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Needs assessment and decision making in the Plunket nurse setting: What's the story?

A thesis presented in partial fulfilment of the requirements of the degree of
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Abstract

Programmes delivered to populations of young children have had a high profile in recent years, as the relationship between childhood health and long term wellbeing is emphasised and funders and policy makers seek effective interventions to reduce health outcome disparity between some groups of children. Plunket nurses are employed by the Royal New Zealand Plunket Society (Inc) (Plunket) to deliver a programme of contacts to families with children aged from birth to five years, under a primary health care programme known as the Well Child Framework (Ministry of Health, 2010c). Seven universal or 'core' visits result in an assessment of family health need which informs decisions about the additional support offered to reduce risk to child health outcomes and improve health equity.

This study was undertaken to clarify how Plunket nurses think about needs assessment, describe how Plunket nurses make decisions when planning care, and explore the influences on Plunket nurse needs assessment and decision making. A constructivist paradigm provided the framework for qualitative interviews with seven Plunket nurses. Data were analysed using narrative and thematic methods to construct three group narratives. The findings add to knowledge of New Zealand well child practice established through the limited previous studies in the Plunket nurse setting.

Plunket nurses' relationships with families emerged as the foundation for needs assessment, a process study participants described as complex, where a range of social, economic and community determinants are considered to establish family resilience and identify risks to child health outcomes. Decisions about planned care are contingent on family participation and agreement, and are influenced by peer and Clinical Leader supervision, the nurse's knowledge and experience, and the available referral options.

The study findings emphasise the importance of facilitative funding models to accommodate the unpredictable nature of work with families in the community, and consistent leadership to translate the underpinnings of service specifications to the reality of practice. Support for the Clinical Leader role, and further research to establish Plunket nurse professional development needs and to improve understanding of the dynamics in relationships between Plunket nurses and families are recommended.

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The decision to embark on this thesis journey was not taken lightly. The final product represents considerable commitment by many people who have contributed time, skills, knowledge and encouragement, and without whom I could not have learned so much, especially about the research process and, most importantly, about needs assessment and decision making in the Plunket nurse setting.

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Dedication

I dedicate this thesis to the memory of Anne Lensen, my dear friend, she sadly did not live to see the result of her prophesy (in the face of my determined denial and disbelief) that I could, and would, complete my masters. I have thought of Anne every day since she died five years ago and mourn the loss of a true nursing leader, great thinker and inspirational role model.

List of abbreviations

ABC	Ask, Brief advice, Cessation support Smoking cessation intervention
CK	Community Karitane
CL	Clinical Leader
CYF	Child Youth and Family
HIPPY	Home Intervention Programme for Parents and Youngsters
HV	Health Visitor
MoH	Ministry of Health
NZDep	New Zealand Deprivation Index
PAFT	Parents as First Teachers
PCIS	Plunket Client Information System
PDRP	Professional Development and Recognition Programme
PEDS	Parent Evaluation of Development Screen
PEPE	Plunket Parenting Education Programme
PHQ3	Patient Health Questionnaire 3
PHR	Plunket Health Record
UK	United Kingdom
WCF	Well Child Framework
WINZ	Work and Income New Zealand

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Chapter 1: Introduction to the study

This thesis documents the research process and findings of a study exploring the Plunket nurse perspective of needs assessment and decision making in the New Zealand well child setting. Needs assessment is an integral and much discussed element of Plunket nurse work. However little research evidence is available to describe the reality of practice, especially from the Plunket nurse perspective.

In addition this study provides background for Plunket leaders and policy makers, and external stakeholders. The findings demonstrate considerable similarity between Plunket nurse participant experiences and those of community child health nurses working in other settings. Therefore this study goes some way to improve confidence in the international literature as a valid source of guidance for developing policy, and practice systems for the New Zealand well child context.

This chapter will provide the background for the study including an introduction to the Plunket nurse role, and needs assessment as it applies to the well child setting. I will describe the context that informed and justifies both the decision to undertake the study, and the research question and study aims. The chapter will conclude with an outline and brief introduction to each of the chapters in the thesis.

Study aims

The aims of this study were to record and analyse stories from Plunket nurse practice and present the narrative findings to:

1. Clarify how Plunket nurses think about needs assessment
2. Describe how Plunket nurses make decisions when planning care
3. Explore the influences on Plunket nurse needs assessment and decision making.

Background

The last five years have seen increased political interest in New Zealand and internationally in the needs of children, the importance of the early years and, in particular, early intervention to improve outcomes for the most vulnerable children. Various recent publications have emphasised the risks to some groups of children in New Zealand (Child Poverty Action Group, 2011; Henare, Puckey, & Nicholson, 2011; Ministry of Justice, 2010; Ministry of Social Development, 2011b) and others have called for early identification of at risk children and integrated well planned support for high needs families to improve the long term outcomes for their children (Allen, 2011; Australian Research Alliance for Children and Youth, 2010; Infometrics Ltd, 2011; Ministry of Health, 2010c; Ministry of

Social Development, 2011a; Pearce, 2011; Public Health Advisory Committee, 2010). A number of highly publicised and tragic child abuse cases have raised public awareness and distress about the outcomes of some children in New Zealand. Consequently the work of practitioners, agencies and organisations in the community child health sector has come under scrutiny, with calls for increased early contacts with high need families, improved identification of at risk children, monitoring and oversight to reduce harm to children and coordinated approaches to care for families (Bain, 2011; Ministry of Social Development, 2011a). In particular the funding and practice context of Plunket nurses has received a lot of attention, especially from the main funder of Plunket nurse work, the Ministry of Health (MoH).

The Plunket nurse role

Plunket nurses are registered nurses, who have completed a post graduate qualification in community child and family health, and who work for the Royal New Zealand Plunket Society (Inc) (Plunket). Plunket is a non government organisation with a 107 year history of providing community based health and wellbeing service and support for families with children aged from birth to five years old. Services include the government funded well child programme and a range of parenting and family support services provided through a mix of state, philanthropic and sponsorship funding.

The Plunket nurse role can be compared to that of the Health Visitor (HV) in the United Kingdom (UK), Maternal and Child Health Nurses in Australia and some Public Health nursing services in Canada. Plunket is differentiated from other providers of similar services, in New Zealand and internationally, by being a national organisation solely concerned with the health and wellbeing of children aged from birth to five years, and their families. Similar programmes are usually managed and funded through state resources and often delivered in association with a larger health service. While Plunket negotiates service contracts with the government, usually through the MoH, the organisation is proudly community owned and governed (Royal New Zealand Plunket Society (Inc). 2010).

Plunket nurse work in the community is underpinned by the principles of primary health care, with interventions delivered to an enrolled case load, usually in a geographically determined area. Plunket nurses work as case managers to provide coordinated care in a wellness model that aims to reduce inequitable health outcomes for children. They recognise the child as a member of a family/whanau group with connections to a community, and Plunket nurses' community knowledge enables them to work with others to support families to enhance their capability to raise healthy children (Royal New Zealand Plunket Society (Inc). 2009b). Plunket nurses deliver well child services, through home visiting, in Plunket clinics and other community settings, to around 90% of New Zealand

families (around 53,000 new babies each year). The well child service schedule is underpinned by principles of weighted universalism, and funded by the MoH with timing and content described by the Well Child Framework (Ministry of Health, 2002, 2010c; Royal New Zealand Plunket Society (Inc). 2010).

Weighted universalism, as it applies to the New Zealand well child setting, means all enrolled clients (children aged from birth to five years) receive a series of universal visits known as core contacts at prescribed ages, for example between four and six weeks, around three months, five months and so on. At each core contact the nurse works with the family to collect information about their social and health history to inform an assessment of family strengths and risks. Prescribed screening and surveillance interventions combine to further inform the nurse's assessment of the child's wellbeing and understand the family's level of need for support. As an outcome of the assessment the nurse and family develop a plan to meet identified health needs which may include targeted intensive support. Such enhanced support is likely to consist of extra, so called 'additional' contacts, referrals for service from other providers, and/or connections with community networks. The process of working with the family to understand their context and capacities in order to plan interventions to improve health outcomes is known in the well child setting as 'needs assessment' and 'care planning'.

Health need and needs assessment

The terms 'health needs assessment' and 'needs assessment' can mean different things in different settings and are often used interchangeably. At population level health needs assessment is an activity undertaken to establish the health deficits and risks for defined groups of people, commonly in health board catchment areas and in the resource planning and funding context (Coster, 2000). Population health needs assessment is associated with principles of apportioning care and service, with the goal of delivering more service to those assessed as needing it most, in the interests of improving health outcome equity in the whole population (Coster, 2000).

Population health needs data undoubtedly informs assessment of individual need, and supports nursing 'needs assessment' of families in the community (Cowley & Appleton, 2000; Trout, 2001; Wass, 1994). At individual and family level, needs assessment has three goals: to recognise health needs; assess the level of need for service or support; and analyse assessment information to plan care to improve health outcomes. In short it comprises the search for health needs. When needs assessment results in planned care to improve health, outcomes can be measured and interventions evaluated to provide evidence of effectiveness (Cowley & Appleton, 2000). Needs assessment takes account of all the factors likely to contribute to wellbeing and requires an understanding of the interplay

between the environmental, socio economic, historic, cultural and personal factors that influence health (Appleton & Cowley, 2008b; Seden, 2002; Trout, 2001).

Therefore needs assessment in the community child health setting is not straightforward, with the context of the family, the community they live in and the characteristics of the population determining the range of health needs. The ultimate goal of establishing need, and planning care and interventions, is improved equity in health outcomes. Equity means fairness, and achieving equity in health outcomes relies on eliminating disparities between population groups categorised by a range of determinants including gender, geographic location or ethnicity (Braveman, 2003). In New Zealand, the Treaty of Waitangi adds another dimension to the outcome of needs assessment in the Plunket well child setting. As a partner with Maori in the Treaty of Waitangi the government, through the MoH and providers like Plunket, is committed to address disparity in health outcomes between Maori and non Maori children. Current health data shows that Maori children, (along with Pacific Island children and children in families with poor socio-economic status) are at increased risk of poor health outcomes with, for example, high rates of Sudden Unexplained Death of Infants (SUDI) and avoidable hospitalisation, exposure to family violence and abuse, poor nutrition and limited access to preschool education (Henare et al., 2011; Ministry of Justice, 2010; Ministry of Social Development, 2011a, 2011b; Public Health Advisory Committee, 2010).

Plunket's organisational commitment to the Treaty of Waitangi, and the competencies for their scope of practice, oblige Plunket nurses to recognise the determinants of need that relate to ethnicity and understand the importance of effective needs assessment to prioritise interventions that improve the health of Maori children (Nursing Council of New Zealand, 2007; Royal New Zealand Plunket Society (Inc.), 2009). In addition the principles of the Treaty of Waitangi align with the recognised relational and process enablers of needs assessment. Therefore practicing in partnership to support all families, and especially Maori, to participate in the care and activities that protect and improve the health of their children is an integral aspect of needs assessment practice.

Plunket nurses, similarly to HV in the UK, Public Health nurses in Canada and Maternal and Child Health nurses in Australia are widely viewed as accessible and appropriate needs assessment practitioners. The process of needs assessment combines nursing knowledge and relational skills to synthesise and prioritise the factors that contribute to child health and wellness. Decisions about care and support are based on the outcome of the assessment, which is most effective if undertaken as a joint effort between the practitioner and the family (Appleton & Cowley, 2008a). The complexity of needs assessment and decision making in the child and family setting can be underestimated with conversational, apparently unstructured approaches and unarticulated, rapid decision

making belying the range of observational, analytical and relationship skills of the practitioner (Cowley, Mitcheson, & Houston, 2004). There is a history, especially in the UK, and more recently in New Zealand, of the needs assessment practice of community child and family practitioners coming under scrutiny. In efforts to stretch limited health resource funders can struggle to understand a process that is undertaken in an apparently well population and that is difficult to articulate in measurable terms, even by practitioners themselves (Appleton & Cowley, 2004, 2008a; Condon, 2011b; Macfie, 2006; Trout, 2001). In New Zealand the needs assessment practice of Plunket nurses has been influenced over recent years by factors mostly related to the organisational context and in particular the funding model applied to the MoH contract with Plunket (Ministry of Health, 2003, 2011b).

The Plunket well child contract

The Plunket well child funding contract is underpinned by the Well Child Framework (WCF) (Ministry of Health, 2002, 2010c). The WCF is a model for providing a weighted, or progressive, universal service. The WCF provides eight universal or core well child contacts to each child¹, with up to 16 additional contacts provided based on assessed need, deprivation and/or first time parent status. Theoretically the current criteria for assessing need is derived from the Family Start criteria², and has an emphasis on assessing risk (Ministry of Health, 2003).

While the WCF is essentially underpinned by sound principles for population health care, it became problematic for Plunket in the years 2002 - 2009 when the allocation of additional contacts for assessed need was overlaid by a service specification that prescribed and measured outputs for additional contacts based on the deprivation index (NZDep) (Crampton, Salmond, & Atkinson, 2007; Salmond, Crampton, King, & Waldegrave, 2006) of the family address as a proxy for need. NZDep is a measure of social and economic deprivation first developed in 1991 with the three main purposes of allocating resource, enabling research and providing data for advocacy (Crampton et al., 2007). NZDep is compiled from the measurement of a range of dimensions of deprivation, based mostly on census data, to determine the relative level of deprivation for groups of people living in specified residential mesh blocks. While the deprivation index is useful for the purposes it was designed for, it is an imprecise instrument and the developers caution against relying on the index as an absolute measure, stressing that it is only ever a partial or indicative

¹ Plunket is contracted nationally to provide the first seven core contacts, the eighth core is known as the B4 School Check and is offered to children between the age of four and five years. The B4 School Check is delivered by a range of providers (including Plunket in some areas) contracted through District Health Boards (DHB).

² Family Start is an early intervention, preventative, home-based service for families facing challenges in the areas of health, welfare or education.

instrument that enables some assumptions to be made about the population living in defined geographic locations (Crampton et al., 2007; Salmond & Crampton, 2001).

In the Plunket service specification use of the deprivation index number of the family address as the proxy for need meant that families living in NZDep areas 8-10 were assumed to need more service than those in NZDep areas 1-7. Deprivation is a reasonable indicator of population health outcomes, and Plunket supported the intent of the WCF to provide more service to families likely to experience high and complex health need related to socioeconomic deprivation. The difficulty arose when translating the contract to Plunket nurses. While promoting needs assessment as the arbiter for allocation of additional contacts, Plunket was under financial pressure to deliver volumes of contacts that could be identified by deprivation level. This model of funding had never been tested before. Anecdotally Plunket staff struggled to balance their understanding of needs assessment with the perception that the contract directed them to deliver high volumes of contacts to families in high deprivation areas, but limited their ability to respond to assessed high need related to factors other than deprivation (Macfie, 2006).

While needs assessment was the on paper determinant for allocating additional contacts, the funding model resulted in staffing levels that meant less time was available for nurses to respond to high need identified in apparently well resourced areas, related to factors other than deprivation, for example family violence and maternal mental health issues (Macfie, 2006; Trout, 2003). Plunket nurses and leaders expressed concern and unease that Plunket nurse practice, traditionally based in a relational model, was compromised by the contract (Trout, 2003).

Consequently the importance of making the most of every contact by working relationally with families was recognised and Plunket began investing in developing the skills of Plunket staff to work in partnership with families. This resulted in a commitment to the Family Partnership Model (Family Partnership) (Davis & Day, 2010; Davis, Day, & Bidmead, 2002). Family Partnership constitutes a model for successful engagement with families and is promoted as a way to improve communication that is not strictly limited to practitioners working face to face with families. Therefore it can be used as a model for supervision and to enhance the communication skills of people working a range of settings (Davis et al., 2002; Wilson & Huntington, 2009). Family Partnership is introduced in a 35 hour course which aims to capitalise and build on participants' existing skills and knowledge to explore the most effective ways of working with families. The elements of partnership are unpacked so that course participants recognise and understand the limitations of the more familiar expert model and practice communication skills to reflect on the most effective ways of helping people. Plunket staff in many areas have attended Family Partnership courses and up till the current time Family Partnership has been

promoted by Plunket in negotiations with the MoH as the preferred model for engagement when well child nurses work with families.

Well Child Framework review

The WCF underwent review between 2006 and 2010. As a result a number of changes were recommended for the content of well child universal contacts, including formalised screening tools for detecting post natal depression (Patient Health Questionnaire (PHQ3)), developmental assessment (Parental Evaluation of Developmental Status (PEDS)) and poor oral health (Lift the Lip). In addition the WCF review recommended improved needs assessment to identify family strengths and protective factors as well as risks, and enhanced promotion of maternal infant attachment (Ministry of Health, 2010a, 2010b). As a result the MoH undertook to review needs assessment and care planning processes. Initially a literature review was undertaken by Plunket in partnership with the New Zealand College of Midwives, under contract to the MoH (New Zealand College of Midwives & Royal New Zealand Plunket Society (Inc.), 2009b). It is notable there was no formal evaluation of the outcomes of the original WCF to inform the review of the WCF. The outcomes for child health were not assessed and in particular there was no review of the impact on well child nursing practice of the deprivation funding model applied to well child contracts between 2002 and 2008 (Ministry of Health, 2002, 2003, 2010b).

The recommendations of the WCF review (Ministry of Health, 2010b) have subsequently been translated into the Well Child Schedule and have resulted in increased formalised screening and surveillance activities in core (universal) contacts (Ministry of Health, 2010a, 2010c). While validated screening tools have their place in standardising assessment it is arguable that too much emphasis on structured assessment limits the exercise of clinical judgment and results in formulaic practice (Appleton & Cowley, 2004). The changes to the WCF seem to indicate lack of understanding and/or lack of trust in clinical decision making and nursing needs assessment, with the added screening activities apparently recommended in an attempt to make an intrinsically variable and subjective process more measurable. The international literature warns of the consequences of such an approach and paradoxically the recommendation of the WCF review for improved needs assessment may have been undermined by the agenda to quantify outcomes of a preventative programme where the results of interventions, as improved health outcomes, may not be visible for several years.

Negotiation of the 2009-2011 Plunket funding contract was heavily influenced by the draft recommendations of the WCF review, and characterised by increased emphasis on the assessment of need as the determinant for allocating additional resource, something Plunket had been advocating for since 2002. Seven core contacts remained the critical

points for needs assessment and decision making about additional support and/or service. The outputs for the funding model continued to be reported by deprivation; however the documented assessment of need took on new significance (Ministry of Health, 2011b). The Plunket implementation of the 2009-2011 contract to managers, leaders and staff emphasised the expectation that while deprivation was no longer the main determinant for allocating additional contacts, more additional contacts were expected to be delivered to those families living in areas of high deprivation due to the risks of deprivation to child health outcomes (Hussey, 2009; Magrath, 2009).

Consequently at Plunket and the MoH there has been a high level of interest in the needs assessment competence of Plunket nurses over the last three to four years. There have also been misgivings in Plunket leadership teams as the MoH has appeared committed to plans to develop a 'new needs assessment and care planning tool' without formal investigation of current practice or the outcomes for children resulting from the funding framework of recent years. My previous experience as a Plunket nurse and Clinical Leader led me to question the effects of further changed funding structures and the possible implementation of an assessment tool on Plunket nurse practice. As a result my own interest in, and organisational support for, undertaking this study was born.

Researcher introduction

I have worked for Plunket for 16 years, as a Plunket nurse, a Clinical Leader and currently I hold the title National Clinical Advisor with part of that role being coordination of the Plunket nurse Professional Development and Recognition Programme (PDRP). I bring particular knowledge and experience to this study with my perspective influenced by my nursing experience and philosophy. My current role and post graduate study have provided opportunities and motivation to reflect on Plunket nurse needs assessment and decision making with the benefit of increased theoretical understanding and a strategic perspective. Part of my work now involves analysis of child health outcomes, and review and development of well child practice in the interests of quality improvement and risk management. As a result I have become interested in the processes and influences involved in Plunket nurse needs assessment and decision making. I understand there are a range of factors involved, many of which I did not consciously recognise during my time as a Plunket nurse.

My current position means I am privy to the high level assumptions made about the skills and practice of Plunket nurses. I have been involved in discussions and negotiation of the Plunket funding contract and as a member of the advisory group for the review of the WCF. At this level I have noticed that the complexity of working in the community can be underestimated, and that solutions to improve practice are applied without, what I consider

to be, informed investigation of the contextual factors that influence and contribute to the reality of the practice setting. My Plunket nurse experience and more recent exposure to case review documentation have heightened my concern that there is a widening gap between the reality for practitioners and the leadership discourses, in Plunket nationally and at the MoH. Furthermore, plans for developing Plunket nurse needs assessment practice have to date been predominantly informed by the literature from the UK Health Visitor context, with very little research specific to Plunket nurses.

The selection of a qualitative methodology and narrative interviews to collect the data for this study was also influenced by my interest in partnership and relational practice. I am a Family Partnership (Davis & Day, 2010; Davis et al., 2002) course facilitator and trainer and consider myself grounded in principles of cooperative and respectful practice. I believe valuable data is provided by people who have experience of the subject being explored, and the analysis of stories shared through a planned and ethical process provides rich and meaningful research product (Josselson, 2007; Mishler, 1995; Riessman, 2008).

Therefore I undertook this study in the interests of providing evidence and insight to the “what is” of Plunket nurse practice in relation to needs assessment. I was interested to know what the nurses themselves thought about when assessing need and making decisions and what influenced their practice in these activities. I anticipated that the findings of the study would provide a snapshot description of the practice setting and insight to inform decisions about policy and professional development to support Plunket nurse practice.

Developments alongside the study

As this thesis study progressed, the MoH proceeded to act on the recommendations of the WCF. Late in 2010 the Werry Centre, based at the University of Auckland, was contracted to develop, pilot and evaluate a ‘new needs assessment and care planning process’, including a training programme for well child nurses, midwives and others in Primary Health Care, and accompanying documentation tool (Werry Centre, 2011a, 2011b). Two Plunket areas were selected to participate in the pilot and I was involved in initial meetings with the contractor to clarify the Plunket setting and understand the scope and projected outcomes of the pilot.

A further and very recent development (August 2011) is a new service agreement between the MoH and Plunket supplementing the well child contract for increased numbers of additional contacts, to families assessed to have high need, in the first three months of their baby’s life. These early high needs additional contacts represent a commitment by the government to provide more support early in the lives of vulnerable children. Target populations are first time parents and families assessed to have long term high need, and

the commitment to early engagement extends to permitting and funding antenatal contacts by Plunket nurses. The philosophy behind the contract is underpinned by best practice notions of increased opportunities for practitioners to develop relationships with families and so that early intervention can be planned when needs assessment identifies difficulties with early parenting. The reliance on needs assessment as the determinant for such important support, and the high profile of child health and interventions in the early years means Plunket nurse needs assessment and decision making practice have stayed in the spotlight.

Overview of the study

Narrative interviews with seven Plunket nurse participants were undertaken between September and November 2010. The data were analysed and are presented in three narratives (thesis chapters four, five and six), each titled to align with the aims of the study.

The Plunket nurses' narratives described their familiarity with the key known principles of needs assessment and partnership practice. It became clear that contextual factors influence needs assessment and decision making, positively through education, policy and supervision; and challenge the nurses' confidence and autonomous practice through leaders' translation of the contract and Plunket nurses' responses to their interpretation of management messages.

The findings of the study offer insight to a complex area of well child nursing practice and demonstrate considerable synchronicity with the available New Zealand and international literature presented in chapter two. Therefore this study goes some way to validating the use of international literature to inform the development of systems to support and develop Plunket nurse practice.

Overview of the thesis

The thesis is presented in eight chapters:

Chapter One: Introduces the thesis with a description of the background to the study, the study aims and an introduction to me as the researcher with reference to my perspective and motivation to undertake the study.

Chapter two: The results of the literature search and review that informed the study is presented to provide additional background to needs assessment and decision making in community child health settings. The limited evidence to describe Plunket nurse needs assessment and decision making is identified and provides partial justification for this study.

Chapter three: The study methodology and methods are described. I present narrative methodology as ontologically appropriate for this study and outline the ethical issues

considered in the course of the project. A full description of ethical considerations, recruitment processes and the data collection and analysis methods is included.

Chapter four: The first of three chapters presenting the study findings in the form of a group narrative constructed to clarify how Plunket nurses' think about needs assessment. The nurses' knowledge of the social and economic determinants of health and their views about the importance of the relationships they develop with families become evident through case stories told by participants and verbatim interview excerpts.

Chapter five: Presents the second narrative from the study findings. The group narrative and case stories in chapter five describe how Plunket nurses make decisions when planning care. The importance of working with families and pacing interventions in order to be effective is described, and the participants allude to the knowledge they call on when making judgements.

Chapter six: The narrative findings related to the third aim of the study are presented from the exploration of the influences on Plunket nurse needs assessment and decision making. The contextual issues that support and challenge Plunket nurses are described. Peer and manager supervision; policy and education are depicted as positively supporting the Plunket nurses, while time constraints and management of the Plunket funding contract emerge as challenging the participants' practice.

Chapter seven: The study findings are expanded and discussed through integration with the literature. The essential elements of needs assessment and decision making are presented along with exploration of the issues and challenges Plunket nurses work with.

Chapter eight: The final chapter documents my conclusions based on analysis of the findings, rationalises the findings in light of the limitations of the study and contains recommendations to capitalise on the knowledge and skills of Plunket nurses and support practice through leadership development, supervision and evaluated contract models.

Chapter 2: Literature Review

Introduction

This chapter will describe the academic and research literature relating to needs assessment and decision making in the community child health setting. Searches of the electronic journal databases Cumulative Index of Nursing and Allied Health (CINAHL), Science Direct and Ebsco were undertaken during 2010 and 2011 using combinations of the search terms *nurse, community, child health, needs assessment, clinical judgement, decision making, Plunket and health visitor*. The search was limited to studies specific to child health nursing in the community, published between 1990 and 2011. Twenty seven articles related to needs assessment and decision making in community nursing and child health were found. Qualitative studies were prioritised however one study that employed mixed methods (Wright, Jeffrey, Ross, Wallis, & Wood, 2009) was included for its relevance to the Plunket setting.

Five New Zealand studies directly related to Plunket nurse needs assessment and decision making and eleven qualitative studies of community child health nursing in the United Kingdom, Australia and Canada were selected for close review. New Zealand health policy, government publications and Plunket organisational documents were also reviewed to inform the study. Secondary searches provided additional electronic journal and book references that offered further theoretical insight and evidence related to the research question.

The chapter will begin by providing an overview of the main research studies considered and go on to broadly describe health need and needs assessment as a population and individual process. The remainder of the chapter will present key findings of studies examining community child health nursing related to needs assessment, clinical judgment and decision making and integrate the main ideas with other relevant literature.

Overview of the literature

Studies in New Zealand related to Plunket nurses' needs assessment, judgement and decision making are limited with just four studies specific to this area of practice (Beatson, 2007; Carter, 2010; Macfie, 2006; Royal New Zealand Plunket Society (Inc). 2005; Trout, 1999, 2001). The Plunket nurse studies each applied a different methodology; however the aims of each study demonstrate interest in improved understanding of how Plunket nurses categorise and assess need and in the judgment and decision making of Plunket nurses. No study specifically explored needs assessment or decision making from the perspective or stories of Plunket nurses. Wilson's (2001) qualitative study presents data gathered through interviews with five Plunket nurses and is included for its insight into the ways

Plunket nurses describe their relationships with parents, especially mothers. Wilson questions the paradox between the goal of working in partnership and the power of the nurse when implicit surveillance activities mean she is collecting information to make judgements without disclosing the full extent of the observation to the parent (Wilson, 2001). Shepherd (2011) extends ideas of unarticulated surveillance in an Australian study where twenty one home visits were observed and group and individual interviews with maternal and child health nurses undertaken to explore the ways nurses consider their role of meeting maternal health needs through their overt and mandated activities of child health and development monitoring.

The international research literature related to community child health nurses and needs assessment is dominated by studies in the UK, North America and Canada. Included studies applied qualitative methods including observations of practice, focus groups and interviews with both nurses and clients (Appleton, 1994; A. J. Browne, Hartrick Doane, Reimer, MacLeod, & McLellan, 2010; Bryans, 2004; Bryans & McIntosh, 1996; Cowley, Bergen, Young, & Kavanagh, 2000; Cowley & Billings, 1999; Selbie, 2009; Williams, 1997; Wright et al., 2009). In particular two large case studies of HV in the UK provide insight into the complexity of assessment, the interplay of skills used, the difficulty HV have articulating the basis for their assessment and decision making, and the influence of imposed assessment tools and guidelines on nursing practice and the HV – family relationship (Appleton & Cowley, 2004, 2008a, 2008b; Cowley et al., 2004; Mitcheson & Cowley, 2003). The earlier study (Cowley et al., 2004; Houston & Cowley, 2002) used conversation analysis of ten tape recorded contacts between HV and clients when a structured needs assessment tool was applied.

In the second study (Appleton & Cowley, 2008a, 2008b) fifteen HV were observed in fifty six home visits each followed by a with debrief interview with the nurse. The study included fifty three follow up client interviews undertaken to establish the client view of the HV practice. The authors are realistic about the limitation of observing only one home visit per family; however the study yields considerable insight to needs assessment from the nurse, family and researcher perspectives.

A 2006 - 2007 study by Louise Condon used telephone interviews with twenty five HV to explore the implications of funding and contracting on the interventions of HV, and the practitioners' views of the effects of policy change on their work. Three articles published from the study were included for their relevance to the Plunket nurse setting (Condon, 2008, 2011a, 2011b).

Further studies considered relevant to this study relate to nursing decision making and judgement. Selected studies are qualitative, with data collected predominantly through

interview and focus group methods. Studies exploring HV needs assessment and decision making practice in the UK (Bryans & McIntosh, 1996; Easen & Wilcockson, 1996; Luker & Kenrick, 1992; Orme & Maggs, 1993) and North America and Canada offered insight into intuition and nursing judgement especially in relation to levels of experience and nurse education (Benner, 1984; Benner & Tanner, 1987; Benner, Tanner, & Chesla, 2009; Fraser, Estabrooks, Allen, & Strang, 2009; Polge, 1995; Tanner, 2006; Watkins, 1998).

In addition, as analysis of the findings progressed, peer and manager support and supervision emerged as an influence on, and support for, Plunket nurse decision making. Studies reviewed in the initial literature search had not identified supervision in the decision making process, therefore the literature was revisited specifically to further understand the place of peer and clinical supervision in nursing decision making. As a result one article directly related to peer supervision in the Plunket setting (Polaschek, 2004), a study in the community nurse setting in Scotland (Willson, Fawcett, & Whyte, 2001) and a very recent study in the health visitor setting (Wallbank & Hatton, 2011) provide insight to the place, value and practicality of supervision as a means of supporting and enhancing decision making and reducing stress for nurses

Health need and needs assessment

Concepts of health need are contestable and mean different things to different people, and in different settings, with individual health need being personal, variable and likely to change over time (Appleton & Cowley, 2008a; Bradshaw, 1972; Elkan, Robinson, Williams, & Blair, 2001). The term 'health need' intimates a benefit from change and it is implicit that once health need is established interventions will be planned to reduce the need. Therefore health need may be defined in terms of what can be provided for a particular person, family or population at any given time to improve health outcomes and reduce inequitable outcomes between individuals and groups (Coster, 2000). Health needs assessment is an activity undertaken at individual level and in populations, and population health needs data undoubtedly informs assessment of individual need, and supports nursing needs assessment of families in the community (Cowley et al., 2000).

For the purposes of this study health needs assessment is specifically related to risks to child health outcomes with the term underpinned by public health principles recognising all the influences on health and wellbeing, rather than focusing on the definition of health as the absence of disease (Cowley & Appleton, 2000). The assessment of need therefore takes account of the social and economic context the child and their family live in and considers the interplay between all the factors known to influence child health outcomes (Cowley et al., 2000; Hughes, Sidey, & Widdas, 2005).

Child health needs assessment in the community

Child health needs assessment is described as a process, occurring over time, that includes consideration of all the social and economic determinants of the family and their community, and is undertaken through screening and surveillance, physical examination, and exploration of factors related to parenting, child safety and illness prevention (Appleton & Cowley, 2008a; Trout, 2001). As a result of the assessment levels of need are established, priority needs are identified, care planned and interventions evaluated for effectiveness (Cowley & Appleton, 2000; Trout, 2001). Trout (2001) and Appleton and Cowley (2008a) are clear that assessment of need in the community child health setting acknowledges both risk and resilience, in the knowledge that it is always possible adversity can outweigh any family's ability to manage difficulties. Therefore while the starting point for the assessment may be a predicted need, based on previous assessment or population health information, the assessment process is likely to uncover a multitude of other unpredicted needs, through exploration of the family situation (Twinn, 2000).

Needs assessment factors and processes

A case study of health visitor practice in the United Kingdom (Appleton & Cowley, 2008a, 2008b) and a qualitative study of Canadian Public Health nurses (A. J. Browne et al., 2010) describe the critical elements associated with needs assessment that reflect the principles of practice with families in the community. Appleton and Cowley (2008a) combined observation of Health Visitor contacts with pre-visit interviews with the practitioner and post visit interviews with parents and Health Visitors to collect data. A.J. Browne et al. (2010) combine interviews with eighteen Public Health nurses and twenty interviews with parents; focus groups involving thirty two nurses, and observation of six Public Health nurses during face to face contacts to explore the ways Public Health nurses contextualise the risk to children and work with families relationally. Both studies emphasise the strength of the relationship between the nurse and family. A trusting relationship that extends to all members of the family is described as the key to the effectiveness of needs assessment. The quality of the relationship determines the depth and quality of information the family will share to inform the nurse's assessment, with the skill and personal approach of the nurse enabling exploration and understanding of all the influences on the child's health (Appleton & Cowley, 2008a, 2008b; A. J. Browne et al., 2010; Bryans, 2004; Davis & Day, 2010; Davis et al., 2002; Fraser et al., 2009; Hartrick Doane & Varcoe, 2005; Samwell, 2005). The importance of the relationship with the family acknowledges that assessment is an interactive, holistic process, with nurses understanding that the health of children is reliant on the health and social wellbeing of their parents (especially their mother), and the rest of their family.

Consideration of the socio ecological nature of human development, health and wellbeing is grounded in the theory of Urie Bronfenbrenner (1979). The nature of problems is often interrelated and many issues rather than any single problem will affect family health and function at any time (Appleton & Cowley, 2008b; A. J. Browne et al., 2010; Samwell, 2005). Appleton and Cowley (2008a) elaborate on the multifactorial nature of needs assessment and describe the ability of health visitors to consider multiple factors simultaneously. The skills and knowledge applied to the process are not well understood, and difficult to articulate, even by nurses themselves (Appleton & Cowley, 2008a; Beatson, 2007; Selbie, 2009). The practitioner contributes significantly to the assessment, bringing their personal qualities and skills, expertise and previous experience to the relationship with families (Appleton & Cowley, 2008a; A. J. Browne et al., 2010; Davis & Day, 2010; Davis et al., 2002; Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007; Selbie, 2009).

Wilson (2001) applied a critical methodology to examine Plunket nurse relationships with parents, with particular emphasis on the nurse mother dyad. While not specifically interested in needs assessment, the study findings demonstrated the emphasis Plunket nurses placed on relationships. Wilson (2001) describes the nurses' relationship with mothers as dynamic and complex, with considerable effort expended by the nurses in maintaining what they described as a partnership relationship. Wilson (2001) however raises issues of power between the nurse and mother and suggests that the observation and assessment activities of the nurse, particularly in the home visit, may be undertaken without the explicit knowledge or agreement of the parent. Ideas about the covert nature of surveillance are raised and questioned, however the author suggests Plunket nurses view the observations they make, especially in the home setting, as legitimate and valuable to their overall assessment and the ways they elect to work with parents (Wilson, 2001). Shepherd reinforces the value nurses place on home visiting as a way to connect with and develop relationships with mothers, thereby enabling the nurse to understand more about the mother's need for support and offering opportunities to address maternal mental health and wellbeing issues (Shepherd, 2011). The nurses in the Shepherd (2011) study appeared constrained by a service requirement to focus on the baby and described their activities responding to the needs of women in terms that suggest they use the cover of the well baby visit to follow up on their assessment, based on observation or intuition, of the mother's wellbeing.

Appleton and Cowley (2008a, 2008b) and Mitcheson and Cowley (2003) agree that the nurse frequently observes more than is disclosed to families. The client interview data in the Appleton and Cowley (2008a, 2008b) case study indicates that while parents were largely unaware of the depth of the HV's assessment, they valued the observations of the HV and particularly appreciated the nurse's knowledge of the whole family. Kirkpatrick,

Barlow, Stewart-Brown and Davis (2007) go further to find that even vulnerable parents accept and appreciate close observation and assessment from a known and trusted HV who has well developed relational skills and demonstrates the principles of partnership.

Alongside skills in developing and maintaining relationships, observation and coordination skills determine the quality of needs assessment (Selbie, 2009). Observations over time enable assessment through comparisons, with the individual's or family's previous health, well being or behaviour, and against knowledge of norms in the rest of the population (Appleton & Cowley, 2008a, 2008b; Benner et al., 2009; A. J. Browne et al., 2010; Bryans, 2004; Fraser et al., 2009; Selbie, 2009). The continuous nature of assessment adds to nurses' relationship with families and to their understanding of the family and community context, strengths and needs.

Complexity is a hallmark of the needs assessment process and Appleton and Cowley (2008a, 2008b) suggest that the knowledge and interpersonal skills needed and used by community child health practitioners may be undervalued. Consequently aspects of needs assessment come under scrutiny in the belief that more definitive approaches may be more effective. One approach is to develop categories of need in order to provide a framework to prioritise interventions and service. Studies of such approaches have called on nurse participation to develop categories of need and have added further to knowledge of how community child health nurses understand health need.

Categories of need

The use of categories to enable prioritisation of service and identify vulnerable families was the subject of a qualitative study in the UK by Williams (1997) and a participatory action research project undertaken by Trout (2001) in the Plunket setting in New Zealand. Williams (1997) applied a combination of focus groups and semi structured interviews to elicit the criteria HV used to determine family vulnerability and prioritise the needs of those families judged to be in need of extra support from the service. Fifty personal, social, economic and environmental factors contributing to vulnerability were described and demonstrated the holistic manner in which the HVs thought about risk to health outcomes (Williams, 1997). While the risks of socio economic deprivation were well considered, less visible risks to child health outcomes arising from social isolation but not related to deprivation were also identified. Participants clearly identified the balance between risk and resilience in weighting vulnerability posed by needs factors, with risk seen as potential for poor outcomes (Williams, 1997). Decision making was described as informed by "gut feeling" or "instinct", "having seen it all before" (Williams, 1997, p. 23) and demonstrated HVs' ability to consider risk and protective factors related to parents' ability to cope with their situation rather than rely on arbitrary criteria (Williams, 1997). The study also showed

that more time was spent with those most at risk and highlighted the importance of a universal service as a vehicle to identify need and target service to reduce risk (Elkan et al., 2001; Williams, 1997).

Trout (2001) sought to verify and refine criteria for Plunket nurse needs assessment. Draft criteria statements were developed through access to the client health records of 140 families. Four hundred and seventy eight episodes of care were examined and four main categories with sub groupings of criteria developed by a group of experienced Plunket nurses using the Nominal Group Technique and informed by a literature review. The criteria statements were reviewed to compare them with participants' recent practice experiences and with the documented records of episodes of care. Using a modified Delphi technique the nurses considered the reasons for the clinical judgments made, taking particular notice of the documented parenting behaviours that influenced decisions.

The outcome of the Trout (2001) study provided four broad categories for nurses to consider need in families: health seeking behaviour; health determinants; relationship building and complexity. Specific descriptors were identified that would be likely to trigger nurses to recognise different levels of need predicted to vary between families and over time (Trout, 2001). It was generally agreed that the development of criteria could support Plunket nurses to more readily identify those families most in need of additional support or targeted interventions (Trout, 2001). The study affirmed the ideals of an ecological model of care whereby families are considered in their macro environment and all the influences on wellbeing are recognised to contribute to health outcomes (Bronfenbrenner, 1979; Trout, 2001).

In 2005, a further Plunket study was undertaken to discover the indicators or risk factors identified by Plunket nurses, the areas of health need considered priorities by Plunket nurses, the ways Plunket nurses distinguished between high and medium levels of need, and how closely the health needs assessed by Plunket nurses aligned with individual clients' deprivation score (Macfie, 2006; Royal New Zealand Plunket Society (Inc). 2005). The researchers sought to understand whether the categories of need, established in 1999 (Trout, 2001) and subsequently integrated in the documentation tool used by Plunket nurses, accurately informed Plunket nurse assessment and documentation of levels of need. At the time of the study, the service contract that allocated service volumes and additional contacts based on the NZDep96 (Salmond & Crampton, 2001) score of the family's residential address had been in place for three years.

In eight selected Plunket areas documentation of core contacts for infants aged around three months were examined, alongside feedback on a research form designed so the Plunket nurses could identify the risk and protective factors they had considered when

delivering the contact. Findings from the study demonstrated variability in the nurses' assessment. Risk and protective factors were well recognised in the research tool, but poorly documented in the Plunket Health Record (Macfie, 2006; Royal New Zealand Plunket Society (Inc). 2005).

Macfie (2006) concluded it was evident that Plunket nurses were clear about the risks associated with socio economic deprivation and recognised that high need families had less protective factors. Plunket nurses also identified a number of risks that existed in all deprivation areas including poor maternal health, parental mental illness, parental relationship issues (including family violence) and lack of social and family connection and support, and a range of protective factors including access to health and wellbeing services and breast feeding (Macfie, 2006; Royal New Zealand Plunket Society (Inc). 2005).

Macfie (2006) highlights the difference between the level of assessed need in each deprivation group and the criteria for additional service prescribed in the funding model at the time (Ministry of Health, 2002). The overlay of a funding model to an essentially sound framework for providing a progressive universal service apparently caused some confusion and tension for Plunket nurses, who resisted the allocation of more intensive support based on deprivation as the main indicator of need (Macfie, 2006; Trout, 2003). Trout (2001, 2003) also raises concern about the use of strict criteria, specifically the deprivation index, for determining the allocation of additional service in the Plunket nurse setting and suggests that while nurses are committed to comprehensively assessing need, resource allocation may limit assessment. Bryans and McIntosh (1996) agree, suggesting that knowledge of available resource influences nursing decisions about assessment and planned interventions. Such a response to models or protocols that direct service is not uncommon with health visitors in the United Kingdom observed as struggling with imposed assessment tools and frameworks (Appleton & Cowley, 2003; Condon, 2008; Cowley et al., 2004; Mitcheson & Cowley, 2003).

In an environment where the resources for health care provision are limited, the imperative for funders to seek ways to identify effective and economic interventions is high. It is often assumed that a tool, commonly in the form of a checklist or similar, will assure that nurses assess health needs accurately, and as a consequence, targeted information and support will be offered to the families who are most in need (Condon, 2008, 2011a; Mitcheson & Cowley, 2003). As a result community nurses can be under pressure to implement tools designed to guide and document assessment with the supposition that the assessment will recognise the most vulnerable in the population so that services can be targeted to meet their needs.

Needs assessment tools

Needs assessment tools are usually assumed to enable a structured opportunity to determine the pathway and level of care required to meet the identified level of need. Elkan et al., (2001) find there is a risk in applying assessment tools that assume families who display few or no obvious problems or needs at the time of the assessment will not require access to service at some time in the future. The use of tools that rely on infrequent opportunities for assessment to make definitive decisions about levels of service denies the complexity of health and social wellbeing in the community and the reality that family life is unpredictable and subject to the influence of changes to social, economic and health circumstances (Appleton & Cowley, 2008a; Cowley et al., 2000; Elkan et al., 2001; Rose, 1993; Schon, 1988; Wright et al., 2009).

Wright, Jeffrey, Ross, Wallis and Wood (2009) confirm that it is not easy to identify those families that will ultimately require the most service. In a study of the intensive home visiting programme 'Starting Well' only around one third of the families who would eventually be rated as high need were identified to receive early assessment contacts. Importantly only half of the families ultimately classified as high need had been identified by the time their baby was aged four months (Wright et al., 2009). Wright et al., (2009) find that while high deprivation is likely to be indicative of high need, attempting to target services based on limited assessment opportunities risks missing those families who might at first appear to be doing well, but who may in future require more intensive support. This demonstrates the need for ongoing assessment of need and affirms the findings of Williams (1997), Macfie (2006) and Appleton and Cowley (2008a) that need exists in all deprivation areas.

Trout (2001) and Scott (2010) suggest the application of criteria or a tool can make the needs assessment process more visible and explicable to the practitioner, the family and the service, and can support nurses to demonstrate the value of their service, so funders are more likely to understand the results. While promoting the holistic nature of assessment Scott (2010) posits that the qualitative nature of describing all the risk and resilience factors in a family is complex, and promotes the use of a tool to identify and visualise multiple needs. Others describe tools as damaging to the nurse family relationship and devaluing the judgment and knowing of the nurse (Appleton & Cowley, 2004; Elkan et al., 2001; Hartrick Doane & Varcoe, 2005; Macfie, 2006; Mitcheson & Cowley, 2003).

Mitcheson and Cowley (2003) and Cowley (2004) recommend needs assessment approaches based on methods capitalising on nurses' communication skills and contribute to open and trusting relationships between practitioners and clients. They criticise the application of tools demanding predetermined questions and answers as limiting the extent and quality of the information collected and impacting on the client/nurse relationship

(Mitcheson & Cowley, 2003). Appleton and Cowley (2004) also find that formal guidelines for assessing family need can cause tension between the practitioner's communication with families, use of professional judgment and control of practice by funders and managers. Traynor, Boland and Buus (2010) agree that nurses negotiate assessment and decision making tools as a technicality and barrier to flexible practice.

While Trout (2001) advocates the value of tools in making health needs explicit so that interventions can be matched to need, she too acknowledges the dilemma for nurses in applying a tool which compromises or reduces the extent to which clinical judgment can be used. Condon (2011a, 2011b) consolidates arguments against the use of strict guidelines and tools in HV practice and criticises the ways policy is translated to practice settings so that service outputs and rationalisation of services become the imperatives for practice. Condon further suggests targeting services through application of assessment tools limits the potential for preventative and anticipatory interventions and consequently increases the pressure on caseloads through escalation of issues that could have been better managed through earlier, less intensive approaches (Condon, 2011a, 2011b).

There is considerable evidence to describe community child health nurse needs assessment as a complex process that is influenced by practitioner and service inputs, and contextual factors. This raises the question of why funders and policy makers continue to favour the development and implementation of nursing practice tools, when it is clear that a balanced approach that capitalises on the knowledge and skill of community health nurses is supported by evidence (Appleton & Cowley, 2004; Hartrick Doane & Varcoe, 2005; Macfie, 2006; New Zealand College of Midwives & Royal New Zealand Plunket Society (Inc.), 2009b). Ultimately needs assessment informs decisions about the level of care offered to families and, at times, protection provided for children. The assessment and decision making process are inseparable and both rely on the application of judgement.

Clinical judgment and decision making

The substantial literature describing nursing judgment uses the terms clinical judgment, clinical decision making, professional judgment, problem solving, critical thinking and decision making interchangeably (Tanner, 2006). Essentially judgements are based on assessment. However it appears that describing decision making processes and the factors that influence judgments is far from straightforward (Dowie & Elstein, 1988). Concepts of analytic reasoning, rationalisation and intuition are highly relevant with levels of experience and expertise also influencing both thinking and decision making (Benner, 1984; Benner et al., 2009; Easen & Wilcockson, 1996; Fraser et al., 2009; Hamers, Huijjer Abu-Saad, & Halfens, 1994; Hamm, 1988; Schon, 1988).

Bryans and McIntosh (1996) restate the axiom that community nurse assessment is continuous and dynamic, and find that decision making in this setting occurs in the context of “temporal unfolding of information” (p.28). Hamers et al. (1994) provide an overview of decision making that identifies steps or components in a process that has similarities to problem solving and the nursing process. Common elements include assessment or information gathering, identification of the problem, planning, implementation and evaluation, and align with the Family Partnership model of helping parents manage their problems (Davis et al., 2002; Hamers et al., 1994). While such processes assume a linear approach, the literature is clear that decision making is unlikely to be a conscious step by step activity. Relevant studies call on theories of decision making, in particular the novice to expert model (Benner, 1984), reflection in action (Schon, 1988) and cognitive continuum theory (Hamm, 1988).

Most decision making situations involve a combination of the characteristics of both analysis and intuition (Hamm, 1988; Watkins, 1998). Schon (1988) suggests that many of the problems that are important and real to clients, exist in a “swampy lowland” (p.67) where there is confusion and where straightforward or black and white approaches to decisions are unlikely to be useful. Such complexity and messiness, with the “it depends” factor (Fraser et al., 2009, p. 345) requires practitioners to consider, weigh and prioritise large amounts of information, often quickly. Bryans and McIntosh (1996) and Fraser et al., (2009) agree that the multiple factors faced by community nurses as they make decisions requires a flexible and responsive approach that considers all the implications of all the dynamics of family resources, beliefs, culture and values. Thompson (2002) also finds decision making is often accompanied by uncertainty which requires nurses to access a range of strategies in order to improve the accuracy of decisions and the care that is planned. Consequently descriptions by clinicians of decision making processes often refer to intuition, previous experience, training, trial and error and complexity (Beatson, 2007; Fraser et al., 2009; Tanner, 2006; Traynor et al., 2010; Watkins, 1998). Appleton and Cowley (2008b) examined the data from their case study to explore the knowledge HV call on to assess need and make decisions. The authors draw on the theory of Carper (1978) and suggest that knowledge is either propositional or non propositional. Propositional knowledge is based in scientific knowing and relates to Carper’s (1978) category of empirics (p.14). Propositional knowledge in nursing is grounded in the professional training and educational preparation undertaken to prepare them for their role. Non propositional knowledge is described by Appleton and Cowley (2008b) as the combination of practical, intuitive, personal and experiential knowledge that nurses apply when making decisions and judgments and aligns with the definitions in Carper’s (1978) aesthetic patterns of knowing.

In 2007 Erin Beatson undertook a small qualitative study to examine Plunket nurses' professional judgment. Data from a focus group of five Plunket nurses were analysed to explore how Plunket nurse professional judgment is shaped and weighted and how Plunket nurses make judgments. Three themes were identified: the place of professional knowledge, the difficulty nurses found in articulating judgment and the influence of contextual constraints on professional judgment (Beatson, 2007). The findings were integrated using Carper's (1978) patterns of knowing in nursing and Appleton and Cowley's (2008b) suggestions that nurses synthesise the information they gather using both scientific or propositional (knowing that) and personal or non propositional (knowing how) knowledge .

The effects of time constraints were found to affect participants' relationships with clients, and their ability to evaluate their practice and plan or implement alternative strategies for effectiveness. Plunket nurses in the study suggested they required experience and confidence to balance the limitations on their practice, most often drawing on non propositional and personal knowledge as the enablers in these situations. As a result it was found that judgment is individual and variable (Beatson, 2007).

Most recently Lynn Carter (2010) undertook a further small New Zealand study examining the decision making of Plunket nurses particularly in relation to reporting children at risk from child abuse. Analysis of interviews with six Plunket nurses resulted in four themes describing the dynamics, stresses and processes applied by Plunket nurses as they make decisions to refer families to Child, Youth and Family³ for suspected abuse. The six participants described challenges to their ongoing relationship with families and the dilemmas posed in referring for such a sensitive reason. References to gut feeling and intuition were common and it was clear that nurses called on both propositional and non propositional knowledge in the decision making process (Appleton & Cowley, 2008b; Beatson, 2007). It was also evident that contextual factors such as time, support and recognition of the work they were doing influenced the nurses' decisions (Carter, 2010).

A number of international studies undertaken in community child health settings attempt to understand the combination of knowledge and processes used by nurses as they make decisions. Findings confirm that the complexity and diversity of health care situations, especially in the community, and particularly when care is delivered in client homes means that clinical judgment and decision making is unlikely to be linear and the relationship and communication between nurse and family is integral to the process (Benner et al., 2009;

³ Child Youth and Family is the statutory agency responsible to respond to reports of suspected abuse and work with families and others to protect children from harm.

Bryans & McIntosh, 1996; Traynor et al., 2010; Watkins, 1998). In the absence of alternative ways to articulate how they make judgments, nurses suggest that personal experience and qualities and skills, including communication skills and level of confidence are important to the judgments they make (Appleton & Cowley, 2008a; Beatson, 2007; Carper, 1978; Polge, 1995). Further, nursing experience, expertise and the characteristics of the decision maker, environmental and contextual influences, and nurses' various understandings of intuition are all identified as contributing to decision making and judgement processes (Appleton & Cowley, 2004; Benner, 1984; Luker & Kenrick, 1992; Polge, 1995; Traynor et al., 2010). Lack of acknowledgement of the value and contribution of training, experience and professional knowledge frequently results in practitioners describing gut feeling or intuition as informing their decisions, however there are a range of views about the place of intuition and nursing expertise in decision making and clinical judgment (Appleton & Cowley, 2008a; Benner et al., 2009; Luker & Kenrick, 1992; Traynor et al., 2010; Watkins, 1998).

Intuition

Practitioners often have difficulty describing and articulating the basis on which they form judgments and their decision making processes, with intuition frequently referred to as an alternative explanation for how nurses make decisions (Appleton & Cowley, 2008a; Beatson, 2007; Easen & Wilcockson, 1996; Luker & Kenrick, 1992). Some refer to intuition as a valid and important aspect of their decision making and judgment, while others seek to distance themselves from a concept seen as irrational and unexplainable and describe the phenomenon in terms of rapid information processing (Benner & Tanner, 1987; Easen & Wilcockson, 1996; Orme & Maggs, 1993; Traynor et al., 2010).

Although nurses describe applying professional knowledge intuitively and unconsciously, on analysis it appears that they are in fact following a continuous information collecting process with their practice experience enabling them to assess information and observations against what they have experienced before in similar situations (Bryans & McIntosh, 1996; Schon, 1988; Watkins, 1998). Benner (1984) presents nursing decision making on a developmental continuum from novice to expert. In such a model of progressive skill development the less experienced nurse relies on conscious and analytic processes to weigh options and locate observations in theoretical or limited clinical experience. On the other hand expert nurses are able to rapidly consider and interpret vast amounts of information in light of previous experience and knowledge. While the expert may appear to be acting on intuition she is in fact operating from deep understanding and analysis of the total situation and is able to come to a decision that takes account of all the variables and contextual factors through accurately prioritising information in order to focus on the important features of the presenting situation (Benner, 1984).

Polge (1995) agrees with Benner's novice to expert theory finding that expertise increases with experience. She proposes that expert nurses more readily describe the use of intuition as the basis of their decision making, however suggests that it is their experience and proficiency that enables them to quickly assess a situation, make a judgment and respond. Luker and Kenrick (1992) are clear, stating that intuition is "knowledge which has been integrated and embedded in long term memory" (p.463). Other authors agree that intuition may be an overused concept and suggest that decision making is underpinned by significant education, practice experience and expertise. While intuition may be the factor that creates heightened awareness assessment is informed by objective observation, propositional knowing and analysis (Appleton & Cowley, 2008b; Easen & Wilcockson, 1996; Hamers et al., 1994; Luker & Kenrick, 1992; Thompson & Dowding, 2002). Nursing skill, experience and expertise are keys to the decisions nurses make with judgements influenced by the use of a range of knowledge, however nursing knowledge, relational practice and expertise can be influenced by other drivers in the practice setting.

Influences on decision making

The literature describing nursing decision making and judgement indicates the interrelatedness of what is known about nursing decision making with factors that influence decisions. Notions of practitioner expertise, knowledge and apparently intuitive responses are prevalent. Variability between how individual nurses rationalise their decisions adds to the challenge of showing how decisions are made, especially when such decisions relate to the allocation of care and resource (Luker & Kenrick, 1992; Watkins, 1998).

In an ethnographic study of decision making about resource allocation by paediatric community nurses, Fraser et al. (2009) identify a number of factors that could apply to the Plunket nurse setting. Three stages of data collection involved semi structured interviews followed by a card sorting activity where the findings from the interviews were coded and the nurses asked to think aloud as they sorted the cards to indicate the hierarchy used to make decisions about resource allocation. Finally participants were asked specific questions, developed from the first stages of the study, to validate and verify the researchers analysis of the data (Fraser et al., 2009). While the eleven nurses in the study worked with ill children and their families, the work relied on relational practice and understanding of the dynamics of family resources and wellbeing. Factors that influenced nurses' decisions in this setting included reflection and consultation with other team members, alongside knowledge of available resources, and consideration of family factors including complexity, socioeconomic situation and capabilities and preferences. Interestingly the nurses valued the use of guidelines to influence decision making, although such guidelines were largely related to decisions about medical procedures and could be compared to standing orders. The nurses made the distinction between guidelines for

practice and criteria for decision making however, suggesting that guidelines enabled more flexibility and guided rather than contained their decisions (Fraser et al., 2009).

A number of authors describe the contextual constraints inherent in the health care setting as significant to nurses' assessment and decision making. Access to resources, available time and caseload size all affect how responsive nurses feel they can be to clients. Shepherd (2011) raises the pressure to demonstrate outcomes of practice in relation to the caring and relational aspects of nursing in the community. In situations where nurses are required to account for all their activities in terms of interventions that are prescribed, and can be measured, the less tangible caring activities nurses believe make a difference to families may be rendered invisible as the nurses hide the work they do that is outside the bounds of what is expected. The availability and suitability of additional services for referral can add to community child health nurses' decision making dilemmas.

Bryans and McIntosh (2004) and Trout (2001) suggest nurses may make decisions about how deeply they explore family issues based on what they know of the possibility to offer support within available resources. Furthermore, emphasis on strict time management and productivity measures is known to influence how nurses exercise and act on their professional judgment in the community setting (Appleton & Cowley, 2004; Beatson, 2007; Bryans & McIntosh, 1996; Condon, 2008, 2011b; Fraser et al., 2009; Mitcheson & Cowley, 2003; Orme & Maggs, 1993; Traynor et al., 2010). The application of assessment tools and criteria designed to guide decision making create challenges to nurses when observed data and their previous experience means they recognise factors relevant to child health outcomes that cannot easily be collected in an assessment tool (Appleton & Cowley, 2004; Condon, 2008; Williams, 1997). In addition when nurses are under pressure to make decisions based on strict criteria, there is a risk that practice becomes formulaic. As a result practitioner expertise, and the decision making usually enabled by both propositional and non propositional knowledge, may be superseded by external drivers (Appleton & Cowley, 2004; Trout, 1999).

Clinical supervision

Clinical supervision is a formal process of professional support that supports safe and effective decision making and promotes self assessment by practitioners. Clinical supervision encourages practitioners to develop their knowledge through reflection, to take responsibility for their practice, and is recognised as a way to improve safety for health consumers especially those with high and complex health needs. In addition, from the practitioner's perspective, clinical supervision provides a structured opportunity to think more clearly about health risks and the decisions they make, to learn from difficult or ethically challenging practice situations and respond appropriately when faced with

subsequent complex situations. Effective supervision can reduce stress and burnout through reducing professional isolation and enabling nurses to share their professional anxiety in an objective and supportive setting (Wallbank & Hatton, 2011; Willson et al., 2001).

Peer supervision is a form of clinical supervision or 'practice support' (Willson et al., 2001, p. 614) that draws on the principles of clinical supervision and is a process between colleagues, usually in a similar role (Willson et al., 2001). In the Plunket setting a peer supervision model relying on reciprocity and termed 'peer reciprocal supervision' was implemented in the late 1990s (Polaschek, 2004). Peer reciprocal supervision is a process where nurses and health workers employed by Plunket participate in supervision with a chosen colleague. Each session offers the chance for each partner to take a turn in the role of both supervisor and supervisee (Polaschek, 2004). The process draws on the communication skills considered integral to community and relational practice, including listening to and exploring issues, challenging to discover alternative constructs of the problem and supporting planning for a solution (Davis et al., 2002; Polaschek, 2004). Peer reciprocal supervision relies on self monitoring and reflection by both partners on their contribution to the supervision process including the influence of their own culture, ethnicity, beliefs and values on the supervision they offer others and how they participate in supervision themselves (Polaschek, 2004).

Training is important for individuals providing clinical supervision and in the case of peer supervision, education and support to develop supervision skills and understand the supervision model defines the effectiveness of the process (Polaschek, 2004; Willson et al., 2001). Other determinants for effective supervision include sufficient and dedicated time and a mandate by organisations and employers for staff to prioritise supervision (Polaschek, 2004; Wallbank & Hatton, 2011; Willson et al., 2001).

Summary

In the community child health nursing setting decisions are made in response to needs assessment, and correspond to prioritisation and planned interventions to promote child safety and wellbeing, and determine the allocation of resources. Nurses call on previous experience, professional education and knowledge of their practice context to make decisions in a process that can be difficult to articulate but which is widely acknowledged to comprise the artful application of a range of skills and expertise.

Qualitative studies in the United Kingdom, Australia and Canada comprehensively portray needs assessment and decision making in the community child health setting as closely associated processes that rely on a number of facilitating factors including nursing knowledge and skills and a practice environment that supports the nurse to work in relation

with families and the community. The complexity and skill required can be under estimated and misunderstood. The New Zealand literature is limited and no study has conclusively found how closely Plunket nurse needs assessment practice in New Zealand aligns with the international literature.

This study of Plunket nurse needs assessment and decision making is justified in the interests of consolidating understanding of needs assessment in the New Zealand well child setting. Previous New Zealand studies have alluded to similarity between the Plunket nurse context and international experience; however previous work has not included a Plunket nurse description of the practice reality. The next chapter will describe the methodological framework, ethical considerations and the data collection and analysis methods for this study.

Chapter 3: Methodology

Introduction

“There is no right way of doing qualitative research but some approaches are more appropriate than others to certain research goals” (Dew, 2007, p. 436).

This chapter will describe my exploration of the methodological underpinnings, and detail the data collection and analysis methods applied for this study of Plunket nurse needs assessment and decision making. Beginning with an outline of constructivism as the theoretical perspective informing the choice of methodology, I will go on to describe narrative inquiry in the context of a qualitative epistemology and justify the choice of narrative methodology as an ontologically appropriate approach for this study. Later I will outline the ethical considerations, recruitment process and data collection and analysis methods that resulted in the research findings.

The constructivist paradigm

The constructivist research paradigm is underpinned by the philosophy that knowledge and meaning are constructed rather than discovered. Constructivism, also known as naturalistic or interpretive inquiry, accepts the contribution of each individual in the creation of reality. While individual realities may overlap or intersect, they are essentially different because every individual constructs their own meaning based on the events and experiences in their lived worlds (Appleton & King, 1997; Denzin & Lincoln, 2008; Grant & Giddings, 2002; Lincoln & Guba, 1985).

The constructivist paradigm informs a subjectivist approach, with studies undertaken in natural settings (Appleton & King, 1997, 2002; Denzin & Lincoln, 2000). Constructivism provides a framework for qualitative research approaches where the participant is respected as the holder and sharer of knowledge. There is a notion of mutual causality and openness, with the interaction and relationship between researcher and participant known to influence the richness of the data as the outcome of the research is co-constructed (Appleton & King, 1997, 2002; Denzin & Lincoln, 2000; Lincoln & Guba, 1985).

Researchers in the constructivist paradigm accept that research findings may yield more questions than answers, the goal is to achieve a consensus of meaning from multiple realities, however the constructivist researcher is always aware that new explanations are possible with the benefit of experience and further information (Appleton & King, 2002; Lincoln & Guba, 1985). Consequently research methods must be underpinned by an epistemological stance of intersubjectivity where participants are enabled to describe their

lived experience and researchers are committed to listen, attempt to understand, and interpret the experience to answer the research question (Grant & Giddings, 2002).

The epistemology of qualitative research

Qualitative research is concerned with making sense of, understanding and interpreting the meanings people make of their experiences in the world. The researcher attempts to see the world through the participant's eyes in order to understand the experience and lived reality of individuals, groups or cultures (Andrews, Sullivan, & Minichiello, 2004; Denzin & Lincoln, 2000; Holloway & Wheeler, 2010).

In the history of qualitative research, methods and methodologies have developed through the application of processes borrowed from different disciplines. The qualitative researcher has become known as an interpreter, a quilt or montage maker, or as a bricoleur (Denzin & Lincoln, 2000, p. 3). Qualitative researchers, as 'bricoleur', employ the strategies and methods they consider most appropriate in order to describe lives, in all their complexity, experienced and described by research participants. Methods that result in such a woven together outcome are characterised by decisions made for pragmatic and contextual reasons. The research result is described as 'bricolage' or a woven together representation of the data (Denzin & Lincoln, 2000, p. 2).

Qualitative approaches are chosen when the researcher considers little is known about the subject, that previous studies have been biased or are insufficiently representative of the reality of participants (Morse & Field, 1996). Data is gathered in the natural world of participants, with the context acknowledged as part of the phenomenon and no attempt made to control the variables inherent in the complexity of individual worlds and settings (Holloway & Wheeler, 2010; Morse & Field, 1996). Qualitative researchers are required to interact with participants and with the data, sometimes over time, in order to describe an event or phenomenon as fully as possible (Holloway & Wheeler, 2010; Sandelowski, 2000). As a result the qualitative researcher must be watchful of their own practice, aware of their influence on the participants, research process and findings of the project. This group of attributes is known in the research context as reflexivity (Denzin & Lincoln, 2003; Grant & Giddings, 2002; Holloway & Wheeler, 2010).

Qualitative research, undertaken in the world of participants and underpinned by constructivism implies an ontological position of respect. The researcher values the participant's views, and through an explicit description of the researcher's role achieves consent or agreement from the participant to interpret the findings through analysis to develop meaning in the data (Grant & Giddings, 2002). From the earliest stages of this study I was interested to work with Plunket nurses, to hear and explore their stories and to develop a research report that was accessible and relevant to a range of audiences. The

choice of a qualitative approach, narrative inquiry, was guided by the research aims and my belief that nurses are natural story tellers and rich information is shared when people are invited to tell stories.

Study design

Narrative inquiry

There is a large literature describing the history, burgeoning use and acceptance of narrative inquiry in research across disciplines and professions (Clandinin & Connelly, 2000; Emden, 1998b). Most narrative theorists go back to the work of psychologist Jerome Bruner (1991, 2004). Bruner locates narrative inquiry in the constructivist paradigm and concludes that narratives provide the means for people to structure experiences and organise memories. He also introduces ideas about the ways people tell stories, including their use of language and choice of story to describe any given situation. Polkinghorne (1988) urges the use of research strategies that enable theory and knowledge to be generated from the narratives people use to understand their world. He suggests that people live their lives immersed in stories to the extent that every aspect of their lives can be told as a narrative (Polkinghorne, 1995). There is however some debate about just what constitutes narrative. Riessman (1993, 2008) presents a range of scholars' views to demonstrate the diversity of the definition of narrative. Most descriptions refer to stories and the ways people use stories to make sense of events in their lives. The terms narrative and story are often used interchangeably, however it is widely agreed that a narrative, as a story, is ordered to represent a temporal sequence, in other words has a recognisable beginning, middle and end (Mishler, 1995; Polkinghorne, 1995; Riessman, 2008; Sandelowski, 1991).

The use of the word story can be challenged when associated with fictitious or made up accounts, however Polkinghorne (1995) is categorical and legitimises the term 'story' by describing stories as "narratives that combine a succession of events into a unified episode" (p. 7). Clandinin and Connelly (2000) succinctly define narrative inquiry as "stories, lived and told" (p. 20) and Sandelowski (1991) explains that narrative is a representation of experience as an individual views, recalls and tells it at a given moment in time. Further, telling stories or narrating events enables people to reflect on, make sense of and explain situations and events in their lives (Hardy, Gregory, & Ramjeet, 2009; Holloway & Wheeler, 2002; Polit & Beck, 2010; Polkinghorne, 1988; Riessman, 2008; Sandelowski, 1991).

Clandinin and Connelly (2000) locate the narrative researcher as also living in a storied world. The choice of research question, the method of data collection, the relationship

between the researcher and participants, data analysis and the research report are shaped by the researcher's construct of narrative as a way to describe, value and understand experience (Clandinin & Connelly, 2000). Emden (1998a) suggests that in the context of narrative research the emphasis is on the knowledge expressed collectively when individual stories are told. Narrative inquiry involves the collection of participants' stories, to describe, explain and articulate an event, experience or perspective. Data is interpreted and organised to create a narrative or research product, potentially representing the collective experiences of participants (Koch, 1998).

Understanding narrative methodology as an appropriate research approach to collect and analyse experiences in partnership with participants aligns with an ontological position of respecting participant's views and accepting their construction of experience is valid and important. The prospect of applying narrative methodology to the study of Plunket nurse needs assessment and decision making is supported by the literature describing narrative inquiry as a commonly accepted approach for researching nurses' practice.

The narrative approach in nursing research

Carson and Fairbairn (2002) postulate that narrative inquiry is an ideal and respectful approach to nursing research because it values stories about practitioners' work, as they are told by practitioners, without attempting to impose the predetermined requirements of other methodological frameworks upon them. In so doing narrative allows nurses to describe practice as it is, rather than as it is described by theorists or prescribed by policy makers. It takes the stories of practice, and of practitioners, seriously and enables nursing views, ways of knowing and experience to be shared with a range of audiences. Nursing narratives and nurses' storytelling provide a way of engaging with the real life problems of clients or consumers of health care and those of nurses and the practice environment (Carson & Fairbairn, 2002). Koch (1998) and Wolf (2008) justify the collection of nursing stories as a legitimate research activity. Further the construction of a group narrative from the stories of individuals, or groups, can make nursing practice, experience, interventions and complexity visible so that practice develops and the nursing situation is better understood, by nurses themselves and by others (Boykin & Schoenhofer, 1991; Koch, 1998; Wolf, 2008).

Tanner (2006) and Benner, Tanner and Chesla (2009) enlarge on this idea and find that narrative is a tool for reflection, enabling nurses to transform experiences into everyday knowing and practical understanding. Stories also ensure that the wisdom of nursing can be passed from generation to generation, with the beliefs, values, customs and norms of nursing described in the narratives of nurses (Wolf, 2008).

Emden (1995b, 1998a, 1998b) applied narrative methodology to a study of the lives of nursing scholars. Kidd and Finlayson's (2009) study of nurses' mental illness and Kelly and Howie's (2007) exploration of the influence of gestalt therapy on nursing practice provide other examples of using narrative approaches in nursing research. While these studies vary in the method of data analysis and final presentation they are each underpinned by the knowledge that nursing stories provide rich data. The studies demonstrate that the collection and analysis of individual nursing stories enables construction of a group narrative that reflects the experience and knowledge of participants, and provides a research product that contributes to nursing knowledge (Emden, 1995a; Kelly & Howie, 2007; Kidd & Finlayson, 2009).

This thesis study was principally concerned to hear the stories of Plunket nurses in order to clarify, explore and describe the processes of, and influences on needs assessment practice and decision making in the well child setting. The constructivist paradigm informed the choice of a qualitative approach to explore the nursing perspective of this aspect of well child practice. Narrative methodology aligns with my ontological position as a nurse who regards the epistemology of nursing as inextricably connected with nurses as the keepers of practice knowledge and reality. I believe nurses are natural story tellers and that stories from practice bring nursing experience to life, providing an accessible method for sharing the knowledge of nursing with a range of audiences. Presenting the Plunket nurses' stories was one of my main goals in the study. In order to collect as much rich data as possible qualitative face to face interviews based around nurses' practice stories were selected as the data collection method for the study.

Qualitative interviewing

Qualitative interviewing enables an interaction between the researcher and the participant whereby a joint effort results in the creation of understanding about an event, or phenomenon (Minichiello, Madison, Hays, & Parmenter, 2004; Mishler, 1986; Polkinghorne, 1988). Qualitative interviews require the researcher and participant to engage in a conversation, largely directed by the participant, in order to collect rich data about people and the events in their lives (Holloway & Wheeler, 2010; Minichiello et al., 2004; Mishler, 1986).

Rubin and Rubin (2005) draw the distinction between a conversation and an interview, and introduce the term "conversational partner" (p.14) to describe the research participant or interviewee. Recognising participants as conversation partners is particularly useful for a study that applies a narrative methodology. It suggests that the researcher and participant are interested to achieve a shared understanding and that the direction of the interview is shaped by both the researcher's and interviewee's concerns (Mishler, 1986; Rubin &

Rubin, 2005; Sandelowski, 1991). Further, the participant is acknowledged as having the power to share as much or as little of their individual and distinct knowledge or expertise, in the way in which they choose as their contribution to the research (Davis et al., 2002; Rubin & Rubin, 2005). Mishler (1986) suggests that the very act of allowing research participants to make sense of and find meaning in their experience by organising the telling is a way of balancing the power between researcher and participant.

Although qualitative researchers regard participants as conversation partners it does not follow that the research interview can be regarded as a conversation, nor does the researcher enter into the relationship or the research process casually. The researcher is seeking to achieve in-depth understanding of the response to the research question and undertakes the dual tasks of maintaining the boundaries of working in partnership with participants and the role of researcher with responsibilities to the goodness, rigour and outcomes of the study (Josselson, 2007; Tobin & Begley, 2004). Adams (2010) and Minichiello et al. (2004) describe the researcher's responsibilities as an active listener, aware of the participant's needs, managing time and guiding the conversation back to the agreed purpose; carefully following the content and asking appropriate open questions in order to clarify they share the participant's understanding of the story.

It is important that the researcher and participant develop rapport, with the quality of the relationship likely to determine the outcome of the interview (Davis et al., 2002; Josselson, 2007; Minichiello et al., 2004; Mishler, 1986; Rubin & Rubin, 2005). The relationship between the researcher and participants is initiated well before the interview event, often through the early communication to invite participation, and develops as arrangements for the interview proceed, and throughout the interview itself (Hardy et al., 2009; Holloway & Wheeler, 2010; Llewellyn, Sullivan, & Minichiello, 2004; Minichiello et al., 2004). My commitment to working in partnership with participants guided a number of decisions in the planning stages of the project. Almost all steps in the study had ethical implications, many of which were considered initially in the process of applying for and achieving the necessary ethical approval to proceed.

Ethical considerations

Qualitative research, which involves collection of information directly from participants, carries more risk of harm than some other forms of inquiry particularly in relation to effects of power imbalance between researcher and participant (Mishler, 1995; Parsons & Oates, 2004). The collection of data involves an intimate interaction between participants and the researcher and analysis requires reflection on and interpretation of people's lived experience. Essentially the researcher is asking to come into a person's life and to learn something from them. Consequently every aspect of the relationship has ethical

implications (Josselson, 2007). The ethical principles that guided planning and the activities of this study were primarily concerned to protect participants from any harm caused by their inclusion in the study. The key considerations were to ensure informed consent, to safeguard participants' privacy and confidentiality, to ensure respect for participants, to avoid deception and conflict of interest and to consider social and cultural sensitivity (Josselson, 2007; Massey University, 2010).

Cultural considerations

It is important for researchers to consider the cultural and special needs of identified groups when planning studies that seek to understand participants' world views and explore personal experience (Johnson, 2002; Parsons & Oates, 2004). Researchers in New Zealand have an obligation to consider the rights of Maori as tangata whenua when planning and undertaking research. The exploration of needs assessment to determine risks to child health outcomes has direct relevance to the health outcomes of Maori children, recognised as a population where disparity means they are more likely to be disadvantaged. The known key elements of needs assessment align with the principles of the Treaty of Waitangi, where working in partnership with families enables reciprocal information sharing and respectful working to enable parents, families and communities to participate in planned interventions to improve and protect their children's health. Although I was unsure if any Maori Plunket nurse would be a participant in the study, or if any process in the study would directly impact on any Maori child or family, I was conscious of the Plunket Research and Evaluation Policy (2006) and also the guidelines of the National Ethics Committee (2006) in the planning stages. I identified an advisor in the Plunket Maori health services team as a resource person should any cultural issue related to Maori emerge in the study.

As I planned the study I was conscious Plunket nurses may tell stories identifying families by ethnicity. In the event during the interviews a number of references were made to Plunket nurses' work with Maori families. I took care to ensure no story or interview included in the findings reinforced stereotypes or identified any individual or family, or Plunket staff member, or their work or home location.

Informed consent

Informed consent is achieved when research participants have agreed to participate freely, knowing their rights, including the right to withdraw at any stage of the process, and understanding any risks involved in participation (Parsons & Oates, 2004). An information sheet inviting participation and describing the procedures for collection, storage and management of identifiable participant details, data recordings and transcripts was developed prior to the commencement of recruitment for this study (Appendix i). The

information sheet also stated my obligation as a registered nurse to take action if unethical or unsafe practice was disclosed in the course of the interview.

I revisited their rights with each participant before they signed a consent form (Appendix ii) and prior to commencement of data collection. In order to ensure no participant was identified I assigned a code to each nurse from the time they signed the consent form. All information relating to each individual nurse was stored using the code. At first this consisted of the letters PN (Plunket nurse) and a number signifying the order in which I met with the nurses i.e. PN 1 = the first nurse interviewed. Later I assigned each nurse a pseudonym bearing no relation to their real name. The study findings are presented using these pseudonyms as a device to locate the nurses as individuals with stories to tell.

Ethical approval

The research proposal was submitted to the Plunket Ethics Committee in April 2010. Initially the Plunket Project Review Group assessed the proposal, suggesting minor wording changes to clarify the situation related to use of Plunket premises and work time for interviews. The suggested changes were made and approval was granted by the Plunket Ethics Committee on 20th May 2010 (Appendix iii).

The proposal was then reformatted for expedited review by the central region Health and Disability Ethics Committee (HDEC). Approval from this process was granted in June 2010 (Appendix iv). Following ethical approval by the Plunket committee and HDEC, the Massey University Human Ethics Committee was advised that the research was being undertaken by me as a student under the auspices of the University (Appendix v).

Beginning the relationship: Participant recruitment

My Plunket role, the scope and aims of the study guided the development of the sampling strategy. In the interests of reducing potential conflict of interest and perceptions of power I elected to recruit participants in areas where I had not had peer or direct report relationships with any potential participants. The size of the sample, a minimum of six and up to ten self selecting Plunket nurses, was decided based on the aims of the study and other narrative studies involving nurses (Emden, 1995a, 1998a; Holloway & Wheeler, 2010; Kelly & Howie, 2007; McCance, McKenna, & Boore, 2001). Plunket nurses who had completed the Plunket nurse training and who worked in a care delivery role providing the Ministry of Health universal contract were eligible for participation, Plunket nurses working in Plunket Family Centres, and those currently in training were excluded.

I recognised access to Plunket nurses could only be achieved through their managers (Minichiello et al., 2004) and predicted participants may foresee conflict between the time obligations of the Plunket contract and participation in the study. Endorsement of the study

by the General Manager Operations clarified the time situation and enabled me to assure Area Managers of my understanding of their management imperatives. I agreed I would work with participants to arrange times that would cause least interference with their contacts with clients.

I approached Clinical Leaders in Plunket areas in the mid North Island for their help in recruiting participants. I sought to attend team meetings to present the study to Plunket nurses. The decision to present the study myself acknowledged the risk of participants feeling coerced to participate by perceptions of power imbalance if the study was introduced by their manager, or that the aims of the study and methodology could be lost in translation if I delegated the initial recruitment to Clinical Leaders (Llewellyn et al., 2004).

I subsequently attended four area team meetings, presented the study, answered questions and invited eligible Plunket nurses to contact me to further discuss participation. I left all eligible nurses with copies of the study information sheet. Subsequently seven nurses, with their Plunket nurse experience ranging from three to twenty four years, and representing an even geographical spread from the research area, volunteered to participate.

I coordinated times and dates for interviews, meeting nurses at the location they selected. This was the Plunket clinic for six nurses and her home for the seventh. Interviews were timed for early morning or immediately following lunch so that there would be as little disruption to the working day as possible. As we arranged the interviews I clarified the purpose of the study and ensured the nurses understood what their participation entailed.

Data collection

Prior to commencing data collection I undertook a pilot interview with a willing Plunket nurse colleague, to reassure myself narrative inquiry would suit my data collection aims, and to test my interviewing skills. The abbreviated interview, recorded on a digital voice device indicated Plunket nurses could talk freely and tell stories from their practice to describe their thoughts about needs assessment and decision making. The pilot interview was also an opportunity to become familiar with the data recorder (Minichiello et al., 2004). I went on to transcribe the interview, learning a lot about the technical and practical details of transcribing and also realising the value of listening repeatedly to the interview as a way of becoming familiar with, and beginning to understand, the data (Emden, 1998a; Holloway & Wheeler, 2010). An interview guide, comprising opening statements, opening questions and facilitative prompts to guide the interview process was developed (Appendix vi). I was clear the schedule was a guide only and that interviews relied on flexibility and responsiveness to achieve rich data (Adams, 2010; McCance et al., 2001; Mishler, 1995; Polit & Beck, 2010; Riessman, 2008).

Mishler (1986) suggests that in the course of interviews, as in conversations, people will often tell a story to emphasise their point, or give an example. I suggested the nurses came to the interview with a story or stories from their practice that could demonstrate how they assessed need and made decisions, and help me understand this area of practice. This worked well; the nurses came prepared with a repertoire of examples offering a framework to enable them to elaborate on their thinking and experience.

Holloway and Wheeler (2010) caution the researcher with intimate knowledge of the research setting to question their own assumptions or risk missing important issues. Mostly this required me to set aside my own ideas and knowledge to listen carefully without interrupting, although at other times I acknowledged the participant had added to my understanding and we discussed an idea further, combining our understanding and looking at an idea from both points of view (Mishler, 1986). These exchanges added to my enjoyment of the interview process and seemed to encourage the nurses to expand their description (Holloway & Wheeler, 2010).

I was conscious of the need to be non directive but also to achieve as clear a picture as possible from the nurse's talk (Holloway & Wheeler, 2010; Mishler, 1986). I strove to ask open questions enabling the nurse to elaborate, rather than imposing my own thoughts on the progress of the story. There was no doubt participants viewed me as an insider, they easily used jargon and acronyms from the practice setting knowing I would recognise and understand their meaning (Minichiello et al., 2004).

Each interview concluded with my thanking the participant and seeking agreement I would return the transcript for checking and amending before they agreed to release it, and that I could contact them to clarify or revisit any aspect of the interview as analysis progressed. After each interview I used my research diary to record my immediate responses and thoughts about what I perceived to be the main ideas in the stories and to note details of the interview (J. Browne, 2004). Travel and accommodation considerations required interviews to be undertaken consecutively in each area, and all interviews were completed over a four week period. This was not ideal as it reduced the time for reflection between interviews (Minichiello et al., 2004). I used driving time to listen again to the recording of each interview. This allowed me to consider my role as the interviewer and the ways I influenced the story telling. I also began to notice similarities and differences in the stories and in some cases identified ideas I then revisited with other participants in later interviews (Johnson, 2002).

Reflexivity

As the study progressed I was increasingly aware of the concept of reflexivity. I constantly challenged myself and reflected on my role as I interacted with the participants and the

data. I came to see the importance of such examination as I recognised the possibility that my role in Plunket could influence participants' contribution and my own knowledge and perspective could have a significant influence on data collection and analysis (Holloway & Wheeler, 2010). This was particularly clear at times during the interviews when I was aware of the effect my theoretical understanding of the research topic had on my listening. It could have been easy to blur boundaries and enter into supervision as participants recounted and reflected on episodes of care and occasionally questioned their decision making. Meetings and email communication with my academic supervisor and conversations with colleagues in the Clinical Advisor team enabled opportunities to verbalise, reflect on and explore my decisions throughout the planning, data collection and analysis process. My research diary was used to record thoughts and questions for later contemplation and reflection, or to prompt discussion with my supervisor.

Data management

The interviews ranged in length between fifty one and seventy four minutes and were recorded using a digital voice device. I transferred the recordings to my password protected home computer as soon as possible after the interview, naming each recording with the assigned code for the nurse.

I commenced transcribing the interviews verbatim once the first five interviews were complete, in the break before travelling to the last area. The initial transcription included all the spoken content of the interview, including my questions and responses, but with names and locations that could identify any participant, client family or other person omitted. Riessman (2008) makes it clear that no transcript can truly represent the spoken word, features are lost and every transcriber will interpret and document an audio recording differently. I attempted to translate the feelings and emotions the nurses expressed, using grammar and quotation marks in the initial transcription.

Transcripts and participant consent forms were stored separately to eliminate the possibility of a participant being matched to a transcript. As each transcript was completed it was returned to the nurse for verification. This was the opportunity for her to alter or delete any content before signing a transcript release form. Apart from minor grammatical corrections no participant requested changes made. While time consuming and challenging, the transcription process was an important aspect of data analysis with repeated listening initiating my recognition of key ideas and similarities between the stories (Holloway & Wheeler, 2010; Mishler, 1995; Riessman, 1993).

Data analysis

The description of the qualitative researcher as bricoleur (Denzin & Lincoln, 2000) took on new significance as I recognised I would draw on a combination of methods to analyse the data and the analysis process was closely aligned with the assessment and decision making processes the nurses described in the interviews. While there is a lot written about narrative as a way to hear how people make sense of the world, guidance for novice researchers to analyse narrative data is harder to find (Emden, 1998a; Hardy et al., 2009). Polkinghorne (1988) offers considerable insight to the collection and use of narrative as research data however he is less definitive about interpretation processes. Mishler (1986) suggests that narrative analysis is open to personal interpretation and Riessman (1993, 2008) states narrative analysis practices are necessarily adaptable, flexible and encompass various strategies and techniques.

Ultimately decisions about analysis methods were based on pragmatism and my developing understanding of narrative as a method to describe an element of nursing practice. The purpose of the study meant analysis was less about examining the structure and language used in the narratives and more about the content (Sandelowski, 1991). The data in the seven interviews was rich in detail and provided insight into a number of areas of Plunket nurse practice. In the interests of containing the data to the scope of the project I returned constantly to the research aims to focus analysis.

Analysis was characterised by constant reflection and questioning of my interpretation of the data, alignment with the principles of narrative inquiry and consideration of the need to protect the identity of the nurses and client families named in their stories. I frequently discussed ethical issues about data inclusion and exclusion and analysis processes with my supervisor, face to face and through email. As analysis progressed I was reminded by Bleakley (2005) of the need for care in approaching and caring for narrative data in order to present the findings, and by inference, participants respectfully. I was aware that inevitably I could influence the outcomes of the study, consciously or not, as I made decisions about what would represent the nurses' knowledge in the research outcomes. A late night entry in my research diary indicates the challenges I perceived and the questioning I engaged in throughout the analysis stage of the project:

"The richness of the data, the insight of the nurses, and range of thinking, the number of key ideas at first seemed unfathomable. I have found myself in an assessment and decision making process. Each time I return to the data I find out more. Each foray into the methodology literature offers new insight. I shared so much in common with participants there is a risk of frustration and collusion. I want to put it all in. There is so little guidance for analysis and such dilemmas in representing all the nurses". (2.5.11)

Early in the project I purchased a student license for the data management software package NVIVO. This was initially useful as a repository for the voice recordings and transcribed interviews. As analysis progressed I recognised the use of codes to organise the data did not align with a narrative approach and I adopted a more tactile system, resorting to hard copies of the transcripts, using the margins for note taking to identify the plots in each narrative and ideas shared between participants. Later, data was moved around in word documents named and saved systematically to indicate progression of analysis.

Polkinghorne (1995) advises the stories people tell to describe events are 'emplotted' narratives and he reconstructs themes as plots whereby "a plot is able to weave together a complex of events to make a single story" (p.19). He suggests temporally ordering a story so themes or sub plots become visible and to enable reduction of full length narratives to more meaningful shorter stories. Polkinghorne (1988) defines two types of narrative analysis based on the treatment of the data.

1. *Paradigmatic analysis* of narratives seeks to identify ideas in the data from a dataset consisting of several stories. The researcher inductively searches for concepts in the data to identify commonalities in the stories in order to group the findings and describe "general knowledge from a collection of stories" (p. 15).
2. *Narrative analysis* involves the organisation of the data into a "coherent developmental account" (p. 15). Narrative analysis treats the data as events, actions and happenings synthesised and configured to produce a story as the product of the research (Polkinghorne, 1995).

Polkinghorne (1988) advises that ultimately the goal of analysis is to uncover themes or plots in and across stories, and Riessman (2008) proposes identifying and analysing themes as an appropriate approach by researchers new to narrative analysis. My initial analysis approach called on both forms of narrative analysis described by Polkinghorne (1988) and later drew on the advice of Reissman (2008) and Emden (1998a).

In order to identify the plots in the interview narratives I set out to create a core story for each participant by reducing the transcript (Emden, 1998a; Kelly & Howie, 2007). This involved a series of steps as follows:

1. Repeatedly reading the transcript to absorb and understand the content.
2. Deletion of all interviewer questions and comments from the transcript.
3. Deletion of repeated words and phrases, incomplete sentences and other words that detracted from the key idea in each sentence.
4. Repeated reading of the remaining text for sense.

5. Steps three and four were repeated until only the key ideas remained. During this phase I returned frequently to the original transcript to ensure ideas were not lost. The resulting transcript offered a shorter, more manageable set of data.
6. A new document was created for each nurse with the case stories and ideas described in the narrative explanations grouped under broad headings representing the case stories, emerging plots, subplots and fragments of themes in a preliminary core story.

At this point I interpreted the narratives as configured in two ways. The case stories related discreet series of events that could be removed from the core story and reordered so each had a beginning middle and end. This resulted in a series of short exemplars relating events about client families. The second narrative configuration was the explanation of the events, and told of the nurses' sense making, thinking and decision making in relation to the case stories. Reference to Bruner (2004) reassured me that indeed narrative could be viewed as being enacted in two landscapes. On one hand the events of the story provide the action landscape while on the other hand the thoughts and reflections of the teller provide the consciousness landscape (p. 698). The Plunket nurses' secondary narrative, whereby they made sense of events in the action landscape was more difficult to order in a temporal way, and so ideas were grouped under broad headings to create a core story representing the nurses' explanation. The consciousness narrative accompanying each nurse's case stories offered a number of ideas common between the nurses. I judged that presenting analysis of each story in the findings would result in repetition and took the decision to present selected case stories as reference points, to the Plunket nurse setting and introduction to the shared ideas that became the plots in the group narratives.

The case stories were returned to the nurses by email asking them to verify events were correctly related, and advising them I proposed to select stories as examples to support the group narrative in the research findings. Six of the seven nurses responded promptly to affirm the story represented the case as it had been at the time of the interview and agreed to use of their story as part of the research report. Non response by the seventh nurse was taken as non consent after further attempted contact by text message, and her case story was not considered for use as an example in the findings.

As suggested by Riessman (2008), step eight involved analysis of the core story plots by following a set of guidelines for thematic analysis (Braun & Clarke, 2006). An initial thematic map included all the ideas identified in the consciousness narratives, using arrows to show relationships between ideas. As this process developed, ideas were grouped and regrouped using the aims of the study as headings in a series of ever smaller thematic maps as I revisited the transcripts and used a simple identifying system to trace emerging plots visible across narratives. Consequently some ideas initially identified as subplots were

discarded due to insufficient evidence in the data to support them, and others took on new significance as relationships between ideas developed. New plot headings were created and excerpts from each transcript relating to that plot were grouped together. I wrote my interpretation of each plot as I went which added to the process of condensing ideas and identifying the story about the data.

The final step in the analysis process was the development of three emplotted group narratives. The plots of the group narratives resulted from constantly reviewing and reorganising the text extracts as themes to identify their relevance to the research question (Braun & Clarke, 2006). The three narratives represent the findings of the study with the plots clarifying how Plunket nurses think about needs assessment, describing how Plunket nurses make decisions and exploring the influences on Plunket nurse decision making. The case story exemplars provide context for the group narratives and introduce key ideas identified across the data.

Trustworthiness

Rigour, or trustworthiness, in qualitative research is judged not by rigid or scientific measures but rather on how well and how obviously the researcher demonstrates and makes visible the use of good science (Sandelowski, 1993). Tobin and Begley (2004) suggest the term “goodness” (p.391) as a criteria for the quality and authenticity of a qualitative study. Goodness is visible when all stages of the research show alignment with the theoretical framework and ethical considerations that underpin the study.

Denzin and Lincoln (2000), Sandelowski (1993) and Lincoln and Guba (1985) advise the criteria for determining authenticity in qualitative research are credibility, transferability, dependability and confirmability. Credibility and confirmability are achieved when the researcher provides sufficient detail to inspire confidence in the research approach, and the data collection and analysis methods (Lincoln & Guba, 1985). This might be demonstrated through detailed description of the research underpinnings and the data collection and analysis process, the return of interview transcripts to participants for verification before the data is included for analysis, or by comparing the results of the study with findings from previous research into the same subject area (Morse & Field, 1996). Dependability can be judged by assessing the congruence between the researcher’s description of the methodological underpinnings, the data collection and analysis methods and the reported findings of the research (Sandelowski, 1993). Transferability refers to applicability of the research findings to other similar settings (Morse & Field, 1996).

Mishler, (1986), Polkinghorne (1988) and Riessman, (2008) go to some lengths to encourage narrative researchers to report findings as trustworthy based on the documented integrity of data collection and analysis. In this study credibility and

confirmability are achieved through the description of the epistemological underpinnings of the methodological approach, and data collection method. Further the documented analysis processes align with the aim of presenting the Plunket nurse perspective of needs assessment and decision making. Verbatim participant quotations and vignette case stories are used in the study findings and original voice recordings and all iterations of the interview transcripts have been retained. Interview transcripts were returned to participants for checking and returned with permission to use them as representation of the truth as participants viewed, understood and told it at the time of the interview. Documented meetings, and emails between my academic supervisor and me provide evidence of the decision trail throughout the study and contribute to the authenticity, confirmability and dependability of the study.

The findings presented in the data analysis and discussion chapters of this thesis demonstrate the study outcomes in relation to what else is known about the study topic. The findings can be applied to other settings, in particular the health visitor situation, therefore contributing to meeting the criteria of confirmability and transferability.

Summary

This chapter has outlined the methodological approach selected for this study. The epistemological and ontological underpinnings are described to locate this qualitative study in the theoretical framework of constructivism. I have explained my position as a reflexive researcher and detailed the ethical considerations and approval processes for the study. The study set out to explore an aspect of Plunket nurse practice from the experience and perspective of the nurses themselves.

In depth interviews were conducted to collect narrative data with seven Plunket nurse participants. The analysis process was underpinned by the work of Bruner (1991, 2004), and Polkinghorne (1988, 1995), heavily influenced by Emden (1998a) and employed principles of thematic analysis (Braun & Clarke, 2006).

The findings of the study are presented in the following three short chapters in the form of the group narratives. Each narrative is titled to reiterate the aims of the study and selected case stories are included as exemplars to introduce the ideas in the group narratives and to locate the findings in the practice setting.

Chapter 4: The needs assessment narrative

Introduction

Data from narrative interviews with seven Plunket nurse participants were analysed to construct three group narratives, each titled to reflect the aims of the study and presented in the following three short chapters. Selected case stories, as told by individual participants, are presented to locate the reader in the Plunket nurse setting, and introduce ideas that are further examined and explained through extended verbatim excerpts from the interview transcripts selected to construct the group narrative.

Plunket nurse participants are referred to as nurse and Plunket nurse interchangeably in the findings chapters. Square brackets [] are used to enclose words added to verbatim excerpts to clarify meaning when participants' words could have identified other individuals or resulted in misunderstanding.

In this chapter the needs assessment narrative is constructed of two main plots, with inter related subplots describing the key ideas about needs assessment as they were expressed by the nurses. The first of the two plots in the needs assessment narrative encompasses the development and maintenance of trusting relationships between the nurse and parents, families, and communities.

The second plot in the needs assessment narrative describes the information nurses consider when meeting and working with families. In the 'information puzzle' plot, needs assessment is depicted as a layering and piecing together process as nurses develop a picture of the family's strengths and needs.

The needs assessment narrative is introduced by the nurses' first response to the question "what do you think about when you are assessing need?"

How do Plunket nurses think about needs assessment?

*"Largely you look at the child's health; you look at the environment and the family".
(Gemma)*

All nurses responded to the opening question of the interview with descriptive lists of the social and economic determinants of need they consider when working with families. The child was clearly located in the context of the family and community and the subtext was that the family indicators directly influenced the nurses' understanding of the child's situation.

The inter-related nature of needs assessment and the rapid decision making that comes with experience are introduced in the following case story told by Carol. Ideas expressed in the story are by no means limited to Carol's experience and introduce sub plots that are expanded in the three needs assessment and decision making narratives.

Carol's Story

I am working in a rural middle socio economic group that ranges from [deprivation level] 1 – 9 and the rural [deprivation score] is very much influenced by the owner of the land rather than the people that are working on the land. One girl was a very young Mum, 16, her family were on the other side of the island, she was living with her partner, and they were in this terrible, cold draughty shearing cottage. She seemed quite confident. At face value she was a dep. 1 [least deprived], but her age, her life experience, the financial side of things, I had a gut feeling that all wasn't what it appeared.

At the first visit she wouldn't let me weigh the baby because the midwife had been the day before and was coming back the following week, and it was very cold, there was no convincing her that this was the thing to do. The referral from the midwife showed that everything was fine and grand, Mum was smiling and happy, she was breast feeding and the partner was there and the baby was wrapped up in a blanket quite alert, quite happy.

Even though it looked like the puzzle was complete; it just didn't feel like all the pieces were there. So I made an appointment for 2 weeks, which was out of my normal run; I only go once a month to those areas.

I went back and she wasn't there, she had high tailed it across the other side of the island. Lots of phone calls to get her on the cell phone to get her to try and go to Plunket, but of course she never got there. I kept going back.

Eventually I caught up with her at about 10 weeks, and weighed this baby that seemed very tiny. By Mum's books everything was fine and dandy, the baby was sleeping well, it was doing well. I had no weight to go on, she had lost her well child book, so you were just looking at what you were looking at and thinking this is really tiny. There was something that told me that there wasn't a good feeling. I didn't know what it was and decided to come back 2 weeks later.

I went back, it is an hour travelling each way and for one person you look at all that sort of thing when you are looking at workloads. The mother had described this perfect picture of this very happy baby who had been settled and feeding, but you knew the instant you saw it that things were not right, even though you could only see it from the chin up. I got her to undress it and it was just skin and bone. They had a broken down old car which they managed to get going and within the hour the baby was in at the hospital. Fortunately the baby took a bottle and it did everything just perfectly.

The immediate needs at that time, or the baby's, were to get it to medical support because it was actually only 20 grams above its birth weight. My priority was that they got into urgent help, and that Mum understood the scenario of what could possibly happen. Later on when I caught up with her at the hospital the mother said that she was very pleased that I had talked her through the scenarios of what may and might not happen. She said it was less frightening when she got in there. They didn't have money, so trying to organise help with the social workers and WINZ and trying to get something set up so they would actually have something to feed the baby with when they came home. And knowing she had no family so assessing what she had available to her instantly and also working through her plans with making contact with her family to be able to put some of those supports in place, so she at least had phone contact. (Carol).

Carol's story begins by outlining the deprivation indicators and social factors she had in her head when meeting a family for the first time. The development of a relationship through persistence by the nurse, and assessment through the application of nursing knowledge, skills and judgment emerge as key ideas in Carol's story. The safety and well being of the baby underpinned the ongoing efforts to contact the mother, based on the feeling that all was not well and ultimately resulted in rapid decision making and planning to safeguard the baby's health.

The group narrative describing needs assessment expands on Carol's story to further outline the range of factors considered when assessing child health need in the community. All nurses were careful to emphasise that the deprivation score of the family address is just one consideration. When describing the factors that comprised the assessment the nurses clearly indicated that the child was assessed in the context of the family and community in which they lived.

"I think about what makes up that family unit, including their extended family, what supports that family have. The social situation for that family, the area that they live in, having prior knowledge of deprivation score, because it doesn't always fit the family. Knowing about education, age, ethnicity, employment, renting or whether they own, and the type of housing as well. Quite a lot of the housing around here is state housing, a lot of it is very cold, a lot of un-insulated housing. Whether it is their first child, the health of the mother, health of the extended family, health of the child, transport, and knowledge of what is in the community and whether the families can get to services, past history of parenting".
(Annette)

"How much knowledge and confidence that the parents have, in particular Mum. How isolated they are, what other issues are going on, postnatal depression, obviously if there are violence or safety issues, that puts a big difference on the level of need as well".
(Frances)

The nurses' initial responses to the question "*how do you think about assessing need when you work with families?*" indicates the multiple determinants they are aware contribute to child health need. Further narrative explanation from the group of nurses constructs the two plots of the needs assessment narrative, with the subplots describing the contextual factors and the process nurses navigate when working to establish family need and make decisions about care.

The relationship

The relationship plot is the backdrop to the needs assessment narrative. The development of a relationship emerged in the nurses' stories as the key to accessing information upon which to begin the assessment of need.

"It is about knowing your clients and building that relationship. You can develop a relationship quite quickly with somebody and how you develop that relationship long term and short term is important to get better outcomes for families". (Carol)

The nurses saw trust as the foundation of the relationship. Primarily the establishment of a trusting relationship was seen to equate with access to the family, and consequently, to reciprocal information sharing.

"No one is going to give you all of that information until they know and trust you a bit more." (Erica)

"It's just acceptance from the client's point of view for you to be in their home, to be welcomed back". (Annette)

"Just by the very nature of the job you get close to people very quickly, you build a trust relationship very quickly. You have to, to be able to do what you've got to do, if you want to be acceptable to the family, and helpful to them and be seen as somebody of value in terms of them bringing up their child". (Donna)

"It is about spending a little bit of time, it is about the first point of contact you ever make, if you establish the relationship with people then, you are much more likely to make headway with change, there is a trust built up, they are not suspicious of you all the time." (Barbara)

Development and maintenance of the relationship was seen to be contingent in part on the nurse demonstrating qualities and skills that facilitate a trusting relationship.

"I think people intrinsically know whether you care about them in a genuine way and they pick up on that very quickly. I think that is part of building trust and that feeds into communication and communication feeds into data collecting and that feeds into assessing need." (Donna)

In addition sufficient and regular contact was seen as important to both the development of the relationship and to accurate assessment. When the frequency of contact is influenced by the context of the working environment, the nurses' skill in maintaining contact and making assessments becomes more important. Barbara and Erica, experienced Plunket nurses, referred to changes in the level of contact possible in the current Plunket setting compared with their previous experience.

"We see families so much less than we used to, you saw people so often that I could walk into a house and say 'oh [name] you are looking a bit down today, what's wrong?' I mean now you can go and you've got to think has this person got post natal depression or is she just shy, because you don't build relationships like you did in the past, so you have to be a lot better at it, and being able to read people". (Barbara)

"We were into the homes quite a bit in those days, you know, every week until 6 weeks and then fortnightly until 3 months. So you almost became a family friend or part of the family and there was that relationship and trust and you picked up a lot more things. These days it is a lot harder, you have to be very vigilant and onto it and sometimes it is just a gut feeling that you have". (Erica)

Gemma has less experience of previous ways of working; however she also saw frequency of contact as valuable in terms of establishing a relationship and maintaining access.

"Largely they need contact and it's not necessarily about me going in there and fixing their problems, it is maybe about me going in and becoming part of that family so that they will have me back again and I think that is probably the key thing with the high need families. I can't fix all their problems but if you can get to a place where you are a natural part of their environment where you go every month or once every few weeks, and you see them when you are visiting the neighbour. You can slowly make an impact". (Gemma)

The nurses suggested that regular contact and being well known meant the family accepted the nurse more readily, and enabled more accurate assessment based on previous knowledge of the family, especially the mother. While the Plunket setting is one influence on the amount of contact between the nurse and family, family factors also have a role and require the nurse to be persistent to access information and maintain the relationship.

Persistence

Persistence on the nurses' part is important to maintaining the relationship and achieving contact. Carol's story indicated her diligence in following up her concern for the baby and 'gut feeling' that she needed more information. In spite of the travelling distance and implications for her caseload she continued to attempt contact. Barbara referred to persistence in light of the complexity of families' lives. She recognised and described the flexibility needed to continue to work with high needs families.

"Persistence is what keeps them in the service, you finally find someone home and you go in there and there are six family members there and you start talking about something and they are all glued to you. I don't take it personally when someone's not home and I have reminded them, because they have lives that are complicated, lives that are highly stressed

for a lot of them. It is one crisis after another, if it's not family, it is the crime things or the drugs thing, or the court thing or the WINZ⁴ thing or the house thing and so when you get there, you make a huge difference. But I don't kid myself that they will be sitting there waiting for me to come, when other things pop up that are more life challenging than well child health and so, they are often not there, even if you remind them, because it doesn't happen that way. And if it was '3 strikes and you're out'⁵, I'd lose ¾ of my clients" (Barbara).

The nurses described the importance of persistence and relationship skills in order to maintain sufficient contact with the family. Understanding complexity and the significance of the relationship extended to the ways nurses described working to maintain contact with families.

In relation with the family and community

In an expansion of the relationship plot, the nurses recognised that while they had relationships with individuals, usually mothers, they also developed connections with families and the wider community.

"It is knowing your community, it is having that knowledge, the connections, if you lose contact with the family you know where someone else is...who will know where to find them". (Annette)

"Often mums will be telling me 'oh such and such, have you caught up with her lately because I am a bit worried about her' and they know that I see most of the mums in that street. It benefits my practice, they trust me and they know me". (Gemma)

Knowing other family members and the community was seen as a key determinant in achieving access and continuity of care, and to additional information on which to base assessment, especially for high needs families.

"When you don't know the community, you don't know who belongs to who, and who is supporting who and who the risky people are perhaps in that wider circle of people". (Donna)

"I've learnt that the first thing you say to a male gang member, is 'what a beautiful dog' and you're in and every time you go there they will hold that dog so it doesn't eat you on the

⁴ WINZ – Work and Income New Zealand

⁵ Assumed to be an analogy to the three stage sentencing regime, now law in New Zealand (Sentencing and Parole Reform Act , 2010) or refer to the rules of softball where three unsuccessful attempts to hit the ball results in the player being disqualified. In this case the nurse suggests that arbitrary limits to the number of attempted contacts allowed to families would result in many being disqualified from receiving the service.

way in, they'll hold it on the way out, and I can go to a house and the head of the gang across the road will say 'oh she's not there, she's gone to [place name] for three days', so it's where you get accepted by not just that family but by community. That is a great spin off because I can say 'oh Auntie, I haven't seen so and so for a while' and she will say 'she's in that yellow house, opposite the couriers, I'm not sure of the street it's kind of past that one' and you say 'any chance of a number?'; 'oh nah, nah, it's the yellow house, paint peeling off, red car outside'. And you think 'oh red car, yellow house, oh that's the one'. So that is relationship building and hopefully it's a spin off for lots of good things." (Barbara)

The relationship plot described the quality of the relationship between the Plunket nurse and the family as a key determinant in accurate needs assessment. The nurses' stories described ideas of working alongside parents, families and communities, with trust as the basis for accessing and sharing information. The nurses saw themselves as facilitators of the relationship and referred to the importance of persistence and flexibility to maintain contact. Carol's story indicated an unfolding process underpinned by access to information through the developing relationship, persistence and understanding risk and resilience factors. Carol alluded to nursing judgment and decision making that will be further explored in later sections.

The information puzzle

A second plot, the information puzzle, emerged in the needs assessment narrative. Erica's story is included here to offer further insight to the needs assessment process and introduces subplots that describe the information nurses consider, the skills they bring, and knowledge they draw on the assessment process.

Erica's story

They were first time parents living in a low dep. area. They had not long been living there and it was a flatting, renting situation. They weren't particularly young, they were early 20s. But there was no phone and they didn't have any transport, they used the bus all the time, and he was unemployed. The first visit I remember turning up to the house to knock at the door and I noticed a crack, down one of the panels of the door and a hole in the side of the wall. And there was a tin can that was just chokka with cigarette butts. I was welcomed in and the place was very tidy and very ordered. The partner was home. Just looking around everything was fine, the baby was beautiful, being bottle fed and had put on weight, but the partner.... he bothered me a bit, because he just was there and he kind of took over the whole of the time I was there. He asked lots of questions which on the surface looked like a very interested and caring partner but it was kind of over the top to me. I had known somebody else in my younger days and so I was a bit alerted to the fact. He was just talking himself up and telling me about what a wonderful father he was and was going to be and the Mum got quieter and quieter. They told me at the first visit, that her parents didn't like him and they weren't going to have anything to do with her parents anymore because they didn't like him.

They were going to get extra visits because they were first time parents and because of some of the other social things, like they were unemployed and no transport and no phone

and probably lower income coming into the family and so some of those health determinants you could see would marry up with having some extra visits.

I made an appointment to go back the following week. I turned up and they weren't home and I left a note. I went back again, probably that same week and caught them both home again and I felt frostiness between the two of them and the mum hardly talked at all, he still did most of the talking. And so I said "could she come to the clinic next time?" hoping maybe she would come by herself. She made it to the clinic appointment, a couple of weeks down the track. She said she had moved back to her parents. She told me that he was physically abusive and he was not letting her have any money and not letting her do anything or go anywhere.

I am not quite sure what happened long term whether she did get back with him. I moved from that area, but I did pass over to the new Plunket nurse and talk to her about them. (Erica)

Erica describes the combination of information that comprises indicators of need. Deprivation factors and her knowledge of the area, combined with her observations and intuitive responses, are in turn influenced by her previous experience and training and the relationship she develops with parents.

"I suppose it is putting all those things together and you can't rely on the dep. score, it is maybe a good indication of what is happening in that house or has been happening in that house as far as income and all those other things, but you have to put it all together with your clinical observations and the information you collect and your feelings about what is going on and you get that from building some sort of relationship with the family" (Erica).

Nurses gave many examples of how they considered the deprivation score as an indicator of need, but were clear that it was only a part of the puzzle. Risks or strengths related to factors other than deprivation could override deprivation as the main consideration when making an assessment. It was apparent the Plunket nurses applied a process that considered family resilience in the light of evident risks to the child.

"Deprivation band doesn't work for a lot of families. Needs assessment is so critical in how you work with families and some of the issues and challenges they face". (Carol).

Frances provides an example where deprivation score was not an effective indicator of family health need and the other factors considered to inform assessment.

"I have got a family at the moment, that are twins and it is a blended family. First children for the mother, and two teenage boys and she has got some experience in early childhood but she is really doubtful of herself, low confidence, now exhibiting some post natal depression and so I have been visiting quite a lot. And even though her education, background and their resources theoretically are good, that is not helping her in her parenting quite so much at this point in time, while the twins are under one. So they are not

a dep 10 [most deprived] but they are still high needs. And that is why it is so different to the deprivation score at some points". (Frances)

In contrast Gemma described a family where the deprivation level and other social information indicated high need, but her judgment of the mother's capacity weighted her assessment of need.

"There is a single mum that I am seeing on the same street as some really high needs, and you just get a feeling, she is ok. It is really quite difficult because on paper she is a single mum, she is in one of those state houses, she has got a car that doesn't have a registration and so she can't drive it but she's got, sometimes I call it 'mojo', she is confident and she is capable and the curtains are always open and she has got her head out of the clouds. She is on a low income, but even in [street name] and in that house, with that family specifically I feel confident that she is doing well, her baby is having all its needs met.

She has still got all those [deprivation] factors so it is not really a case for me to decide that I have got a feeling that there is nothing to worry about here. Part of my job and the clinical assessment is looking at all the factors, and realistically, all these factors look like this lady might be busy, stressed. This is not her first baby, she feels very confident about that sort of stuff. But even if there is no level of need it is just nice to keep a presence, and again, if you have a presence when there is no need, she will feel that you are accessible if she has a need. So wanting to build a good relationship with her". (Gemma)

In this case Gemma assessed the parent's resilience providing protection against the risks posed by the socio economic and deprivation factors. Her decision to maintain contact recognises the potential for the situation to change and suggests she understands the risk to family coping mechanisms and the implications for long term health outcomes when deprivation is considered. Erica also alluded to the fragility of family strengths and potential risk to children where the family is compromised by social and economic deprivation.

"Some families may be in a dep 10 band. So long as nothing much goes wrong they can get by and they are doing quite well, but I think the health determinants mean that that baby is still more slightly disadvantaged than one where there is more income coming into the house. And so maybe something that happens might not blow another family out of the water, will blow them out of the water and they just can't cope" (Erica)

Annette told the story of a high need family in her caseload. She provides an example of the ways the nurses considered family strengths as a balance against risks in the social and economic situation. Further, she articulates the judgements the other nurses described as they considered all the factors that indicate need and offers a link between the needs assessment and decision making narrative.

“My general feeling was she was a second time Mum who had lost a child [removed by Child Youth and Family], but was doing a really good job, actively sought information, had pretty good supports in place, but had the battles more of the socio economic side of things; no transport, low income, the past history and her doing community service and just getting her life on track. She’s got a partner that is not the father of the child and that brings in certain complexities too to do with the attachment of that partner to the child. She is still young but her last experience was when she was 16, three years in a teenager’s life. Well, she has probably matured quite a lot so there is probably a slightly different parenting experience; I think she is wanting to make it a really positive one. Things like deprivation, hasn’t changed, children have been uplifted, young mum, there are the strengths, she actively seeks and she was accessing her GP, but... really a lot of her social situation hasn’t changed for her”. (Annette)

Gemma most succinctly located socio economic indicators in the context of child health risks.

“Health wise living in a cold house is only going to make glue ear and all those other child health problems worse anyway. When they are cold they smoke inside, and often state houses are two story houses and the only heater is downstairs so the whole family will sleep downstairs on a mattress in the lounge, including new born babies so there are safe sleeping and hygiene issues and they all have the curtains closed all day”. (Gemma)

Constructing the information puzzle was viewed as an ongoing process. Similar determinants may have different implications for each family. The assessment process involves gathering information through asking questions, observation and the application of judgment to establish *what is* for each individual family.

“Needs assessment is something you are doing in every minute of every visit. It is not something you do at the beginning, it’s something you do continuously and it changes”. (Donna)

“Definitely the socio economic influences some of your decision making, but it is deeper than that, in a way that kind of puts people into boxes, it is just making sure that we are looking at the individuals as individuals. It is about gathering more information, remembering that the box isn’t always square, it can be octagonal, it can be round, it can be broken and bent and you’ve got to find ways into that box to remove the bits that you need to make that assessment. That it is untangling what we have got to make it clearer in our own heads to get a picture of what the need is for this parent, when it looks at face value like they are very similar, and that comes from what the parents have told us. It might be the one thing that they haven’t told us that you think that’s what makes it different”. (Carol)

The nurses described the place of the deprivation score and other factors they consider as they meet and get to know a family. Information from other sources is also essential and influences how the nurses regard the 'on paper' information and, in some cases, begin planning care before they meet a family.

Sources of information

Plunket nurses receive information before they meet a family, usually from the midwife referral, and suggest that such information and their knowledge of the area can be the foundation of their assessment and beginning of planning. The referral template provides general information including family, birth and post natal history. A copy of the referral is left with the mother and the quantity and quality of information varies between referrals. Gemma described a situation where the midwife contacted her to offer information, not included in the formal referral, which initiated her process of assessment and informed planning before she met the family.

"I saw a baby yesterday where the midwife had called me to just give me a little heads up to ask the mum about her maternal mental health. So that is always a factor that can take a low needs family on paper up to a more high needs situation. This is a mum that has got three children and well resourced but she is suddenly overwhelmed. She has become really high need, even though they own their own house, they have both got cars, he has got a good job, she is just on maternity leave, she has a good job, but her mental health is suffering. It was great knowing that before I went there, I planned myself a bit of extra time, I didn't feel rushed and I knew we would need to talk about that sort of stuff". (Gemma)

Donna provided another example of undocumented information sharing, in this case of critical information, which underpins assessment prior to the first meeting.

"You might have a note from the midwife saying don't see this family until you've spoken to me and then there are CYF issues and partners are in jail and a lot of other stuff that actually before you even set foot in the house is spinning around in your head, thinking so I need to just be aware of what this might mean for this baby. Are there care and protection concerns? Is this baby safe? Is this mother safe? Yeah, it gets more complex". (Donna)

Frances pointed out that information shared at handover of care within Plunket was a further source that influenced assessment and prioritisation decisions about planned contacts.

"If I get some notes marked as a high level of need, I know that I have got to be really aware that possibly they might take me more time particularly for my initial visit to do some really good ground work, relationship stuff. I have to be aware that there are lots of factors going on for this family". (Frances)

Nurses described an unfolding process with the picture of family need developing as the relationship grows, over time and with a number of contacts, or as the timing is judged appropriate to ask more or challenge the parent. Erica and Donna described the challenges nurses can face as they strive to find out more.

“I think sometimes, you go to families and you know they are telling you all the things they think you want to hear and that’s what I was getting from him, he had worked out what he thought a Plunket nurse would want to hear. The first and even the second home visit was just, very orchestrated by him, so I wasn’t going to get a good picture I don’t think”. (Erica)

“Things like family violence, or things like other people who seem to be in the household, that you can’t ask the mother about the first time because the whole whanau are there. Or there are all sorts of other adults who you have got no idea who they are, are there, so that is a barrier in terms of needs assessment in that sometimes you can’t get all the information that you might need to inform a plan at one bite, so you have to keep nibbling at it”. (Donna)

In the interests of gradually accumulating information, nurses referred to the effectiveness and preference to continue contact and assessment of the family themselves rather than refer to a health worker.

“I think that is where we are lucky here in that we do our own additional work. So you haven’t got the complication of yet another person going in there and seeing something different. You can actually keep at it yourself”. (Donna)

“I guess we work always with Community Karitane nurses⁶ and they can go into the homes too and do those additional contacts and sometimes that is the way to go and other times you just think well no it is probably more important that I get back, because I have these thoughts or ideas and I can pass them on to someone but sometimes it is hard for them to have lots of different people going in and especially families that are a little bit more fragile, they don’t want a whole lot of different people coming that they have to tell their story to another time.” (Erica)

Assessment over time and information gathered from a range of sources enables the nurse to construct a picture of the family’s need. While all such information forms the basis of the assessment and consequently decisions about planned care, the nurses described their own contribution to the assessment as a range of skills that are developed through education and experience.

⁶ Community Karitane are Plunket Health Workers educated to Level 4 on the NZQA who work under the direction of a Plunket nurse to deliver delegated care, usually related to parenting practice.

Nursing skills

Erica's story described the cues she identified and was considering from the time she received the referral, and then as she approached the home and interacted with the parents. Observation skills combined with experience, training and intuition were described as elements nurses relied on to make assessments. The home visiting setting was seen to yield helpful and important information and the nurse's skill to identify cues further enabled the construction of the information puzzle.

"Maybe as a much younger person I might not have noticed that or been alerted, but it is the work we do so we are used to going into people's houses and thinking about how things might be for them, so we are probably pretty vigilant, and those things are like little cues". (Erica)

"I think we come with a lot of knowledge and skills and I think nurses are very good at observing, we get so used to doing it day to day that we don't even know we are doing it sometimes". (Carol)

"Whether you are seeing them at home or in the clinic makes a huge difference to how much information you have got to begin to gather up that data in order to start assessing need. We are not just looking at symptoms; we are absorbing the whole picture that is sitting around us". (Donna)

Nurses expressed a range of views about the place of intuition, or gut feeling in their assessment. Carol suggested in the first case story that her 'gut feeling' and lack of sufficient information led her to want to find out more and prompted her persistence in returning until she could fully assess the baby. Erica referred to her unease about the male partner in the case story as a 'gut feeling'.

"I think sometimes Plunket nurses use that in our work, we think 'something isn't quite right here, it doesn't sit quite right'. And so you do go back and you go back until you have something a bit more concrete". (Erica)

When asked to describe gut feeling or intuition more clearly all nurses suggested intuition was informed by more than an unfounded suspicion.

"Just years of experience in nursing, I think knowledge and experience are the key and perhaps that is what adds, or enriches the gut feeling, that is why you have got a gut feeling because subconsciously it is all going on but we don't categorically go through the ching, ching, ching of the grey cells as you are doing it". (Carol)

Frances and Gemma, the least experienced nurses in the study, were the most cautious about ascribing assessment to gut feeling. They were clear that observation and experience underpinned any instinctive response to a situation.

“It [intuition or a feeling] is definitely something that you get. But I don’t really think you could ever say it is that on its own. If you walk into a house where there is a great big terrifying dog, AND they are smoking inside AND is it a state house AND there is no furniture AND you don’t want to sit on the couch because it looks so gross, it is not just a feeling, I don’t think it would ever be just a feeling”. (Gemma)

“...but are they instincts or just the number of factors that are compiling but you just can’t name them? You know, instinct is about, a whole lot of constructs that have come together to form that opinion, but there is something that has been there to form it in the beginning isn’t there?” (Frances)

Frances expanded her thinking about intuition in the context of her learning from a Family Partnership course. She suggested the importance of clarifying an instinct through questioning in order to be accurate about assessment.

“Because sometimes you can be so off the mark it’s not funny and the instinct will only get you so far. But if you have got a good enough relationship that you can say ‘Hey I’ve been wondering about this for you’ or ‘you said something to me a number of visits ago and just wanted to revisit that’ ”. (Frances)

Summary

Plots and subplots in the needs assessment narrative offer insight to the ways Plunket nurses think about needs assessment. They view the relationships they establish and maintain with families, and the wider community, as critical to achieving access and thereby to information that enables them to develop a picture of families’ needs. The child is considered in the context of the family, social and economic context. The nurses suggest that ongoing contact and observation over time layers their knowledge of the family. The information jigsaw describes the range of information the nurses accumulate and organise, and the sources from which the information is accessed. The nurses’ descriptions of the ways in which they view the information suggest they apply experiential and professional knowledge to the assessment process. It was clear that while the nurses were collecting information as the foundation for the assessment they were also making decisions based on their interpretation of the assessment factors.

The next chapter presents the group decision making narrative. The plots and subplots describe how Plunket nurses make decisions, indicate how assessment informs decision

making and describe the contextual and organisational influences on decision making in the well child setting.

Chapter 5: The decision making narrative

Introduction

Two plots construct the group narrative related to decision making. Firstly the nurses told of the importance of working with and including the family in decisions. This especially related to decisions about referral which are also informed by the nurses' views about effectiveness and appropriateness, and influenced by judgments about the effect on the relationship. The second plot describes the ways nurses make decisions through a process of prioritisation, with the child's safety and wellbeing the bottom line and sometimes overriding the nurses' stated principles of working in partnership with the family.

A case story told by Barbara offers insight to the complexity of the Plunket nurse practice setting. Barbara's story reinforces ideas of relationship, persistence, and constructing the information puzzle described in the group needs assessment narrative. The story sets the scene for the nurses' decision making narrative, introducing ideas about timing, prioritisation and working with the family.

Barbara's story

I was referred to a Maori Mum who's in her late 20s and has got 5 children. [It took] Six attempts before I got to do the first assessment. I walked in the door, there was a little boy sitting on the couch, who I thought must have been about 6 or 7 but he turned out to be just 4. And he was HUGE.

We started off talking about the new baby and how things were going, and after that I said to the little boy 'do you go to Kohanga or do you go to kindy?'" and he said 'no'. She [the mother] said 'I don't send him because I'm worried he might get teased'. I thought, this was my opportunity to say 'are you concerned about his weight?', it was just like opening up a total can of worms for this family, because they'd had a baby, prior to this little boy, that had died of pneumonia, they had taken him to the doctor and the doctor had said he was fine and they had taken him home and he had passed away.

She technically isn't with the partner, she said that he had been violent while she was pregnant. It turned out that her partner was using P.... I said to her, 'Has he always used drugs?' and when they'd lost this little boy, he had started to use drugs and he had started to become abusive. He hasn't been violent since he hasn't been using P, but that is a concern for me.

So, the picture got painted more and more and it turned out that this boy had been totally spoiled, particularly by his father, because he was the child they had almost 10 months after they had lost this baby. When I talked to her about it, she said he [Dad] had been coming in and taking him into McDonalds and giving him 2 double breakfasts, because that was his way of treating him.

Every time I go back I think, what I am going to find out this time, what travesty has occurred? I can make an appointment and they are not there. They do spend a lot of time up [location], and the cell phone doesn't work up [location] and the landline has been disconnected about 3 times and they've probably had about 3 cell phone numbers since I

first met them. I might call 5 or 6 times and leave a note and then suddenly I will get a text, when they have got money on the phone, or when they have got a phone that works.

I have got them enrolled in HIPPY⁷. HIPPY is home based, they have been going along to huis and it's almost like taking little steps first before she can just feel comfortable at him going off to kindergarten. I just think that she didn't know where to start and I think she was feeling really guilty because she knew he was grossly overweight and felt embarrassed about that, so hopefully one thing will lead to another and she will have confidence.

Dad comes out now when I am there, and I always make a point of talking to him and saying hello when I get there which I find has made him warm up a bit. So little things are happening slowly, but not probably as quickly as I'd like them to be. But for that family they are making great strides I think. (Barbara)

Working with the family

Barbara emphasised the nurse's role in advising families of their options and supporting them to be involved in choices about contacts and referrals. The family view of their situation was considered alongside the nurses' assessment and decisions were made through capitalising on family expertise to achieve joint ownership.

"I could jump in there and say 'right, you need grief counselling and you need drug and alcohol service' but to me the challenge with a family like this, is to get alongside them and it is a very complicated thing to be able to get them to see what they need, because you can't just go in and say, 'this is what you need', because it doesn't work that way" (Barbara).

Frances suggested that including the family in the decision about level of contact can be challenging when the nurse recognises risks due to socio economic factors, but the family does not. Such a situation demonstrates the importance of the nurse's skill in negotiating to maintain the relationship, while working to provide the level of contact she assesses the family needs.

"I am very much into having the family determining how often and what I put into their visit and then that becomes what they are assessing their need as and I am measuring that up against what I think their level of need is and how often I should be visiting and trying to marry that together.

What you get sometimes in high deprivation areas, is you have families that don't have the education and don't have the parenting skills, and they are eligible for more visits and I think they are needing more visits, but then they don't see the need, then there is a negotiation around that". (Frances)

⁷ HIPPY- Home Interaction Programme for Parents & Youngsters is a home-based programme that supports parents in becoming actively involved in their four- and five-year-old children's learning.

Erica described her philosophy to deliver care that recognises the parents' expertise and acknowledges their assessment of need as valid. She suggests that the approach may require the nurse to navigate organisational or contextual issues. It was notable that as some nurses suggested they would respond to family need, either assessed or expressed, the subtext suggested they considered they were following a plan that was outside the allowable contact for the family.

"If a mother is concerned about something then it is worth following up and if she says something is so, then it is, she is the expert in her child. Sometimes if a mother is saying 'I want to have more visits' or 'I want more reassurance', that is ok by me. I don't know if that is what Plunket would think but it is valid for me, if someone is saying "I need extra" then..."
(Erica)

The nurses described their practice of advising the family of their entitlements and what was available to them from the Plunket service and from others. They recognised the need for the family to understand and agree with any plan, inferring principles of partnership and acknowledgement of the family's expertise and preferences. The narrative expanded on these ideas in relation to decisions about referring families to others, either within Plunket or external services.

Decisions to refer

Nurses talked at length about making decisions to refer to others. The decision making narrative described a preference to continue contact with the family in the interests of the developing relationship and access to sufficient information to make the assessment.

"You do have to do the whole thing in partnership and find out what they actually want from the service". (Erica)

Nurses suggested that although there was an imperative to refer to others in order to make the most of the available resource, their referral decisions were influenced by a number of other factors including family preference and the nurses' knowledge of the quality and availability of referral services, and the scope of practice and capability of others.

"So I haven't sent in anyone else, because I just don't feel that they will accept another person into that family at this time". (Barbara)

"Ultimately it is the parents' decision because there is no point in me saying "I am going to get the Karitane in to visit you" and they are thinking 'well why?' and they don't really want that to happen, so you have to be really careful about what the family is wanting not just what you think they should have and knowing who they are and how they respond to new people". (Frances)

Gemma described a more standard approach, that is nonetheless modified by the 'it depends' factor underpinning many of the nurses' descriptions of the balancing and judging that informed their decisions about referral. Gemma usually refers clients to the Community Karitane (CK) for support between her first visits, in the interests of managing her time and the caseload. She also recognises the expertise of the CK. However her decisions are mostly influenced by her own relationship with the family and her judgements about effectiveness.

"If it is a first time mum, quite routinely I will ask [CK name] to visit between my first two visits, because I think when you have a new baby and it is your first baby you have a level of need for some information early on. There is a lot to cover in that short space and I have another appointment to get to. It depends on the need I have assessed. Still thinking about that family I visited yesterday, I have known that family for 3 ½ years and I have a good working relationship with them and I have a good understanding of that situation, so I will probably do some additional visits myself there, it is not out of my way in that area".
(Gemma)

Annette described the value of referring to Plunket health workers, in the context of making the most of team expertise, managing time and the caseload.

"It is good just to have extra input with para professionals. I have a particular role and their role would be quite different. Every client is entitled to their health checks and in their time frame. If I am doing a lot of extra support visits myself then there is potential that there is someone else who is missing out on being seen for one of their scheduled health checks".
(Annette)

Knowledge of the scope, expertise and availability of referral services was a factor in decisions about referral. Decisions about referral were shaped by nurses' views about effectiveness and responsiveness of the services available for referral and considered safety for the family.

"Family Start is a good support network to refer to but unfortunately in [location] Family Start are predominately someone's family and therefore, there is almost no confidentiality and I have got quite a number of families that say 'oh no I don't want to get involved with that because Aunty so and so works there and I don't want them finding out what's going on' ". (Barbara)

"You have got to be really knowledgeable about the other services, because if you refer on, sometimes it won't be a right fit for a number of reasons. If you know they possibly can't provide what you are asking them to provide, or they are without a coordinator and that

referral is going to sit there for a number of months, then you have got to be very careful, and talk to the family about what they can expect". (Frances)

Nurses described a philosophy aligned with a partnership approach where both the nurse and family contribute their expertise and work together to make decisions. Nurses understood the need to devolve care to others in order to manage their own caseload; however decisions about referral were influenced by the nurse's knowledge and view of other services' availability, capacity and capability. Participants were clear about the expectations and responsibilities of their role in relation to child protection and while they appreciated the importance of family input to effectiveness and the relationship they also recognised the need to prioritise interventions.

Priorities and child safety

Barbara's story introduces the Plunket nurses' ideas that decisions are made in response to opportunities, timing is important and the approach the nurse adopts influences the relationship. The intersection between assessment and decision making is clear especially in relation to priority setting and working to protect child wellbeing and safety. Nurses outlined the ways they capitalise on cues in the home and adapt their approach in the interests of developing the relationship, while working to protect child health.

"I don't go in with a formula, I go in there with thoughts that I want to cover certain topics. I think you seize the moment and you do that with every client you ever see. You see a multitude of things in the home, but it is about what is the most significant, or the most life threatening, or what is the biggest health hazard for mother or baby? And you work on those first. There are often lots and lots of things you need to address". (Barbara)

"It is not just in terms of family violence or any of that big stuff; it is little things, like you might just notice that there is a [baby] bottle of tea sitting on the sideboard. And so you might think 'is the toddler in this family drinking tea?' and just file that away so that the next time you might say 'well let's have a look at so and so today and how are you getting on with her and what's she eating and drinking?' and you unpack it without confronting, they tell you and then you can do something about it". (Donna)

"You can't walk in there and say 'hi my name is [name] stop all that' but bit by bit you can give them a bit of strength and quietly have a few conversations that might eventually have a bit of impact". (Gemma)

The nurses were sure that the bottom line was the wellbeing and safety of the child. While they generally described practice that was grounded in principles of partnership they also outlined situations where child protection overrode the importance of the relationship.

“You have to keep your eye on the ball and that’s what often will direct your decision, is thinking of the child and the best outcomes. If it is not going in that direction then you have to get more assertive about how you work with families, and that involves asking the hard questions”. (Carol)

“I think safety, the whole care and protection, the safety of the baby in terms of nutrition and rest and basic needs are paramount, that has always got to come first”. (Donna)

Summary

Plots in the decision making narrative indicate Plunket nurses make decisions underpinned by a philosophy of considering family knowledge and preference about ongoing contact and referral. Decisions about referral are considered in light of the nurses’ knowledge of the availability, scope and capability of others, and the nurses’ judgment of effectiveness for the family. Caseload management is a further factor the nurses consider when making decisions based on their understanding that referral to others is the means by which they can deliver care to the whole caseload. Balancing priorities and making judgements combine in a continuous process of decision making. The nurses described making the most of opportunities and adapting their approach to work with the family in ways grounded in the principles of partnership, while being sure that child safety is paramount.

The decision making and needs assessment narratives describe dynamic and inter related processes that call on the nurses’ knowledge and training, and their personal and professional skills. The nurses’ narratives introduced the contextual factors that influence their practice. The next chapter extends the decision making narrative to describe the organisational and contractual influences on Plunket nurse needs assessment and decision making.

Chapter 6: Influences on decision making narrative

Introduction

The group narrative exploring the influences on Plunket nurse decision making cannot stand alone. Interviews clarified that assessment and decision making are inextricably connected. Nurses reiterated that the safety of the child was paramount as they described the influences on their decision making. Exploration of the influences on Plunket nurse decision making elicited two plots. Firstly ideas about the place of supervision and peer support, and the nurses' experience and education emerged and were shared sufficiently in the group of interviews to represent an emplotted group narrative.

The second plot describes the influence of the Plunket contract on nurses' decision making. While the participants each referred to the Plunket contract throughout the interviews this was the area of the nurses' talk that showed the greatest variation. Therefore individual narratives are presented to best demonstrate the range of ways the Plunket contract influences decision making.

Supervision, education, experience and policy

The nurses all described peer and Clinical Leader supervision as an influence on and support for decision making. They viewed supervision as an important safety net and opportunity to explore options, especially when they were challenged by a particular case. It appeared they had good access to the Clinical Leader and valued her contribution and reassurance especially when faced with practice dilemmas.

Gemma introduces ideas the participants raised about the place of supervision in supporting safe practice and influencing her decisions.

"It is just helpful being able to talk to someone who has not necessarily had the same family, but they have had similar situations and certainly someone who does the same job as you. The people I do peer supervision with have been doing this job longer than me but we have all just got different things to put into the pool and so it is good to get some ideas and often it is just reassurance that that you are on the right track. [CL] works in this building as well, so I can talk to her most days. Otherwise you end up just so in your own world doing your own thing that you need to stop and say 'hey is this the right thing to be doing?' You need to be checking in with someone else and sharing what you are doing".
(Gemma)

“Because you are really under pressure to make that decision by yourself, and sometimes other people just see it from a different perspective or they say ‘oh had you remembered about such and such?’” (Donna)

“That’s where I tend to use professional supervision, go to your peers, their knowledge can give you a little bit of support or direction”. (Carol)

“Colleagues to talk things over, ‘this is the situation, this is what I have done, can you think of anything else?’ Clinical Leader advice, I am not slow to ring GP practices”. (Annette)

The nurses sought supervision in a range of challenging situations. They also described education, Plunket policy and their practice experience as influences that supported decision making, especially in relation to child protection and family violence situations.

“Education around family violence and the violence cycle and things is always on your mind”. (Erica)

“I look back to when I was first a Plunket nurse and realise how unprepared I was for knowing what to do about some of those care and protection issues. I think it wasn’t something that ever came up in the training at that time, and sometimes you would strike a situation and you didn’t really know what action you should take, you didn’t have the information to tell you this and this and this means that this child is not safe now and I need to act on that. It wasn’t clear cut”. (Donna)

“I’m well aware of the policies and things on domestic violence”. (Barbara)

“I follow the Plunket umbrella really, the Tamariki Ora schedule and the policies, the education, and the things that Plunket has put in place to keep us safe because we get real extremes”. (Carol)

The nurses identified peer and Clinical Leader supervision, education and Plunket policy along with nurse experience as influences on decision making. Supervision, education and policy are part of the Plunket organisational and systems context. The other element in the Plunket context that emerged as an influence on decision making is the Plunket contract (to deliver the well child schedule) with the Ministry of Health.

The Plunket contract

The Plunket contract and nurse and manager interpretation of the contract emerged as a discreet influence on nurse thinking and decision making. References to the Plunket contract were woven through each interview however nurses described a range of understanding of the Plunket contract.

No case story could be identified to introduce or represent the group narrative describing the influence of the Plunket contract on decision making. Therefore the findings in this section represent individual consciousness narratives and demonstrate the range of understanding, and practice in response to interpretation of the Plunket contract.

Time and daily contacts

Participants expressed understanding of their obligations to the contract in terms of the time they had available and the expected daily contact rate. Gemma sets the scene and describes a number of elements other nurses referred to when describing the influence of time and output expectations on their decision making.

“And my responsibility to meet the contract, the numbers side of this business as well. I know that the ideal aim is to see seven a day. I consciously plan my week, if I have a full day of clinic you could book 12 or more, but I usually see 8 or 9 and that full day allows me to have the luxury of taking my time on my home visiting day for those visits that need the time. And you have to be flexible with that but that seems to me to be a mix that has worked well for me so I am meeting my obligation with the numbers game and still seeing all those people who are able to come here, while taking the time to see the new babies in their own home and the high need families that don’t have cars. And just having the time to go and visit them and not feel like I have only got 20 minutes and then I have to be gone. Because you are not doing a good job like that I don’t feel like they will want you to come back, and they don’t need to feel the pressure that I am being rushed”. (Gemma)

References to the pressure to see a certain number of families each day were common, and seemed to reflect the way the contract was interpreted by the nurses and their managers. Erica described time as an influence on her decision making in relation to an expected number of contacts to fit into the day, and the difficulties that can pose when managing a caseload. Her thoughts relate to the ideas described in the needs assessment narrative when the nurses talked of needing to make repeated visits to be confident they had sufficient information to make decisions or follow up on an observations or concerns.

“I guess time is always a factor. I know that there is this expectation that you see so many people per day and there is a lot of paperwork these days and so time sometimes is a factor to fit all these things in and getting back to someone who you have been a little bit worried about and you have all the other things as well”. (Erica)

Frances described her understanding of the number of contacts expected in a day. She indicated her manager had oversight of her contact rate and that she needed to account for her decisions to respond to assessed need.

"I am very aware that we need to be seeing so many people a day. Say the goal is 7 or 8, a day, and if I have seen someone quite a lot recently I need to be sure that I don't have too many families like that, or if I am that I need to flag that with my Clinical Leader just to make sure that she is ok with that, so I can account for my workload the changes in my stats reporting..... cos we are accountable, we can't just do whatever we want in a day,... well you can to a certain extent". (Frances)

Gemma was aware of the need to manage her workload and prioritise contacts when planning individual and population care. She extended the time management idea as she also described the ways she prioritises when an unexpected meeting or event requires her to rebook contacts with families.

"One thing that will always affect your decision making is time. I might be visiting with a family and I am already 20 minutes late and it is like 'wrap it up, wrap it up, wrap it up', and even if it is a high needs family you might have to say 'look I have to get going now, but I will come back...' When you can fit it in. A new baby shouldn't really wait unless it is absolutely essential. But a 9 month visit could wait for another week and it wouldn't necessarily be a problem. If there is a really high needs family that I had booked in here because I had really big concerns I wouldn't want to reschedule that. New babies take priority largely, because they have a little window when they can be seen. And if I have got a family I really want to see this week, I have got concerns, or I have rescheduled with this mum seven times to get this time, you know that is a really big deal, if a mum works and she is only available within these hours". (Gemma)

Barbara spent little time reflecting on the contract. However she too referred to the time pressure and expectation to see numbers of clients. She located her ideas in the complexity of working with high needs families suggesting that volumes of contacts and prescriptive content are difficult to achieve and may not be effective when working with families who have complex health needs.

"We have just done PEDS [Parental Evaluation of Developmental Status] training and I think to myself, this is all in the half hour of time that you have got to do all the things that the Ministry of Health have outlined, like nutrition and sleeping and maternal health and safety, wow, we are really good aren't we? Because you spend at least, maybe 30 seconds on this to be able to fit it in to the reality of what we are expected to do and the reality of how it pans out on the job, it is a tad of a joke really, because you think well either you are not seeing all these numbers that you are supposed to see, and do a job, or you can't do all of the things and see all the numbers you are supposed to see in areas where people are not home. It's not a case of you ring up and go 'oh I'd like to make an appointment to come

and see you thank you very much goodbye', and you go there and spend your hour filling out all those forms, because it doesn't work that way". (Barbara)

The ways the nurses described working in the Plunket contract varied and seemed to reflect the ways their managers, usually the Clinical Leader, translated the contract and supervised outputs. Overall, there was a focus on numbers, with the principles of assessment to establish the level of need and plan care in response apparently over ridden by the imperative to do the numbers.

Categories of need

Assessed need was categorised by the nurses as named levels - high, medium or low. These categories are used Plunket Client Information System (contact data recording) system, and until recently were also the categories for documenting assessed level of need in the Plunket Health Record. The 'high need' category relates to need that is long term, related to social and economic determinants (for example family violence, poverty, unsupported or very young parents) and requiring ongoing intervention, probably with multiple services and agencies involved, to reduce risk to child health outcomes. 'Medium need' is the category that describes risk to child health outcomes that is modifiable. Therefore an assessment of medium need would usually indicate that short term intensive support is needed to compensate when the family's usual resilience is challenged but where the family's protective factors limit the risk to child health outcomes, for example where the mother has post natal depression or where there are difficulties with breast feeding or with adjustment to parenthood. 'Low need' is the category that describes a family that is well resourced and resilient, generally able to access the services and support they need to keep their children well.

Some nurses' narratives indicated confusion between the level of need related to socioeconomic determinants and consequently risk to child health outcomes, and the level of need for service from Plunket.

For example, Frances suggested the named level of need was an indication of the level of service the family would receive from Plunket rather than a description of the family's assessed health need based on socio economic indicators or long term risk to the child's outcomes.

"When an issue comes up that is needing more intensive support, whether it is from me or from some other part of Plunket then definitely the level of need within Plunket goes up, but if those needs are being addressed really well outside of Plunket then their need for service from Plunket drops. That means I don't need to be so intensive and then the level of need might actually drop a little". (Frances)

In addition, interpretation of the Plunket contract, as a driver for both the level of need and the level of contact, seemed to further influence Frances's decision making.

"If I put a level of need as medium, but I wasn't doing anything over and above the core visits, I would need to justify why that it is a level of medium need, or, if it was a fourth time family and they are needing more support, then they can't just continue to be low needs and me to visit more often so they would then need to be medium. So that is not the thing that drives the level of need, but it is an awareness that you have to have around funding and justifying the work that you do". (Frances)

Annette told a story of a family she assessed as high need from the outset of her contact with them. She identified the social and economic factors that informed her assessment.

"This mum is 19 at the moment; she had the first child when she was 16. She is in a relationship; her partner is not the father of her baby. Her current partner doesn't have any children. I have visited with this family right from the first visit, baby was 4 weeks and 6 days, and her first child was uplifted and is in CYFS care, with the paternal grandparents.

They were living in private rental accommodation; it was a big old, cold house. The deprivation was dep10, they are a low income family, neither Mum or her partner were working, they didn't have any transport, her mother was visiting at the time and seemed interested and appeared to be a good support to her daughter in her parenting this time around. CYFS [Child, Youth and Family Service] were involved supporting the mother, they had referred her to Barnardos, and the mother was actively seeking information about parenting programmes. I was able to give her information about PEPE⁸ [Plunket parenting Education Programme]. I also did a referral through to PAFT⁹ [Parents as First Teachers]. Mum was really keen, showing positive signs of wanting to do a good job". (Annette)

Annette described making several contacts herself in the early weeks and over that time continued to assess the family to be high need. A number of other services were involved, and as she assessed the situation to be more stable Annette delegated additional contacts, for parenting support, to the CK. She stated that the complexity of the family situation had not changed.

"Based on the complexity of her situation we can put in those extra visits, to support her in her parenting role to keep her child".

⁸ PEPE – Plunket Parenting Education Programme

⁹ PAFT – Parents as First Teachers provides free, practical support and guidelines to encourage and support parents as their child's first and most important teacher.

Annette recognised that family progress was on a continuum and concluded that ongoing compliance by the mother and engagement with services would alter the level of need, in spite of recognising that the big picture was complex.

“The complexity of it was just looking at the big picture of where she has been and where she is coming to and it is still early days. I would foresee that if everything continues as it is, she probably will shift into the medium.”

This assessment exemplifies the situation where some nurses focused on naming a level of need, which consequently assigned a level of Plunket service to the family, and did not necessarily indicate the nature or complexity of need from the perspective of long term risk to child health outcomes. In this case it seemed that the ‘shift to medium’ would mean Annette herself would not be accountable to deliver additional contacts, and at some point the family may not need any additional service from Plunket. This may be the case, the care planning involved considerable coordination and other services were involved, however the family situation held a number of risk factors for child health outcomes and would more appropriately be categorised as high need. This is an example that shows how the underpinning ideals of the well child framework are apparently blurred by the funding framework and reporting mechanisms and consequently influences the nurses’ practice.

The emphasis on a named and documented level of need as a determinant for the level of service was further complicated by an apparent emphasis on deprivation level as the determinant for the level of contact. The ways managers translated the contract and monitored nurses’ contact rates was an influence that was evident in some participants’ stories.

Manager influence

In an apparent reference to the previous Plunket contract that set contact volumes based on deprivation level, Annette alluded to perceived pressure to see families based primarily on their level of deprivation. This understanding seemed to place pressure on her knowledge of needs assessment as a process of balancing deprivation against family strengths. She questioned the requirement to provide more service based simply on deprivation level.

“Knowing you have got the push from management to increase your dep 8, 9 and 10s. I actually ascertain, based on what is happening for the family, at that time. I am not routinely going through and thinking let’s have a look at all my 7 month [dep] 8, 9 and 10s and let’s pull all those out. But there is still that niggle in the back of your mind that we need to be seeing more [dep] 8, 9 and 10s”. (Annette)

Manager translation and leadership to update nurses about the contract seems important, the Clinical Leader especially is the conduit between the nurses and the principles and pragmatics of Plunket funding. Gemma seemed to lack clarity; she acknowledged there had been a change to the contract. Funding and justifying contacts featured in her description of planning care for a low deprivation, high need family. She suggested she would deliver care as she assessed the need, though she was concerned that this might not be what was available in the contract.

“In theory the contract is all different now, but when I started here, it was, if you live in dep 8,9 and 10 you get paid as a level of need for these families whereas [deprivation level] 1,2, 3 don’t necessarily need additional if they have already had babies because that is not the way we fund. This lady is a dep 4 with her third child so the way that that system used to work, any additional visits would now be unfunded. I understand the contract is different but I don’t understand it fully, but she is a high level of need, she will get what she needs, it was a core visit I did yesterday so that doesn’t matter but you are conscious about that as well in this job, because you don’t necessarily get growled at, but there is that side of things that we have to upkeep as well”. (Gemma)

It was notable in all the references to the contract that the nurses did not describe the specifics of the universal service where core contacts (seven in the current contract) are the opportunities for needs assessment and decision making about additional contacts. Gemma’s assertion that she would deliver the care she assessed the family needed indicated confidence in her decision making, in spite of mixed understanding and interpretation of the contract. Erica and Carol also suggested they would deliver additional service by applying the principles of needs assessment and relational practice.

Understanding the contract

Erica and Carol appeared relatively confident when planning care and understanding the contract. This could be based on their experience; clinical leadership or grounding in needs assessment. Reflecting on the current contract, as she understood it, Erica described the underpinnings of a more responsive model where needs assessment is the foundation for deciding the level of service. She alludes to the notion of planned care to meet assessed long or short term need.

“If you looked at it, it is quite prescriptive what we do as Plunket nurses and how many visits people have and what they are entitled to but we have this big leeway where we can make the decision and say these people need more for these reasons, they have got this problem at the moment and I know that if I helped out now and if I put some extra in then that would be better and then other families are going to need ongoing support and

referrals from you and we have the capacity to do that and I am really pleased about that”.
(Erica)

Carol was the nurse who indicated most clearly that she understood the renewed focus on needs assessment freed nurses to make decisions about additional contacts.

“That is what is great about the needs assessment now is that there is more licence, for so long the deprivation thing reared its ugly head and people were, well, not frightened, but you thought long and hard about it whereas now you know that you can put the support visits in place”. (Carol)

Overall there appeared to be a lack of shared understanding of the underpinnings of the Plunket contract and apparently mixed leadership and translation of the funding and care delivery model by Clinical Leaders.

Summary

The nurses’ stories describing the influences on needs assessment and decision making indicated a range of experience. Organisational structures, including policy, education and supervision were viewed as influential and supportive to the nurses’ practice.

Interpretation of the Plunket contract seemed to compromise understanding of needs assessment for some nurses. Nurse experience and clinical leadership appears to contribute to confidence in navigating the contract and management pressures, with the more experienced nurses having less to say about the contract than those with less time in Plunket nurse practice. Translation of the contract by some managers caused confusion about the place of deprivation in needs assessment and allocation of contacts with some participants describing feeling pressured by time constraints and obliged to justify decisions to managers.

The next chapter will discuss the findings of the study in the context of the literature related to community child and family nurse needs assessment decision making from New Zealand and overseas.

Chapter 7: Discussion of study findings

Introduction

The previous three chapters presented the findings of this study of Plunket nurse needs assessment and decision making in the form of emplotted group narratives.

The choice of methodology for this study was underpinned by the intent to offer Plunket nurse participants the opportunity to describe their perspective and experience of needs assessment and decision making through the telling of stories from practice. The aims of the study were to:

- Clarify how Plunket nurses think about needs assessment
- Describe how Plunket nurses make decisions
- Explore the influences on Plunket nurse needs assessment and decision making

This chapter of the thesis constitutes an expansion and discussion of the study findings in the context of the international and New Zealand literature related to needs assessment and decision making in the community child health nursing setting. The study findings were presented as separate narratives titled to align with the study aims. The following discussion of the findings takes a more integrated approach in recognition that the three areas of the study (Plunket nurse needs assessment, Plunket nurse decision making and the influences on Plunket nurse needs assessment and decision making) are so inter related drawing distinctions between them undermines the complexity of this area of practice.

In order to further contextualise the study findings and recommendations I conclude the chapter with a brief overview of activities and developments related to needs assessment and Plunket nurse practice that occurred while this study was in progress through 2010 and 2011.

Needs assessment

Appleton and Cowley (2008a) name seven basic needs assessment principles in a model where the constraints and realities of the practice setting are recognised as surrounding the process. The relationship between the practitioner and family underpins the process and is well recognised as the key to the nurse accessing information about the child and working to improve the child's health. The critical attributes named by Appleton and Cowley (2008a) are: needs assessment is a multifactorial and complex process; assessment requires a holistic approach where the wellbeing of the whole family is recognised to impact on the child's health; the ongoing nature of assessment; difficulty articulating the process; the

influence of practitioner personal values and life experience; recognition that all families potentially have unmet needs, and prioritisation. Browne et al, (2010) describe Public Health Nurses' needs assessment in very similar terms to Appleton and Cowley and while the findings of this study will be discussed under headings derived from the Plunket nurse interviews it is evident the plots in Plunket nurse narratives are congruent with the critical attributes identified by Appleton and Cowley (2008a) and the Browne et al, (2010) findings. In addition the study findings expand the qualitative perspective and build on the findings of earlier studies related to Plunket nurse needs assessment and decision making (Beatson, 2007; Carter, 2010; Macfie, 2006; Trout, 2001).

The relationship

The Plunket nurses' stories in this study clearly describe the importance they assign to the relationships they have with families. The nurses' emphasis on working in positive relationships with families provides the backdrop for their practice and the processes that underpin needs assessment. Participants unanimously described the relationship as a key determinant in successfully assessing need and working with families to support the care of children. They suggested trust is the enabler of information sharing and access, and in the uptake of the plans agreed with families.

The Plunket nurses acknowledged their access to the child was contingent on parents, in the first instance, and families welcoming them into the home or attending the Plunket clinic. The importance of the relationship as the vehicle for access was expanded by the nurses' recognition of extended family and community as integral to the child's wellbeing, and their descriptions of being in a relationship with family groups, neighbours, friends and others in the community influential to the child. Appleton and Cowley (2008a) and A. J. Browne et al. (2010) agree that the ability to work relationally with families in the community enables nurses to contextualise risk by understanding the whole of the family situation, including the factors that influence family resilience and strength.

In a number of stories the Plunket nurses suggested it was a challenge to translate their professional knowledge into an agreed plan with families, while maintaining the balance of the relationship. Participants described situations where they had to negotiate the parents' or other family members' knowledge and understanding of their child's health and wellbeing and find ways to work with prevailing preferences and knowledge. At times this resulted in the nurse being persistent, accepting the family view as valid and pacing the advice and information she offered. Staying in contact with families also required the nurses to be persistent and called on their understanding of the competing priorities in family lives. Barbara and Carol described situations where they took account of the contextual issues for the family and exhibited considerable persistence as they sought to maintain contact.

A.J. Browne et al, (2010) suggest persistence and flexibility is a key element in effectiveness when working in the community and especially with vulnerable families, whose complex lives challenge imposed or restricted contact times and schedules. Ultimately the Plunket nurses were very clear they were responsible to find ways to maintain the relationship in the interests of improving the health and wellbeing of children. They described approaches with families suggesting they were invested in the relationship and went to some lengths to stay in contact.

Wilson (2001) describes this approach as “gentle surveillance” (p.298) and agrees Plunket nurses balance their professional knowledge and the ways they collect and share information, with the complexity and fragility of the relationships they have with parents, especially mothers, recognising that they are responsible to practice in ways that “keep the mothers coming” (Wilson, 2001, p. 298). Relationship challenges were one of the reasons the nurses accessed supervision as they sought support to effectively work with families. The importance Plunket nurses place on their relationship with families and concern about damaging the relationship causes stress for Plunket nurses. This in turn can influence the decisions they make about referral, especially for issues related to child safety where the nurse is concerned she will initiate a response that will have considerable impact on a family for example in child protection cases (Carter, 2010).

It is widely accepted that working with families is complex and that nurses require qualities and skills to maintain relationships, alongside their professional training and expertise (A. J. Browne et al., 2010; Davis et al., 2002; Mitcheson & Cowley, 2003). However the so called artistry of staying in relation with families, while undertaking the surveillance activities related to searching for and responding to health needs, is not easily understood and frequently underestimated (Schon, 1988; Twinn, 2000).

Relationship and decision making

It was in relation to decision making that participants most clearly expressed their conviction that working with the family and consequently moderating their approaches, negotiating and navigating barriers was most important to success. The nurses were very aware their judgment of the problem and possible solutions was only one element in the plan. They were, without exception, clear that no plan could be effective unless the family contributed to it, shared and agreed with the nurse’s understanding of the issues and were ready to participate in interventions. The reality of this in practice is that nurses must remain flexible, capitalising on opportunities and acknowledging the validity of parent constructs (Davis et al., 2002). Practicing in this way means the nurses allocated more contacts, or additional time to pace their activities rather than adhering to a predetermined agenda. The processes of decision making in this setting are consistent with the findings of

the international literature and call on both analytic and intuitive critical thinking (Appleton & Cowley, 2008a, 2008b; Cowley et al., 2000; Easen & Wilcockson, 1996; Polge, 1995; Schon, 1988).

The Plunket nurses described a number of incidents where they made decisions they later reflected on as instinctive or intuitive. On further exploration however they could name and describe the factors they considered, and recognise that while their thought processes had not been linear, there was considerable information and reference to experience underpinning their decision. It was notable that the more experienced nurses in this study were more likely to suggest their assessment and decisions were informed by intuition as a first response, the younger and less experienced nurses were clearer that the number of cues and observed facts they assimilated were what informed their conclusions.

Benner (1984) provides seminal ideas about the relationship between increasing nursing expertise and apparently effortless nursing decision making. Notions of intuition can infer irrational processes, however it is widely accepted that what is referred to as intuition is more usually a response to a set of cues or sequence of events, recognised and processed rapidly while calling on previous experience and training (Appleton & Cowley, 2008a, 2008b; Benner, 1984; Benner & Tanner, 1987; Easen & Wilcockson, 1996; Hamers et al., 1994; Polge, 1995; Tanner, 2006; Watkins, 1998).

Power and partnership

On the whole the Plunket nurses' consciousness narratives described their thoughts and philosophies of working with parents and assessing need in partnership, and they expressed the elements of partnership clearly in the abstract. It was noticeable however that their action narratives frequently intimated their role as an expert, particularly in relation to infant feeding and growth. Mitcheson and Cowley (2003) and Wilson (2001) raise the issue of partnership and power in the community child health setting, verifying that clients find it important that nurses interact with them collaboratively and respectfully. However it is not uncommon for observation of contacts between nurses and families to reveal that interactions are top down and authoritarian, with nurses offering unsolicited advice and/or focus on problems without parents' agreement about priorities (Davis & Day, 2010; Davis et al., 2002; Mitcheson & Cowley, 2003). This can be influenced by the level of practitioner skill and confidence, but can also be the result of contractual and other structural influences resulting in routine and expedient ways of collecting information and a prescriptive or structured programme overriding the art of needs assessment (Mitcheson & Cowley, 2003; Schon, 1988; Twinn, 2000).

While assertions Plunket nurses are truly working in partnership relationships with families may be contestable, the case stories told in the course of this study indicate that the

importance nurses place on, and the investment they make to develop and maintain relationships with parents and families. Further the stories the nurses told suggested that the relationships they established were sufficient to enable knowledge of the family and thereby other processes of needs assessment.

Assessment over time

Needs assessment is a serial activity and the information nurses collect at each contact with a family builds on their picture of the family's health need (Appleton & Cowley, 2008a). The Plunket nurses' narratives stressed their understanding of the importance of frequent and ongoing contact and described the assessment process as one where considerable information was gathered over time. The needs assessment was initiated, usually before the nurse met the family, with information from a range of sources contributing to the beginning of what the nurses described as construction of a puzzle or putting together a picture of the family. The assessment process continued as pieces of the puzzle were located over time to develop a picture of the family, as the relationship between the nurse and the family developed. Development of a trusting relationship facilitates sharing information to inform the assessment and while some families allow this to happen readily, vulnerable or high need families often take more time to develop sufficient confidence in the practitioner to disclose meaningful health information (Appleton & Cowley, 2008a). The importance of the relationship and the value of repeated contacts was one reason Plunket nurses offered for electing to see the family themselves rather than delegate care to a health worker or other referral agency. Participants frequently referred to the Plunket team approach, where they worked with Plunket health workers and also with other providers in the community, as a model designed to share the available resource, prioritise interventions and manage their caseload.

However, the imperative to refer challenged participants who understood that the quality of the relationship they had with parents determined the amount of information the parent would share with them. Uncertainty about the family situation, lack of time with the family and pressure to make decisions based on insufficient assessment are issues that can disrupt the assessment process for clients as much as for nurses (Appleton & Cowley, 2008a; A. J. Browne et al., 2010; Davis et al., 2002). Nurses suggested that they needed sufficient information to make appropriate decisions about planned care and referrals. Lack of clarity and needing to know more sometimes caused them to be reluctant to hand over care, for example to the Community Karitane, which would require the family to accept another person who might interpret their situation differently. Some participants offered examples of having a system for routinely sending the health worker for contacts between their visits for some families. At other times the Plunket nurses suggested they considered it was more helpful to deliver contacts, including additional contacts, themselves. They saw

this as especially important when working with high need, fragile families, in the interests of building on the relationship and continuing to develop a picture of the family including when they needed to clarify a previous observation or confirm a 'gut feeling'. Overall, while the nurses clearly understood they could not be everything to everyone, they described a flexible approach where the need to manage their workload was balanced by their judgements about the consequences to the relationship and effectiveness.

The nurses explained the importance of the parents' understanding, commitment to, and acceptance of referral to another person. They recognised that unless the referral was agreed it was unlikely to be effective and acknowledged that some families themselves preferred not to see a variety of people, especially once they had established a trusting relationship with the nurse. Participants described the risk of referring a family to a service that could not meet their needs, or had a long waiting list. An essential component of primary health care and community nursing is knowledge of the community and other agencies (Wass, 1994). The Plunket nurses understood this part of their role; however perceptions that some services were not reliable, not suitable or not acceptable to families meant that Plunket nurses were careful about referrals and sometimes decided to continue to undertake all contacts themselves based on their judgement of the suitability or availability of other providers and/or personnel. The consequences of perceived lack of referral services are identified by Appleton (1996) who refers to the fringe work a nurse might undertake to fill gaps herself when she assesses services are either not available, are unreliable, or unsuitable for the needs of a vulnerable family.

There is more to need than the deprivation score

Nurses require a range of skills and knowledge in the assessment process, where the nurse is considering a vast amount of information and combination of factors. The group narrative in this study indicated that the nurses recognised needs assessment as a multifactorial and complex process (Appleton & Cowley, 2008a). Deprivation score was one of the first identifiers the nurses used, and recognised as a determinant of health outcome, when outlining family histories. However participants were clear that this was only one factor for consideration, and readily identified the range of social, health and economic determinants of wellbeing they considered when weighting family strength and resilience in the needs assessment process. While a number of case stories ultimately related to a specific identified problem (e.g. infant feeding, growth, maternal mental health) the nurses included considerable detail as they described the other factors that contributed to the family context and presentation of the issue. Decisions about interventions, including the frequency of contacts and referrals were made in response to a combination of factors, which in turn varied between families.

In common with participants in other key studies (Appleton & Cowley, 2008a; Cowley & Appleton, 2000) and similarly to the findings of the earlier Plunket studies (Macfie, 2006; Trout, 2001), the Plunket nurses recognised that all families might potentially have unmet needs. The nurses described a process of weighting family strengths against risks and confidently recognised that evidently well resourced families could exhibit high and complex need when, for example, mental health, family violence or relationship issues impacted on their resilience. Equally participants related examples where apparently deprived families exhibited strengths and resilience that enabled them to overcome risks associated with deprivation and poor socioeconomic status. The literature supports the nurses' understanding, especially the evidence related to universality and repeated opportunities for assessment as a way to ensure that unanticipated need in apparently resilient families is not overlooked (Appleton, 1996; Appleton & Cowley, 2008a; Cowley & Appleton, 2000; Elkan et al., 2001; Williams, 1997; Wright et al., 2009).

The influence of the nurse's personal values and experience

The Plunket nurses recognised that their previous experience, knowledge of the area, and in some cases previous contact with other family members, combined with the referral and information gleaned prior to the first meeting, influenced the picture they began to build of the family and the assessments they undertook in ongoing contacts. Bryans and McIntosh (1996) agree the referral information community nurses receive is important in the pre-decisional phase of planning. The nurse stores the information for comparison with her previous experiences to identify potential problems and thereby inform further information gathering and decisions. Appleton and Cowley (2008a) and Davis et al. (2002) suggest there is a risk that a predetermined idea of a family based on information received before the first meeting will mean the practitioner has difficulty being non judgemental and therefore hinder the initiation of a respectful relationship. Browne et al. (2010) concur that a non judgemental position is paramount when establishing relationships with at risk families however they suggest that the nurse is responsible and must be supported to reflect on assumptions in order to practice safely when working closely with families.

The Plunket nurses appreciated that it was important not to categorise families, recognising the individuality of each family's response to any given situation, and suggested they needed to be open and check in with families to clarify assumptions. Largely however the nurses described the value of early information that enabled them to anticipate opportunities for health interventions once they were in contact with the family and could alert them to personal danger or risk to the child. Furthermore referral information influenced the priority the nurse placed on a contact, for example when family violence or maternal mental health issues were indicated.

Taking a holistic view

Needs assessment requires a holistic approach, where the care of the family is recognised as central to the wellbeing of the child, and assessment is underpinned by acknowledgement that child health and family wellbeing issues are interrelated (Appleton & Cowley, 2008a; A. J. Browne et al., 2010; Trout, 2001). The nurses identified the value of home visiting as a basis for establishing a relationship and also as a way to access information and understanding of the whole family situation. Home visiting is a little evaluated, but highly valued component of child and family community health services, in New Zealand, Australia, the United Kingdom, Canada and USA (A. J. Browne et al., 2010; New Zealand College of Midwives & Royal New Zealand Plunket Society (Inc.), 2009b; Shepherd, 2011).

The Plunket nurses readily located children's health in the context of their family, community and societal determinants. While participants did not refer to theoretical models to support their practice, their case stories and consciousness narratives were identifiable as being underpinned by the socio ecological model of health described by Bronfenbrenner (1979). Barbara's story provides just one example of the way Plunket nurses regard the whole family as they assess need and make decisions. Barbara described considering all the factors that contributed to the obesity of the preschooler, as she recognised that grief for a lost child may have been the root cause for a number of issues impacting on the family health and wellbeing.

Appleton and Cowley (2008a) suggest practitioners may be under pressure to focus on a schedule or organisational agenda that dictates the content of contacts with families resulting in compromise in the holistic aspect of needs assessment. The Plunket nurses' stories indicated they recognised they had specific criteria and topics to cover in their contacts with families; however they did not confine their visits to a pre-determined agenda, and capitalised on family or environmental cues to address health concerns whether they directly related to the baby or child or to another family member. This was described by the Plunket nurses in terms of prioritising and taking opportunities.

Prioritising and taking opportunities

Prioritisation is a process integral to needs assessment and decision making and is linked to notions of equity and population health outcomes. Prioritisation relates to the decisions nurses make when determining levels of service based on service and contractual specifications, parents' expressed need and the nurse's assessment of risk to health outcomes (Appleton & Cowley, 2008a; A. J. Browne et al., 2010). The Plunket nurses were grounded in the idea that they were required to manage a caseload which meant decisions, especially about the number of contacts planned for families and regarding referral, relied

on prioritisation. While their narratives were not noticeably underpinned by theoretical descriptions of population health principles, participants' descriptions of the decisions they made, about additional and repeated contacts and referrals for example, reflected their understanding that assessment resulted in decisions about allocation of contacts in a model where the universal service provides opportunities to plan more care for those who need it most.

As a result nurses often prioritised contacts based on their assessment of risk to the child and/or family. Sometimes this meant that they planned additional contacts to provide further opportunities for assessment, either to clarify a feeling or instinct, to follow up on new information or to enable a plan that was paced to be acceptable to the family. Carol's story, of repeated trips outside her usual schedule of contacts to a remote area and managing her caseload to prioritise the needs of a baby she assessed at risk, offers one such example of managing the caseload to account for a priority. Child safety and wellbeing was a non negotiable reason to prioritise contacts, and in some cases to put aside partnership practice, with the nurses describing instances of insisting parents accept a plan, for example uptake of a referral, or feeding recommendation; or told of resorting to consultation with the GP without the family's consent.

The well child schedule and activities prescribed for age and stage contacts were in the nurses' consciousness at each contact, however they consistently appreciated the need for a flexible approach and described the ways they responded to family and environmental cues to address the 'on top' issues with the family. This prioritising in action at individual contacts means they sometimes abandon any predetermined content related to the well child schedule and focus completely on the situation they discover when meeting a family.

Participants also described prioritising contacts in response to the expressed need of the parent/family, recognising that the family is expert in their child and expressed need for additional support or assessment is valid. A.J. Browne et al. (2010) validate prioritising in this way, finding that the very act of a high need parent seeking contact can be appreciated as resourcefulness. Responding to parents who initiate contact is a way of adding to the relationship through acknowledging parents' expertise and decision making to improve the health of their child.

Making needs assessment visible

The needs assessment and decision making process is acknowledged to be complex, and practitioners struggle to articulate an activity they suggest is seldom made explicit (Appleton & Cowley, 2008a; Beatson, 2007; Bryans & McIntosh, 1996; Luker & Kenrick, 1992; Schon, 1988; Trout, 2001). Four of the seven Plunket nurse participants in this study commented that preparing for and participating in the study had offered an opportunity to

reflect on and appreciate the complexity of the work they do. The results of their reflection led them to acknowledge the complexity of the information they consider and organise when assessing all the factors impacting on a child's health.

Difficulty articulating the basis for decision making and the invisible nature of much of the nurses' reasoning is likely to continue to present challenges to acceptance that nurses' professional judgment is a reliable and effective method of allocating resource. Attempts to categorise need result in findings that the process has so many variables, and the "it depends factor" (Fraser et al., 2009, p. 346) is so prevalent, that the judgement and skill of the practitioner to recognise, and assess the big picture relies on the ability of the system and the practitioner to apply a transparent, fair and open process (Fraser et al., 2009). Appleton and Cowley (2004) suggest that lack of understanding of the assessment process, variability of assessment and outcomes, and unarticulated reasoning and decision making lead funders and policy makers to resort to developing tools to make the process more visible and explained. The importance of describing strengths and risks and articulating the basis for decisions made is relevant to the Plunket setting given the recent project undertaken by the Werry Centre under the auspices of the MoH (Werry Centre, 2011b).

The evaluation of the Werry Centre pilot to develop a needs assessment process by a contractor from outside the nursing and well child setting indicates how the complexity of the process can be underestimated. The tool developed in the pilot, ostensibly to guide decision making, was described as clinically unsafe and a barrier to relational practice by the pilot participants (Werry Centre, 2011a). Similar findings are reported from the preliminary stages of developing a common assessment approach for those in the early child setting in Australia. Clinician stakeholders suggest that tools that attempt to capture every element considered in the assessment process become overlong and complex, and consequently impede their ability to work flexibly and responsively with families (Australian Research Alliance for Children and Youth, 2010).

Appleton and Cowley (2004) are clear about the limitations of tools that attempt to contain the needs assessment process, and submit there is a fine line between limiting the artistry of the process and making visible the analysis of needs assessment factors as the basis for decision making. Plunket nurses currently use a documentation tool (the Plunket Health Record (PHR)) to document the care delivered and planned with families. The PHR has recently been reviewed with the recommendations of the WCF review in mind. The revised PHR is structured to guide Plunket nurses through an assessment requiring documented information about child, family and community wellbeing as the framework for the health history. Individual contact activities are documented in a continuum that means information

collection, analysis and decision making leads to a plan of care. Noticeably the Plunket nurses in this study did not refer to the PHR as a tool to guide needs assessment.

Fraser et al., (2009), Beatson (2007) and Luker and Kenrick (1992) note that the community nursing discourse lacks reference to theoretical underpinnings or models to articulate assessment and decision making process. It is suggested that nurses may take theory for granted and fail to articulate the contribution of professional learning as the primary source of their knowledge as they integrate theoretical knowledge in practice. The participants in the current study did not refer to the nursing research or theoretical models that informed their practice. However in contrast to Beatson's (2007) study where participants defaulted to describing assessment and decision making as a largely intuitive information gathering activity, participants in this study verified the findings of the paper exercise undertaken by Macfie (2006). The Plunket nurses described the range of factors they considered to inform their assessments and indicated their understanding of the need associated with high deprivation, while asserting that high need could be related to factors other than deprivation. In addition the narratives demonstrated that the nurses recognise the essential principles of needs assessment described by Appleton and Cowley (2008a). This may indicate the emphasis on relational practice and needs assessment in Plunket nurse education and leadership over the last five years. Further, while the Plunket nurses did not refer to the research underpinning their practice they recognised their training, and Plunket policy as a support and influence on their practice. Plunket policies were seen to guide decision making and offer a reference point, especially in relation to family violence and child protection issues. Likewise education, especially related to child protection, was identified as improving the quality of nurses' decision making.

Contextual influences on needs assessment and decision making

The Plunket nurse narratives described a number of additional influences on their needs assessment and decision making practice located in the Plunket and wider funding context.

Supervision

The Plunket commitment to peer reciprocal supervision and the Plunket Clinical Leadership structure are positive influences that support staff in their practice. The nurses identified the value of supervision, informal and formal, with their colleagues. Peer support and supervision was seen as an opportunity to debrief, to test ideas and challenge their decisions and case management with someone removed from the situation and able to be objective when presented with the case story. Peer supervision was called on to clarify decisions especially when the nurse is concerned about the safety of a child. Clinical Leader supervision was a further influence on decision making. Similarly to the reasons cited for peer supervision Clinical Leaders were seen as expert and able to clarify situations

where the nurse was pressured by her position as a lone practitioner, or where child safety was at risk. In addition the nurses saw their colleagues as a resource when they had problems contacting families, especially if they were new to an area, when they relied on others who were more familiar with the community.

Supervision is not a feature in the HV needs assessment literature reviewed for this study and is absent in the background documents in the MoH work on needs assessment (New Zealand College of Midwives & Royal New Zealand Plunket Society (Inc.), 2009a; Werry Centre, 2011b). A recent paper (Wallbank & Hatton, 2011) describes the value of clinical supervision in relation to HV clinical safety and effectiveness, and as a human resource protection through safeguarding employee wellbeing and reducing turnover. HV are under significant pressure due to heavy caseloads, time constraints and the increased targeting of service to prevent and identify child abuse. Therefore decision making for nurses has considerable implications and HV are increasingly working with families with high and complex needs. The UK experience is relevant to New Zealand when considering the recommendations of various recent reports, calling for increased coverage and monitoring of very vulnerable children (Bain, 2011; Ministry of Justice, 2010; Ministry of Social Development, 2011a, 2011b). Carter (2010) describes the challenges nurses report in relation to child protection decisions currently. The new specifications for early high need additional contacts increase the onus for Plunket nurses to engage early and effectively with the highest need families (Ministry of Health, 2011a) therefore clinical supervision takes on renewed importance for staff health and safety and child health outcomes.

Plunket nurses are accountable through the competencies for their scope of practice and Plunket nurse Standards of Practice (Nursing Council of New Zealand., 2007; Royal New Zealand Plunket Society (Inc.), 2009) to participate in reflection on their practice. The value the Plunket nurses placed on supervision supports the Plunket organisational commitment to peer supervision. Peer reciprocal supervision has been a component in the training for all Plunket clinical staff for the last decade (Polaschek, 2004; Royal New Zealand Plunket Society (Inc). 2009a). Plunket staff have training in peer supervision techniques including solution focused conversation and open questioning (Polaschek, 2004). Non contact time is allocated for supervision and Clinical Leaders are responsible to encourage staff to participate. It was beyond the scope of this study to explore the quality of the supervision the nurses relied so heavily on, however Polaschek (2004) identifies some limitations and possible barriers that are worthy of future consideration, most notably the impact lack of time may have on the quality of peer supervision.

Contracts and funding

The influence of the policy, funding and strategic setting on child and family nursing is well described in the UK context (Condon, 2008, 2011b; Mitcheson & Cowley, 2003). In New Zealand Trout (2001) and Macfie (2006) describe the challenges faced by Plunket nurses as a funding model was imposed on the sound model of weighted universalism that underpins the Well Child Framework (Ministry of Health, 2010c). The findings of this Plunket nurse study indicate that the deprivation funding model implemented in 2002 continues to influence Plunket nurse practice and the way Plunket nurses and Clinical Leaders think about planning care in response to needs assessment. It is evident that interpretation of the Plunket funding contract, by Plunket managers, and thereby staff, is a significant factor in the way the nurses apply their knowledge and skill in practice and influences their stated intention to work in partnership with families.

Time

The Plunket nurses' repeated references to time constraints supports findings of earlier studies related to Plunket nurse needs assessment (Beatson, 2007; Carter, 2010; Macfie, 2006; Trout, 1999). Challenges of time constraints are known to affect the relationship between practitioner and family (Davis & Day, 2010; Davis et al., 2002). The effect of time pressures relates to the earlier observation that nurses may adopt an expert position despite articulating and clearly understanding the principles of working in partnership for best results. Twinn (2000), Mitcheson and Cowley (2003) and Appleton and Cowley (2004) suggest that lack of time, contractual and contextual constraints contribute to difficulty for nurses to apply the principles of partnership when they are working with schedules or assessment tools that require a structured approach. Mitcheson and Cowley (2003) go so far as to suggest that if nurses are overly constrained by time or structured assessment tools, the needs assessment process is rendered ineffective, due to the nurse missing cues, or proceeding with an agenda or advice giving that is not relevant to, or requested by the client.

Lack of time, directly with families and when coordinating care with other services, was reported to be very challenging by the Plunket nurses. Participants repeatedly referred to 'the time factor' and the number of contacts they were expected to see each day. The time factor and a view that expedience was the only workable way to manage time may partly explain the examples of advice giving and apparently expert led practice identified in some of the nurses' case stories. The Plunket nurses also referred to limitations on the number of contacts families could have. The findings reveal a range of responses to this challenge with the more experienced nurses apparently calling on their history to influence their understanding that repeated and frequent contact was needed to accurately assess need.

Consequently they described how they applied the contract flexibly so that the content of contacts could be legitimately linked to the prescribed content of core contacts, and of managing their workload to deliver the service they judge the family needs. The Plunket nurses with less experience seemed less confident and their narratives were characterised by an imperative to justify their decisions and clarify exceptions with the Clinical Leader. Condon (2008) describes a similar finding where health visitors navigate and manipulate contractual or organisational requirements to practice in ways that they believe best serve the family, however the finding is not aligned with levels of experience.

Levels of need

A finding of this study important to the current context at Plunket was the participants' apparent lack of exposure to the recently adopted terms for naming levels of need (New Zealand College of Midwives & Royal New Zealand Plunket Society (Inc.), 2009a; Werry Centre, 2011b). The categories 'high', 'medium' and 'low' were the only levels of need referred to by participants. 'High', 'medium' and 'low' need were first introduced to name levels of need as a result of the Trout (2001) study and have been the recognised names for documenting level of need in the PHR and Plunket data collection system for some twelve years (Macfie, 2006; Royal New Zealand Plunket Society (Inc). 2002). The recent work on needs assessment and the latest service specifications emphasise that care, especially additional contacts, will be delivered and funded based on new definitions of 'high long term', 'high short term' and 'low' need (Magrath, 2009; Werry Centre, 2011b).

The Plunket nurses expressed a range of comprehension of levels of need with some apparently understanding that the level of assessed need equated to the service (number of contacts) Plunket could offer, rather than being a reflection of risk to child health outcomes from combined socioeconomic determinants. This may indicate how the overlay of a service model and the way it is interpreted undermines the articulated knowledge of some nurses (Appleton, 1996; Appleton & Cowley, 2004; Condon, 2011b; Mitcheson & Cowley, 2003).

The influence of managers and their translation of the funding and contracting models varied. In two areas the nurses seemed confident to manage the contract and described delivering care based on the need and risk to child health outcomes they assessed. While they protested the lack of time and gave examples of applying judgement when planning frequency and content of contacts, the level of need and the Plunket contract was not a feature in their stories of planning care. It is notable that these nurses were the most experienced of the participants

In the two other areas the importance of the contract and confusion about level of need and deprivation based service volumes was more evident in the nurses' stories. In these areas

the nurses reported more oversight by the Clinical Leader and emphasised the pressure to see a certain number of clients each working day. This resulted in the nurses adopting a range of ways to manage their caseload, including capitalising on their prioritisation skills and referral to the Community Karitane (CK) (including for clients with complex health need). The structures in place for managing communication and feedback in these situations was important and generally the nurses described having a system for feedback on the care they delegated to the CK.

The other notable finding in the second two areas was the reported direction by managers to manage caseloads based on the deprivation level of clients. The nurses understood an imperative to see all the high deprivation families frequently. This challenged the nurses' understanding of service in response to assessed family need and seemed to undermine their confidence. The confusion extended to the nurses' described care planning. For example one nurse named a number of indicators of complex and high long term need that would constitute risk to child health outcomes, but repeatedly asserted that she would expect the level of need to go to 'medium' as long as the families complied with all the interventions currently in place. This seemed to be based on a perception of the number of ongoing contacts the families were entitled to from Plunket rather than the level of risk to the long term outcomes for the child resulting from high socio economic deprivation and parenting practice deficits.

The nurses' consciousness narratives did not clearly describe familiarity with the concepts underpinning the recently revised level of need criteria. While the nurses provided additional contacts for the short term needs of apparently well resourced families when resilience was challenged, they seemed less confident that these contacts were permissible and often suggested they should be delegated to a health worker. The emphasis some participants placed on the contract and management directives as the determinant in levels for levels of need and frequency of contacts appeared entrenched. I suggest this indicates a need for significant support and development for some groups of nurses and their managers, to reinstate the validity of the nurses' judgements as the basis for planning care. The findings related to contextual influences and especially the variability in the nurses' responses to the MoH contract take on more significance when considered alongside the activity that has taken place alongside the progress of this study.

Recent activity in well child health

Concurrent to this study political and public interest in the outcomes of children has seen renewed emphasis on the importance of the early years as the foundation for lifelong health and wellbeing. Plunket and the MoH have been engaged in ongoing activity that has a direct impact on Plunket nurse practice and needs assessment in particular. My work at

Plunket has exposed me to high level activities and conversations related to needs assessment and the increasing imperative to do more to improve outcomes for the most vulnerable children. While I have remained clear about the scope of this study, I have been very aware that the findings and recommendations from the project are likely to be considered in light of the following recent developments.

Plunket contract

In 2011 the Plunket contract with the MoH was renegotiated, with the service specifications revised to reflect the place of needs assessment in determining the allocation of additional support for families assessed to have high need (Ministry of Health, 2011b). At the same time the government commitment to provide additional targeted support for high need families has resulted in an extension to the Plunket contract providing more funding for additional contacts to be delivered in response to assessed need in the first three months.

Needs assessment pilot

The WCF review identified effective needs assessment, and especially improved identification of psycho social issues related to attachment, as a priority for well child practice. In 2010 the Werry Centre (University of Auckland) was appointed to lead a project to develop, pilot and evaluate a new needs assessment and care planning process for well child nurses, midwives and primary care. Two Plunket sites participated to pilot the process. Three days training was provided for Plunket nurses, Tamariki Ora nurses¹⁰ and midwives in the pilot sites. While Plunket was involved in the pilot in both advisory and operational capacities there has been considerable unease and uncertainty about the expected outcome of the pilot, and the implications for Plunket nurse practice. The mixed, mostly unfavourable, findings of the pilot evaluation validate the findings related to needs assessment tools in the UK and emerging Australian literature (Appleton & Cowley, 2004; Australian Research Alliance for Children and Youth, 2010; Condon, 2011b; Mitcheson & Cowley, 2003)

The well child framework

The changes resulting from the WCF review (Ministry of Health, 2010c) have been implemented in the two year period this thesis has taken to complete. Plunket nurses have been required to integrate formal child development (PEDS) and maternal mental health (PHQ3) screening, smoking cessation interventions (ABC) and oral health promotion (Lift the Lip) into each core contact, resulting in anecdotal reports of considerable pressure on

¹⁰ Tamariki ora nurses are trained well child health nurses employed by Maori health service providers to deliver the Well Child Schedule through contracts with the MoH.

time and practice. Plunket staff have had a number of professional development days as introduction to the revised elements of assessment and Clinical Leaders, Educators and Advisors have been active supporting nurses with small group and one to one sessions to embed the changes.

Plunket developments

In further activity during 2010 and early 2011 the Plunket documentation tool used to collect health information, and record planned care (The Plunket Health Record (PHR)) was in review. The PHR review was underpinned by the aims of improving the standard of documentation and updating the guide for Plunket nurses to undertake a systematic well child assessment based on a model where the child is considered in the context of its family determinants and community setting. Plunket was familiar with the work being undertaken by the MoH and the Werry Centre; however the PHR review was initiated before the Werry Centre pilot began, and by the time the pilot commenced was so advanced that deferring was determined to be uneconomic. The PHR review involved a lengthy consultation period and pilot phase and was underpinned by the available needs assessment literature. Familiarisation with the revised PHR has added to the melting pot of change and demand on Plunket nurse time and practice, with anecdotal reports suggesting nurses are feeling burdened by an environment of apparently continuous change and high workload.

Summary

This study builds on previous work related to needs assessment in the New Zealand Plunket nurse context. The findings provide a new perspective to an integral area of Plunket nurse practice by articulating the ways Plunket nurses think, and talk about, needs assessment and decision making.

Plunket nurses identified the elements of needs assessment they recognised and described the enablers and barriers they considered to influence their practice in very similar terms to earlier Plunket studies and other, larger scale, international studies. In particular the descriptions in the Plunket nurse needs assessment and decision making narratives are congruent with the essential elements of needs assessment identified by Appleton and Cowley (2008a). In addition the findings of this study show the complexity of the New Zealand well child context to be equal to that identified in other child and family health settings (Appleton & Cowley, 2008a, 2008b; A. J. Browne et al., 2010; Bryans, 2004; Bryans & McIntosh, 1996; Condon, 2011b; Cowley et al., 2000; Houston & Cowley, 2002). Therefore this study offers some validation of the use of international evidence to inform the development of policy, education and practice guidelines for the New Zealand well child setting.

The next and final chapter of this thesis will present conclusions from the study, describe the factors that limit the findings of the study and submit recommendations for development and further research to enhance Plunket nurse needs assessment practice.

Chapter 8: Conclusion

Introduction

The final chapter of the thesis concludes the report of the research project *Needs assessment and decision making in the Plunket nurse setting: What's the story?* The decision to investigate needs assessment and decision making was initiated by my concern that while there was a focus on Plunket nurse needs assessment and decision making in Plunket and MoH policy and contracting conversations, much of the discourse was based on international evidence and assumptions about current Plunket nurse practice. There had been little previous research to describe how Plunket nurses themselves thought about needs assessment and decision making.

There has been ongoing interest in Plunket nurse needs assessment in the two years this study has been in progress. The importance of the early years to lifelong wellbeing outcomes is on the political agenda and recent discussion documents, recommendations and position statements indicate that the outcomes of interventions to improve child health are important to the public, politicians and practitioners themselves. The complexity of New Zealand's social and economic landscape has implications for the health and wellbeing of children. Growing numbers of children are identified as vulnerable and there is an obvious equity gap between the outcomes of those children who are doing well and those who are not, in particular for Maori and Pacific children. The interventions of Plunket nurses are just one influence on health outcomes when the wellbeing of children is considered in the socio ecological context, where the systems contributing to wellbeing extend well beyond individual practitioner work with individual families. However the Plunket nurse workforce is grounded in the primary healthcare setting and has the professional training to contribute to improved child health outcomes. The findings of this study offer insight to the day to day work of Plunket nurses and add to previous studies describing the enablers and barriers to effective utilisation of the skills and knowledge of this group of nurses working in the community child health setting.

In this chapter I will summarise the findings of the study and review the trustworthiness of the methodological approach that resulted in the study findings. Finally I present recommendations for Plunket and the MoH to consider with a view to developing and supporting Plunket nurse practice and improving health outcomes by reducing disparity for New Zealand children.

Needs assessment and decision making in the Plunket nurse setting

The aims of the study were to clarify how Plunket nurses think about needs assessment, describe how Plunket nurses make decisions when planning care, and explore the influences on Plunket nurse needs assessment and decision making. Interviews with seven Plunket nurses produced the data for the study and resulted in the construction of three narratives each titled to reflect the aims of the study. The nurses' individual narratives shared many similarities. In turn the group narratives expand on earlier studies in New Zealand, and confirm a number of elements that are well documented in the international literature.

The narrative findings indicate that Plunket nurses understand the social and economic determinants of health, and assess need in a continuous information gathering process where the relationship with families is regarded as pivotal. Nurses described the range of factors they consider when weighting social and economic determinants to establish the strengths and risks in each family situation. Notions of working with families, to establish shared understanding of their needs and involve them in care planning, were described by participants in the context of effectiveness.

Work in the Plunket nurse setting is complex with pressure on the nurse to make decisions in situations where they are faced with the task of establishing and maintaining relationships; observing and filtering large amounts of information, prioritising family need, while simultaneously managing time and contractual obligations. The nurses' practice was influenced internally by their personality, experience and confidence, and professional judgement is the result of a combination of all these factors.

Participants described a number of factors they understand to comprise assessment and contribute to decision making, some of which are easily articulated and transparent, and others that are less tangible involving feelings and judgements and the application of a range of knowledge and skills. Assessment and decision making were identified as intrinsically connected, rarely linear, serial activities. While nurses suggested intuition influenced their judgements, they acknowledged their professional background and expertise, and personal experience, as contributing to their assessments and the decisions they make. Experience seemed to contribute to rapid assessment and decision making in a process that at first appeared taken for granted; however on reflection all participants identified the combination of factors they were considering as they assessed need and planned interventions. Clinical leadership, supervision and peer feedback were seen to support reflection and safe decisions, policies and training were recognised as factors that added to the nurses' resources. The nurses indicated that work with families requires flexibility and contextual influences can disrupt the process.

The Plunket contract emerged as a discreet influence on decision making. Nurses variously referred to the contract in the context of their practice experience and setting. Perceived time constraints, varied translation, and apparent misinterpretation, of the Plunket contract by managers and the nurses themselves challenged some participants' knowledge of the principles of needs assessment, and directly influenced their judgments and decisions about planned care. The nurses understood the expectations of their work outcomes as numbers, and described management oversight to achieve targets. The Plunket nurse narratives described time as a further pressure and their stories seemed to indicate that lack of time influenced how they work in partnership with parents. Perceived limitations on the number of contacts nurses can have with families affects relationship development and consequently impacts on the information gathering that underpins assessment. In addition, limited or compromised referral options influence the plans Plunket nurses make with families and may result in the nurse undertaking planned additional support herself.

As the analysis phase of this study progressed, the congruence between the Plunket nurse narratives and findings of earlier Plunket and international studies related to needs assessment and decision making became apparent. In spite of the small number of participants, the findings from this study provide evidence that Plunket nurses have considerable knowledge of the accepted principles of needs assessment. The Plunket nurse narratives expand on the earlier quantitative study of Plunket nurse needs assessment (Macfie, 2006), and qualitative studies designed to explore judgement, relationships and assessment and referral practice (Beatson, 2007; Carter, 2010; Wilson, 2001). The categories of need developed in the study by Trout (2001) were relevant to the nurses' thinking, with the determinants of family strength and risk evident in the nurses' stories. In addition the findings of this study show the complexity of needs assessment and decision making in the New Zealand well child context to be equal to that identified in other child and family health settings (Appleton & Cowley, 2008a, 2008b; A. J. Browne et al., 2010; Bryans, 2004; Bryans & McIntosh, 1996; Condon, 2011b; Cowley et al., 2000; Houston & Cowley, 2002).

In light of recent and current developments related to child health outcomes in the New Zealand the findings from this study validate the use of existing New Zealand and international evidence to inform the development of policy, education and practice guidelines for the New Zealand well child setting.

Strengths and trustworthiness of the study

The participant group in the study comprised a self selecting sample of seven Plunket nurses, from one region in a national organisation, who volunteered to participate through a process of informed consent. The participants represented a range between three and

twenty four years of Plunket nursing experience. The main strength of the study lies in the congruence between the individual Plunket nurse narratives, and consequently the group narratives constructed from the study data, and earlier New Zealand and international studies exploring needs assessment and decision making. Therefore the Lincoln and Guba (1985) criteria of confirmability and transferability are evident and contribute to the trustworthiness of the findings of this study. Trustworthiness is also evidenced through the transparent and complete description of the methods for collecting and analysing the data, which provides confirmation of alignment between the research process and the epistemological, methodological and ontological principles underpinning the stated aims of the study. The study findings are presented with the express agreement of the Plunket nurses and through participants' own words and stories. Interview transcripts and individual case stories were validated by participants before data were included for analysis. Voice recordings, interview transcripts and various iterations of participants' core stories are retained and stored electronically and so the findings could be audited for dependability and authenticity (Lincoln & Guba, 1985; Tobin & Begley, 2004). Therefore the findings of the study can be accepted as legitimate to inform recommendations for further research and practice development related to Plunket nurse needs assessment and decision making.

Limitations of the study

The constructivist conventions I followed in this study mean that the findings represent only one interpretation of the narrative data, constructed in a particular time period. The stories told by the Plunket nurses describe their understanding and sense making of their experience of needs assessment and decision making, as they configured it, at the time of the interview. The nurses came to the interviews prepared to participate based on their understanding of the research questions and their narratives told of past events as the nurses recalled them. The nature of people's sense making means the same stories are likely to be related differently or with alternate emphasis if the interviews were repeated at another time or under different circumstances.

My understanding of the principles of narrative inquiry and my conviction that the interview must be led by the participant limited the depth of questioning in the narrative interviews. In addition, my novice interviewing skills and concern participants may interpret focused questioning of some aspects of their stories as a challenge to their practice means some narrative examples were not explored in depth.

Recommendations

The data from the interviews in this narrative study was rich, and the findings add to previous research evidence showing community well child services rely on skilled,

knowledgeable practitioners enabled by a practice environment where they can respond flexibly to the unpredictability of family health need to plan care that improves child health outcomes. The Plunket nurses in this study articulated the known and established principles of needs assessment, they understood community well child health practice and they were passionate about working with families to support them to keep their children well. However they also described a number of contextual factors, which I consider modifiable, that challenge and compromise their practice and influence the decisions they make.

Plunket nurses are a professional workforce well placed to contribute to improved health outcomes for New Zealand children. I recommend the findings of this study are considered alongside the international literature and earlier studies of Plunket nurse practice and that the MoH and Plunket consider investing in the following structures and systems to support and capitalise on the skills, knowledge and professional judgment of Plunket nurses.

1. Service specifications

The well child service specifications require the universal programme to be delivered by registered nurses with additional post graduate training in well child and family health, in recognition that the work is complex, and that particular skills are needed to assess need and identify risk to child health outcomes (Ministry of Health, 2011b). Such a well qualified workforce has considerable capability to improve health equity and contribute to reduced health disparity between groups of children.

This study reinforces the findings of earlier work to examine Plunket nurse needs assessment and decision making (Beatson, 2007; Carter, 2010; Macfie, 2006) and indicates time constraints and prescriptive content limits practice and causes stress for nurses. It appears current contracting and management of the funding model has undermined confidence in Plunket nurse clinical judgement, and reduced the potential for Plunket nurses to work most effectively with families. Change to what has become accepted management of the Plunket contract by counting contact numbers will require a coordinated effort by Plunket and the MoH

I recommend Plunket and the MoH work together to develop a facilitative funding model that accommodates the flexibility needed to respond to the unpredictable nature of family health need. In addition I propose that future service specifications validate the underpinning principles of the Well Child Framework with child health outcomes as the deliverable for Plunket well child services, and reinstate Plunket nurse decision making as a reliable and effective basis for allocating planned care. Planned evaluation of changes to funding structures could identify the resources and inputs needed to achieve the outcomes of an effective programme.

2. Clinical Leadership and supervision

The Plunket nurses indicated that the Clinical Leader influenced their confidence to apply clinical judgement to decision making and had a key role in decision making, especially about complex or challenging situations, however the study findings indicate variability in Clinical Leadership. It is recommended that Plunket invest in professional development, support and education for Clinical Leaders. Two important issues emerged from this study that relate to Clinical Leaders.

Translating the foundations of service specifications

Clinical Leaders are pivotal in translating service specifications and ensuring Plunket nurses understand the underpinnings of care delivery contracts. The funding and contracting discourse can become the default management imperative and if Clinical Leaders do not confidently describe contracts in terms of child health outcomes rather than outputs and numbers, the validity of the nurses' clinical judgement and care planning is challenged. Therefore Clinical Leaders need education and support to ensure they can confidently call on evidence and theory to convey the intent of service specifications and contracts. It is important to service quality and child health outcomes that the principles of a weighted universal programme are not over ridden by management focused on outputs.

I recommend a structured performance framework is developed for Clinical Leaders to assess individual capabilities and identify learning needs. Some Clinical Leaders may need professional development to improve consistent leadership for Plunket nurses. In addition I recommend sufficient dedicated meeting and planning time is allocated to consolidate shared understanding of the foundations of service specifications between Clinical Leaders and Area Managers. Agreement and clear understanding between the managers concerned with operations and those charged with leading clinical practice could ensure the output imperatives of funding contracts are balanced by the principles of nursing assessment and care planning. Ideally practitioners receive consistent messages about the funding arrangements and health outcome expectations of their work with families.

Clinical supervision

The Plunket nurse Standards of Practice (Royal New Zealand Plunket Society (Inc.), 2009) and the Nursing Council of New Zealand Competencies for Registered Nurses (Nursing Council of New Zealand, 2007) call on nurses to reflect on and evaluate the effectiveness of nursing care with peers and experienced nurses. The complexity of the practice setting, the known risks to children from abuse and family violence and the current emphasis on effectiveness, particularly for the most vulnerable families, elevates the importance

reflection on practice through quality supervision. The Plunket nurses in this study relied on the Clinical Leader for expert advice and guidance when faced with challenging situations. Therefore I recommend Clinical Leaders are offered additional training to develop supervision skills particular to supporting staff working with families with high and complex need.

In addition, given the weight the Plunket nurses placed on peer support to clarify decision making, I recommend that the availability, uptake and quality of peer reciprocal supervision are reviewed. Polaschek (2004) and Wallbank (2011) identify some barriers to effective supervision, with lack of time being the main limitation. It was beyond the scope of this study to clarify the quality of supervision the nurses relied on, however given the nurses' repeated references to time constraints it may be valuable to review the peer reciprocal supervision system for effectiveness and uptake. Training updates and assessment of Plunket staff peer supervision skills and monitoring participation through performance appraisal is recommended to monitor the system and inform planning for professional development.

3. Further research

Investigate the nurse - family relationship

The international evidence and the Plunket nurse narratives emphasise the importance of trusting relationships to facilitate needs assessment and plan interventions. It was beyond the scope of this study to critically explore the nature of the nurse family relationship, or analyse the effectiveness of the decisions the nurses made. Further the study did not collect any parents' view of their relationship with the Plunket nurse. Given Plunket's recent commitment to, advocacy for, and training in the Family Partnership Model (FPM) (Davis & Day, 2010; Davis et al., 2002) as the basis for engaging with families, further research to understand the nature and effectiveness of Plunket nurse relationships with families, including exploring the parent perspective, is warranted.

The Appleton and Cowley (2008a, 2008b) case study provides a model for developing an approach that applies observation of contacts alongside interviews. While such a study has ethical and resource implications, it could further improve understanding of Plunket nurse effectiveness, particularly in relation to understanding the quality of Plunket nurse – family relationships. Further, given the findings in the UK literature about the impact of tools and guidelines on HV practice (Appleton & Cowley, 2004; Condon, 2008; Mitcheson & Cowley, 2003), and the recent changes to the WCF, it would be useful to explore the implications for relationships and partnership practice in the Plunket nurse setting when universal contacts

have a high level of prescribed content, contact time is limited and targets are measured in numbers of contacts.

Explore professional development needs

Education, especially related to child protection, was identified by participants as an area influencing decision making. Ongoing emphasis on needs assessment and decision making, and the importance of Plunket nurse decisions about resource allocation means education to further develop the skills and knowledge of practitioners emerges as a priority.

The Plunket nurse narratives indicated levels of expertise and experience influenced how the Plunket nurses made decisions. Currently the Plunket professional development programme is provided to all Plunket nurses, often in response to perceived needs identified by Clinical Leaders and Educators without differentiating for existing knowledge or experience. For example in 2010-11 all Plunket nurses had education to improve competence and understanding of the screens included in the revised WCF (Ministry of Health, 2010c). I suggest it is likely Plunket nurses with considerable experience are not challenged or developed when receiving the same education as less experienced practitioners. Further study to understand how the current Plunket education programme is meeting the needs of all Plunket nurses could identify the needs of individuals and groups and inform targeted approaches to Plunket professional development to capitalise on and extend existing skills and knowledge.

Concluding statement

Needs assessment in the well child setting is a complex process, the end goal is the identification of risks to child health to inform decision making about interventions that will improve long term outcomes and reduce health disparity for some groups. At the very least equitable health outcomes are a basic human right for all children. More importantly the rights and status of Maori children described by the Treaty of Waitangi oblige the New Zealand government and its agents to find ways to improve health outcomes for Maori children. If New Zealand is serious about improving outcomes and reducing disparity for the growing number of vulnerable children, particularly in Maori and Pacific populations, the services offered to families must be planned and resourced to take account of the evidence that describes effectiveness. Plunket nurses demonstrate considerable potential to work in the community and improve child health outcomes; however the findings from this study indicate the pressure of recent policy and funding decisions has resulted in some variability in practice. Continued reliance on funding models and service specifications founded on quantitative measures such as outputs and contact volumes is likely to limit practice to prescribed content and undermine the potential a well trained workforce can offer.

I suggest it is time for Plunket and the MoH to come to a common understanding and develop a realistic expectation of the outcomes possible from the well child programme. Does New Zealand want a programme where all children are seen, boxes ticked and the outcomes and funding continuity confined to measuring outputs, or is there a vision that skilled nursing assessment, combined with an agenda that responds primarily to parents' needs and concerns, leads the interventions of care delivery? It seems clear Plunket nurses can 'do the numbers'; probably any nurse could deliver a programme of screening and surveillance given sufficient tools and checklists. However the underpinning principles of the well child framework ask much more of well child nurses, and the programme relies on a workforce with specialist skills and knowledge, including training at Level 8 of the New Zealand Qualifications Authority framework. I consider this study adds to the existing evidence describing what works for families, and the possible outcomes of enabling nurses to work in partnership with families and communities. My interactions with participants in this study confirmed my conviction that Plunket nurses are passionate and committed to their work with children and families in New Zealand. In closing I urge Plunket and the MoH to look at the evidence and work together to agree high trust contracts to capitalise on the potential of the Plunket nurse workforce, develop service systems to facilitate relational practice, and re-establish the place of professional judgement as the foundation for decisions about planned care.

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¹¹ Referencing for the thesis is in American Psychological Association (APA) 6th format.

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Appendix i: Participant information



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

1

"Plunket nurse needs assessment and decision making: What's the story?"

Information for Participants

Dear Plunket Nurse,

My name is Alison Hussey. I am a student at Massey University, undertaking a thesis study to complete a Masters of Philosophy (Nursing). As you may know, I also work as a Clinical Advisor at the Plunket National Office.

As a Plunket nurse working in the Hawkes Bay, Manawatu, Wanganui or Taranaki Plunket area you are invited to participate in this study.

This information sheet will provide you with details of the study and the rights and protection of Plunket nurses who consent to participate.

Project description

The goal of the study is to provide an insight to the nursing perspective of needs assessment and decision making in the community well child setting by conducting a study that hears and analyses the practice stories of Plunket nurses.

I aim to:

- Clarify how Plunket nurses think about needs assessment
- Explore the influences on Plunket nurse needs assessment and decision making
- Describe how Plunket nurses make decisions when planning care

The study will employ a narrative approach; this means that data will be gathered from the stories of participants, through in depth interviews. While there has been little previous study of this aspect of community child health nursing the work is known to be difficult to articulate, skilled and complex. The findings of this study will add to nursing, organisational and funder understanding of nursing work with families and children in the community.

Participant inclusion and recruitment

The study will involve up to ten Plunket nurses who consent to participate. This number of participants will provide a range of views and experience and is similar to the number of participants in other studies of well child nurse assessment. I will be undertaking all the interviews and so this number of participants is also manageable in the time available for the study.

Information sheet v 3 20th May 2010

Te Kunenga
ki Pūrehuroa

School of Health and Social Services, Wellington Campus
Private Box 756, Wellington 6140, New Zealand T +64 4 801 5799 F +64 4 801 2884 www.massey.ac.nz

You will receive a copy of the transcribed interview to check for accuracy and you may amend or delete any part of the interview before you agree that it can be used to inform the study.

You will be asked to complete an authority for the release of transcript data once you have had the opportunity to review, and edit or amend the transcript

You can choose to receive a personal copy of your interview recorded on CD. All interview recordings will be deleted from the hard drive of my computer and/ or memory stick, by me, at the conclusion of the study (Dec 2011).

Hard copies of transcribed interviews will be stored for a period of five years in a secure filing cabinet not accessed by other family members or visitors, at my home. Transcripts will be destroyed by shredding five years after the conclusion of the study.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question
- request that interview recording is suspended or stopped at any time
- withdraw from the study at any time with no negative consequences
- ask any questions about the study at any time during participation
- provide information on the understanding that your name or any other identifying details will be kept confidential
- receive a summary of the project findings when it is concluded.

Researcher's Obligations

As a registered nurse I am obliged to question unsafe or incompetent nursing practice. In the unlikely event that I hear any information in the course of this study that indicates unsafe or incompetent practice I will first discuss this with you. I may be required to take the matter further with your manager or regional Clinical Advisor.

Your next step

If you agree to participate in this study, you need more information or have any questions about participating in the research please contact me before 31st July 2010 on

04 567 7782 or
027 4456 772 or
husseyco@xtra.co.nz

If you have any additional questions about this research or you are concerned about the conduct of this research please contact my academic supervisor Dr Jill Wilkinson – Massey University j.wilkinson@massey.ac.nz 04 801 5799 ext 6639

This project has been reviewed and approved by the Royal New Zealand Plunket Society Ethics Committee and the Central Region Health and Disability Ethics Committee.

Appendix ii: Participant consent form



MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKĒNGA TANGATA

"Plunket nurse needs assessment and decision making: What's the story?"

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ **Date:** _____

Full Name - printed _____

Te Kūnenga
ki Pūrehuroa

School of Health and Social Services, Wellington Campus
Private Box 756, Wellington 6140, New Zealand T +64 4 801 5799 F +64 4 801 2884 www.massey.ac.nz

Appendix iii: Plunket ethics approval

Plunket
whānau āwhina
caring for young families

national office po box 5474
lvl 3, simpl house wellington 6145
40 mercer st ph: 04 471 0177
wellington 6011 fax: 04 471 0190

Ms Alison Hussey
17 Hathaway Avenue
Lower Hutt

20 May 2010

Dear Ms Hussey

Plunket Nurse Needs Assessment and Decision Making: What's the story?

The Plunket Ethics Committee has considered your application and has approved it. However, a couple of minor adjustments will improve it.

1. Ensure that participant information is presented in a non-identifiable way as a protection for their confidentiality.
2. The information sheet/consent form should contain a statement to the effect that participants are able to withdraw from the study with no negative consequences for them.

If needed, please feel free to respond directly to me at <gareth.jones@otago.ac.nz>

Yours sincerely

pp R.J. Mura
D Gareth Jones
Chair, Plunket Ethics Committee



plunketline 24/7
0800 933 922
www.plunket.org.nz



Appendix iv: Health and Disability Ethics Committee expedited approval



Central Regional Ethics Committee
Ministry of Health
Level 2, 1-3 The Terrace
PO Box 5013
Wellington
Phone: (04) 496 2405
Fax: (04) 496 2191
Email: central_ethicscommittee@moh.govt.nz

25 June 2010

Alison Hussey
Student
School of Health and Social Science
Massey University
Private Bag 756
Wellington 6140

Dear Alison Hussey

Ethics ref: **CEN/10/EXP28** (please quote in all correspondence)
Study title: **Plunket Nurse Needs Assessment and Decision Making: What's the Story?**
Investigators: Ms Alison Hussey

This study was given ethical approval by the Central Regional Ethics Committee on [insert date].

Approved Documents

- Information for participants, Appendix 1
- Participant Consent Form, Appendix 2
- Interview Schedule, Appendix 3

This approval is valid until 30 December 2010, provided that Annual Progress Reports are submitted (see below).

Access to ACC

For the purposes of section 32 of the Accident Compensation Act 2001, the Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out. Participants injured as a result of treatment received in this trial will therefore be eligible to be considered for compensation in respect of those injuries under the ACC scheme.

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment

— information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 20 October 2011. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Requirements for the Reporting of Serious Adverse Events (SAEs)

For the purposes of the individual reporting of SAEs occurring in this study, the Committee is satisfied that the study's monitoring arrangements are appropriate.

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see www.ethicscommittees.health.govt.nz for more information on the reporting of SAEs, and to download the SAE Report Form.

We wish you all the best with your study.

Yours sincerely

S Scott

Sonia Scott
Administrator
Central Regional Ethics Committee
Email: sonia_scott@moh.govt.nz



MASSEY UNIVERSITY

9 August 2010

Alison Hussey
17 Hathaway Avenue
LOWER HUTT 5010

Dear Alison

Re: Plunket nurse needs assessment and decision making: What's the story?

Thank you for your HDEC Notification which was received on 6 August 2010.

Your project has been recorded on the database for applications referred to HDECs which is reported in the Annual Report of the Massey University Human Ethics Committees.

Please advise this office of any changes required by the approving HDEC. These will be placed on your file. Please also supply to the office a copy of the approval letter from the approving HDEC, when received.

Best wishes for your research.

Yours sincerely

Professor John O'Neill
Director, Research Ethics
Chair, Massey University Human Ethics Chairs Committee

cc Dr Jill Wilkinson Prof Steve LaGrow, HoS
School of Health & Social Services School of Health & Social Services
WELLINGTON **PN371**

Massey University Human Ethics Committee
Accredited by the Health Research Council

Te Kunenga
ki Pārehuroa

Research Ethics Office, Massey University, Private Bag 11222, Palmerston North 4442, New Zealand
T +64 6 350 5573 +64 6 350 5575 F +64 6 350 5622
E humanethics@massey.ac.nz animalethics@massey.ac.nz gtc@massey.ac.nz
www.massey.ac.nz

Appendix vi: Interview schedule

“Plunket nurse needs assessment and decision making: What’s the story?”

Interview Schedule

Opening questions / invitation to tell a story

I am interested in a story or examples from your practice that will help me understand the needs assessment processes you use when working with families. I am interested to know how you think about needs assessment and make decisions about the care you deliver, and the factors that influence your decisions.

Can you tell me a story of any particular case/family that might help you describe the ways you assess the needs of families in your work as a Plunket nurse?

Can you tell me a story that describes how you make decisions about the care you plan with families?

Can you tell me how you think about needs assessment?

Can you tell me how you make decisions about the care or service you provide families?

What do you consider when you are planning care with families?

Facilitative probes/prompts

I expect the participant to lead the conversation, and tell the story at their own pace. The following prompts/probes are suggestions to encourage a participant to expand or clarify the story. Any or none of these suggestions may be used in the research situation.

What happened?

Why do you think that happened?

Can you tell me a bit more about.....?

How did you know that?

Why did you decide that?

What was the outcome of that?

What happened next?

Why was that important?

What else did you consider?

What were your concerns?

What else was happening?

Who else was involved?

Has this happened at other times? Can you tell me about that?