autonomous practice (p. 202). Further, through clinical supervision, an individual's practice is made "visible" and this visibility provides a mode of surveillance that ensures correct professional activity is maintained and regulated (Gilbert, 2001, p. 201). None of the nurses within my study raised concerns about surveillance arising from clinical supervision or reflective practice as offered in the

current group format of the workplace. Nor does there appear criticism of these practices in the literature relevant to CFHN practice and the FPM. On the contrary, both clinical supervision and reflective practice are strongly recommended as practices that support and sustain health professionals aiming to work in the FPM with parents (Davis & Day, 2010; Day et al., 2015; Fowler, Lee, et al., 2012).

The sticking point in this debate regarding the salience and intent of clinical supervision and reflection as factors influential to CFHNs partnership work with mothers arises in the potential use of videography as a reflective tool. The majority of nurses in this study were positive of the use of the video as a tool that facilitated their reflection on practice. It helped them to pay attention and become more mindful of their practice. Reviewing their videotaped footage helped to reveal the subtleties within partnership practice and the interactions that occurred during their consultations with mothers/babies. It also appeared that it was the first time these nurses had had an opportunity to review a video recording of themselves with mothers during a consultation. This opportunity appeared empowering in itself as they were able to conduct their own surveillance of their practice rather than by others.

The videorecording of consultations has been used in previous research with CFHNs and health visitors as a tool to assist their reflections on their interactions with parents (Bidmead & Cowley, 2005b; Grant & Luxford, 2009; Hopwood, 2014b). Although, the data collection, analysis and limitations of the video recording methods used varied in each study, all highlight the value of this rich resource to enhance nurses' ability to reflect on practice. In my study, some nurses were very enthusiastic about its potential use as a valuable teaching tool in conjunction with a clinical supervisor stating *"It's excellent. I wish we'd do it more often".* Sandy also suggested that excerpts from videos could be used as teaching tools to help critique practice because "*the more people critique practice the better it gets".* Nurses identified that reviewing the videos enabled them to focus on their practice and see the nuances of the interactions that is difficult to do with the mother while working with them. One nurse identified this as "*trying to hear the unseen";* that is, the unspoken cues given by a parent that may be more easily identified when able to take the time to reflect on the interactions that are recorded on the video. Jean suggested that video recordings of consultations could perhaps be used as evidence of nurses' actions should there be later concerns for the well-being of a child and investigations of the conduct of involved health professionals. In Jean's example, six week old Paul was recorded on camera at the end of the consultation making eye contact. Jean was relieved

about this stating "*it's on video and…a record".* In this example, the videorecording as "surveillance" was found to be useful in reaffirming the baby's development, and not just her own partnership approach.

Two nurse participants agreed that review of their videoed consultations could provide additional depth of reflection if used during clinical supervision. However, they recommended this only occur during individual clinical supervision, in confidence with a trusted clinical supervisor. Angela stated she did not want "*other colleagues watching …to avoid feeling judged"* and under their surveillance and regulating gaze*.* This nurse had previously expressed concerns about her colleagues monitoring and censoring behaviours of her practice and clearly did not want her practice to be made "visible" to them. This highlights the potential detrimental regulating and surveillance function of clinical supervision and reflection that could occur should videoed consultations of nurses' practice be used as a focus of group discussion without the concurrent existence of trust and collegiate relationships based on the principles of partnership.

5.3.3 Exosystem Summary

At the exosystem level of society the factors influencing mothers and nurses' ability to work in the FPM with them is exerted through the characteristics and culture of organisations, settings or relationships that indirectly affect them. In this study, historical and structural forces were identified that affect the CFHN service at the exosystem. The nature of the pre-and post-registration education undertaken by CFHNs emerged as an influencing factor. A greater uptake of tertiary education at Master's level by CFHNs may facilitate their ability to take more active leadership roles in policy development and service redesign that affect the profession. These may, in turn, be factors that positively influence their ability to work in the FPM through having a greater understanding and ability to instigate agency with practice issues impacting on their ability to work in partnership with parents. It was also identified that traditional, hierarchical structures found in hospitals also permeated the community health settings where CFHNs work. Nurses expressed concern regarding their perception of a longstanding community and professional invisibility of the CFHN role suggesting the broader societal perceptions of the CFHN role and its lowly status within the nursing and midwifery profession.

The historical baby and child health focus of the service and CFHNs' contemporary practice orientations were identified as influencing factors. Privileging the child's well-being over the mother's and vice versa, may influence the nurse's understanding of the

issues presented and, therefore, her subsequent communication and ability to work in partnership. Being either "mother" or "child" focussed, however, may help explain why Australian fathers remain significantly under involved in CFHN services.

The invisibility and gender, race and class features of the CFHN role and the nature of the nurses' body work were identified. The universal CFHN workforce is comprised of virtually an all-female, white, middle classed, educated cohort which visits the homes of parents (women and babies). It is, therefore, overall, a feminised workforce role in comparison to other nursing specialities. In a neoliberal economic landscape the potential for removal of aspects of the bodywork performed on infants and children may threaten the acceptability of the CFHNs' work with mothers and, therefore, impact adversely on their ability to work in the FPM with mothers.

The leadership of the nurse manager and her value and modelling of the FPM was found to significantly influence the workplace culture of the team and the models of care practised by CFHN nurses in this study. Aspects of the landscape of nurses' workplaces such as room configuration and seating were factors identified as physical resources influencing partnership. The computer was a dominating focus within nurses' consultation rooms. Overall, the use of computers in the workplace was identified as both a support and a detractor from CFHNs' partnership work. At times in this study, it denoted a power asymmetry when the nurse's computer use for completion of work tasks was prioritised over the development of the relationship and the needs and concerns of the mother/baby. None of the participant mothers, however, raised the issue of computer usage by their CFHN during consultations as an issue that detracted from their relationship possibly because for this age group of mothers (Millennial and Gen X), their nurse's computer usage wasn't a problem. The mothers did recommend that the CFHN service upgrade its use of internet and web services to meet the needs of the current generation of technology and social media savvy parents.

This study revealed the influence on the ability of nurses to work in the FPM resulting from a substantial difference in the amount of time allocated for the routine six-eight week and six month child health check appointment within the LHD of this study. The time differential advantages the nurses and mothers/babies in one team compared with nurses and mothers/babies from the other two teams. It suggests that these CFHN appointment schedules require further investigation to determine the optimum timeframe for the provision of quality care in partnership with mothers as well as equity in distribution of resources such as time. A further disparity appears to exist in the way the time for

consultation work of CFHN's is structured in comparison to allied health staff such as social workers and psychologists. It appears that CFHN centre based consultations have not been re-structured to adequately reflect the intensity of the psychosocial and communication work now required by CFHNs. Nor, it appears, has CFHN work been equitably restructured to reflect the additional workloads of computer documentation and maternal and infant screening checklists while aiming to work in partnership with mothers. Further investigation is warranted regarding how and why some health professional groups appear to be able to exercise control and power regarding their appointment structures in comparison to others.

The exosystem factors identified that support and sustain CFHN practice include ongoing education and updates in the FPM and general professional development opportunities. Clinical supervision was described by most nurse participants as a workplace based support that aided their capacity for self-reflection on practice and to deal with workplace stressors. However, there are features of clinical supervision that may be considered consistent with governmental technologies associated with the regulation and surveillance of individuals and groups. None of the CFHNs within this study, however, raised such concerns of regulatory surveillance arising from clinical supervision nor does there appear criticism of these practices in the literature relevant to CFHN practice and the FPM. Nurse participants were very enthusiastic about the potential use of the videorecording of consultations as a valuable teaching tool that enabled reflection on practice in conjunction with a clinical supervisor. Two nurse participants, however, recommended this only occur during individual clinical supervision, in confidence with a trusted clinical supervisor to *"avoid feeling judged*" by colleagues. This view highlights the potential detrimental regulating and surveillance function of clinical supervision and reflection that can occur when nurses' practice is made visible.

5.4 INFLUENCING FACTORS AND THE NATURE OF THEIR IMPACT AT THE MESOSYSTEM[17]

The mesosystem comprises the various microsystem connections and interrelationships that effect or exert influence on the nurses' and mothers'/babies' ability to jointly work in partnership. In the context of this study, this includes the CFHN's relationships and connections with her work colleagues and managers, the mothers and babies/children and their partners, families and friends as well as other influencing colleagues in other health disciplines and organisations. As identified in the macro and exosystem levels of this discussion, nurses' colleagues and managers were factors found to be highly influential to their ability to work in the FPM with mothers. This links directly to study Theme 1 Subtheme 2: "*Working* [relationships] *with Others"* (Section 4.4.1, p. 97). This discussion of the influence of the CFHN's manager and colleagues on nurses' ability to work in the FPM with mothers/babies continues below as it applies to the mesosystem level of their interpersonal relationships in the work environment. The absence of fathers' participation in this study is also discussed.

5.4.1 The Influence and Nature of CFHNS' Interpersonal Relationships with Nurse Managers and Colleagues on their Ability to Work in the FPM with Mothers

Most nurse participants in this study identified their colleagues as a significantly positive influence on their ability to work in the FPM with mothers. Two nurses, in contrast, revealed their concerns about nurse colleagues' judgemental and censoring behaviours that to me resembled horizontal violence. Nurses' CFHN colleagues were generally reported to provide both practical support, for example "*swap*[ping] *workloads to help each other"* as well as emotional and psychosocial support, for example when nurses needed to "*come back* [from clinic or home visits] *and unburden".* Colleagues were described by one participant as "*the first line of defence"*. This metaphor suggests that colleagues provided a defensive buttress against potentially harmful forces in the workplace whether from onerous workloads or troubling client care concerns. Further, working with likeminded colleagues with shared attitudes to clinical practice and a FPM ethos and approach benefited the ongoing care of parents and babies. Working within a "peer culture that acts similarly and supports reflection and change" (Davis & Day, 2010, p.

[17] In the ecological model, the mesosystem refers to the interconnections among various microsystems such as family and peers (Siegler et al., 2014).

270) is, predictably, consistently reported in the literature as being a positive influencing factor for partnership work with parents (Day et al., 2015; Hopwood et al., 2013; Keatinge et al., 2007; Rossiter et al., 2011).

In contrast, a work environment where conflict and tension with colleagues exists was reported as detrimental to working in the FPM with mothers and resulted in some nurse participants resorting to subversive nursing practices with mothers. Fowler et al. (2012) suggest that the introduction of new approaches with mothers such as the FPM can be stressful for nurses when it places existing clinical skills and competency open to the scrutiny of others. The ability to work in the FPM with ones' colleagues appears dependent on an individual's power that is, how they access, maintain and further it, as well as peoples' differences in organisational goals and interests (Hegyvary, 2006). The research literature to date on the FPM and nursing appears to focus predominantly on working in partnership with parents and less so in relation to partnership with peers, colleagues and managers and concepts of power.

5.4.1.1 The Influence and Impact of the Nurse Manager's Leadership Style and Interpersonal Relationships with CFHNs

Consistent with the literature, and following on from the discussion at the exosystem in Section 5.3.1.4, (p. 250), the leadership style of the nurse manager was found to be particularly influential to CFHNs' ability to work in the FPM with parents (Davis & Day, 2010; Day et al., 2015; Hopwood et al., 2013; Rossiter et al., 2011). The managers' influence on nurses' ability to work in the FPM with mothers ranged from being very supportive to one that conflicted with working in partnership. For example, Donna was committed to the FPM being practiced by her team, and nurse participants from another team described their nurse manager as protective of her staff and someone who shared "*the same philosophy about the job".* In contrast, it was revealed that a previous nurse manager of the remaining team had bullied some of the CFHN participants and their colleagues and this conflicted with and undermined their implementation of the FPM with mothers.

In this study, Donna, who was fully committed to the FPM, expected her nursing staff to work in partnership with parents as routine practice. This was despite the conflict in values of the FPM and State driven CFHN UHHV performance measures. Donna said she challenged nurses in her team that were assessed by her as unable to work in partnership with mothers. Donna gave a concrete example of this when stating she removed a CFHN

reported to use a directive, expert approach from facilitation of parent group sessions. This nurse was replaced by CFHNs who instead used more partnership style approaches with mothers. Donna stated some parents subsequently complained about the change in group facilitation style but said this couldn't be helped: "*If you try to meet everybody's needs you just wouldn't really do it".* This comment implied that Donna was upholding the evidence underpinning the FPM as the most effective facilitation method to help parents with their concerns (Davis & Day, 2010; Day et al., 2015).

Donna's invested authority as manager influenced the nature of the care received by mothers as well as the work nurses were allowed to do. Donna also stated that some CFHNs staff members who were unable to work in the FPM with parents had chosen to resign. The resignations of nursing staff from Donna's team appear to me to be the result of working within a service system which validates the FPM as the preferred mode of practice and does not support other models. Nurses practising outside the FPM are "othered" (Fine, 1998, p. 130) and possibly ostracised by colleagues who prefer to work in partnership or at minimum, don't wish to be seen to hold other than the orthodox FPM viewpoint. The workplace culture enforced in Donna's team contrasts markedly from research conducted by Fowler et al. (2012) where CFHN participants identified the potential for "nurses who embrace the model to be *victimised* by other staff" (p. 3311). For women such as CFHNs who are "othered", resigning and leaving work is a solution that avoids "further negative interactions" in the workplace (MacIntosh, 2012, p. 762). My study identified that power is exercised at the macrosystem, exosystem and mesosystem levels of the CFHN service by the enforcement and regulation of the behaviour of workers in order to coincide with the institution's ideology of partnership (Foucault, 1982). Nurses must "self-regulate their behaviour and are disciplined to follow the rules" (Foucault, 1982, p. 4). Those CFHNs who were unable or resisted FPM practice and did not (or could not) "self-regulate their behaviour" in accordance with the accepted new FPM norms of the workplace chose to resign from Donna's team. Mothers as a result have a reduced choice in selecting their preferred CFHN and model of care. While working in a service in which management and the collective cultural ethos supports partnership practice is the altruistic ideal, in this example of nurse resignations from Donna's team there are overtones of hegemonic and "new regulatory regimes" (Hopwood, 2014a, p. 3) governing CFHN practice.

In contrast to the robust support of the FPM by the NUM participating in this study, some nurse participants from another team reported their previous NUM had exhibited bullying

behaviours with nursing staff inconsistent with the tenets of the FPM. Vessey, Demarco, and DiFazio (2010) argue that across all health care professional groups the evidence supports that bullying, harassment and horizontal violence is the "greatest problem intraprofessionally within nursing" (p. 134). In this study Annie (from the team with the bullying NUM), stated: "*I had huge issues with bullying happening…with me and also with others"* in the two years prior to the appointment of the current NUM. During this time Annie stated she had considered *"moving on".* Workplace bullying, harassment and horizontal violence (BHHV) lack standardised definitions in the literature however commonalities are reported across each of these terms (Vessey et al., 2010). In comparison to horizontal violence, however, bullying has an element of a "real or perceived power differential" between the bully and the recipient (Vessey et al., 2010, p. 136). Vessey et al. (2010) have provided an overarching definition of BHHV that can be used for the context of this discussion.

> BHHV is defined as repeated, offensive, abusive, intimidating, or insulting behaviour, abuse of power, or unfair sanctions that makes recipients upset and feel humiliated, vulnerable, or threatened, creating stress and undermining their self-confidence. (p. 136)

Annie, however, said that her love of the job had prevented her from leaving the CFHN profession in spite of the bullying she experienced. Women's love of the job as a reason identified for staying in a workplace where bullying is experienced is consistent with findings by MacIntosh (2012). However, working in an environment where bullying is tolerated is known to be detrimental to nurses' physical and mental well-being, organisational culture and intraprofessional communication and patient [mother/child] outcomes (Vessey et al., 2010).

Analysis of interviews revealed that Sandy and Annie, both from Team 2 (See Figure 3, p. 86), remained reluctant to trust and build a relationship in partnership with their newly appointed NUM as a result of their experience with the previous (bullying) NUM. Sandy identified in her first interview that things with their new NUM were *"…so far, so good…* [but] *I don't want to rock the boat"*. Sandy's reluctance to test out and challenge her new NUM appeared to me to be coloured by her previous adverse experience with manager/s. This self-censoring behaviour has been described as "silencing the self" (Jack, 1993, 2011). The metaphor "not rocking the boat" suggests a strategy aimed at keeping the peace and avoiding conflict within interpersonal relationships (Jack, 1993). Annie voiced the unjust irony of the situation that some CFHNs found themselves in with their managers in

relation to the FPM: *"…the interesting thing is that they* [the managers] *don't work in partnership with their colleagues"*. Davis and Day (2010) clearly articulate the need for congruence between "management action and the notion of partnership" (p. 254). Nurses are reported in the literature and from the findings of this study to likewise look to their managers for leadership regarding the FPM and its embedding within the culture of the workplace (Hopwood et al., 2013; Rossiter et al., 2011).

5.4.1.2 The Influence of Colleagues on CFHNS' Ability to Work in the FPM with Mothers

Most CFHNs in this study readily identified the influence of supportive collegial relationships as positively impacting their ability to work in partnership as with mothers. In contrast, however, a few nurses described their colleagues' behaviour as censoring and a reason for them to occasionally resort to subversive clinical practice when working with mothers. Angela expressed a fear discourse and concern regarding her colleagues' critical judgement should she be overheard by them giving certain types of breastfeeding information and advice to mothers. In order to manage this predicament Angela stated she used a subversive or "*sneaky"* practice to provide support for breastfeeding women that was under the radar of her colleagues censoring eyes and ears.

Angela's *"sneaky"* discourse suggests that she covertly resisted the organisational constraints present in her work with parents by "bending the rules" (Varcoe & Rodney, 2009, p. 137). In doing so she enacted her "moral agency" by going outside "*the rules"* to provide what she believed was good nursing care (Varcoe & Rodney, 2009). Varcoe and Rodney (2009), however, argue these "guerrilla tactics" can backfire leading to sanctions if the nurse is "caught" resulting in more stringent enforcement of the rules (p. 137). It also raises ethical concerns about the rightness or wrongness of a dichotomised practice; that is, practising according to one's own rules rather than that of the organisation (Varcoe & Rodney, 2009). Furthermore, women and families in the community may become concerned about the inconsistencies in care and information provided by different CFHNs and centres. Angela's *"sneaky"* practice discourse suggests to me she was concerned about what might happen, that is, "*a fear of retribution"* should she be overheard by some CFHN colleagues when in consultations with mothers. Angela also expressed concern that in her team meetings, some CFHN colleagues were more strategic in ensuring that their voices were heard and able to present "*how it should be".*

A few CFHN participants discussed the existence of workplace horizontal violence in this study. There appears to be no published research on the existence of nurse-to-nurse workplace bullying and violence in the Australian CFHN literature. The majority of nurses in this study indeed readily described their colleagues, in contrast, as one of their main supports that enabled their ability to work in the FPM with mothers. Nevertheless, in relation to the "legitimation of workplace bullying in the public [health and social] sectors" in Australia, Hutchinson and Jackson (2014) state a contemporary dilemma for nurses and nurse leaders is how to "sustain caring work in an authentic and genuine manner while located in institutions that may be antithetical to the values of caring" (p. 8). Workplace power dynamics that privilege cultures in opposition to the value of caring (Hutchinson & Jackson, 2014), are significant detractors from CFHNs' ability to foreground their partnership work with mothers. Furthermore, the perpetration of BHHV by CFHN managers and/or nurse peers should not be tolerated as it is unjust and a breach of a person's human rights (Australian Human Rights Commission, 2011). It adversely impacts on the physical and psychosocial well-being of the CFHN victim and ultimately her ability to work in the FPM with mothers.

5.4.1.3 The Influence of Working with Interprofessional Teams, Agencies and Interpreters

Nurse participants identified a number of positive and less positive influences resulting from working with staff from interprofessional teams that impacted on their ability to work in the FPM with mothers. Jean, for example, stated her capacity to think, reflect and develop new insights about her clinical practice with mothers/babies had been enhanced as a result of working with staff from interprofessional disciplines and agencies. This, in turn, had helped limit her "*judgement calls"* in relation to her personal beliefs and values when working with mothers and children. The capacity to be non-judgemental is a prerequisite quality of the practitioner in the FPM (Davis & Day, 2010).

CFHNs in this study spoke of the influence of working with other services in relation to their FPM work with mothers. Erica described her role at times when working with mothers was like a "*listening post and then a sign post"*. This metaphor meant that she listened to their concerns and then directed them to the appropriate secondary referral service with the mothers' agreement as required. Referring mothers/babies to other services and teams reflects CFHNs' ability for team work, patient safe communication and a recognition of the proficiency of others' to provide for specific care needs (Levett-Jones, Gilligan, Lapkin, & Hoffman, 2012; Levett-Jones et al., 2014). The metaphor also indicates,

however, the power of the nurse in this context, for example, in gatekeeping or facilitating access of mothers to services.

Erica also identified the problem, however, of some referral services having inflexible intake/exclusion criteria or not providing home visiting services where there was safety issues identified. The reported inflexible inclusion and exclusion referral criteria for families into their programs was the main practical and structural challenges identified by CFHNs in working with staff from some interprofessional teams and secondary referral agencies. This is problematic as the often chaotic nature of families experiencing complex health and/or psychosocial issues is that they may be less able to engage or sustain the ability to fit in with criteria for service delivery and/or may actively resist approaches by services (Armstrong & Murphy, 2012; Barlow et al., 2004; Peckover, 2002). Therefore, as Erica explains, "*you feel like the people who need the most can't have them* [services] *because they've* [the mothers] *made themselves ineligible".*

Vulnerable families who were referred to these services by the CFHN for extra support but were *"unfairly dropped"*, that is, unfairly excluded from the service because of failure to meet certain criteria; were a source of anguish for CFHN participants providing universal services. The CFHN may identify certain parent/child/ family vulnerabilities and refer the family to a designated secondary service. If this secondary service does not accept the referral or the family does not engage with them the CFHN is currently not able to bridge the gap by providing more services as "*we have to get out and see… people for the first home visit. That is the ...key indicator that we have to do the home visit within 14 days".* This "reduced capacity to care" for identified vulnerable mothers and children in the community conflicts with and compromises CFHNs' professional standards and FPM ethos when the organisation's demands for UHHV outcomes take precedence (Grant, 2012, p. 1).

Erica also voiced her wish for better collaboration with General Practitioners (GPs) and the Department of Family and Community Services (FACS). She recognised that this increased communication, collaboration and coordination of the care of parents and children would be beneficial and a partnership focused approach for all concerned. However, she stated that the sharing of information with services such as FACS, although acknowledged to be improving due to recent legislative changes to the care and protection of children (NSW Parliamentary Counsel's Office, 1998), still had a long way to go because "*Everybody's so guarded in what they say"* (about client information and privacy concerns). Communication and collaboration issues with other services identified in this study are consistent with those reported as challenges in the research conducted by Schmied et al.

(2015) into the views of health professionals' regarding the implementation of a national approach to universal child and family health services in Australia. Schmied et al. (2015) reported a key barrier to effective communication and collaboration was the "limited mechanisms for sharing information and linking data about children and families across professions, services and government agencies" (p. 163).

Working with interpreters, especially phone interpreters was reported by Fiona as a practical challenge to the communicative nature of partnership work with mothers. The "*language barrier*" and need for the presence either in person or by phone of an interpreter was felt to detract from the depth of the relationship developed with the mother. This nurse felt that if she was able to speak the same language as the mother that *"they would be more accepting of our service…and partnership would be built…stronger".* However, research into the intercultural communication of CFHNs by Grant and Luxford (2008) does not bear this out. These authors found that CFHNs in their study were overall well-meaning in their descriptions of their work and approach with mothers and families from culturally and linguistic diverse (CALD) groups. However, when observed in consultation with CALD families, the CFHNs were observed to not take account of the diversity of the mothers' cultural ideologies and experiences of motherhood. They instead "treat[ed] them the same" (Grant & Luxford, 2008, p. 316), as they would treat mothers from the white majority of the population which reflects insensitivity and a lack of cultural competence by the nurses (NSW Ministry of Health, 2012). Therefore, simply being able to speak the same language as Fiona has suggested, may not be the solution for improving partnership based relationships with mothers (Grant & Luxford, 2008). I did not have the opportunity to observe instances of intercultural communication with CALD families in this study, however, because the participating mothers were from predominantly Anglo/Celtic backgrounds.

5.4.2 The Absence of Fathers/Partners

I refer to the absence of fathers at the mesosystem level of discussion as they were the unseen other "parent" alluded to in the research question. Although the inclusion criteria for this study stipulated "parent" participants, no fathers volunteered. The lack of fathers/partners in this study may have occurred for a number of reasons. I did not specifically ask for fathers to participate in this study when I used the catch all phrase *"Dear parent"* in promotional flyers left in the CFHN centre waiting rooms (see Appendix H). I realise now that the word "parent" is often assumed by mothers, fathers and professionals to mean "mothers" (Fletcher, May, et al., 2014) and that this error may have

contributed to their lack of participation. Further, I recruited all of the participating mothers following my face to face meetings with them at their parenting group sessions conducted by the CFHN. None of the fathers were present at these group sessions because their babies by this time were aged between four and eight weeks old and they had returned to work. I did not specifically ask the mothers to invite their partners to come to their videotaped CFHN consultation I was to observe. This lack of a direct invitation for fathers may also have reduced their opportunity to attend because some mothers may not invite them or are unwilling for them to be included (Maxwell, Scourfield, Featherstone, Holland, & Tolman, 2012).

The lack of directed father inclusive practices in children's education programs and in maternal/child oriented services such as midwifery and the CFHN service is well documented (Cullen, Cullen, Band, Davis, & Lindsay, 2011; Fletcher, May, et al., 2014; Government of Western Australia, 2012). There are very few men working clinically in the midwifery and CFHN workforce (Australian Institute of Health and Welfare, 2011) who may assist with the promotion of the role of fathers and redress the imbalance of primary service focus on the mother/child dyad. The universal CFHN service generally operates during business hours on weekdays that may further reduce opportunities for working fathers to attend. As discussed previously in the exosystem section, the gendered nature of the CFHN role also lacks visibility in society and within the nursing discipline in part because it is conducted with mothers and babies in the privacy of homes and may be conceptualised by both men and health professionals as "women's work". Further, expectant and new fathers have reported feeling marginalised and demeaned by maternal and child health services where the health professional is woman/child focussed and the father/partner is relegated to a subordinate role (Panter-Brick et al., 2014; Rowe et al., 2013).

The absence of fathers' views is acknowledged as a limitation of this study. It is important, however, to purposefully capture fathers' views in future studies investigating the "parent/s" experience of care by CFHNs and similar health professionals. Fathers are usually the mother's main support and as such they are extremely influential to the mother's well-being and in her care of their baby (Redshaw & Henderson, 2013). There is compelling research that demonstrates the positive influence of fathers' in their children's health, social well-being and academic achievement (Fletcher, May, et al., 2014). This significant influence of fathers in the lives of their children is separate and complementary to that of mothers in assisting their child's successful transition from infancy to adulthood

(Fletcher, May, et al., 2014). Attitudes to fathers' well-being may also be changing with issues like father's "post-natal" depression for example, being considered as part of a national routine screening approach similar to maternal perinatal depression (Fletcher, Dowse, et al., 2014). As (Fletcher, Dowse, et al., 2014) state:

> The "F" in FPM [Family Partnership Model] clearly implies that support is framed around family units rather than individual family members: inclusion of fathers is, therefore, implied. (p. 6)

For some nurses in this study, however, it appeared their central interest was to get all the work required by the hierarchy and health bodies completed and currently this work predominantly focuses on the mother's care of the baby.

The support to new mothers provided by other family members such as grandparents is acknowledged here in the mesosystem. However, this discussion did not feature in the responses of mothers during their interviews. Monica, however, discussed that occasionally mothers would call on her as an intermediary in relation to certain parenting practices where current evidence was in conflict with how their own mother/mother-in-law was providing infant care. This nurse gave the example of swaddling, where grandmothers from some cultures were at risk of overheating their new grandchild and the practice conflicted with current SIDS guidelines (SIDS and Kids, 2014). In these instances, Monica said she would give practical information that reflected the current guidelines at an appropriate time in a consultation when both the new mother and grandmother were present.

5.4.3 Mesosystem Summary

The factors influencing the ability of the CFHN to work in the FPM with mothers discussed at this mesosystem level of the Conceptual Framework included their workplace interpersonal relationships. The nurse manager's leadership style was frequently identified by most CFHNs as an important influencing factor. The manager's leadership and authority meant that she could use this vested power to model and enforce the tenets of the FPM within her team. This capacity for modelling and reinforcement of the FPM within a CFHN team was exemplified by the examples provided by Donna. The nurse participants from Donna's team also gave testament to the critical role Donna played in sustaining their individual FPM practice within their nursing team. In contrast, reports of bullying by a previous nurse manager from a different CFHN team in this study were reported as responsible for creating a work environment that was unconducive to the

caring work of partnership required by nurses with mothers. The ramifications of this nurse manager's impact on her team's confidence and trust lingered in nurse participants from that team who did not yet trust their new nurse manager enough to "rock the boat".

Most nurses reported supportive relationships with their nursing peers and colleagues that aided their work of partnership with mothers. However, this harmonious work environment was not experienced by all CFHN participants with some recounting their experiences of feeling censored and judged by their colleagues. One nurse described using "sneaky" or "subversive" practices at times with mothers to avoid being censured by her colleagues' critical gaze. Using subversive practices, however, has significant limitations both for nursing practice and clinical outcomes for mothers and babies. Such nursing behaviours also do not address the issues constraining practice within the work environment but instead maintain the status quo and the unfair exercise of power over others by some CFHN staff.

At the mesosystem level of this study, fathers are likely to be the key interpersonal relationship of the participating mothers and, in turn, of their baby. Therefore, they are the key other "parent" who could help answer "the nature of the impact" part of the research question. Fathers, however, did not volunteer to participate in this study.

5.5 INFLUENCING FACTORS AND THE NATURE OF THEIR IMPACT AT THE MICROSYSTEM[18]

The microsystem is the central level of Bronfenbrenner's (1979) model which I adapted for the Conceptual Framework of this study. My conceptualisation and application of Bronfenbrenner's (1979) Ecological Model Of Human Development (See Figure 2) places the CFHN and participating mothers and babies within this central level. However, it is the CFHNs who are foregrounded within the microsystem because they are the focus of interest of this study. The mothers and babies remain in view though because it is with them that the CFHNs seek to work with in partnership. The babies are the central focus of the mothers and their well-being, therefore, is generally the main reason for the mothers' consultations with their CFHN. Thus, the mother/baby dyad is placed at this central micro level though it is the mothers' experiences of their relationship with the nurse which was sought.

[18] In the ecological model, the microsystem refers to the 'immediate environment that an individual personally experiences and participates in over time' (Siegler et al., 2014, p. 367).

In addition to factors influencing the interpersonal relationships developed between the CFHNs and mothers, this microsystem level focuses on the intrapersonal experiences identified by nurse participants that influence their ability to work in the FPM with mothers. The discussion also addresses the body and emotion work undertaken by CFHNs in order to fulfil their work roles and the impact of this on their ability to work in partnership with mothers. Thus, this microsystem level focuses predominantly on the discussion of findings from Theme 2: Managing the Body: CFHN Body Work and Partnership Practice and, Theme 3: A Mindful Space.

5.5.1 Ageing and Menopausal Discourses of CFHNs

The age and midlife stage of the CFHN was identified in this study as an influence which could adversely impact on their ability to work in partnership with mothers. Erica, for example, cited her age and concurrent menopausal symptoms as factors that adversely influenced her ability to work in partnership with parents. Erica also identified that many of her colleagues *"are around that stage"* implying they were at a similar age to herself and possibly also experiencing midlife menopausal symptoms. Although only one nurse participant identified her experience of menopause as a factor which influenced her ability work in partnership with mothers, I believe the finding is significant. Most nurses in this study were around the mid-life stage and as a predominantly female workforce, also likely to experience some of the symptoms of menopause and ageing. As Newhart (2013) asserts "menopause matters" (p. 365). Menopause is described as a major life transition experienced by women that takes place over several years and varies in onset, length and the symptoms experienced (Newhart, 2013). Newhart (2013) states that often age "stands in for menopause status" (p. 365). Discussions of the experience of menopause within a nearly all female, mid-life CFHN workforce appears absent from the literature. It also appears absent in literature that describe factors that influence the CFHN's ability to work in partnership.

Two further nurses in this study stated they also found the CFHN role exhausting. The fatigue arising from the CFHN role perplexed one of these nurses who compared the CFHN role with hospital ward based nursing. The experience of fatigue, *"not feeling up to par"* or being unable to think clearly were reported as detracting from CFHNs' ability to work in partnership with mothers. The nurses stated they had reduced energy available for the necessary concentration and attention required of them when working in the FPM. It appeared more physically, emotionally and cognitively taxing for CFHNs' to sustain focused attention on the interpersonal relationship with the mother required when

working in partnership; compared with the provision of task focused, physical activities of acute care nursing of patients in hospital.

In 2011, the average age of the CFHN workforce was reported as 48.5 years (Australian Institute of Health and Welfare, 2011). Further, the CFHN profession has one of the 'highest proportion of nurses aged 50 years or older' in Australia at 50.6% (Australian Institute of Health and Welfare, 2011). In a recent national survey of Australian CFHNs with 1098 respondents, the mean age was reported as 51.2 years and 99.5% were female (Fowler et al., 2015). There is also reported an increasing societal workforce participation of the "grandmother generation of women [who are] over the age of 60" (ABS, 2006) cited in Rowe et al. (2013, p. 46). One nurse in this study identified that she and her CFHN colleagues are comprised of generally older women who have many commitments outside work. This is consistent with findings of contemporary middle-aged working women who are managing their own transitions of menopause while their children are leaving home and care needs of parents or other elderly relatives emerge (Graham & Duffield, 2010). This nurse also stated, as mentioned, that this age group of CFHNs do not have the same understanding of information technology as younger generations who have grown up with it.

Gabrielle et al. (2008) identified that ageing nurses experience an associated physical and emotional toll and revise work strategies such as their work hours to accommodate this. However, the effects of physical and emotional stress arising in the workplace are reported as being more significant for older nurses due to their reduced musculoskeletal and cardiorespiratory capacity, and possible existence of concurrent injuries or chronic illness associated with ageing (Gabrielle et al., 2008). One nurse in this study revealed that there were *"not many full time staff in the service".* This nurse presumed that *"most staff worked part time because the job's exhausting".* In fact, apart from the NUM, all nurses in this study said that they worked part time, usually three to four days per week. This is consistent with a recent Australian Nursing and Midwifery Workforce report which state CFHNs work an average of 30 hours per week (Australian Institute of Health and Welfare, 2011).

5.5.2 The Toll on CFHNS from their Body and Emotion Work and its Impact on their Ability to Work in the FPM with Mothers

This section begins with a quote from Pam Smith (2012) who, in outlining her research and scholarship on the *Emotional Labour of Nursing* states:

> The emotional labour analysis pays attention to the division of labour within the health service and the gendered nature of care and has been expanded by Hochschild to examine the notion of a 'care deficit', which goes beyond the individual to systems and processes and the wider society in which nurses and others operate to reveal how care as a core value has become increasingly threatened and devalued. (Smith, 2012, pp. 19-20)

Smith's research into the emotion work of nursing was inspired by the original and ongoing work of Arlie Hochschild (Hochschild, 1983, 2012) author of *The Managed Heart: Commercialisation of Human Feeling.* This notion of care and of helping parents is fundamental to the work of CFHNs and it underpins the FPM (Davis & Day, 2010). CFHNs in this study identified their struggle to provide the care they wanted to give mothers and babies because of the conflicting and increasing demands on them within their current health work environments.

Professionals such as CFHNs are expected to develop expertise in regulating their bodies, mind, and forms of conduct in order to achieve the primary health care agenda of the neoliberal State (Davies et al., 2006; Nursing and Midwifery Board of Australia, 2008a, 2008b). In the context of this study, this expertise is required in order to project the required demeanour and skills associated with the FPM so as to engage with and facilitate partnership based approaches of care of mothers and babies. For the CFHNs in this study, this regulation of body and emotion to demonstrate partnership with mothers was clearly in accord with their own philosophy of practice. All CFHNs in this study said they valued the FPM and its effectiveness in helping mothers and babies (despite the variations in my observations of their actual clinical practice with the mothers). This endorsement of the FPM is stated to be consistent with the "vast majority of practitioners" that agree on the effectiveness of the FPM when working with families (Day et al., 2015, p. 170).

The nurses in this study cared deeply about the mothers and babies in their service and in the importance of their nursing role with them. However, well intentioned CFHNs who

may be inclined altruistically to be "overly concerned with the needs of others" may be more susceptible to experiencing burnout (Hochschild, 2012). The definition of burnout used over the past thirty years, was first described by Maslach and Jackson (1981) and includes three components. These components are:

- emotional exhaustion;
- the development of negative thoughts, a cynical attitude and depersonalisation toward one's clients; and,
- a tendency to evaluate oneself negatively particularly in relation to one's work with clients (Maslach & Jackson, 1981; Maslach, Leiter, & Jackson, 2012).

In the following discussion, it will be seen that the toll on nurses in this study from their body and emotion work associated with the CFHN role and working in the FPM with mothers, is comprised of some of these components of burnout. Further, sustaining the ability to work in partnership with mothers throughout the whole consultation proved difficult for some nurses in this study. This difficulty in sustaining the energy, concentration and skill required when working in partnership with mothers I believe emanated from the distractions they experienced from unfair workplace demands and the reality of the limitations placed on them by their physical bodies. These findings are consistent with those reported in the *Family Partnership Reflective Practice Handbook* (Day et al., 2015). The authors suggest that effective FPM practice requires practitioners to "**engage their hearts and minds**" (authors' emphasis), and that the "emotional toil" of working with families can be challenging (Day et al., 2015, pp. 170, 172). This discussion of CFHNs' physical and emotional labour when working in partnership with mothers in the current work landscape builds on the work of Day et al. (2015) in its analysis of the characteristics and sequelae when the toll of body and emotion work on nurses goes unchecked. The feminised and gendered nature of this emotion work and the toll it can take is consistent with depictions of "women's work"(Hochschild, 1983, 2012).

There are societal expectations on mothers too, as parents of newborn infants, to be proactive in a neoliberal world in maximising their own and their child's potential (Clarke, 2013). The consistent pressure to regulate and maximise the body's performance to reach arbitrary goals of health and well-being as well as one's position in society is consistent with the concept of the "entrepreneurial individual" (Miller & Rose, 2008, p. 98). Martin (1997) uses the metaphor of a "tightrope walker" to illustrate how in the neoliberal societal context which demands personal control and responsibility for oneself'; the self is compelled never to rest (p. 360). Therefore, in the neoliberal environment it is not

possible for the mother to rest as she strives to maximise her own and her child's potential (Clarke, 2013) as recommended by health and other experts; and/or, as a result of her adoption of the ideology of intensive mothering (Hays, 1996). Likewise, CFHNs are less able to rest as they must continually strive to meet governmental demands and targets that move and change as workloads are increased and the expectation in the workplace is one of continued improvement.

The bodywork of CFHNs was featured in this study as they strived to incorporate the knowledge and skills of the FPM into their clinical practice. Nurses varied in their range of conceptualisation and integration of the FPM into their clinical work with mothers and babies. Well intentioned CFHNs in this study did the best they could to demonstrate partnership in their consultations with mothers and their babies under varied work environments including differences in:

- their centre's physical state and furnishings;
- managers' leadership styles;
- levels and nature of collegial support;
- access to clinical supervision and mechanisms to sustain FPM practice; and,
- unfair disparities in the time available for consultations with mothers.

A number of nurses in this study described their responses to the bodily and "emotional labor[19]" (Hochschild, 1983, 2012), that was necessary to sustain a partnership approach with mothers as extremely physically and emotionally tiring. What appeared obvious to me both as an insider and experienced CFHN, and from observing nurse participants' practice in consultation with mothers in this study, was the long periods of intense concentration that was required of them in order to cue into mothers' verbal and non-verbal communication for the entirety of the session. Maintaining the ability to concentrate and focus intently during the entirety of each consultation throughout the day with each and every mother and family was reported as very, very tiring, especially toward the end of the day. Virginia stated that tiredness and work overload were challenging issues that significantly detracted from CFHNs' ability to work in partnership with mothers. There were also competing demands on nurses, as previously mentioned, of computer data entry, supervising students and new staff and other aspects of the CFHN role such as completing maternal and infant assessment checklists that led some CFHNs in this study to become task focused and directive in their consultations with the mothers that I observed. This combination of unrelenting work demands when working with

[19] Referred to as "emotion work" in this study

families is identified as contributing to workers "feeling emotionally overburdened...as well as overloaded and overworked" (Day et al., 2015, p. 172).

CFHN participants were required to employ emotion work (Hochschild, 1983, 2012), to display the necessary facial and bodily visual cues to the mother that indicated they were listening and interested. Some of these easy to spot cues I observed were smiling, nodding, eye contact, leaning forward, and at times a synchrony of movement with the mother. I observed the taller nurses adjusting their office chairs to sit at the same head level as the mother to ameliorate suggestions of power and superiority that might be indicated by sitting at a higher than the mother. Fiona described how she adjusted the way she spoke with mothers and where she sat, for example, on the floor with the toddler, in order to try to make a young mother feel more at ease during the consultation. This intensity of concentration and regulation of body and emotion was required by CFHN participants in order to respond to mothers using the requisite family partnership skills, qualities and steps in the helping process they learned during their FPM training (Davis et al., 2009). They may also have been trying to use aspects of the Personal Construct Model (Kelly, 1955), one of the psychological theories [construction processes] that underpin the framework of the FPM (Davis & Day, 2010), in order to build as clear a picture of the mother's situation and concerns. Engaging with the mother and developing the relationship helps to build the necessary trust to explore the mother's situation, concerns and goals, and together work toward finding solutions.

It was brought home to me during my interviews with Jean and my observations of her consultation with mother Millie and baby Paul that CFHNs' undertake significant emotion work to ensure their facial and bodily movements are congruent with physical displays that are demonstrative of working in the FPM with mothers. As described in the Findings Chapter Section 4.5.1.3, Jean had a limited ability to use her facial muscles to smile as a result of a medical condition. This meant that Jean couldn't use her perioral musculature to fully form a smile, including the tell-tale wrinkles around the eyes known colloquially as "crow's feet" that indicate an authentic smile, also known as a Duchenne smile (Manjula, Sukumar, Kishorekumar, Gnanashanmugam, & Mahalakshmi, 2015). Smiling is viewed as a socially outward visual cue across most cultures that is used in greetings and to indicate one is happy (Gladstone & Parker, 2002; Manjula et al., 2015). Smiling is one of six "universally recognised facial patterns reliably linked to emotional experience in humans" (Gladstone & Parker, 2002, p. 144). Authentic smiling also helps make someone appear more likeable and approachable than non-smilers (Gladstone & Parker, 2002). Before Jean

disclosed to me about her physical limitation I had assumed she was tired (it was the end of the day), or lacked enthusiasm and was less able than other nurse participants to engage with the mother and baby. Jean said she disliked seeing herself on the video recording of her consultation because it mirrored to her clearly her lack of ability to smile and how this may be perceived by others, especially mothers. However, in this instance her other skills and qualities appeared to have been sufficient to engage Millie who was very positive in her estimation of her interactions with Jean and of their consultation as a whole. Jean's manner was warm and attentive toward this mother and baby. She was focused on their needs during the consultation. From this brief encounter, it appears that the nurse's outward facial expression and cues is just one element of the body and emotion work that comprise partnership with mothers.

In the above example there was a disjuncture between the bodily facial display of smiling Jean ideally wished to convey to Millie and Paul, and her ability to do so. Disjuncture of a different nature may occur in practice, however, when CFHNs are tired, lacking in energy or interest or are task focused but must still undertake the emotion work required to work in partnership with mothers. Hochschild (2012) states that it is this:

> *…pinch between* [author's emphasis] a real but disapproved feeling on the one hand and an idealized one, on the other, that enables us to become aware of emotional labour. (pp. x-xi)

Monica, for example, when reviewing her videotaped consultation with mother Juanita said she:

> *…remembered sitting there thinking* [during the consultation]*: "I would like to move this along a little faster but I'm supposed to be doing family partnership! Where's the family partnership in this?"* [Monica]

Monica's experience of dissonance between her true feelings and what she felt obliged to convey during her consultation with mother Juanita led to her expression of a guilt discourse. She attributed this to a heightened self-consciousness because of her efforts in trying to emulate partnership in her clinical practice. This was, in part, she said due to my presence at the consultation undertaking a research study which focused on CFHNs and the FPM. What I believe Monica was also expressing, however, was her use of "surface acting"; where she has tried to hide what she was truly feeling and pretending to feel what she does not (Hochschild, 2012, p. 33). Monica's feelings in this situation can be used to "give a clue to the operating truth" of her experience (Hochschild, 2012, p. 33). This

disjuncture between what a worker feels and what is publicly displayed, Hochschild (2012) suggests, is a source of workplace stress.

> A thread woven through the whole work experience: the task of managing an estrangement between self and feeling and between self and display. (p. 131)

Like Monica, many of the CFHN participants in this study identified their bodies as being overburdened. They provided descriptions of discrepancies between what was expected of their work performance by managers; what they expected of themselves when working in the FPM with mothers; and, with what they could actually manage to achieve when feeling overburdened. Very experienced CFHNs such as Virginia stated: "*I think you've got to be really careful of burnout".* Virginia's statement highlighted the ever present risk of burnout in their CFHN roles with mothers and that burnout significantly detracted from their ability to work in the FPM with them. In relation to the "human cost of emotion work", Hochschild (2012) suggests there are three positions taken by workers:

1. The worker identifies too wholeheartedly with the job, and, therefore, risks burnout;

2. The worker clearly distinguishes herself from the job and is less likely to suffer burnout; but she may blame herself for making this very distinction and denigrate herself for being "just an actor; not sincere;

3. The worker distinguishes herself from her act, does not blame herself for this, and sees the job as positively requiring the capacity to act; for this actor there is some risk of estrangement from acting altogether and some cynicism about it. (p. 187)

In over identifying with the job the worker in (1), is less able to separate "herself" from the job and is more susceptible to suffering stress and burnout (Hochschild, 2012). Hochschild (2012) asserts that such workers react passively in these situations by stopping caring and by becoming remote and detached from the people to whom they deliver the service. In Monica's example with Juanita above, she appears to have taken the position of the worker in (2). Her statement "*I'm supposed to be doing family partnership"* indicates that she was distinguishing herself from the job and berating herself when watching the video recording for "acting" in her work of partnership with the mother. Monica had also described at length during both interviews how her CFHN role made her physically and

mentally tired and the negative effect of her experience of burnout on her ability to work in partnership with mothers.

> *When you feel burnout, ….you don't want to know about problems, you have less empathy, you get irritated, feel resentment…you're just trying to get through the day as best you can and finding that it does take a toll. You don't really want to participate in Family Partnership.* [Monica]

Monica's description of her symptoms of burnout are consistent with the first two components identified by Maslach and Jackson (1981) of emotional exhaustion and cynicism discussed earlier in this section. Monica's language suggests she is moving toward what Hochschild (2012) describes as "emotional numbness" (p. 188). Emotional numbness according to Hochschild (2012, p. 188) reduces stress by "reducing access to the feelings through which stress introduces itself". This maladaptive strategy can assist the worker to remain on the job by shutting down their access to feelings but is achieved at great personal cost (Hochschild, 2012). In the CFHN context, it disengages nurses from their ability to effectively work in the FPM with mothers. I conjecture also whether the worker described in (3) above comprise the CFHNs who may "choose" not to work in FPM or, as in Neroli's description of some of her CFHN colleagues, are cynical and speak disrespectfully of the model. Are these CFHNs disengaged and cynical of the FPM partly in order to manage their workplace stress and experience of burnout? I was unable to ascertain this information because in my study, despite my observations that some CFHN participants were unable to fully demonstrate a partnership approach during their consultation with their mother/baby, all the CFHNs who volunteered to participate spoke of their belief and commitment to the FPM.

Experienced CFHNs such as Virginia may be less vulnerable to burnout because they can differentiate the acting and non-acting side of themselves, and may see their role with mothers as clearly requiring the capacity to act (Hochschild, 2012). Virginia explained during interview that her consultation with mothers is the "*rehearsal*" for what they [mothers] might later do in their real lives. Virginia's use of the word "*rehearsal"* suggests she is aware that her role as a CFHN places her in a "performance" with the mother. Virginia also stated that "*I can't befriend them* [mothers] *all*". By this statement, Virginia indicated the limitations to the role she could play in the lives of mothers and babies and that not all mothers would wish to engage with her. Like the worker in (3) above, Virginia did not blame herself for this limitation or the need to act at times in performing her CFHN role. Experienced workers and CFHNs such as Virginia can develop a "healthy [emotional]

estrangement" that allows them to distinguish a "clear separation of self from [work] role" (Hochschild, 2012, p. 188).

Problems resulting from the emotion work of CFHN may also be encountered when the organisation "institutes a speed-up" (Hochschild, 2012, p. 188). This was the experience of many CFHN participants in this study. The phrase "speed-up" indicates that the worker literally has to speed up and move faster when on the job. This may occur in CFHN, for example, as a result of policy changes; reductions in staff resulting in more work for individual nurses; and, increases in the birth rate without similar increases in the ratio of nurses to newborns. CFHNs in this study spoke of numerous changes to practice including the expanded and additional assessment activities they needed to undertake with mothers and infants. This increase in activity is situated in a context of an increased birth rate and reduction in overall CFHN numbers (Cowley et al., 2012); a computerised environment where documentation takes longer; and where I observed a significant disparity and inequity in the amount of time designated for child health checks in different parts of the same LHD. CFHNs in such a context may, as Hochschild (2012) suggests, becomes estranged from the "acting" itself; that is, estrangement and detachment from the regulation of their bodies and emotions that is required when working in the FPM with mothers. This estrangement results as a consequence of the organisation maintaining its call for emotion work from CFHNs yet the work has sped up and makes it impossible to sustain its delivery to mothers without taking a personal toll. It similarly leaves the CFHN little room to "slow down", to be mindful and to reflect both in and on practice (Kinsella, 2009). Situations such as these may be worsened by the CFHN's lack of control over the conditions of work (Hochschild, 2012). CFHNs may consequently experience a practice dissonance. Additionally, since the CFHN workplace calls for good family partnership skills with mothers, the CFHN who is experiencing burnout and estrangement may be seen as doing the job poorly. It was the nurses who were seen as not working in the FPM with mothers in Donna's team whom she stated she challenged or who were reported by Donna to have already left her service. Challenging some CFHNs on their inability to demonstrate or sustain working in partnership with mothers given the physical and emotional toll placed on them daily in their current workplace environment may be considered unfair and unjust under these circumstances.

CFHNs in this study also identified their bodies as overburdened from juggling the demands of the workplace with the reality of their ageing body's experience of fatigue and the physical and psychological symptoms associated with menopause. Nurses such as

Angela disclosed the daily significant emotional discomfort she felt in having to ask mothers the maternal psychosocial assessment questions when it elicited for her what appeared distressing concerns of a personal nature. Neroli also identified that it was vital for CFHNs to be in a *"good headspace"* when undertaking FPM work with mothers. The ability for some nurses in this study to stay in a *"good headspace*", against a backdrop of a workplace nursing culture where bullying occurred, was also identified as challenging and unfair. Nurses' experience of feeling overburdened and their risk of burnout increased when more demands were placed upon them at work. This makes their emotion work of partnership harder to enact with mothers. The workplace conditions that CFHN participants in this study have identified as stressful and contributing to their feelings of burnout and decreased ability to work in partnership with mothers is consistent with six broad social and organisational domains of "job-person mismatch" known to contribute to burnout (Maslach et al., 2012, p. 297). The six domains include:

> …work overload, lack of control, insufficient reward, breakdown of community, absence of fairness, and value conflict. Any or all of these areas may align well with employees' preferences or capacities, encouraging engagement, whereas poor alignments may aggravate burnout. (Maslach et al., 2012, p. 297)

Further, as mentioned, the need for CFHNs to keep up to date clinically, meet performance development requirements with their managers, such as Annie mentioned regarding her CNS status, and working in a "speed–up" work environment may result in their inability to rest or find time to reflect while at work. These identified issues are all influencing factors adversely impacting on the CFHNs' ability to work in the FPM with mothers.

5.5.3 Bodywork and Power Relationships between CFHNS, Mothers and Babies

All CFHN participants identified the positive and negative contribution of the mothers and babies/children to their professional partnership relationship. Nurses identified the personally fulfilling, intrinsic rewards they received from working with confident, motivated mothers who were committed to the care and nurture of their children. This was the motivation for some nurses remaining in the CFHN role despite the challenges of the work environment. Annie, for example, stated the positive feedback she received from mothers during follow up visits was very rewarding and also influential to her ability to work in the FPM. This positive feedback helped reinforce for Annie that the "way" in which

she had worked with the mother on a particular issue had been helpful thus reinforcing her practice of the FPM to help facilitate positive outcomes for mothers and babies.

In contrast to these positive examples, working with mothers who want immediate solutions to their problems was the situation most commonly identified as difficult by nurse participants in this study. It posed a significant challenge to CFHNs' ability to work in the FPM with these mothers. This situation has been reported in the literature and by the authors of the FPM as a known "barrier" to nurses' ability to work in the FPM with parents (Davis & Day, 2010; Davis et al., 2002; Rossiter et al., 2011). Nurses in this study reported varied strategies for managing this situation. Some nurses suggested it demonstrated respect for the mother's wishes in this instance to steer her and her baby/child toward care by particular nurses who may be more prescriptive in their approach. In contrast, other nurses including Donna, the NUM argued the evidence based limitations of working in expert approaches made it an invalid and unhelpful mode of working with mothers. What is apparent is that this is a recurring situation where nurses' FPM practice does not meet the perceived needs of the parents. Virginia statement, previously mentioned, *"You can't befriend them all"* acknowledges that the FPM is not a "one size fits all parents" approach. However, one nurse in this study identified the difficult situation she sometimes found herself in when mothers and/or fathers became angry and defensive when she was trying to use FPM approaches with them. Sandy recounted a number of clinical scenarios where this had occurred and when at times, she had become angry in return. Sandy expressed uncertainty regarding how best to deal with this issue. Sandy didn't mention whether she had discussed the issue with her colleagues or approached her NUM or clinical supervisor for support. From Sandy's descriptions, however, the CFHN holds the power to exercise the mode of approach she chooses with a parent regardless of whether the parent wants to work in this way. It is also another example of CFHN's emotion work when the demand from the client [mother] exceeds the capacity of the nurse's ability to sustain working in the FPM. Sandy said she responded in anger back at the mother being unable to keep this emotion in check. Further, just as a small number of nurses will be unable to acquire the expertise to implement the FPM (Day et al., 2015), some mothers and/or fathers may be reluctant to work in the FPM and find its application with them unhelpful (Rossiter et al., 2011).

In regard to the body work practised by CFHNs with mothers and babies and its relationship to power, I support Wolkowitz' (2002) assertion that the nature of body work preferentially advantages the power of the worker over the person/s receiving care. This

may be due to the worker's age and social class which may be perceived as superior by the care recipient, for example, in the case of the older CFHN, by a young, poor or otherwise socially disadvantaged mother. During a CFHN consultation, new mothers may feel the need for reassurance and approval of their care of their baby by the nurse. First time mothers in this study revealed their lack of confidence in their new role and the power with which health professionals such as CFHNs and doctors had exercised in either affirming their care of their baby or to make them feel silly or inadequate. Other concerns of mothers during their CFHN consultation may include whether: the baby will be considered appropriately clean and dressed; growing adequately and meeting the relevant developmental milestones; the mother's infant feeding and infant sleep space choice meet with the CFHN's approval; and, will the nurse be gentle, kind, understanding and not make the baby cry during her examination. Concerns of mothers about the surveillance and judging practices of nurses in roles similar to CFHNs in NSW have been reported internationally (Peckover, 2002; Wilson, 2001) as well as by my own acquaintances, friends and family members in Australia.

Neroli identified this potential power differential when comparing a home visit to a centre based consultation: *"I think working in a person's home is actually easier to adopt this* [FPM] *model …we are a guest…I think we have more power* [over parents] *potentially in the clinic".* Regardless of the setting, however, the CFHN generally requires the baby or child to be restrained in order to conduct the physical examination, the micro politics of which may threaten partnership based relations with the mother. Twigg et al. (2011) suggest that this "exercise of physical power is …characteristic of most body work interactions to some degree" (p. 180). Furthermore, Einboden, Rudge, and Varcoe (2013) argue that the measurement and technologies associated with childhood developmental assessments:

> reproduce ideologies that situate individuals as solely responsible for their own life circumstances and that hold families [especially mothers] accountable for the provision of nurturing environments that promise to sculpt brain architecture in ways that maximise the child's biological potential (p. 213).

These authors suggest that the child has become a "site of the intensified scrutiny of technobiopower" (Einboden et al., 2013, p. 221). Nursing practices that monitor child development such as performed by CFHNs may inadvertently "deprive children of agency" by fostering the production of "normal or ideal children" (Einboden et al., 2013, p. 212). It follows then that despite the altruistic intent of the FPM, CFHNs' scrutinising health

surveillance practices have the potential to deprive both mothers and developing children of agency. In addition, (and previously discussed in Section 5.2.3, p. 236), according to Hays (1996), the "ideology of intensive mothering" is already a pervasive and oppressive social construction and worldview adopted by many Western women (p. 4). Mothers may hold themselves responsible for maximising their child's brain and overall development and thus present their babies to the CFHN for examination and validation that their child is growing "normally". The nurse's role can be viewed as powerful in providing this validation or otherwise of the "normally growing child" and consequently, the mother's parenting competence.

Jean identified her need to work in the FPM not only with the mother but with the child, and to get "*permission"* from the baby to examine him/her. Jean's respectful intent toward the baby appears to parallel her FPM approach with the mother. She viewed the baby as an individual and deserving of the same respect and courtesies as an adult such as asking "permission" to proceed with the examination. The baby was not just an object "body" (Sakalys, 2006) for Jean to examine but his or her own person. None of the other participants commented about the mothers' babies in terms of working in the FPM with them, perhaps because they were not the focus of the study. Although Jean appeared genuinely caring and altruistic in making these comments, I contend there is a covert governmental agenda operating behind the gendered nature of the partnership work of the CFHN with mothers and babies. This agenda is the screening and assessment of mothers and babies/children; prevention and early intervention of ill health or disability; and, promotion of healthy lifestyles; consistent with one hundred years of CFHN clinical practice (NSW Kids and Families, 2014). The well-being of the baby is generally central to his/her mother's concerns. Therefore, it's crucial that the CFHN "gets on" with the child in order to conduct the examination. This serves both the interest of the nurse who wants to be able to assess the well-being and development of the child in order to complete the mandated child health check; and the mother, to ensure her child is "normal" (Einboden et al., 2013; Lowe et al., 2015). Thus, the bodywork that comprises the nurse working in the FPM in a "hands on" manner with the child as well as the parent helps the nurse achieve the agenda of the state. The clinical encounter inhabits a space that is both personal (intimate) and professional.

5.5.4 CFHNS' Capacity for Agency

Tensions, identified throughout this chapter, were ever present in the workplace for CFHN participants. These tensions lay between the demands of the institution and the workplace

environment; and the nurses' core professional value and belief in providing optimal care and support to mothers and babies enacted through working in the FPM with them. Being constrained by the amount and type of care they could provide to mothers and babies due to institutional demands on their time and their roles resulted for many nurses in this study in a "value conflict" (Maslach et al., 2012, p. 297). In the context of this study, the value conflict was the CFHN participants' reduced capacity to work in the FPM with mothers and babies. Experiencing a value conflict as a nurse is hard emotional labour (Smith, 2012; Varcoe & Rodney, 2009). Nurses unable to readily integrate personal values and beliefs into their nursing care are known to experience "moral distress" (Goethals, Gastmans, & de Casterlé, 2010; Varcoe & Rodney, 2009). The term "moral distress" first coined by Jameton (1984), refers to a situation when nurses judge a decision to be correct but can't implement it due to situational factors (Goethals et al., 2010). The unchecked moral distress of nurses is linked to burnout and "leaving the profession" as a maladaptive coping strategy (Oh & Gastmans, 2015, p. 28). In this study, Angela said she had considered resigning over the conflict between "*the rules of the organisation*" and what she believed was the *"rules of* [family] *partnership"* when working with mothers and babies. Annie had considered resigning as a result of her experience of a previous manager's bullying behaviour. Bullying behaviour I consider, at minimum, is an "absence of fairness"; a factor known to contribute to burnout (Maslach et al., 2012, p. 297). As previously mentioned, Angela used subversive clinical practices to manage her experience of value conflict. While Angela's tactics may be considered a form of "moral resistance" (Varcoe & Rodney, 2009), this strategy does not lead to change in the status quo and, as previously mentioned, has a number of potential adverse consequences. Feeling overburdened, value conflict, moral distress and burnout can all result in the CFHN experiencing practice dissonance and disengagement from their work and the emotional connectedness and energy necessary to work in the FPM with mothers.

The purpose thus far in this discussion chapter has been to unmask and make visible the factors within the various systems that constrain or sustain CFHNs family partnership work with mothers. There has been an emphasis on discussion of the constraints to working in the FPM identified in the study findings. However, the primary outcome of this focused ethnography is to increase CFHNs' understanding and awareness of the supports, constraints and "specific societal issues that affect different facets of [their specialist] nursing practice" (Cruz & Higginbottom, 2013, p. 36) and ability to work in the FPM with mothers. This greater awareness may enable CFHN's to enact their moral or "human agency" (Bandura, 2006). There were examples of CFHN participants in this study using

their human agency to positively impact on their ability to work in family partnership with mothers. There were work based supports that nurses accessed such as clinical supervision. They would also turn to their colleagues when they needed to offload work or share concerns when overburdened at times. Nurse participants ensured they stayed up to date clinically through continuing education opportunities. There were no examples, however, of how nurse participants used their agency and political power to effect change at the mesosystem, exosystem and macrosystem levels. The nurse participants likewise did not identify solutions that may help to create the change needed in the organisational context to better support them in their FPM work with mothers.

The next section presents the major findings of this study not previously identified. I discuss how some nurse participants in this study appeared to use their human agency to create the right "space" for them to be prepared and sustain the body and emotion work of family partnership with mothers and babies. The strategies that these nurses undertook included self-care, reflection and the practice of mindfulness, that is, an immersion in the moment. These three factors appeared essential to the embodiment of partnership within this study and that mindfulness was the key, not yet stated factor, to being able to implement the FPM with parents. These nurse participants did not label this latter strategy as mindfulness but the conditions they described and the techniques they used correlate closely with its secular definition. A well-known definition used to explain the concept of mindfulness is: "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgementally to the unfolding experiences moment by moment' (Kabat-Zinn, 1994, p. 4).

5.5.5 Creating a Mindful Space for Partnership with Mothers

In this section, I discuss the strategies some nurse participants in this study used to create conditions conducive to finding space to work in the FPM with mothers within the demands of the busy health care environment and distractions of an intrapersonal nature. This space for family partnership, I suggest is synonymous with the nurse's capacity for self-care, reflection, and most importantly, for mindfulness. Therefore, this section is particularly relevant to Theme 3 – A Mindful Space and its associated subthemes.

5.5.5.1 Self-Care (Being Mindful of Self)

Nurse participants in this study who identified performing self-care practices both on and off the job, reflection in and on practice (Schön, 1992) and said they purposively "paused" between consultations were observed to demonstrate the greatest capacity to work in the FPM with mothers. These nurses, Neroli and Virginia, admittedly were advantaged in that they were experienced FPM trainers and thus, were able to revisit the model in greater depth much more frequently than their CFHN peers. Additionally, these nurses had Donna, a champion of the FPM as their NUM, and had the longer, one hour appointments for infants' six week and six month child health checks. In comparison, most of the remaining CFHN participants in this study had to contend with minimal to zero opportunities to revisit the FPM, varying levels of support from their managers and colleagues and consultation times of thirty minutes for the same infant child health checks.

Monica, however, was from the same team as Neroli and Virginia and had the same or similar workplace conditions. She was not a FPM group facilitator but said she had opportunities via Donna's leadership and championing of the FPM to revisit the model in clinical supervision, team meetings and educations days for it to be fore-fronted in her clinical practice with mothers. However, despite this fairly equivocal workplace environment I observed differences in Neroli, Virginia and Monica's ability to conceptualise and demonstrate family partnership in practice with mothers. Neroli and Virginia appeared to "live and breathe" the FPM both in their described conceptualisations of the model, examples of practice discussed and in my observations of their clinical practice in consultation with mothers. Monica, in contrast, and like Angela, however, conceptualised the FPM as part of her practice tool kit to be used in the right circumstances with mothers. There was too much to do on home visits, Monica had explained, to be always able to work in the FPM with mothers. This tool kit approach to the implementation of the FPM has been described as "selective and piecemeal" (Day et al., 2015, p. 171), adversely impacting on nurses' ability to effectively meet families' needs. In these busy instances, nurses such as Monica, Angela and Sandy appeared instead to become more task focussed and directive with mothers. These three nurses, therefore, were unable to consistently demonstrate the same degree of recognition as Neroli and Virginia regarding the need for mindfulness when working with mothers and babies. The divergence in the care these nurses would like to give mothers and babies [to work in family partnership] with what they could provide [directive and expert approaches]

created a value conflict and guilt discourse. This value conflict has also been identified by Grant (2012).

The specific strategies that appeared to enable Neroli and Virginia to sustain their ability to find "space" to work in the FPM with mothers, came down to three closely interrelated key criteria: self-care and being mindful of self; reflective practice; and, a purposeful capacity to be mindfully present when with mothers. They were interrelated because regular mindful self-care activities such as exercise facilitated, for example, purposeful reflection on practice; mindful awareness before and during each consultation appeared to enable these nurses to provide a calm and mindful presence when with the mother/baby. These three strategies that assisted their ability to sustain their partnership work with mothers were in addition to their CFHN clinical knowledge, skills, experience, additional FPM training and workplace supports. Combined together these attributes appeared to fundamentally facilitate their ability to work in partnership with mothers despite the external and internal constraints they may be experiencing.

Neroli, in particular, explained how she implemented self-care activities in order to sustain her ability to work in the FPM with mothers. Neroli said she achieved this by walking each evening after her work day, reflecting on what had happened and then *"put*[ting] *that it in a safe place".* Neroli's "*safe place"* indicates she employs a psychological strategy to separate work events and her personal life. It indicates a purposeful activity to spend time thinking though the day's events at work; situations that may have occurred with mothers/babies, processing emotions, and perhaps developing future care strategies. Once this reflective self-care process is complete, Neroli indicated she stores it in a "*safe place"*. Use of the word "safe" indicates that a threat to her well-being may exist if she left these work events "unprocessed" or if they were continually mulled over.

Self-care is a strategy critical for health professionals such as CFHNs who wish to strengthen their therapeutic communication skills with mothers (Rossiter et al., 2014). Two nurses mentioned they regularly exercised as a self-care strategy aimed to help cope with the demands of their role and to more effectively work in partnership with mothers. None of the other CFHNs mentioned using specific self-care strategies in their personal lives to nurture themselves in order to strengthen their ability for therapeutic presence and work in partnership with mothers. CFHNs frequently remind new mothers to nurture themselves in order to recharge and sustain the energy necessary in providing sensitive and responsive care of their babies twenty four hours a day, day after day. Performing regular self-care activities, for example, complementary modalities such as yoga and

meditation, may likewise assist CFHNs to maintain the work-life harmony necessary for mindful, therapeutic presence with mothers (Bernstein et al., 2015; Cohen-Katz et al., 2004; Geller & Greenberg, 2012; Hick & Bien, 2008; Newsome, Waldo, & Gruszka, 2012; Raingruber & Robinson, 2007; White, 2014). For example, registered nurses in the US participating in a three month self-care program consisting of either tai chi, yoga, meditation or reiki health sessions reported a greater ability: to relax; for problem solving; and an increased ability to focus on patients' needs (Raingruber & Robinson, 2007). Similarly, a small randomised controlled trial of undergraduate nursing students undertaking yogic exercise one day per week for three months identified significantly decreased life stress and postprandial blood glucose levels measurements in the intervention group (Sang Dol, 2014). Furthermore, nurses are interested in mind-body training for greater spiritual and emotional well-being (Kemper et al., 2011).

5.5.5.2 Reflective Practice

The CFHNs in this study identified that time to reflect in and on practice (Schön, 1992) assisted their ability to work in the FPM with mothers. Reflective practice has been widely adopted in nursing education and clinical practice (Kinsella, 2009). It is a key constituent of the clinical reasoning cycle which is linked to safe nursing practice (Levett-Jones et al., 2010). Neroli and Virginia, however, stated that reflection for them was a *daily* work practice. The majority of the remaining nurses in this study identified the need for reflection but blamed their busy work environment for not making enough time for it. A busy work environment with "relentless work demands" and the "emotional toil" that working with families can have on practitioners such as CFHNs are recognised by the authors of the FPM as barriers to reflective practice (Day et al., 2015, p. 172). Both Neroli and Virginia in contrast, identified the need to remind themselves each day about their purpose and reason for coming to work; and question their motivations behind their work with mothers and babies. Virginia identified this as "*stopping and stocktaking"* and said this deliberate pause helped her to clearly distinguish her professional boundary when working with mothers. Reflection also provided Virginia with a clear perspective in her work with mothers.

Reflective practice is considered to be closely correlated with a practitioner's ability to effectively work in the FPM with parents (Day et al., 2015). Day et al. (2015) state that the quality and effectiveness of the FPM practice with parents rests on three key factors:

- The presence of congruent service and organisational conditions that support the implementation of the FPM;
- The skills and commitment of individual practitioners; and
- The support of practitioners' access to regular and structured reflection on practice guided by the FPM framework to develop and sustain the FPM in practice. (pp. 160-161)

In this study, Neroli, Virginia and Monica appeared to have the greatest access to support for structured reflection using the FPM framework. This was because Donna tried to ensure that clinical supervision and case review were facilitated using the FPM helping process, although the facilitator may have not been expressly trained in the FPM model. As FPM facilitators, Neroli and Virginia also had the opportunity to regularly revisit the FPM when facilitating FPM training groups and accessing the associated clinical supervision. The remaining CFHN participants had similar access to clinical supervision but it was not identified as being guided by the FPM.

The personality characteristics of individual nurses also appeared to influence their uptake of reflective practice. Jean, for example, appeared to be more quiet and introspective than the other nurses in this study. Jean identified the importance of reflection to heighten her awareness of her beliefs and judgements and how they may affect her work with mothers and babies. Jean and other nurse participants welcomed my research as an opportunity for them to examine their practice because it provided them with time to observe and reflect on their practice.

Similar to findings by Grant and Luxford (2009), the use of the video recorded feedback of consultations in addition to interview, proved to be valuable in assisting nurse participants' in this reflective process. The video graphed consultations could offer deeper exploration of CFHN practice and use of the FPM during clinical supervision and education processes. The videotaped consultations facilitated the participant observation component of ethnographic data collection in this study and helped to highlight and make visible (Twigg et al., 2011) the body and emotion work of CFHNs. When using video to aid reflexivity, ethical issues need to be considered such as consent, privacy, confidentiality and the well-being of participants. In addition, use of the video assisted the emancipatory nature of this focused ethnography through the "co-construction of research data with the [CFHN] participants" (Grant & Luxford, 2009, p. 229).

5.5.5.3 Mindfulness

In order to be present and give them their undivided attention when with them, Neroli and Virginia both described similar strategies to consciously prepare themselves before their consultations with their participant mothers/babies. They identified leaving their own issues outside the consultation room to ensure they remained "*client focussed*"; and *"stillness*" to portray the FPM helper qualities of empathy and unconditional positive regard (Davis & Day, 2010) of the mother, baby and their concerns. During this study I had the opportunity to observe all nurse participants closely during their consultations with mothers/babies and afterwards during analysis of their videos. From analysis of Neroli and Virginia's data the subtheme "*Being present in the moment: A mindfulness discourse"* emerged as pivotal to the ability of nurses to work in the FPM with mothers and babies and a key finding from my study. This finding is discussed in detail in the next section.

5.5.6 Mindfulness: A Key Factor in Enabling Partnership in CFHN Practice

I contend that Neroli's and Virginia's clinical practice with their participant mother/baby in this study was mindful despite neither Neroli nor Virginia ascribing the term "mindfulness" in their work or daily lives. I make this claim based on my contacts with them during this research, particularly during my observations of their consultations with their participant mothers/babies, where they indeed appeared to be "paying attention in a particular way, on purpose, in the present moment, and non-judgementally" (Kabat-Zinn, 1994, p. 4). Further, my observations of these nurses' demeanour and presence during interviews with me; and, the mothers' evaluation of the care received, helped confirm my recognition of mindfulness as the defining feature of their ability to work in partnership and is a key finding of this study. These two nurses may have been predisposed to what has been termed "dispositional mindfulness [which indicates] how [naturally] mindful an individual tends to be in their daily life" (Malinowski & Lim, 2015, p. 1). The mindful presence I observed these nurses demonstrate appeared equivocal to the following statement by Hick (2008) about its use in professional therapeutic relationships with clients: "within the client-therapist relationship, mindfulness is a way of paying attention with empathy, presence, and deep listening" (p. 5). Geller and Greenberg (2012), however, caution that the terms "mindfulness" and "presence" should not be used interchangeably. They draw the distinction that mindfulness is a "*technique* that can help to cultivate [with practice], the *experience* of presence" (Geller & Greenberg, 2012, p. 181). Thus, this

technique of mindfulness, with practice, could be honed by CFHNs to provide mothers with therapeutic presence.

Nevertheless, Hick (2008) makes an important distinction stating that mindfulness constitutes a "shift from a 'doing mode' to a 'being mode'" (p. 5). The ontological shift of "being" rather than "doing" helps in focusing on the here and now rather than the past or future (Cohen-Katz et al., 2004; White, 2014). This attitudinal attention may assist "busy" CFHNs to focus on the "now" when with mothers/babies rather than the list of tasks they may have on their mind to do. It is a calming approach conducive to creating conditions for patient centred, effective, communication with mothers (Levett-Jones et al., 2014; Rossiter et al., 2014). Patient [or mother/baby]-centred health professionals are reported to be "*ethical, open-minded, self-aware* and have a profound sense of *personal responsibility* for [their] actions *(moral agency)"* (Levett-Jones et al., 2014, p. 15). These attributes are consistent with the actions demonstrated by some nurses in this study and in particular, by Neroli and Virginia.

Susan and Lisa were the mothers linked with Virginia and Neroli. In their follow-up interviews, both of these mothers described their experience of mindfulness in their CFHN'S practice. They could feel the empathy, care and concern for their well-being from their respective CFHN during their videotaped consultations. Susan said, for example, "*I think it was the way she spoke…her main focus was our wellbeing".* Lisa, who had a pre-existing nurse-client relationship with Neroli from her first child said: *"I can feel that she empathises with the situation…just by the way she responds"*. From these statements, and my observations of their consultations, it appeared to me that Neroli and Virginia had created the conditions conducive to effective therapeutic communication (Rossiter et al., 2014). They were also patient [mother/baby]-centred (Levett-Jones et al., 2014) in their consultations with Lisa and Susan. Recent research has identified the presence of "mirror neurons" (Geller & Greenberg, 2012; Rizzolatti & Sinigaglia, 2008), the neurobiological mechanisms that facilitate this experience of "feeling felt" (Zarbock, Lynch, Ammann, & Ringer, 2015, p. 29) by another person such as the mother by the CFHN. Zarbock et al. (2015, p. 29) describes this mirroring as "embodied empathy which helps us 'feel' for the other person". This capacity for embodied empathy can be enriched in health professionals such as CFHNs through the practice of mindfulness because it enhances awareness of the present moment and one's availability to be open to the needs of another (Zarbock et al., 2015). Similarly, during immersion in the research process, I experienced "reflexive embodied empathy" (Finlay, 2005, p. 271). This is the process where

"researchers affect and are affected by their participants in a process of reciprocal transformation" (Finlay, 2005); the researcher has the capacity to empathise with participants and vice versa. I could "feel" and empathise with participants and their stories, particularly during consultations, and, they likewise, could sense and empathise with me. Enriching the capacity for empathy as well as "being present" with awareness may act to enhance the ability of CFHNs to work in the FPM with parents.

Most of the other mothers in this study similarly experienced their consultations with their nurse as positive with the CFHN being described in one instance as a "*trusted advisor"*. One mother, Dani, however, did not feel a *"relationship"* as such had been established with her nurse Sandy possibly due to her perception of this nurse's "busyness" and task orientation during their consultation. Neroli's and Virginia's descriptions of their practice and the comments made by their clients lead me to conclude that the difference during their consultations compared to other CFHN participants', was the mindfulness they employed when working in the FPM with Lisa and Susan. Their whole attention appeared focussed solely on these mothers and their babies for the entirety of the consultation. There was seriousness present in their approach and interactions with the mothers in this study as well as in my interactions with them. They appeared to take their professional work responsibility with mothers/babies seriously and were definitely not "going through the motions" or "trying" to work in partnership with them. Neroli and Virginia also spoke of their strategies, as mentioned previously, to have this same approach with each mother/baby during each consultation throughout their work day. Their capacity for mindfulness facilitated a commitment to mother/baby centredness that appeared to me the difference in their partnership practice and depth of relationship building with mothers compared to their CFHN colleagues participating in this study.

Mindful practice and mother/baby-centredness facilitated Neroli's and Virginia's ability to work with Lisa and Susan by creating the "mindful space" for partnership to flourish. This concept of a "mindful space" while complementary, is different to the concept of "spaces of engagement" described by Fowler (2000). "Spaces of engagement" refers to the conditions that enhance opportunities for engagement and shared learning and positions the parent as equal partners with the CFHN in the co-production of parenting practice (Fowler, Lee, et al., 2012, p. 9). The concept of a "mindful space is also different from the description of "emotional space" identified by Day et al. (2015, p. 167). "Emotional space" was described as the restorative effect on practitioners which resulted from participation in reflection on practice (Day et al., 2015). Reflective practice enabled practitioners a space to think and

reflect thereby assisting with the maintenance of enthusiasm for their partnership work with families (Day et al., 2015). This was also identified as an important factor by CFHNs in this study. However, the "emotional space" described by Day et al. (2015) occurs for the practitioner after the practitioner-parent encounter. In contrast, a "mindful space" provides the capacity to focus with expanded awareness and compassion (Geller & Greenberg, 2012) on the crucial and contemporaneous component of what is happening in the space between the CFHN and mother when working in in the FPM. "Mindfulness helps the therapist [CFHN] to be open, accepting, and present with one's self in order to be fully open, accepting and present with others" (Geller & Greenberg, 2012, p. 182). Mindfulness enables the CFHN to find the "space" and concentration for the negotiated relationship and emotion work that partnership with mothers entails.

The FPM group training program currently prepares health professional for their helping roles with families by explaining the "what" (the FPM framework), the "why" (the evidence behind the model) and the "how" (a step by step approach to implementation of the model in practice with parents) (Davis & Day, 2010; Davis et al., 2009). The FPM training program, therefore, tells CFHNs and other professionals who work with parents how to "do" the FPM. The *Family Partnership Model Reflective Practice Handbook* (Day et al., 2015) is a valuable and thoughtfully designed companion resource designed to facilitate health professionals to reflect, review and plan their use of the FPM in helping parents with their concerns. The *FPM Reflective Practice Handbook* aims to describe processes whereby supportive service managers, organisations and practitioners that work cohesively together to implement the FPM can improve effective services to families. It acknowledges the many challenges that exist for them to do this and describes processes for structured reflective practice that may aid sustainability of the FPM for practitioners (Day et al., 2015).

In a sense, this reflective practice resource assists health professionals such as CFHNs to look to their past and future use of the FPM in their helping work with parents. However, when caught up in the present moment of a consultation with a mother/baby, I argue *mindfulness* makes the difference to the CFHN's ability to "be" therapeutically and non-judgementally present (Hick, 2008; Zarbock et al., 2015) in family partnership with the mother rather reflection before or after a care episode alone. It is more than the CFHN preparing to be with the mother/baby, though this is acknowledged as an important element. The addition of mindfulness builds on the thoughtful concepts, framework and processes of the FPM (Davis & Day, 2010) as well as those outlined within the *FPM*

Reflective Practice Handbook (Day et al., 2015). Epstein (1999) in his seminal article on "*Mindful practice*" suggests that for practitioners, mindfulness is the "logical extension of the concept of reflective practice" (Irving et al., 2009, p. 61). Thus, being in the present moment may help the CFHN to stop dwelling on past or future events or other intrapersonal or external distractions and to focus attention on the here and now, that is, on the issues presented by the mother/baby during the consultation. Being mindful when communicating with mothers about themselves and/or their babies can *enhance safe care practices* (Rossiter et al., 2014) by being more attuned to what is said and unsaid in conversations. This greater capacity for attunement with mothers can be enhanced from the observance and practice of the five facets of mindfulness identified in the model developed by Baer, Smith, Hopkins, Krietemeyer, and Toney (2006). These five facets that include:

- Acting with awareness- being fully present to whatever you are doing;
- Observing- includes observance of intrapersonal emotions, thoughts, experiences and observing events, situations or objects;
- Describing - naming what you perceive simply, for example, tiredness;
- Non-reacting- learning to inhibit the tendency to react automatically to events including physical, verbal and mental reactions;
- Non-judging- being able to step back from one's initial evaluations of events (distressing, sad, joyful) and the subsequent thoughts and feeling which may result from them. (Zarbock et al., 2015, pp. 16-20)

Within this model, the five identified factors work to reinforce one another and support the central element of mindfulness which is "acting with awareness" (Baer et al., 2006; Zarbock et al., 2015). From my observations of study participants I concluded that Neroli and Virginia demonstrated these and the central element of mindfulness.

The current FPM is limited in its capacity to be used in all helping situations with parents (Grant & Luxford, 2008). Some health professionals also lack the ability to incorporate its theory and teachings into their practice (Davis & Day, 2010). I contend that what is missing from the existing FPM framework is an explicit reference to the concept and practice of mindfulness as a technique to enhance the practitioner's capacity for presence. As it stands, the FPM has a number of important limitations. It shows us how to "do" partnership but does not sufficiently address the frequently experienced issue of distraction when "with" parent/s. The Personal Construct Model (Kelly, 1955), an underpinning framework within the FPM (Davis & Day, 2010), is a psychological cognitive

theory designed to help people uncover and understand their own "constructs" or world views. It is indeed a very useful model within the FPM that can facilitate the CFHN to get a clear picture as possible of the parent's situation and constructions and facilitate change where needed in the way they construe their situation (Davis & Day, 2010). However, the Personal Construct Model does not offer the level of self-awareness and ability to focus required by the nurse when with the parent that is also critical to effectively work in the FPM. It's an intellectual, cognitive theory that doesn't provide a mechanism for self-care or for the nurse to develop greater self-awareness that the practice of mindfulness can offer (Cohen-Katz, Wiley, Capuano, Baker, Deitrick, et al., 2005; Irving et al., 2009; Irving et al., 2014; Santorelli, 1999; White, 2014). For example, Angela and Sandy may be less likely to be distracted when with mothers, be less self-critical and reactive when they become aware of being distracted (if practising mindfulness), and come back, with self-compassion, to the present moment. The practice of mindfulness facilitates the capacity to develop greater concentration and the ability to respond non-judgementally and with compassion to situations and to oneself rather than reacting as if on autopilot (Irving et al., 2009). *Non-judging of one's experience* is an attitudinal foundation of mindfulness practice (Hertzman & Power, 2003). As these authors explain:

> Mindfulness is cultivated by paying close attention to your moment-to-moment experience while, as best you can, not getting caught up in your ideas and opinions, likes and dislikes. (Hertzman & Power, 2003, p. 21)

The work of psychologists Rogers (1959) and Egan (1990, 2010), that also comprise the FPM framework, help to explain the qualities, presence, skills and helping process required when assisting parents with their concerns. However, despite these broad psychological underpinnings and other aspects of the FPM framework such as the service context and family characteristics identified in the current FPM (Davis & Day, 2010, p. 9), the current evolution of the FPM framework remains limited in its capacity to assist practitioners in their moment to moment awareness and presence when with parents. It proved difficult for most CFHN participants in this study to sustain the ability to work in the FPM with mothers due to the factors identified in the findings, which exist within the busy workplace and from their experience of the reality of their own bodies. My research findings lead me to propose that the FPM be extended to include mindfulness as the overarching concept and practice of the practitioner. I have diagrammatically represented this in Figure 5: The Mindful Family Partnership Model below.

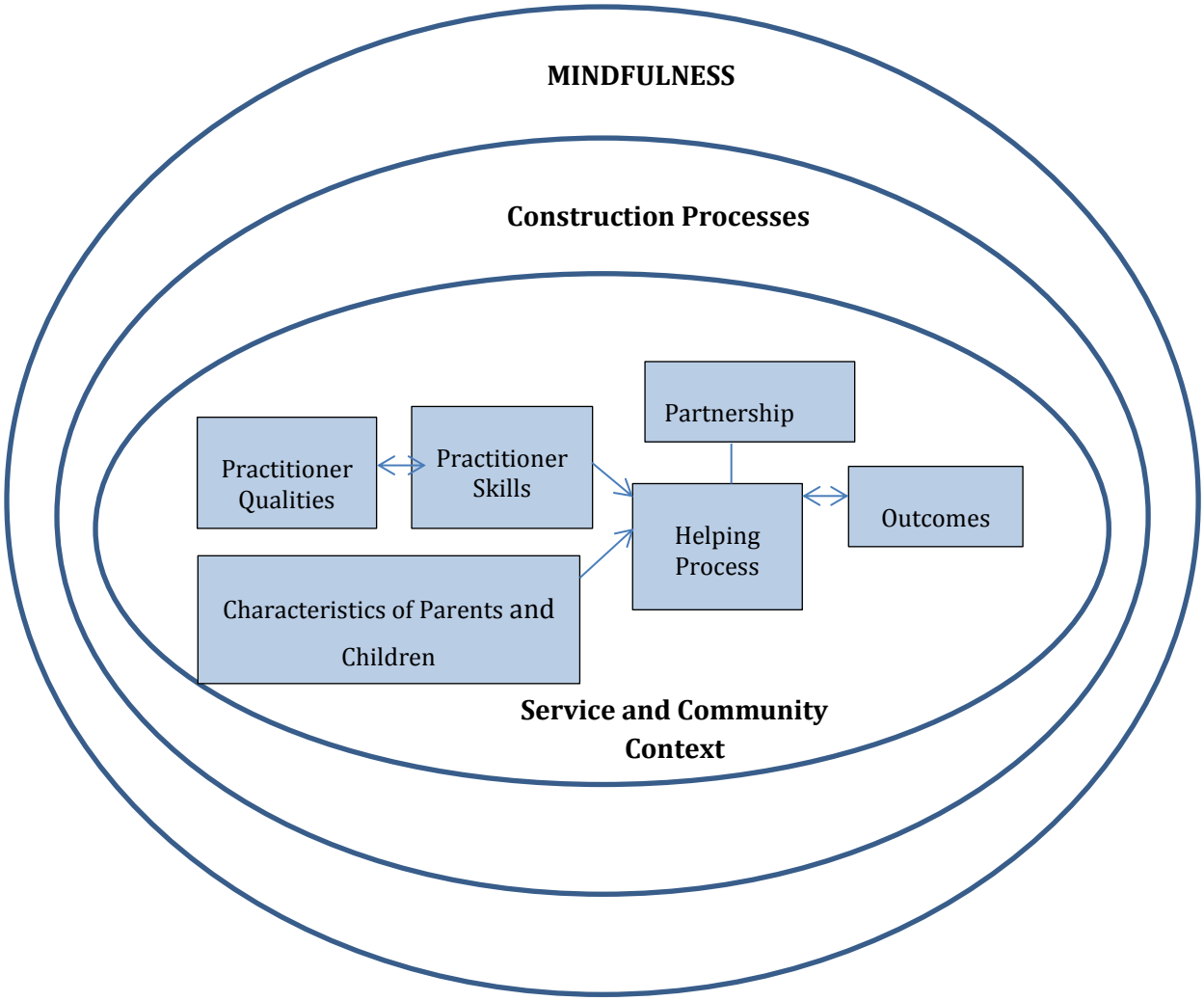

Figure 6: **The Mindful Family Partnership Model**

adapted from (Day et al., 2015, p. 9)

Figure 6 captures this new finding of the key role of mindfulness within the logical evolution of the FPM framework. In this model, mindfulness is shown to be fundamental to, and to encompass all aspects and processes of the FPM. This finding is the culmination of my research findings that answer the research question:

What are the factors influencing, and the nature of their impact, on the child and family health nurse's ability to work in partnership with parents, as described in the Family Partnership Model?

The existence and elements of a mindful space is the key to "The Mindful Family Partnership Model". It completes the original Family Partnership Model (see Figure 1, page 2) and captures the expertise displayed by Neroli and Virginia in this study. Effective implementation of the FPM by CFHNs calls for competency in the ability to build and sustain both the therapeutic relationship and therapeutic communication with mothers. Nurses need this capacity to listen deeply and jointly work with mothers to find the solutions for concerns they may have for themselves or for their baby/child. Based on my findings, I assert that regular mindfulness practice may help CFHNs to build this capacity to sustain empathy, listen deeply and respond effectively when working with mothers/babies (Irving et al., 2014).

Mindfulness is also now considered an important self-care practice for workers in helping professions such as nursing to prevent the stress and burnout commonly experienced (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2005; Escuriex & Labbé, 2011; Foureur et al., 2013; Irving et al., 2009). The emotional labour and exhaustion that is a key feature of burnout and that was highlighted in nurses' descriptions in this study, has been found to be powerfully impacted by mindfulness programs such as the *Mindfulness Based Stress Reduction Training* (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2005). Being mindful of relationships and communication may also improve CFHNs' interpersonal collegial relationships with peers and managers. I propose that further research be conducted to test the incorporation of mindfulness into the FPM theoretical model and training programs to determine:

1. Its effect on CFHNs' ability to build and sustain partnership with parents
2. Its effect on CFHNs' capacity for self-care
3. The effect of mindfulness training on the existing CFHN workforce in relation to their sense of well-being; and,
4. The impact of CFHNs' mindfulness practice on mothers/families/babies.

The proposal to implement mindfulness as an essential component of the FPM framework and CFHN practice is not intended to deny the presence of or perpetuate power asymmetries and/or constraining ideologies identified in this study that currently

adversely impact on CFHNs and their FPM practice. Likewise, I refrain from the stance of some critics who have labelled the growing popularity of mindfulness as "*McMindfulness"* (Purser & Loy, 2013). Critics have raised concerns that its secularised version has become mainstream; a "universal panacea" for all ills and used as a tool by corporations to boost employee productivity (Purser & Loy, 2013). Rather than adding to the burden of CFHN work, I propose that mindfulness may enrich the FPM and offer CFHNs an opportunity for greater self-awareness, self-compassion, self-care and nurturance. An enhanced ability for awareness, self-care and resilience may in turn provide CFHNs with a greater ability to build and sustain their family partnership work with parents. Consideration and recognition of the impact of CFHNs having consistently sufficient time to implement this approach during visits with families must occur at the State level. At present there is marked, inequitable discrepancy between services in the time allocated for the same CFHN child health check consultation. Further research is recommended to determine a transparently fair and reasonable amount of time to undertake CFHN consultations and work with mothers using a mindful, family partnership approach.

Frontline nurses such as CFHNs also need much greater consistency of organisational support and recognition of the need for the creation of the "mindful space" needed to provide the necessary body and emotional work (Varcoe & Rodney, 2009) that working in the FPM with mothers entails. In this study, two nurses demonstrated an inherent capacity for mindfulness which clearly benefited mothers as well as their own clinical practice and well-being. They appeared able to achieve this mindful presence despite the constraints of the workplace or intrapersonal distractions. Other nurse participants, however, were hampered in their ability to work in the FPM because of external workplace factors and/or intrinsic factors related to the reality of their bodies previously discussed. As Varcoe and Rodney (2009, p. 140) state "such space needs to be created for nurses who provide direct care rather than allocating the thinking space only to those who practice in roles removed from direct care".

5.5.7 MICROSYSTEM SUMMARY

A significant number of factors were identified at the microsystem that influence and impact on the ability of CFHNs' to work in the FPM with mothers. In this study, ageing and menopausal discourses of the CFHNs were identified as adverse factors. It appears that discussions of the experience of menopause and its effects on work performance within a predominantly female, mid-life CFHN workforce is absent from the research literature.

Therefore, the findings are novel in relation to factors that influence the CFHN's ability to work in the FPM with mothers.

Nurses reported experiencing symptoms of burnout from the increasing demands of their CFHN role and the body and emotion work of family partnership with mothers. A feeling of being overburdened and burnt out was amplified for this older cohort of CFHNs who may also be experiencing menopausal and other midlife issues associated with ageing. Nurses in this study also reported experiencing a value conflict arising from the inability to provide the care to mothers they felt was needed within the constraints of the workplace and performance targets. The experience of workplace value conflict is linked to burnout and detachment from the ability to empathise and care for mothers' well-being. It is also linked to attrition from the workforce. My research identified the incorporation of mindfulness as the logical evolution to the existing FPM framework and associated training. As a result of my findings, I identify mindfulness to be a key component in CFHNs' greater capacity for self-care, well-being and their ability to work in the FPM with mothers. My research demonstrates that mindfulness can be used as a strategy both personally and professionally by CFHNs in order to gain awareness and more effectively manage the emotional labour that arises in the course of their work. A greater moment to moment awareness of one's current thoughts, emotions as well as the external environment enables the possibility of compassionate responses both towards oneself and the other person/s or situation (Anthony & Vidal, 2010; Razzaque et al., 2013). Mindfulness practice assists health care providers to respond rather than react, potentially defusing work based sources of stress and increasing job satisfaction (Cohen-Katz, Wiley, Capuano, Baker, Deitrick, et al., 2005; Escuriex & Labbé, 2011; Hick & Bien, 2008).

5.6 SUMMARY OF APPLICATION OF BRONFENBRENNER'S (1979) ECOLOGICAL MODEL TO THIS STUDY

The application of Bronfenbrenner's (1979) Ecological Model enabled a systematic exploration of the factors impacting on CFHNs' ability to work in the FPM with mothers from the macro to micro level. There are direct corollaries with its use in this study and with the FPM itself. The FPM uses the same Ecological Model (Bronfenbrenner, 1979) to understand how "child, parent, family and community factors combine and interact to shape and influence developmental progress and outcomes" (Day et al., 2015, p. 19).

In this study, the use of the ecological model (Bronfenbrenner, 1979) enabled me to identify and consider the supporting and constraining factors that impacted on CFHNs and

their ability to work with mothers in the FPM. It also provided the capacity to examine factors that influence and impact on parents, especially mothers' ability to care for their baby/child, from a macro to micro level. Examination of these factors in this systematic way was important because it provided greater visibility at each of the systems' levels that either supported or constrained nurses' ability to work in the FPM with mothers; as well as identification of some of the supports and constraints impacting on mothers generally. Having a greater conceptual awareness of impacting factors on the FPM at the systems levels may assist organisations and managers to develop mechanisms to better support CFHNs and mothers to work together in partnership. A greater understanding of the constraints affecting their FPM practice may also help to emancipate CFHNs' from their experience of value conflict and foster the development of moral agency.

5.7 STUDY CONCLUSION

This study has added empirical knowledge about the factors influencing, and the nature of the impact, on the CFHN's ability to work in the FPM with mothers. The FPM was originally introduced in 2002 into CFHN practice and policy in NSW. It was implemented as an evidence based framework to assist their work of helping parents in response to the new *NSW Health/Families NSW Supporting Families Early Package – Maternal And Child Health Primary Health Care Policy* (NSW Department of Health, 2009). Its philosophy and the associated training were embraced by most CFHNs who believed in its altruistic intent and who genuinely wanted to work in the FPM with mothers/babies. For CFHNs in my experience and for the nurse participants in this study, the FPM was seen as a helpful framework that enhanced their ability for engagement and "caring" work with mothers and babies. However, organisationally, my study findings suggest that the FPM was introduced as a strategy imposed by the State on CFHN policy and practice that covertly assists in the active surveillance and regulation of populations. Nurses were asked to conduct this work in a faster paced, work landscape and culture where there were expanded maternal/infant assessments to conduct and targets for UHHVs to meet which reduced their ability to flexibly provide ongoing care to mothers/babies. The covert use of "governing from a distance" and rationalisation of services identified in this study is consistent with a neoliberal political economy. It was found in this study to be antithetical to nurses' emotion work with mothers/babies and for a number of CFHNs in my study, a value conflict which caused them to experience significant symptoms of burnout.

Significant historical and structural forces were identified as influencing societal and professional perceptions of the CFHN role. In this study, nurses identified longstanding

community and professional views that the CFHN role was invisible. It was also perceived to hold a lowly ranked status among other nursing specialties. These perceptions were linked to the gender, race and class features of the CFHN service. The CFHN was identified as a feminised role whose responsibilities encompassed the body and emotion work generally associated with "women's work". However, potential removal of aspects of this "hands on" bodywork to lower paid workers in a neoliberal economic environment, may threaten mothers' ongoing acceptability of the CFHN role. This is because mothers predominantly attend for the health and wellbeing of their child. They are, therefore, not generally cognisant that this is an important opportunity for CFHNs to also gauge mothers' health and well-being through evidence based surveillance mechanisms. This, in turn, will influence the ability of the CFHN to continue to work in the FPM with mothers.

The physical and cultural landscape of the workplace influenced CFHNs' capacity to implement the FPM with mothers. Inequity and limitations in the maintenance of the seven CFHN centre buildings, furnishings and office configuration were all factors which promoted or constrained the physical comfort and ease of engagement of both nurses and mothers/babies. There was sharp contrast between the design and upkeep of centres within the one LHD which was suggested by one nurse participant to be linked to political funding and vote seeking by governments in marginal electorates. This is significant as the research into the architecture on "healing spaces" is known to affect the wellbeing of both health care providers and service clientele.

Information and communication technology (ICT) programs were both a help and a hindrance to the daily work of CFHNs and were identified as influencing factors which impacted on their ability to work in the FPM with mothers in this study. Time for computerised documentation now took longer than their previous use of written medical records. However, in most centres there was no additional increase in the amount of time nurses had for consultations with mothers and babies. This occurred against a backdrop of an unexplained and unfair disparity among the centres in this study in the time allocated for the same type of child health check consultations. There was also significant difference in the use of office computers by individual nurses during their consultations with mothers: some not using it at all and others whose computer usage interrupted communication from lack of eye contact or attention. The main benefactor of the CFHNs use of computerised records and reporting systems appeared ultimately to be the organisation. It aids the governmental processes of calculation and measurement of

nurses' activity against set performance targets as well as assisting its surveillance of the population at a distance.

The mothers in this study, in contrast, did not identify nurses' computer usage during consultations as an issue. On the contrary, a number of the mothers recommended that CFHNs increase their sophistication and use of ICT to improve their capacity for communication at a distance. These mothers willingly shared with me their mostly positive experiences of care from their CFHN. They identified where improvements could be made to service delivery and regarding how nurses' conduct themselves at the first consultation with a new mother and baby. Recommendations were made by mothers to increase the visibility of CFHN services in the community and make them more accessible and relevant to internet savvy parents.

CFHNs in this study described their fatigue both physically and emotionally from the intensity of the helping work that partnership with mothers entailed. They identified constraints from the challenges faced in the regulation and discipline of their bodies to demonstrate appropriate family partnership with mothers. CFHNs are a cohort of mainly older women managing the challenges of midlife which included dealing with the effects of menopausal symptoms at work. The findings of my study identified that discussions of the experience of menopause and its effects on work performance within a predominantly female, mid-life CFHN workforce is absent from the research literature. Therefore, these findings are novel in relation to the influencing factors that adversely impact on the CFHN's ability to work in the FPM with mothers.

This fatigue and its effect on CFHNs' emotional availability for family partnership with mothers was compounded depending on their work environment and their interpersonal relationships with colleagues and managers. Nurse participants identified the detrimental effect on themselves and their ability to work in the FPM from working with managers and/or colleagues who demonstrated bullying and/or controlling behaviours. The nurse manager's support or otherwise for the FPM or other models of care was found to be pivotal to their ability to work in the FPM with mothers. The nurse manager in this study overwhelmingly supported the implementation of the FPM in her CFHN workforce. However, there were overtones of hegemonic control in the enforcement of the FPM with nursing staff to the exclusion of other models of professional and clinical practice.

Despite the numerous significant challenges identified to CFHNs' physical and emotional well-being, some nurses in this study demonstrated an observable capacity to sustain their

ability to work in the FPM with mothers/babies. This difference, I believe, was their innate attention to self-care, reflection and mindfulness. These three activities enabled these nurses to find crucial "mindful space" within a demanding work environment and constant distractions from their physical bodies to effectively work in the FPM with mothers. Mindfulness was evident in their demeanour and presence and was observed to enhance their capacity to be present with awareness and non-judgementally, when in consultation with their mothers/babies. As a result of my study, it is proposed that mindfulness be incorporated into the FPM theoretical model in order to:

- Enhance therapeutic presence and CFHNs' capacity to sustain an ability to work in the FPM;
- Reduce the toll of emotion work;
- Enhance CFHNs' sense of well-being and personal agency; and,
- Improve interpersonal workplace relationships.

5.7.1 Thesis Statement:

I developed the following thesis statement as a result of this study:

CFHNs are subject to multifactorial influences and stressors of an intrinsic and/or extrinsic nature that impact positively or negatively on their capacity to work in the FPM with mothers. My study found CFHNs are challenged by the reality of their bodies and undertake significant body and emotion work when attempting to work in the FPM with mothers. This occurs within a work environment influenced by a neoliberal economic and political system steeped in governmentality practices. Nurses identified experiencing symptoms of value conflict, potential burnout, and practice dissonance which negatively affected their ability for family partnership work with mothers. Findings from this study suggest that NSW Health and other agencies invested in the promotion of parenting capacity and the health and well-being of children, consider the implementation of processes that support and sustain the emotion work and FPM practice of CFHNs with mothers. My study findings suggest the practice of mindfulness as one such process. CFHNs' are largely constrained in their ability to work in the FPM framework with parents given their current work landscape and the distractions presented by their bodies. Mindfulness practice, however, if integrated with the FPM, could assist CFHNs find the essential "mindful space" and moral agency required to sustain family partnership work with mothers/babies as well as enhanced personal well-being and greater practice accord.

5.7.2 Study Aims Addressed

The first aim of this study was to:

1. Identify CFHNs and managers' views of the factors that may influence the ability of the child and family health nurse to work in the FPM with parents (mothers/fathers/babies) and investigate how these factors may impact on this ability in the practice setting.

This aim was comprehensively addressed through the interviews conducted with CFHNs in this study. The scope of the nurse managers' views was limited, however, as only one nurse unit manager participated. Nevertheless, this manager had very strong views and examples from practice as she was very committed to the sustainability of the FPM by CFHNs.

The second aim of the study was to:

2. Identify parents' experience of the relationship and interaction with the child and family health nurse.

Fathers did not volunteer to participate in this study. Therefore, the views of parents were limited to the mothers' evaluations of care from their CFHN. These views were obtained through interviews that I conducted following their consultation with their linked CFHN. Mothers had mainly praise for the care and attention received from their CFHN whom they came to regard as a "trusted advisor". However, they made two clear recommendations for improvements to the CFHN service. These were to ensure that nurses conducting the first visit establish a rapport for asking sensitive personal questions such as the maternal psychosocial assessment; and, to modernise and develop much more user friendly CFHN information technology systems in order to improve the capacity to engage and communicate in partnership with parents at a distance.

The third and final aim of the study was to:

3. Enable child and family health nurses and managers to reflect critically on developing and existing work practices, education processes and context and scope of practice in relation to the factors that influence and impact on their ability to work in the FPM with parents.

This aim was achieved in part from nurses' and the NUM's participation in this study through interviews and, from their reflections on their video recorded consultations. Nurses welcomed the opportunity participation in the study provided them to review their existing work practices and reflect critically on how it might be different and thereby enhance their ability to work in the FPM with parents. Nurses suggested (with some provisos), that future videorecording of their consultations may aid the structure of clinical supervision sessions through focussed reflection and discussion of practice. It was recommended that there were also more opportunities for FPM refresher education sessions. Nurses were frustrated and constrained by the expansion to the screening aspect of their roles and the need to achieve UHHV targets. These changes were identified as responsible for the reduction in their ability to provide flexible follow-up to vulnerable families and their challenged their ability to work in the FPM with mothers. A few nurses identified self-care and reflective strategies that helped them sustain family partnership work with mothers. The majority, however, reported an ongoing struggle with the physical and emotional toll that constant caring and helping of families engendered. Nurses did not have solutions to these systemic issues. The adoption of regular mindfulness practice as a self-care strategy is a potential solution to positively impact on CFHNs' general well-being and on their ability to work in the FPM with mothers.

5.7.3 Implications for Clinical Practice and Further Research

The findings from my study provide CFHN services with evidence of the need for greater congruence between the values, policies and performance measurements defined for them by the health institution. Nurses experience a value conflict between the policy-directed and time limited care they are mandated to provide mothers and babies with that of a parent led, family partnership model agenda. My study found the CFHN service was constrained by the effects of rationalisation from a neoliberal political economy at the time of data collection. Issues related to workload, human resource planning, and workplace bullying were identified that require further investigation. Further multi-site research is suggested to uncover the impact of health budget cuts on CFHN practice. These research findings can be taken up by CFHN leaders and professional bodies to provide a collective voice to the relevant government departments regarding the impact of reductions to health expenditure in relation to CFHN care of mothers and babies in the community. This is especially relevant when new policies and initiatives are introduced that add to CFHNs' already expanded workloads in the future.

The CFHN service requires congruence in the demonstrable measurements of performance that support and reflect the valuable care and emotional toil of CFHNs' family partnership work with mothers and babies. A greater visibility, awareness and acknowledgement by CFHNs and their managers of the toll of the physical and emotional labour inherent in their work is a first step toward strategies that may assist to manage these issues. CFHNs and managers have a responsibility to engage in debate at all levels about policies that affect them and their ability to obtain the "mindful space" for their FPM work with parents. This "mindful space" was found to be enhanced in nurse participants in this study whose practice included regular self-care activities, reflection and mindfulness.

There were limitations regarding the configuration of CFHNs' office space in relation to where the nurse and parent/s could sit comfortably to relax and talk during consultations. CFHN services and managers could consider taking cues from midwifery practice and interdisciplinary research (Harte, Leap, Fenwick, Homer, & Foureur, 2014) in the redesign of new CFHN centres. Midwifery birth spaces aim to promote feelings of calm and connectedness in both birthing mothers and midwives and to keep stress levels low in order to optimise conditions for normal labour and birth (Harte et al., 2014). Keeping stress levels low between mothers/babies and CFHNs may likewise foster "healing spaces" conducive to mindfulness and an enhanced ability to work in the FPM together.

CFHN participants identified watching the video recording of their consultations as a reflective practice development tool. This could be used in conjunction with a trusted clinical supervisor to deepen nurses' understanding of their communication, interaction and helping ability with parents/babies. Guidelines could be developed to explore this application within the CFHN service with a view to strengthening nurses' ability to work in the FPM with parents.

My research found mothers want a rapport developed with the CFHN before the sensitive maternal psychosocial questions are asked. Mothers also identified a clear preference for continuity of carer relationship with the CFHN. They want to continue the relationship and developing partnership established with their initial CFHN at the UHHV at their subsequent visits at the CFHN centre or home. This is another important lesson that can be learned from my research and from existing midwifery research and practice where caseload midwifery models have found improved outcomes for women and babies from continuity of care from the same midwife (Sandall et al., 2013). Lastly, mothers in this study clearly identified that the CFHN service needs to modernise and become better equipped in ICT modalities in order to meet the needs of contemporary Generation X and

Y mothers. A thoughtful approach to the upgrade of the CFHN service's use of ICT which includes consumer input is warranted to meet the needs of these internet and social media savvy parents.

My study identified the next logical evolution of the FPM framework to be the addition of mindfulness. It was identified as the overarching factor that influenced nurses' effective and sustained use of the FPM when assisting mothers with their concerns. Mindfulness encompasses the actions of a therapeutic practitioner and communicator when working in partnership with parents. There are numerous clinical implications for this fundamental addition to the FPM framework that warrant further research. Further research is needed to:

1. Explore the concept of mindfulness and its application to the FPM.
2. Explore the concept of mindfulness and its impact on CFHN practice including nurses' ability to work in the FPM with mothers, and its effect on nurses' well-being.
3. Explore the impact of CFHNs' exposure to mindfulness practice on parents and babies
4. Understand whether continuity of care by the CFHN during the infant's first year results in greater job satisfaction by CFHNs
5. Understand the impact of continuity of CFHN care on the mother's experience.
6. Explore the use of videoed consultations as an education and/or clinical supervision strategy. Consider using simulation (acting) of the nurse/parent roles.
7. Understand the Aboriginal and Torres Strait Islander experience of partnership within the Building Stronger Foundations (NSW Kids and Families, 2015) program.
8. Seek the views of rural and remote CFHNs and parents in future CFHN research studies where relevant.
9. Further investigate how and why some health professional groups appear to be able to exercise control and power regarding their appointment structures in comparison to others.
10. Determine the amount of time required to effectively conduct CFHN consultations and that aid working in the FPM with parents

11. Understand fathers' access and use of universal CFHN services
12. Develop CFHN service specific father inclusive practices and approaches which strengthen the parenting partnership
13. Explore parents' and CFHNs' views regarding the development of internet and social media applications including the greater use of smart phone technology and apps pertinent to CFHN care, communication and intervention with mothers, fathers and babies.
14. Have parents' participate in the development and trial of new CFHN software, social media and internet applications using action research methodology.

5.7.4 Study Strengths and Limitations

5.7.4.1 Design

This qualitative study has provided new insights into the views of metropolitan and regional CFHNs and mothers as well as one nurse manager on the factors influencing, and the nature of their impact, on nurses' ability to work in partnership with mothers, as described in the FPM. The use of video recordings of consultations provided opportunities for both the nurses and me beyond that of interviews, to reflect on practice and the micro processes that occur within interactions. In this study, my follow up interviews with mothers occurred either directly after their CFHN consultation, or within the next seven days. This proved a logistical challenge for me, however, when meeting other competing demands both at work and home. I observed that even one week's duration between the consultation and interview affected some of these new mothers' ability to recall specific events that had occurred. This is not surprising as new mothers undergo numerous psychophysiological changes in the postpartum period (Saxton, 2015); are transitioning to a major life change as mothers of newborns; and are often sleep deprived in the early weeks and months of parenting (McGuire, 2013). Impaired sleep is known to affect the ability to process new information and learning and, therefore, recall (Klumpers et al., 2015). This is prudent for future researchers to bear in mind when designing studies that includes the views of new mothers. Further exploration of issues identified in this study may also help to provide evidence for the future direction of the FPM as it and CFHN practice continues to evolve.

The use of focused ethnography was a strength of this study. It proved valuable because it enabled a concentrated depth of focus, thinking and interpretation on this specific area of nursing practice where I moved between the insider and outsider role. I required this focus to go beyond the face value of the analysis of transcripts and videos to recognise the constraints, power relations and ideologies that impacted on CFHNs' ability to work in the FPM with mothers. The limitation of the focused ethnographic method, however, was the amount of data generated and the additional time component that the systematic analysis of data required. Focused ethnographic methodology also limited the capacity for an in depth exploration of power and discourse within the study. A further limitation was the amount of travel I undertook during the study because I had to go so far out of my local LHD to recruit participants. Managing the logistical requirements of data collection at a distance was challenging whilst also working full time (Dowse et al., 2014). Lastly, I did not use data management software to help store and organise the data as I preferred a less mechanical approach. In future studies of this size, however, it may be more pragmatic to use NVivo™ 10 or similar for data management.

5.7.4.2 Participants

The participants in this study were female, middle class, educated Caucasians from urban areas. There was no representation of other cultural groups including Aboriginal and Torres Strait Islander nurses or mothers. This was a limitation of who volunteered to participate and the views of these groups are absent from the findings. In particular, the views of Aboriginal and Torres Strait Islander participants are underrepresented in studies of this nature. This underrepresentation, however, may be as a result of the NSW Health dedicated program called "Building Strong Foundations (BSF) for Aboriginal Children, Families and Communities (NSW Kids and Families, 2015). The BSF program, in partnership with local Aboriginal people, provides free, culturally appropriate, early childhood health care for Aboriginal and Torres Strait Islander parents and children (NSW Kids and Families, 2015). Therefore, they may be less likely to use mainstream CFHN services.

Research exploring the intercultural communication in CFHN services in Australia has previously been conducted and these insights have featured in the discussion of the findings (Grant, 2008, 2012; Grant, 2013; Grant & Luxford, 2008, 2009; Grant & Luxford, 2011). In particular, these authors have critiqued the use of the FPM in the context of CFHNs' intercultural communication with culturally and linguistically diverse (CALD) parents (Grant, 2008; Grant & Luxford, 2008, 2009; Grant & Luxford, 2011). The focussed

attention of these authors on intercultural communication and the FPM including the use of videography of consultations in their research means the lack of CALD participants in my study may be considered less of a weakness. However, it is acknowledged that the focus, study context, time period and methodologies of the two studies are not comparable.

As this study was conducted in urban and regional settings, there is an absence of rural and remote CFHNs' and parents' views on the issues pertinent to this study. A further limitation of this study is that only one nurse manager volunteered to participate and discuss her views about the factors influencing CFHNs to work in the FPM with mothers. Therefore, I have not been able to more comprehensively identify the full impact of the role of the leader (NUM) in environments in which the FPM is implemented. The nurse unit manager and all nurse participants in my study were supporters of the FPM. Therefore, the views of nurses and managers less positive or dismissive of the FPM were absent from the findings.

The other obvious absence in this study was that of fathers. This is considered a weakness of the study because fathers are generally the other crucial parent within the family unit and parenting partnership. Therefore, it is important to include their views in future research in relation to CFHN services and the well-being of their partner, new baby and themselves as new Dads.

5.7.4.3 Reflections on Being the Researcher

My background as a CFHN and FPM group facilitator was both a strength and weakness in the conduct of this focused ethnography. It was a strength because I had an insider's knowledge of the policies, systems and practice of CFHNs' and the conduct of child health checks with mothers and babies. I had a good working understanding of the FPM and some of the issues facing the sustainability of its practice by CFHNs at the beginning of the study. I had also conducted previous research [Master of Nursing (Research)], which included the use of the FPM in the CFHN context. I was encouraged by the CFHN participants and managers who were committed to the FPM to complete this study and share the findings with them. They were also interested in the potential for action resulting from the findings in relation to their practice and the FPM. The mothers too valued the CFHN service and were generous in sharing their views and recommendations for improvements to service delivery. The "working in partnership" focus and nature of the study facilitated all parties' learning from the shared encounters and discussions, especially my own.

I came to understand the weakness of having this insider's knowledge, however, when I found myself tempted to pre-empt interview questions or comment during participant observation during consultations. I also saw the limitation of being an insider when my supervisors challenged some of my critical judgements of nurses' practice and premature conclusions in relation to the findings. These personal insights were valuable as they served to highlight to me the power differential present between myself and the participants which I was then able to ameliorate. The growing focus of mindfulness and its application within the FPM and CFHN in this study was a constant reminder to me to be mindful of my own and others' wellbeing during this study.

5.7.4.4 Rigour

Rigour demonstrates the why and how [methodology] the findings of a study should be heeded (Mayan, 2009). Rigour within qualitative studies is commonly assessed using the criteria of credibility, transferability, confirmability and dependability (Lincoln & Guba, 1985). Credibility was maintained in this study through triangulation of data sources and perspectives. The study was investigated from the perspectives of CFHNs, the nurse unit manager and mothers. Data sources included interviews, observations, videotaped consultations and researcher field notes, study diaries and journals. Nurse participants' provision of feedback on their video-recorded consultations aided clarification, verification and depth to my observations of their interactions with the mothers and babies in the study. There were opportunities for participants to review their interview transcripts and make changes if needed. One nurse provided written feedback to me regarding changes to her interview transcript. However, the suggested comments consisted of corrections of typographical errors only.

Transferability was achieved through the provision of rich description of the participants and setting. Confirmability was attained from my detailed descriptions and rationale provided for recruitment processes, methods of data collection and analysis. Finally, dependability was obtained by maintaining detailed study diaries throughout each stage of the research. I also used a field journal and study diary to capture my activities, observations, decisions and growing capacity for reflexivity and mindfulness throughout the study. I attended regular meetings with my supervisors to discuss the progress of the study and they were invaluable in gently challenging my assumptions about my data analysis, findings and study conclusions. Finally, ethical approval was obtained and ethical and university processes for participant care were observed throughout the study.

5.7.5 Concluding Comments

Over the years this research took to complete I changed jobs, housing, had numerous overseas adventures, became a grandmother and a cancer survivor. Throughout, I was privileged as a result of this research, to retain a conscious [or subconscious] focus on "partnership" and its manifestation, in both personal and professional matters. Being able to embody "working with" and "being with" others in a compassionate and mindful way has grown to become a closely held personal value, although I acknowledge it is not always easy to demonstrate.

Since completing the data collection phase of my research I've changed careers and now work as a full time midwifery lecturer. The knowledge I have gained as a result of my study informs my relations with university and health district staff and students. It particularly informs my discussions with students regarding ways they can foster partnership approaches in their care of women and babies. Further, I am acutely aware of the challenges and stressors students face both clinically and academically and recognise the benefits that undertaking a mindfulness practice could provide them. I look forward to the creation of opportunities for further exploration of mindfulness and its application for student [and staff] well-being.

This thesis represents the voices of nurses and mothers who clearly valued the CFHN role and the philosophy and practice of working in partnership with parents. I am extremely grateful for their participation and willingness to share their views and experiences. They have greatly enriched my understanding of relationships and partnerships and how these apply to clinical practice and private endeavours.

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Appendices: Appendix A Letter of Authorisation

[redacted]

[redacted]

Dear Eileen,

This is to advise you that your proposed project titled:

'The influence and the nature of the impact of factors affecting the child and family health nurse's ability to work in partnership with parents', was discussed at the Xxxxxxx Xxxxxxx Area Child and Family Management meeting on 8th December 2009.

The meeting group raised concerns regarding two issues,

- The amount of time required for interviews with nurses and if these could be done in clinical time or out of hours
- The recruitment of families for the research project by child and family health nurses

In principle support for the research project was given by the meeting group with the following recommendations:

- There is flexibility in when interviews with child and family health nurses are conducted with clinical work taking precedence
- The researcher, that is Ms Guest[20], undertakes the recruitment of families. This could be done through either presentations at parenting groups or through the placing of notices requesting volunteers for the research project in child and family health settings.

Yours Sincerely

Xxxxxxx Xxxxxxxxxx

Area Clinical Nurse Consultant

On behalf of:

Xxxxx Xxxxx Xxxxx

Area Director Child and Family Health

[20] Please note my change of name. It was Eileen Guest at the beginning of the study and during data collection. It is now Eileen Dowse.

Professor Xxxxx Xxxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxxxx XXxxxxx
The University of Newcastle
Faculty of Health, School of Nursing & Midwifery
University Drive, Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Research Project Information Statement for the Child and Family Health Nurse Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxxx Xxxxxxx *School of Nursing & Midwifery* *Faculty of Health* *The University of Newcastle* Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxx xxx xxx Xxxx School of Nursing & Midwifery Faculty of Health The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

You are invited to participate in the research project identified above which is part of a study being undertaken as a component of Eileen Guest's PhD project at the School of Nursing and Midwifery at the University of Newcastle. The supervisors for this PhD project are Professor Xxxx Xxxxxx.

Why is the research being done?
The purpose of the research is to explore the factors that may influence the child and family health nurses to work in partnership with parents. Your participation may contribute to changes in nursing practice used in child and family health nursing in the future.

Who can participate in the research?
We are seeking child and family health nurses currently working in a permanent or contract basis in the Xxxxxxx Xxxxxx Xxxxxxxx Xxxx Service who have completed education in the family partnership model. Participating nurses are not accountable to the student researcher for management or practice issues.

If the numbers of nurses willing to participate in the study is greater than the expected numbers that are needed, then eligible nurses and managers will be recruited by drawing names out of a hat in the presence of the Chief Investigator of the project. Unsuccessful nurses will be thanked for their offer to participate.

What choice do you have?
Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you do decide to participate you may withdraw from the project at any time without giving a reason and you have the option of withdrawing any data which identifies you.

What would you be asked to do?
If you agree to participate, I will seek to attend one family consultation with you to observe the nature of the professional relationship that develops during this consultation. Observations may include the nature of conversations and interactions between the nurse and parent(s), processes observed in the home or Centre during the consultation, and the use of participants' verbal and non-verbal cues. With your consent and the consent of the family, this consultation will be video recorded.

You will also be asked to take part in two interviews at your child and family health centre or a venue of your choice. The first interview will be held prior to your consultation with a participating family. The second interview will be held after the consultation with this family. The purpose of the first interview is to obtain your views on the factors that may influence you to work in partnership with families and how these factors impact on your ability to work in partnership in the practice setting. This second interview will be held in order to seek your clarification on particular matters observed during your consultation with the participating client family and will be facilitated by the use of feedback from video recorded observations of this consultation. With your consent, interviews will be audio-taped. You may ask the researcher to stop the audio tape or stop the interview at any time. You may also ask the researcher to stop the video recording. You will also be invited to review the transcripts from your audio tape.

How much time will it take?
Each interview will take about 1 hour. The observations held during the consultation with the participating family may take slightly longer than the routine amount of time taken when conducting a home or centre based visit.

What are the risks and benefits of participating?
Nurses may benefit from participation in this research by viewing and reflecting on their clinical practice through discussion and the use of the videorecorded consultations. There are no anticipated risks to participating. However, should the child and family health nurse feel distress from issues that are the focus of the study; assistance can be obtained through regular workplace clinical supervision and/or the area health service employee assistance program. The interview will be stopped in the event of any distress occurring.

How will your privacy be protected?
During the period of the study all data will be stored on a password protected file on the researcher's computer. Your contact details and consent forms will be stored in a locked filing cabinet in the researcher's office. Only members of the research team will have access to electronic and document data (including video recordings). All information provided by participants will be confidential except where the nurse manager may need to be consulted if during the course of the study concerns arise regarding a nurse's clinical practice. Participants will not be reported or identifiable in the reporting of the research, unless they have provided their consent to be identified.

At the conclusion of the videorecorded consultation you will be offered the opportunity to:

- View your video image
- Have your video image edited prior to use
- Have your video images pixelated prior to use.
- Have your voice recording edited or dubbed prior to use.

You will be asked to specifically re confirm your consent at this time for the researcher to use the video recordings of the consultation.

All data, including video recordings used for conferences, will be destroyed 5 years following completion of the study; electronic data will be deleted from the computer system; and participants' contact details and consent forms will be destroyed following University of Newcastle procedures for shredding of sensitive documents.

How will the information collected be used?
The findings will be reported in the research thesis, project reports, nursing journals and conferences. Text data will be de-identified. A short summary of the outcomes of the study will be available to you if you would like to receive one. You can indicate your request for this summary on the attached consent form. Your video images and voice recording may be selected for use in conferences and /or workshops. You will be asked at the end of the videorecorded consultation to confirm your consent to use your video image or voice recording from the consultation in the manner outlined in this information statement.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher: Eileen Guest Phone: xxxx xxx xxx.

If you would like to participate, please complete the enclosed Consent Form and return it to the researchers in the enclosed stamped addressed envelope. I will then contact you to arrange a time convenient to you for the interview.

Further information

If you would like further information please contact:

Eileen Guest Xxxxx@xxxxxxxx.xxx.xx

Professor Xxxxx Xxxxxx Xxxxxx@xxxxxx.xxx.xx

Dr. Xxxxxx xxx xxx xxxx xxxxxx@xxxxxx.xxx.xx

Professor Xxxxx Xxxxxxx

Complaints about this research

This project has been approved by the Xxxxxxxx Xxxxxxx Xxxxxx Xxxxxxxxx, Approval **No. 1003-088M** and the University of Newcastle Human Research Ethics Committee **Reference No H-2010-1181** 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 the [redacted]

Appendix C Child and Family Health Nurse Consent Form

Professor Xxxxx Xxxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxxxx XXxxxxx
The University of Newcastle
Faculty of Health, School of Nursing & Midwifery
University Drive, Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Consent Form for the Research Project
Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxxx Xxxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxx xxx xxx Xxxx School of Nursing & Midwifery Faculty of Health The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

1. I,……

of.....……

agree to participate as a subject in the study described in the participant information statement attached to this form.

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the project at any time without prejudice to my relationship to the University of Newcastle and the Xxxxxx Xxxxx Xxxxxxx Xxxxxxx.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Eileen Guest on telephone xxxx xxx xxx, who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.
Complaints may be directed to:
Professor Xxxxxxx Xxxxxxxxx
School of Nursing & Midwifery, Faculty of Health, The University of Newcastle
Tel: xx xxxx xxxx

I consent to:

- Participate in an initial interview and have it recorded
- Participate in a subsequent interview that is recorded

Signature of subject **Please PRINT Name** **Date**

……

I consent to:

- Participate in a video recorded consultation with a family

Signature of subject **Please PRINT Name** **Date**

……

I confirm my consent that the video recording may be used in the manner described in the Participant Information Statement and that my video images and voice recording may be selected for use in conferences and /or workshops. I have been offered and consent to the following choices in relation to the use of my image and voice recording:

1. View my video image
   - □ Yes
   - □ No
2. Edit my video image
   - □ Yes
   - □ No
3. Have my video image pixelated prior to use.
   - □ Yes
   - □ No
4. Have my voice recording edited or dubbed prior to use.
   - □ Yes
   - □ No

I would like a summary of the findings at the conclusion of the research

- □ Yes
- □ No

I have had the opportunity to have questions answered to my satisfaction.

Participant Signature **Please PRINT Name** **Date**

……

Phone Number:	E-Mail:
Address:	

Professor Xxxxxx Xxxxxxxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxxxx Xxxxxxxx Xxxxxxxxxx
The University of Newcastle
Faculty of Health, School of Nursing & Midwifery
University Drive
Callaghan
NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Research Project Information Statement for the Child and Family Health Nurse Manager

Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxxxx Xxxxxxx School of Nursing & Midwifery Faculty of Health The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxxx xxx xxx Xxxx School of Nursing & Midwifery Faculty of Health The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

You are invited to participate in the research project identified above which is part of a study being undertaken as a component of Eileen Guest's PhD project at the School of Nursing and Midwifery at the University of Newcastle. The supervisors for this PhD project are Professor Xxxxx Xxxxxxx.

Why is the research being done?
The purpose of the research is to explore the factors that may influence the child and family health nurses to work in partnership with parents. Your participation may contribute to changes in nursing practice used in child and family health nursing in the future.

Who can participate in the research?
We are seeking managers of child and family health nurses currently working in a permanent or contract basis in the Xxxxx Xxxxx Xxxxxx Xxxxxx Service who have participated in education related to the family partnership model or who have knowledge of this model of practice.

If the numbers of child and family health nurse managers willing to participate in the study is greater than the expected numbers that are needed, then eligible managers will be recruited by drawing names out of a hat in the presence of the Chief Investigator of the project. Unsuccessful managers will be thanked for their offer to participate.

What choice do you have?
Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you.

If you do decide to participate you may withdraw from the project at any time without giving a reason and you have the option of withdrawing any data which identifies you.

What would you be asked to do?
If you agree to participate, you will be asked to take part in one interview at your usual place of work or at a venue of your choice. The purpose of interview is to seek information about your perceptions of partnership and what factors may influence the child and family health nurse to work in partnership with parents. Your views will be specifically sought regarding factors that may be present within the service and work environment that positively or negatively impact on the child and family nurse's ability to work in partnership with parents. With your consent, your interview will be audio-taped. You may ask the researcher to stop the tape or stop the interview at any time. You will also be invited to review the transcripts from your tape.

How much time will it take?
The interview will take about 1 hour.

***What are the risks and benefits of participating*?**
Managers may benefit from participation in this research by reflecting on their clinical practice through discussions with the researcher. There are no anticipated risks to participating. However, should the child and family health nurse manager feel distress from issues that are the focus of the study; assistance can be obtained through regular workplace clinical supervision and/or the area health service employee assistance program. The interview will be stopped in the event of any distress occurring.

How will your privacy be protected?
During the period of the study all data will be stored on a password protected file on the researcher's computer. Your contact details and consent forms will be stored in a locked filing cabinet in the researcher's office. Only members of the research team will have access to electronic and document data. All information provided by participants will be confidential and participants will not be reported or identifiable in the reporting of the research.

All data will be destroyed 5 years following completion of the study; electronic data will be deleted from the computer system; and participants' contact details and consent forms will be destroyed following University of Newcastle procedures for shredding of sensitive documents.

How will the information collected be used?
The findings will be reported in the research thesis, project reports, nursing journals and conferences. Text data will be de-identified. A short summary of the outcomes of the study will be available to you if you would like to receive one. You can indicate your request for this summary on the attached consent form.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher: Eileen Guest Phone: XXXXXXXXXX

If you would like to participate, please complete and sign the enclosed Consent Form and return it to the researchers in the enclosed stamped addressed envelope. I will then contact you to arrange a time convenient to you for the interview.

Further information

If you would like further information please contact:

Eileen Guest Xxxxx@xxxxxxxx.xxx.xx

Professor Xxxxx Xxxxxx Xxxxxx@xxxxxx.xxx.xx

Dr. Xxxxxx xxx xxx xxxx xxxxxx@xxxxxx.xxx.xx

Professor Xxxxx Xxxxxx

Complaints about this research

This project has been approved by the Xxxxxx Xxxxxxx Xxxxxxx Xxxxx Approval **No.1003-088M and the University of Newcastle Human Research Ethics Committee, Reference No: H-2010-1181.** 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 the [redacted]

Appendix E Child and Family Health Nurse Manager Consent Form

Professor Xxxxxx Xxxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxxxx Xxxx Xxxxxx
The University of Newcastle
School of Nursing & Midwifery, Faculty of Health
University Drive, Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Consent Form for the Research Project
Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxxx Xxxxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxx Xxx Xxx Xxxx School of Nursing & Midwifery Faculty of Health The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

1. I,……

of.....……

agree to participate as a subject in the study described in the participant information statement attached to this form.

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the project at any time without prejudice to my relationship to the University of Newcastle and the Xxxxx Xxxxx Xxxxxxxxxx Xxxxxxx.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Eileen Guest on telephone Xxxx xxx xxx who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to:
Professor Xxxxxx Xxxxxx (Chief Investigator and Supervisor)
School of Nursing & Midwifery, Faculty of Health, The University of Newcastle
Tel: xx xxxx xxxx

I consent to participate in an interview and have it recorded

I would like a summary of the findings at the conclusion of the research
☐ Yes
☐ No

Signature of subject **Please PRINT Name** **Date**

……

Phone Number:	E-Mail:
Address:	

Appendix F Parent Information Statement

Professor Xxxxxxx Xxxx
Chair Paediatric, Youth and Family Nursing
Xxxxx Xxxxxxxxx Xxxxxxx
The University of Newcastle
Faculty of Health
School of Nursing & Midwifery
University Drive
Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Research Project Participant Information Statement for the Parent:
Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxx Xxxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxx Xxxxxxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

You are invited to participate in the research project identified above which is part of a study being undertaken as a component of Eileen Guest's PhD project at the School of Nursing and Midwifery at the University of Newcastle. The supervisors for this PhD project are Professor Xxxxx Xxxxxxx.

Why is the research being done?
The purpose of the research is to explore the factors that may influence the child and family health nurse to work in partnership with parents. Your participation may contribute to changes in nursing practice used in child and family health nursing in the future.

Who can participate in the research?
We are seeking English speaking parents with children 0-5 years attending child and family health nursing services in the Xxxxxxx Xxxxxxx Xxxxx Xxxxxxx.

What choice do you have?
Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, your decision will not disadvantage you or affect the care you or your child receives from the child and family health nurse.

If you do decide to participate you may withdraw from the project at any time without giving a reason and you have the option of withdrawing any data which identifies you.

What would you be asked to do?
If you agree to participate, the student researcher will seek to attend a consultation held with your child and family health nurse either at your home or at the child and family health centre. The purpose of attending this visit is to observe the nature of the relationship between yourself and the child and family health nurse and observe the interactions and conversations that take place such as the use of verbal and non-verbal cues. With your consent, this consultation will be video recorded. You may ask the researcher to stop the video recording at any time

You will also be asked to take part in one interview at your home or a venue of your choice. This interview will be sought with you at a suitable date and time following the completion, and separate to, your consultation with the child and family health nurse. The purpose of this interview is to seek your views regarding your perception of the relationship and interaction that occurred with the child and family health nurse during your consultation. For example, did you feel listened to, were you asked about your health goals. This interview will also be audio taped with your permission. You may ask the researcher to stop the audio tape or stop the interview at any time. The audio taped data will be transcribed and you will be invited to review the transcriptions of the tape.

How much time will it take?
The consultation with your child and family health nurse may take slightly longer than the routine amount of time it takes to have a home or centre based visit. The interview will take about 1 hour.

What are the risks and benefits of participating?
There are no anticipated risks or benefits to you in participating in the study.

How will your privacy be protected?
During the period of the study all data will be stored on a password protected file on the researcher's computer. Your contact details and consent forms will be stored in a locked filing cabinet in the researcher's office. Only members of the research team will have access to electronic and document data (including video recordings).

At the conclusion of the videorecorded consultation you will be offered the opportunity to:

- View your video image
- Have your video image edited prior to use
- Have your video images pixelated prior to use.
- Have your voice recording edited or dubbed prior to use.

You will be asked to specifically reconfirm your consent at this time for the researcher to use the video recordings of the consultation.

All data, including video recordings used for conferences, will be destroyed 5 years following completion of the study; electronic data will be deleted from the computer system; and participants' contact details and consent forms will be destroyed following University of Newcastle procedures for shredding of sensitive documents.

If you should raise any underlying issues of concern during the interview, sources of support may be suggested. This may include your general practitioner and/or other relevant government and non-government agencies. The manager of the child and family health nursing service may also be contacted regarding this issue. Options for your further support will be discussed with you.

Observations will be made on the interactions that occur during the consultation held with the child and family health nurse at your home or at the Centre. If at any time during the study, participants report incidences of illegal behaviour or the researcher has a concern for the safety, wellbeing and welfare for an infant or child participating in the study, the researcher may be obliged to report the information to the community services or the police. The manager of the child and family health service may also need to be contacted if any of these issues arise.

How will the information collected be used?
The findings will be reported in the research thesis, project reports, nursing journals and conferences. Text data will be de-identified. A short summary of the outcomes of the study will be available to you if you would like to receive one. You can indicate your request for this summary on the attached consent form. Your video images and voice recording may be selected for use in conferences and /or workshops. You will be asked at the end of the videorecorded consultation to confirm your consent to use your video image or voice recording from the consultation in the manner outlined in this information statement.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher: Eileen Guest Phone: xxxx xxx xxx.

If you would like to participate, please complete the enclosed Consent Form and return it to the researchers in the enclosed stamped addressed envelope. I will then contact you to arrange a time convenient to you for the interview.

Further information

If you would like further information please contact:

Eileen Guest Xxxxxx@xxxxxxx.xxx.xx

Professor Xxxxx@Xxxxxxxxx.xxx.xx

Dr. Xxxxxxxxxxxx@xxx.xxx.xx

Professor Diana Keatinge

Complaints about this research

This project has been approved by the Xxxxxx XXX Xxxxxxxxx Approval **No. 1003-088M** and the University of Newcastle Human Research Ethics Committee **Reference No H-2010-1181** 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 the Human Research [redacted]

Appendix G Parent Consent Form

Professor Xxxxxx Xxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxxx X xxxxxxx
The University of Newcastle
School of Nursing & Midwifery, Faculty of Health
University Drive, Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Consent Form for the Research Project Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxxx Xxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxx Xxx Xxx Xxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

1. I,……

of.....……
agree to participate as a subject in the study described in the participant information statement attached to this form.

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the project at any time without prejudice to my relationship to the University of Newcastle and the Xxxxx Xxxxxx Xxxxxxxxx Xxxxxxx.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Eileen Guest on telephone xxxx xxx xxx who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to:
Professor Xxxxx Xxxxxxx
School of Nursing & Midwifery, Faculty of Health, The University of Newcastle

Tel: xx xxxx xxxx

I consent to:

- Participate in an interview that is recorded

Signature of subject **Please PRINT Name** **Date**

……

I consent to:

- Participate in a video recorded consultation with the child and family health nurse

Signature of subject **Please PRINT Name** **Date**

……

I confirm my consent that the video recording may be used in the manner described in the Participant Information Statement and that my video images and voice recording may be selected for use in conferences and /or workshops. I have been offered and consent to the following choices in relation to the use of my image and voice recording:

1. View your video image
   - □ Yes
   - □ No
2. Edit your video image
   - □ Yes
   - □ No
3. Have your video image pixelated prior to use.
   - □ Yes
   - □ No
4. Have your voice recording edited or dubbed prior to use.
   - □ Yes
   - □ No

I would like a summary of the findings at the conclusion of the research

- □ Yes
- □ No

I have had the opportunity to have questions answered to my satisfaction.

Signature of subject **Please PRINT Name** **Date**

……

Phone Number:	E-Mail:
Address:	

Appendix H: Research Flyer

Study Title

Parents and child and family health nurses working in partnership

Dear parent,

You are invited to participate in a research project carried out by Eileen Guest as part of her doctoral work at the University of Newcastle. The project is investigating how child and family health nurses relate to parents and children attending the child and family health nursing service.

The study intends to look at what sort of relationships develop between nurses and the families they visit and is hoped in the longer term to improve the care you and your baby/child receive. If you agree, Eileen will observe a visit you have with your child and family health nurse that is video-recorded, either at your home or the Centre, whichever is convenient to you. You would also be asked to participate in an interview with Eileen that is audio-recorded lasting approximately 1 hour.

If you would like to participate or find out more about the project, please contact Eileen on Phone: xxxx xxx xxx

Further information

If you would like further information you may also contact Eileen's research supervisors:

Professor Xxxxx Xxxxxxx Chair Paediatric, Youth and Family Nursing Xxxxxx Xxxxxx Xxx Xxxxxxx The University of Newcastle Faculty of Health School of Nursing & Midwifery University Drive Callaghan NSW 2308 Australia Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxx Xxx Xxx Xxxx School of Nursing & Midwifery Faculty of Health The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx

Appendix I Child and Family Health Nurse *First* Interview Prompts

- The nurse is reminded of the researcher's role and topic of research
- Ask the nurse if he/she considers he/she does work in partnership and why he/she thinks this?
- Ask the nurse about his/her experience of working in partnership with parents
- Ask the nurse how he/she would describe the culture of the organisation or any cultural aspects that might influence practice
- Ask the nurse about what he/she thinks the factors are that influence him/her to work in partnership with parents
- Ask the nurse about how these factors may impact on her ability to work in partnership in the practice setting
- Ask the nurse for his/her ideas about how any issues they might raise might be addressed in relation to working in partnership with parents

Appendix J Child and Family Health Nurse *Second* Interview Prompts

- Thank the nurse for her participation and ask for his/her views on the consultation held with the parents
- Asks their perceptions about the nature of the relationship developed with the parents during the consultation
- Ask for concrete examples (using the video recording of the consultation to assist recall) of where the nurse used elements of the partnership approach during the consultation
- Ask the nurse about what he/she thinks the factors are that influenced him/her to work in partnership with the parents during this consultation
- Using the video recording to assist recall, ask the nurse to clarify particular issues that may have arisen during the consultation in relation to working in a partnership approach with the family
- Ask the nurse for his/her ideas about how any issues they might raise might be addressed in relation to working in partnership with parents
- The nurse is thanked for his/her participation.

Appendix K Manager Interview Prompts

- The manager is reminded of the researcher's role and topic of research
- Ask the manager about his/her perceptions of the factors that influence the child and family health nurse to be able to work in partnership with parents
- Ask the manager about how these factors may impact on his/her child and family health nursing staffs' ability to work in partnership with parents in the practice setting
- Ask the manager for specific work place or environmental factors and examples of these factors that may influence the child and family health nurse to be able to work in partnership with parents
- Ask the manager how he/she would describe the culture of the organisation or any cultural aspects that might influence practice
- Ask the manager for his/her ideas about how any issues they might raise might be addressed in relation to his/her child and family health nursing staffs' ability to work in partnership with parents in the practice setting
- The manager is thanked for his/her participation.

Appendix L Parent Interview Prompts

- Greetings, reminder about research topic, thank for participating
- Ask for his/her/their views on the consultation held with the nurse – any benefits/issues
- Ask about their perceptions of the nature of the relationship developed with the nurse during the consultation
- Ask for concrete examples of where he/she/they felt listened to/not listened to during the consultation
- Ask for examples where they felt /perceived they were being treated as partners in the consultation
- Ask the parent for his/her/their ideas about issues they may raise in relation to developing a helpful relationship with the child and family health nurse
- Thank the parent for his/her/their participation.

Appendix M Summary of Study Findings for Participants

Please find a brief summary of the research findings. Thank you again for your generous participation in this study.

Short Title:

The factors influencing, and the nature of the impact, on child and family health nurse's ability to work in the Family Partnership Model with parents

Nine child and family health nurses (CFHNs), one child and family health Nurse Unit Manager and nine mothers with babies aged between five and nine weeks participated in the study.

The analysis of the audio recorded interviews and video recorded consultations of nurses and mothers/babies identified four main themes. These are presented with a short summary of each below. Please note, however, the first three themes are drawn from the nurses and manager's contributions. The fourth theme specifically represents parents' contributions.

1 The CFHN work environment and culture

2 Managing the body: CFHN body work and partnership practice

3 A mindful space

4 The mothers' evaluation of CFHN care

Theme 1 The child and family health nursing work environment and culture

The first theme relates to the culture and work situation that influence and impact on CFHNs' ability to work in the Family Partnership Model (FPM) with mothers. People that CFHNs encounter and interact with in the work environment form the "other" half of the professional relationship with the nurse. The three key groups of "others" identified in the findings include the CFHNs' colleagues, managers and client parents/infants. Nurses described how individuals in these groups could imbue them with a sense of support and personal gratification or conversely, be a source of stress that detracted from their ability to work in the FPM with mothers. Nurses, for example, identified work environments where colleagues and/or managers exerted powerful, controlling influences that required them to resort to using subversive strategies in their clinical

practice. Some nurses had managers very supportive of the FPM who modelled it in their own interactions with their staff. Other nurses reported having more adversarial managers in the past that did not “walk the talk” but instead were reported to have bullied the CFHNs in their team. What the mother/child brought with them to the professional relationship with the CFHN was also identified, not surprisingly, as factors highly influential to the nurses’ ability to be able to work in the FPM with them.

The physical workplace of CFHN centres and the use of computers influenced CFHNs’ capacity to be present with the mother during the consultation. Nurses reported feeling constrained by limitations to office layouts including the location of the computer, the comfort of the chairs available for parents and whether there was air conditioning on the premises. Despite the benefit of having client records at their fingertips, nurses voiced frustration at the amount of data that was now required to be entered onto computers. This requirement shortened the time available for discussions with the mother as data entry needed to be factored into appointment times. Some nurses mentioned the distraction from working in the FPM with the mother when they had competing demands of knowing that assessment tasks required completion and that time was passing.

The views of nurses and the NUM differed regarding whether there were, in fact, barriers present to working in partnership. Some argued that everything could be answered by going back to the FPM and that the use of the word “barrier” was an excuse for saying that things were just “too hard”. There were, however, tangible differences in the various work environments of these nine nurses. For example, three nurse participants from one team had sixty minutes to perform the six-eight week child health check whereas the remaining six nurses across the other two CFHN teams from the same Local Health District had half this amount of time with just thirty minutes allocated. There was no rationale for this thirty minutes time difference. However, these differences appeared to have a significant bearing on nurses’ job satisfaction overall; and were impacting factors identified as influential to whether or not they felt it possible to put partnership into practice with mothers.

Challenges were reported by all nurse participants in meeting their role requirements whilst keeping a partnership focused approach with mothers. Nurses identified discordance with the performance targets and policies set by NSW Health while being expected to work in the FPM with parents. At the time of the interviews, nurses found the amount of screening and assessments required, particularly at the Universal Health Home Visit (UHHV), to be challenging when a rapport was not yet established with the

mother. Some nurse participants were able to recognise these challenges and had adjusted their clinical practice accordingly. Others identified difficulties working in partnerships with so many checklists to complete. Nurses recognised that data entry was necessary for external validations of the worth of the CFHN service. However, family partnership, which is a relationship based communication approach with parents, was identified by two CFHNs as unable to be calculated by external measures. These factors associated with the nurses' changed and expanded role as a result of policy changes regarding UHHV and increased assessment requirements, were overall reported as influences that adversely impacted on their ability to work in partnership with mothers.

Sustainability issues were revealed regarding working in the FPM with mothers when there were few chances to revisit the model once the initial training was completed. For the CFHNs in this study, the initial training had been completed more than four years earlier. All nurses identified that clinical supervision, team meetings and access to education helped to reinforce their family partnership practice. However, there were reported limitations with clinical supervision as a support mechanism. While reported as valuable in affirming practice, its limitation was that it was generally a group session for one hour, once per month that in some instances, also incorporated case review. Hence, this one hour timeframe was difficult for nurses to discuss individual client or workplace issues when there was limited time and airspace to share with colleagues. The use of videoed consultations was suggested by some nurses as a potentially valuable addition to reflection on practice during clinical supervision that could enhance nurses' partnership skills with parents. Two nurses expressed caution though that that this should only occur during individual supervision sessions. There were competing demands for education timeslots at education inservice sessions. Some CFHN participants, said that it was easy for them to slip back into "fix it" or expert modes of practice and forget their partnership skills when feeling rushed and time pressured when working with mothers. Despite these partnership practice "lapses", overall, the CFHN participants in this study endeavoured to the best of their ability to work in the FPM with their linked mothers/babies. However, the gaps present in the education and support structures of the CFHN workforce to sustain working in the FPM made this difficult for most of the nurses and, therefore, are identified as factors adversely influencing their ability to work in the FPM with mothers.

Theme 2 Managing the body: CFHN body work and partnership practice

The second theme relates to the various ways nurses experienced and regulated their bodies within the challenges of the work environment, in order to conform to the body work necessary to demonstrate partnership. This includes the challenges for nurses to holistically conceptualise, integrate and implement an embodied FPM practice given the constraints of their workplace; of their own understandings of the FPM; and; their own bodies' available physical, emotional and psychological energy to implement the FPM with mothers and their children.

CFHNs identified during interviews a range of conceptual understandings of the FPM. This was partly attributed to the lack of refresher education on the FPM. There was also a corresponding range of integration of the FPM into nurses' embodied practice during their video-taped consultations with mothers/babies despite these CFHN participants expressing a clear commitment to working in the FPM with parents. Some nurses identified at their follow-up interviews when they had been more task than partnership focused during the consultation held with their participant mother/baby. They expressed frustration and were perplexed as to how to better manage their consultations in order to be more present in partnership with mothers. One CFHN also expressed confusion regarding the deployment of her clinical expertise in the context of working in partnership with parents.

CFHNs discussed the reality of coping with the limitations of their physical bodies and the challenges that this presented for embodied partnership practice with mothers. The nurses in this study were all in the vicinity of being middle aged. They discussed the reality of managing the necessary body and emotion work[21] when trying to work in the FPM with mothers when feeling tired and drained, particularly at the end of the day. One nurse disclosed how her own mental health status and aversion to conducting the maternal psychosocial screening assessment could adversely affect her capacity for partnership causing her to feel "*disconnected*" and another nurse to be *"not in a good head space"* with the mothers at times. One nurse discussed her difficulty dealing with menopausal symptoms and coming to work "*feeling not up to par"*. It is conjectured that a number of the CFHNs in this study may have also been experiencing peri-

[21] Emotional labour (or emotion work) requires workers to induce or suppress their feelings in order to sustain the outward expression that produces the proper state of mind in others (and) the sense of being cared for in a warm and safe place (Hochschild, 1983). It refers to the process by which workers are expected to manage their feelings in accordance with organisationally defined rules and guidelines.

menopausal symptoms that may at times adversely impact on their ability to work in partnership with mothers. Challenges in regulating the body in response to the stressors within the work environment placed these nurses at risk of experiencing burnout symptoms which adversely impacts on their ability to work in the FPM with mothers and babies.

Theme 3 A mindful space

Creating “a mindful space” for working in partnership with parents was identified as the third theme of this study. Despite the structural challenges present within the CFHN work environment and the reality of their physical bodies, three of the nine nurse participants were able to demonstrate a high level of reflective practice and ability to be in the present moment in partnership with their client mothers and babies. The FPM does have a strong focus on the importance of reflective practice for clinicians. However, having a theoretical model that is infrequently visited through education and/or clinical supervision does not help to embed FPM concepts or integrate it in a sustainable way into individual CFHN’s practice. The study findings identified that what may enable nurses’ ability to find the necessary “space” for partnership is the practice of mindfulness. This suggestion acknowledges, however, that the health institution has responsibilities to provide the necessary leadership and work conditions to support CFHN staff if they wish them to practice the FPM in its entirety with mothers and babies/children.

None of the three nurses in this study who practiced at the very skilled end of the partnership continuum specifically spoke of having a mindfulness practice. They did, however, speak of daily self-care activities and skilful workplace habits that enabled them to refresh and focus between consultations in order to be fully present in the moment with each mother/baby as best they could. It is suggested that to build sustainability of FPM practice in the CFHN service that the FPM evolve to include a mindfulness component: both as part of its theoretical underpinnings; and, as part of initial and ongoing education and supervision of staff. Partnership work with mothers may help to instil parallel partnership behaviours between mothers and their children. Similarly, practising mindful ways of being with mothers may help to instil similar practices for them with their children (Kabat-Zinn & Kabat-Zinn, 1997). It is suggested that the implementation of mindfulness into the FPM and subsequent training programs may also be nurturing for the CFHN. It may enable more CFHNs to give themselves permission to pause and refocus at times throughout their work day; to enable “a mindful space” for themselves as well as a greater capacity to work in partnership with

each and every mother and baby as well as their colleagues and managers. This may provide a welcome respite for nurses working within a continually demanding and changing work environment and culture.

Theme 4 The mothers' evaluation of CFHN care

Overall, the mothers who participated in this study said they found their experiences of their baby's six-eight week child health check consultation with their CFHN as positive. In most instances, this relationship was described as being professional while being friendly and the nurse considered as a "trusted advisor". Mothers appreciated the other services offered at the CFHN service including the parent group programs.

The mothers gave concrete suggestions for improvements to the delivery of CFHN care. These suggestions are factors likely to be influential to nurses' ability to establish partnership based relationships with other mothers. The suggestions included: ensuring that nurses strive to develop a rapport at the first home visit *before* asking the maternal psychosocial assessment questions. These questions should also be asked in a conversational manner rather than as direct, closed questions. One of the main recommendations from mothers was that CFHN Services should improve their communication processes through the implementation of internet based services and technology. This would have more relevance to this generation of young women and parents who were used to web based communication on mobile devices such as smartphones with each other and expected it from their clinical providers. The availability of modern information and communication technology systems could help CFHNs to achieve partnership with parents from a distance.

Dear participants,

Your contributions to this study have enhanced understandings of the nature of the work of child and family health nurses in NSW. It has shed light on the influences, and the nature impact of these, on child and family health nurses' ability to work in the Family Partnership Model with parents. It also represents the views of a small, but important group of mothers who have generously provided clear recommendations for improvements to Child and Family Health Nursing Services. If you would like to make comment on these findings or wish to discuss them further, please email me at Eileen.Dowse@newcastle.edu.au

Again, my sincere thanks to each of you for joining me in this research project.

Eileen

Appendix N – Excerpts of Analysis Phases 1-3

PHASE 1: FAMILIARISING MYSELF WITH THE DATA

- **Example entry:** CFHN First Interviews prompts (Appendix I): Ask the nurse about his/her experience of working in partnership with parents.
  "…because of the nature of the work, it's quite…because it's …sitting and hearing families' distress or… listening is quite an exhausting job". (Monica, 1st Int. p.23)

PHASE 2: GENERATING INITIAL CODES

- **Example of early grouping of ideas and coding entry:** "A *first visit is very hard* to be …*it's very hard to use partnership*. *There's lot of pressure to get…information out of the visit, give them information and get out of there for your next visit. So I've found … some visits that it's too stressful to use"* **(**Monica, 1st Int., P9).
  Coded for: Meeting UHHV targets; Get information; Stressful and hard to work in partnership on some first visits.

  My reflections (in red font) from reading transcript*:* Monica talks about the FPM as a set of skills that can be *turned on and off* when needed, e.g. hard to use them during UHHV as too much content to cover and questions to ask parents.

- **Example entry of initial coding for "*Influence of Manager*"**
  "We're really fortunate. Our manager really supports family partnership. I think if your management has an understanding of it and is supportive … all the other things can flow on." (Virginia, 1st Int.)

  "[Managers]….*are mostly supportive but some managers have bullied staff. I had huge issues with bullying happening* [from previous manager]". (Annie, 1st Int.). *Reflection*: Goal of team is to work in partnership but in the last two years prior to current NUM there was some workplace bullying and Annie had considered "moving on".

Example entry of coding and my reflections within *"Summary Table of Emerging Themes - CFHNs' First Interviews"*

Factors influencing	Nature of Impact		Discussion /Recommendations (of participants)	My Reflections
	Positive	**Less Positive**		
CFHN Colleagues	*"We have supportive team members".* [Virginia] [Collegiality of co-workers] *"*At this centre *it's very democratic."* [Monica] *"The family partnership model it's with us as a service"* [Neroli] [gave example of starting with 1st client phone call] *"I think working with the colleagues you know, that are of similar like-mindedness and also you know, built a very similar rapport to the way you do*,[makes following on with client easier]. [Erica] Colleagues with a similar philosophy and attitudes	*"Fearful colleagues will overhear her conversations with families"* [Angela] *Discussed subversion by colleagues and use of power and control at team meetings.* [Angela] *'Nurse colleagues with strongly held views & beliefs:* [e.g. on breastfeeding] *"they don't hear what mothers are saying"* [Annie]	**Team work** *"Within our team, you may try and spread the load and help support less experienced staff and make time for them".* [Monica] **Changing/challenging colleagues behaviour** *"Managing other colleagues' behaviour* [who are flippant about the model] *by 'modelling the model' and encouraging them to be a little reflective."* (Neroli, 1st Int. p 5)	*There is no designated Clinical Nurse Consultant (CNC) for one of CFHN teams in this study and no nurse educator. Therefore, different nurses take on responsibility for different aspects of training new staff etc.* Neroli tries to minimise impact of colleagues on client outcomes by mirroring what colleagues say to avoid parent confusion. Power rhetoric discussed: breastfeeding, needs of mother vs child, sleep, staff beliefs and staff contradicting one another. Annie has knowledge that other CFHN will give conflicting advice to parents (Annie is talking about staff with passionate beliefs about breastfeeding)

- **Example of grouping:** ***Researcher Notes of Videographed Consultation of Neroli and Lisa (mother) and Baby Poppy / Neroli's Second Interview***

Position: Neroli is tall. She notes during her second interview that although her seat is at its lowest point she is still not at same eye level as the mother but sits a bit taller.

Gaze: Mutual relaxed gaze.

Body language: Neroli leans in frequently; Neroli and Lisa often have legs crossed in synchrony. Neroli has hands loose and relaxed in her lap, notes that she is often nodding in agreement or encouragement of parent. Lisa had to stand to rock and console Poppy for quite some time in the beginning of the hour consult and after baby had been examined. This was not stressful and Poppy was relaxed once breastfed. (The video was turned off briefly at Lisa's request while she was latching the baby).

Interaction: Very comfortable with each other. Lisa very open and Neroli displays warmth and empathy while been calm and confident in her practice.

The way they speak, accents, tone, busy or relaxed. Did not appear at all rushed today – Lisa speaks quite animatedly but was open.

Landscape of the room: Felt a bit crowded in room. Usual set up of mother's chair back against wall beside nurse's computer desk. Neroli sat at the end of the desk close to mother with just corner of desk available to jot into baby's PHR. They are almost sitting front on with each other with knees touching…Neroli leaning in at times. Lisa sits back nursing Poppy over her shoulder when she is not standing

Example entry*: Table of CFHN 2nd Interviews and Parent Interview*

Interview Question: Describe the nature of the relationship developed with the nurse/mother during the consultation	
CFHN 2nd interview - Neroli	**Parent Interview - Lisa**
"*We have a relationship yet are still strangers; yet they trust us and here* [watches video] *Lisa has truly shared* [not filtered her information]; *it was a true reflection."* [Neroli]	"*I get along very well with Neroli. She's very supportive and I can open up comfortably with her. She helped me through when I had mastitis with my last baby. I've stuck with her as much as I could*." [Lisa]

PHASE 3: SEARCHING FOR THEMES

Example entry*: Data Synthesis Table*

Factors Influencing	Nature of Impact						
	Nurse 1st interview NUM interview POSITIVE	Nurse 2nd Interview & Mothers' Interview (blue font) POSITIVE	Nurse 1st interview NUM interview LESS POSITIVE	Nurse 2nd Interview & Mothers' Interview (blue font) LESS POSITIVE	CFHN 1st First interviews; CFHN 2nd interviews Mothers' Recommendations	My Reflections (red font)	
Challenges of Meeting Role Requirements UHHV Maternal Psychosocial screening Workloads Health budgets	"I think *working in a person's home is actually easier to adopt this model …* we are a *guest … I think we have more power potentially"* [in the clinic]. *[*Neroli] *"It's a bit like a squishy ball. You squish on one side and it pops out the other side almost."* [Neroli] *METAPHOR* *"The first visit and the psychosocial questions. I use them as a rationale and to premise the relationship with the parent."* [Annie]	*"Doing the EDS & DV scales is helpful"* [Angela] *"The home visit is good and helps establish the relationship"* [Virginia] *"I found the first home visit really good."* [Dani] *"The first home visit was good. I was happy with the overall service including breastfeeding support."* [Millie] Millie's views of the psychosocial screening*: "It's not a problem; it's good that the nurses bring it up."* [Millie]	*"It's hard to work in partnership on the first visit"* [Monica] *'Psychosocial screening can initially be a barrier with inexperience."* [Neroli] *"…maybe the budget? So you're always just a bit short 'cause I don't know any centre that's perfectly happy."* [Sandy] *"The volume of work is the difference and partnership can't be 'ticked'"* [Sandy]	*"No home visit until 4 weeks postpartum and we had no communication from the CFHN service."* [Susan] *'The questions on the first home visit are confronting. I felt uncomfortable with them."* [Susan] *"The first home visit questions are more like a checklist. They didn't bother me. It was good it was at home."* [Juanita]	Susan suggested to me that nurses need to get to know the mother first and ask questions in a more conversational style	Monica describes the FPM as a set of skills that can be *turned on and off* when needed. E.g. hard to use them during UHHV as too much content to cover and questions to ask parents. Neroli's 'Squishy ball' metaphor is comparing the team and manager support with broader health policy requirements and limited health budget. Susan experienced discomfort with UHHV questions. Some nurses asking the maternal psychosocial questions like a checklist.	

Appendix O Withdrawal from Research Form

Working in a Partnership Approach with Parents

Revocation of Consent

I hereby wish to **WITHDRAW** my consent to participate in the study described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with The University of Newcastle and the Xxxxx Xxxxxx Xxxx X xxxxxxxx.

Signature: ……
Date: ……..

Please PRINT
Name: ……..

The section for Revocation of Consent should be forwarded to:

Professor Xxxxx Xxxxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxxxx xXXxxxxxx
The University of Newcastle
Faculty of Health, School of Nursing & Midwifery
University Drive, Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Appendix P: Visitor Information Statement

Professor Xxxxxx Xxxxxxxxxx
Chair Paediatric, Youth and Family Nursing
Xxxx Xxxxxxxx X xxxxx
The University of Newcastle
Faculty of Health
School of Nursing & Midwifery
University Drive
Callaghan NSW 2308 Australia
Tel: xx xxxx xxxx F: xx xxxx xxxx
xxxxxxx@xxxxxxxxxx.xxx.xx

Research Project Participant Information Statement
Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxx Xxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxxx Xxx Xxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xxxx xxx xxx xxxxxxxxx@xxxxxxxxx.xxx.xx	

You are invited to participate in the research project identified above which is part of a study being undertaken as a component of Eileen Guest's PhD project at the School of Nursing and Midwifery at the University of Newcastle. The supervisors for this PhD project are Professor Diana Keatinge and Dr Pamela Van der Riet.

Why is the research being done?
The purpose of the research is to explore the factors that may influence and impact on the ability of the child and family health nurse to work in partnership with parents. Your participation may contribute to changes in nursing practice used in child and family health nursing in the future.

Who can participate in the research?
We are seeking English speaking parents with children 0-5 years attending child and family health nursing services in the Xxxxx Xxxxxxx Xxxxxxxx Friends and family of participating parents and children who may coincidentally visit the family during the consultation with the child and family health nurse have the option of consenting to participate. However, the focus of the study will be the nature of the interactions that may occur during the consultation between the nurse and the parent.

What choice do you have?
Participation in this research is entirely your choice. Please take time to consider if you wish to be included in the study. You may choose to remain as a visitor but to sit out of view of the video and voice recordings. Only those people who give their informed consent will be included in the project. If you do decide to participate you may withdraw from the project at any time without giving a reason and you have the option of withdrawing any data which identifies you.

What would you be asked to do?
If you agree to participate, the student researcher will seek your consent to participate in the interview and include your image and voice that may be video recorded during the parents' consultation with the child and family health nurse. The purpose of the researcher attending the consultation is to observe the nature of the relationship established between child and family health nurses and parents, and observe the interactions and conversations that take place and the use of participants' verbal and non-verbal cues.

How much time will it take?
The consultation with the child and family health nurse will take from 1 – 1 ½ hours. This is the usual amount of time it takes to have a home visit.

What are the risks and benefits of participating?
We cannot promise you any benefit from participating in this research. There are no anticipated risks to participating.

How will your privacy be protected?
During the period of the study all data will be stored on a password protected file on the researcher's computer. Your contact details and consent forms will be stored in a locked filing cabinet in the researcher's office. Only members of the research team will have access to electronic and document data (including video recordings).

At the conclusion of the videorecorded consultation you will be offered the opportunity to:

- View your video image
- Have your video image edited prior to use
- Have your video images pixelated prior to use.
- Have your voice recording edited or dubbed prior to use.

You will be asked to specifically re confirm your consent at this time for the researcher to use the video recordings of the consultation.

All data, including video recordings used for conferences, will be destroyed 5 years following completion of the study; electronic data will be deleted from the computer system; and participants' contact details and consent forms will be destroyed following University of Newcastle procedures for shredding of sensitive documents.

Observations will be made on the interactions that occur during the consultation held with the child and family health nurse at the home or at the Centre. If at any time during the study, participants' report incidences of illegal behaviour or the researcher has a concern for the safety, wellbeing and welfare for an infant or child participating in the study, the researcher may be obliged to report the information to the community services or the police. The manager of the child and family health service may also need to be contacted if any of these issues arise.

How will the information collected be used?
The findings will be reported in the research thesis, project reports, nursing journals and conferences. Text data will be de-identified. A short summary of the outcomes of the study will be available to you if you would like to receive one. You can indicate your request for this summary on the attached consent form. Your video images and voice recording may be selected for use in conferences and /or workshops. You will be asked at the end of the videorecorded consultation to confirm your consent to use your video image or voice recording from the consultation in the manner outlined in this information statement.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, contact the researcher: Eileen Guest Phone: xx xxxx xxxx.

If you would like to participate, please complete the enclosed Consent Form and return it to the researchers in the enclosed stamped addressed envelope. I will then contact you to arrange a time convenient to you for the interview.

Further information

If you would like further information please contact:

Eileen Guest Xxxxx@xxxxxxxx.xxx.au

Professor Xxxxxxx Xxxxxxx

Dr Xxxxxxxxx Xxx

Professor Xxxxxx Xxxxxx

Complaints about this research

This project has been approved by the [redacted] Approval **No. 1003-088M and the University of Newcastle Human Research Ethics Committee Reference No: H-2010-1181.** 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 the [redacted]

Appendix Q Visitor Consent Form

Professor Xxxxx Xxxxxxxxxx
Chair Paediatric, Youth and Family Nursing
Director of Xxxxx Xxxxxxx
The University of Newcastle
School of Nursing & Midwifery, Faculty of Health
University Drive, CALLAGHAN NSW 2308 Australia
Tel: xx xxxx xxxx Fax : xx xxxx xxxx
Email : xxxxx@xxxxxxxxxxx.xxx.xx

Consent Form for the Research Project
Working in a Partnership Approach with Parents

Researchers:	
Professor Xxxxxx Xxxxxxxx School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	Dr Xxxxx xxx Xxxx (Co-Supervisor) School of Nursing & Midwifery Faculty of Health, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx
Eileen Guest (PhD Student) School of Nursing and Midwifery, The University of Newcastle Tel: xx xxxx xxxx F: xx xxxx xxxx xxxxxxx@xxxxxxxxxx.xxx.xx	

1. I,……

of.....……
agree to participate as a subject in the study described in the participant information statement attached to this form.

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the project at any time without prejudice to my relationship to the University of Newcastle and the Xxxx Xxxxxxxx Xxxxxxx Xxxxxxxxx.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Eileen Guest on telephone xxxx xxx xxx who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to:
Professor Xxxx Xxxxxxxx xxxxxx
School of Nursing & Midwifery, Faculty of Health, The University of Newcastle
Tel: xx xxxx xxxx

I consent to:

- Participate in a video recorded consultation with the child and family health nurse

Signature of subject **Please PRINT Name** **Date**

……

I confirm my consent that the video recording may be used in the manner described in the Information Statement and that my video images and voice recording may be selected for use in conferences and /or workshops. I have been offered and consent to the following choices in relation to the use of my image and voice recording:

1. View your video image
   - □ Yes
   - □ No
2. Edit your video image
   - □ Yes
   - □ No
3. Have your video image pixelated prior to use.
   - □ Yes
   - □ No
4. Have your voice recording edited or dubbed prior to use.
   - □ Yes
   - □ No

I would like a summary of the findings at the conclusion of the research

- □ Yes
- □ No

I have had the opportunity to have questions answered to my satisfaction.

Signature of subject **Please PRINT Name** **Date**

……

Phone Number:	E-Mail:
Address:	

Appendix R NSW Health SAFE START Maternal Psychosocial Assessment Questionnaire

Example of preamble:

In this health service we ask all women the same personal questions about a number of things, including violence at home. We ask about these things because we know that there are some issues for women or their partners that can affect parenting. The answers to these questions can help us to help you and your family to care for your baby.

You don't have to answer the questions if you don't want to. What you say will remain confidential to the Health Service, except where we are seriously concerned for you or your children's safety.

Variables	Psychosocial questions
1. Lack of support	1. Will you be able to get practical support with your baby? 2. Do you have someone you are able to talk to about your feelings or worries
2. Recent major stressors in the last 12 months	3. Have you had any major stressors, changes or losses recently (i.e. in the last 12 months) such as financial problems, someone close to you dying, or any other serious worries?
3. Low self –esteem (including self-confidence, high anxiety and perfectionistic traits)	4. Generally do you consider yourself a confident person? 5. Does it worry you a lot if things get messy or out of place?
4. History of anxiety, depression or other mental health problems	6. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks? a) If so, did it seriously interfere with your work and your relationships with friends and family? 7. Are you currently or have you in the past, received treatment for any emotional problems?
5. Couple's relationship problems of dysfunction (if applicable)	8. How would you describe your relationship with your partner? 9. a) Antenatal: What do you think your relationship will be like after the birth? b) Postnatal (in a community setting): Do you have concerns about how your relationship has changed since having the baby?
6. Adverse childhood experiences	10. Now that you are having/have a child of your own, you may think more about your own childhood and what it was like. As a child were you hurt or abused in any way (physically, emotionally, sexually)?
7. Domestic violence Questions must be asked only when the woman can be interviewed away from partner or family member over the age of three. Staff must undergo training	11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner? 12. Are you frightened of your partner or ex-partner? (If the response to questions 11 and 12 is "No" then offer the DV information card and omit questions 13–18)

in screening for domestic violence before administering questions.	13. Are you safe: here at home/to go home when you leave here? 14. Has your child/children been hurt or witnessed violence? 15. Who is/are your children with now? 16. Are they safe? 17. Are you worried about your child/children's safety 18. Would you like assistance with this?
Opportunity to disclose further	19. Are there any other issues or concerns you would like to mention?

From: NSW Department of Health, 2009 (p. 41)