Title: Contemporary child health nursing practice: case studies of services offered in metropolitan and outer Brisbane areas

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ABSTRACT

This paper describes the findings of a qualitative study which sought to identify the changing role of the child health nurse within the contemporary health service environment. Using a case study design a picture of contemporary child health nursing services in Brisbane and surrounding areas was established. Contemporary services include both individual consultations with mothers and their children, group education sessions, parent management clinics and parenting programs. These contemporary services represent a significant shift in focus from original infant welfare services established in the early 20th century, but are also similar in their aim of providing education and support for women and their families in the community setting.

KEY WORDS: case study method, child health nursing, nursing history, health services

INTRODUCTION

This project arose from interest in the changing role of the child health nurse as new initiatives and work practices are implemented within child health services. A shift from universal provision of services to a more targeted and selected approach focusing on families in need has led to significant changes in nursing practice. This, together with an increasing emphasis on the role of social and environmental conditions on health (AIHW, 2002) and a mobile and changing client population has created both challenges and opportunities for child health nurses.

A three-phased study was undertaken to identify the impact health service changes have had on the roles and responsibilities of child health nurses and to identify professional development needs. Phase 1 consisted of case studies, Phase 2 focus groups and in Phase 3 a workshop was conducted with participants from earlier phases to discuss the findings and develop strategies to address identified issues. This paper describes the child health nursing services within the Brisbane metropolitan and provincial area. The historical and social development of child health services is discussed in order to
provide background to contemporary services and to compare historical and contemporary approaches to practice.

THE INFANT WELFARE MOVEMENT

The infant welfare movement in Australia developed in the early 20th century in response to concerns about high infant mortality which, together with declining fertility rates threatened population growth (Mein Smith 1997). In Victoria during this period, for example, it was estimated that for every 1,000 live births, 100 children died during the first year of life and that 20% of these deaths were caused by gastroenteritis (McPherson et al 1980).

The Commission on the Decline of the Birth Rate and on the Mortality of Infants in 1903-4 considered concerns about infant mortality. Despite poor public health measures at the time, the Commission believed the cause of the high infant mortality was inadequacies in women's infant rearing practices. Such concerns led to strategies aimed to educate women and to replace traditional childrearing practices with scientific rationality, a newly found concept successful in industry, now applied to the domestic sphere (Selby 1992, Ritson 1997). In most states in Australia the implementation of such strategies was through the introduction of maternal and infant welfare services. McPherson et al (1980, p.32) states that the original task of these services was in 'instructing mothers in hygiene and feeding matters'.

In Queensland the provision of education and supervision of mothers was achieved through the development of baby clinics. The first clinic was opened in Fortitude Valley in 1918 and in the first month of operation provided services to 39 babies (McFarlane 1968). The impetus for the establishment of the maternal and child welfare service in Queensland was a belief by the Labor government of the time that infants had the best chance of survival if mothers received advice and guidance from a trained nurse in a baby clinic (Selby 1992).

The growth in baby clinics continued during the first fifty years of the service, with clinics numbering approximately 280 by 1968 (McFarlane 1968). The long distances between Queensland centres were
overcome in a variety of ways, the most innovative of which is the introduction of the Rail Car equipped as a baby clinic with a lecture room and staff quarters.

Clinic nurses worked both inside and outside the clinic, conducting baby clinics but also home visiting and residential care. Services for isolated women included a correspondence service which provided information pamphlets, recipes and clothes patterns for mothers (Selby 1992)

Improvements in infant mortality during the first half of the 20th century have been attributed to the development of maternal and infant welfare services, as described above. Mein Smith (1997) argues that the decline was possibly due to improved public health services and changes in the environment, a position supported by other commentators (for example, McCalman 1984, Selby 1992, Thorley 2000).

The 1970’s saw a shift from a surveillance and monitoring model focusing on developmental health to a wellness model of child health. Changes in attitudes to childbirth and parenting as normal natural events, underpinned changes to the way services were conducted. The development of the discipline of health promotion provided a framework for child health services. Services were not targeted to specific groups but rather the focus was on individual consultation and care planning.

In the last decade there has been an increasing recognition of the importance of provision of health services for children and families, with early identification of children at risk and early intervention linked to better health outcomes (Boss et al. 1995, Hall, 1996, Commonwealth Department of Health and Family Services 1996, Hodnett & Roberts 1999). The National Goals and Targets (1992) identified key areas of concern in relation to child and youth health. The goals and targets aim to reduce preventable premature mortality and disability and the incidence of vaccine preventable diseases, reduce the incidence of conditions which occur in adulthood which begin in childhood and enhance family and social functioning. Providing services for children and young people, and their families is now focused on prevention, support and early intervention.

In the Queensland context, structural and organizational changes to state child health services during the past two decades has meant a shift from a centrally controlled service to devolution of responsibility.
to Regional Health Authorities in the early 1990’s and currently to Health Service Districts (HSD). This has led to significant diversity across the state, in terms of services offered, resource allocation, and in policy and practice.

It is against this historical and developmental background that a study of contemporary child health nursing services, using an explorative, descriptive study utilising a multiple case study approach was undertaken. Ethical approval was obtained from the university and Health Service Districts prior to data collection.

METHOD

An explorative descriptive study comprised of multiple case studies and focus group discussions was undertaken. A case study approach was chosen as the cases were expected to yield similar information and predictable findings (Yin, 1989) and this methodology enabled the comparison of services offered in child health clinics. This methodology also facilitates an explanation of the impact changes in the health system have made on child health nurses. Case studies are useful for investigating complex issues, where “the boundaries between the phenomenon and context are not clearly evident” (Yin, 1994, p13).

Focus groups facilitate an understanding of the perceptions, beliefs, attitudes and experience of a homogenous group and to explore the context in which these were formed (Krueger, 1994). The use of group processes during focus group discussions enables participants to explore and clarify their views, ensuring comprehensive data collection (Polit & Hungler 1999, Morrison-Beedy et al 2001).

Procedure

Case studies

A purposive, convenience sample of one child health clinics from each of three HSD were selected to reflect different socioeconomic areas throughout the Brisbane metropolitan and provincial areas. Data for the case studies was collected from a range of sources, including individual semi-structured interviews, focus group discussions; observation and document analysis. Documents examined
included policy documents, printed client information available to clients in consulting rooms, parent management clinics and waiting areas, and client service data were collected. At each child health clinic an in-depth interview, following a developed format to describe the external and internal environment, staff and client profiles and services offered, was conducted in each targeted clinic with the Clinical Nurse Consultant. Following this, discussions with one Clinical Nurse in each targeted clinic focused on the professional development opportunities available to nurses working in that clinic. Field notes were taken during all interviews and recorded in detail immediately after the interview.

**Focus groups**

Focus group discussions were conducted with all available nurses from the same child health clinics. 22 nurses participated. Participants were female, aged between 31 and 64 years (\( \bar{X} = 50.3; \) SD 7.3) and had been nursing for between 9 and 43 years (\( \bar{X} = 27.8; \) SD 7.6). The majority were in a married/defacto relationship, held a child health certificate (95.5%) and had worked in child health for more than 10 years. An interview guide with open-ended questions developed from the literature and researchers’ experience in child health was used (Jansson et al 2001). Group processes and probing questions were used to deepen, further develop and clarify responses. The moderator, the fourth author, was familiar with both the topic and group processes (Morrison-Beedy et al 2001). Discussions were recorded by a data reporter and again transcripts returned to participants for clarification.

**RESULTS**

The case study data was collated to identify similarities and differences in services provided by child health nurses. Districts are restructuring current services to incorporate new child health initiatives as the focus of child health changes from an individual approach to a population approach. The common services presently offered in the districts studied are home visiting, one-on-one consultations, parent management clinics, drop-in clinics, and the Triple P (Positive Parenting Program) program.
Home Visiting

Mothers and babies, assessed during the antenatal or hospital period as ‘at risk’ are visited at home to provide educational/health promotional information and support. The way in which this service is offered varies between districts. For example in one area all new mothers are offered a home visit, although the majority of visits are made to premature babies, multiple births and vulnerable families. Home visits in this area account for 14.3% of nursing hours. In the other two health districts home visits are made on a needs basis, with the focus on families at risk, multiple births, premature or at risk babies or families living in transient accommodation. At the time of the study a structured intervention program (Family Care) including home visiting for at risk families was being trialed in a number of pilot sites across Queensland.

Individual Consultation

Developmental screening and assessment of the mother, child and family are undertaken during individual consultations. Information on normal baby development and any current concerns is provided. Resources allocated to individual consultations varied between sites, with an increasing tendency to promote other services offered and for individual consultations to be limited to the recommended National Health and Medical Research Council (NHMRC) screening schedule. Individual consultations are organised through an appointment system and the time allocated to each appointment varied between sites.

Drop-in clinics

This service complement the individual consultations described above, in that clients are able to arrive at anytime during the clinic and wait in turn to see the nurse. Consultations last approximately 5 minutes during which parents receive either a 5-minute educational session, follow up on feeding advice or return for a check weight following a parent management clinic. One district did not have a specified drop-in clinic. Mothers having problems were able to visit the clinic without an appointment at anytime.
Parent management clinics

This service provides mothers with young babies (generally 0-4 months) with the opportunity to spend a day in the clinic to address feeding and settling problems. Nurses assess identified problems and provide appropriate support, health education/promotion and information over the course of the day stay.

Triple P (Positive Parenting Program)

This program is a behaviour management, positive parenting program run by a child health nurse trained as a coordinator. These programs are conducted over an 8 week period and aim to prevent severe problems in children, by increasing knowledge, confidence and skills of parents.

The programs described are increasingly the ‘core’ interest of child health nursing services, however, some districts continue to conduct additional activities, for example, enuresis and sleep clinics and group programs, such as post natal depression support groups, new mothers and young mothers groups. Increasingly, child health services are focusing on selected and indicated populations in terms of physical and psychosocial health. New initiatives have shaped the way in which child health services are offered and ensure that resources are directed to populations in most need. This contrasts with former child health services that took a universal approach to screening, education and illness prevention. A health promotion/primary health care framework underpins services offered by child health nurses in Queensland. The core activities as described above can be categorized in terms of primary prevention and health promotion, secondary prevention and tertiary prevention strategies as shown in Fig. 1.

The changes nurses experienced associated with changes in service provision, and the impact of the change, was explored through focus group discussions. Most frequently identified were: nurses’ limited involvement in decisions for changes in and to services, the shift from the individual to groups with the associated perception of undermining of the value placed on the nurturing relationships developed.
between nurses and clients and dealing with constant change. These factors significantly impacted nurses' job satisfaction. Other findings from the focus group discussions are explored elsewhere.

DISCUSSION

Australia has a long history of infant welfare services and nurses have been part of that history, in both the development and provision of services to women and children in the community. In a number of ways there are both similarities and differences between the original services offered and the contemporary services discussed above.

Rationale for Services

Traditionally, infant welfare services focused on reducing mortality and improving physical development. This aim was considered vital for the maintenance of the population and the welfare of the nation. In contrast, contemporary services are responding to both physical and psychosocial morbidity in order to prevent problems in adulthood which originate in childhood. The aim is not to maintain the population but rather to ensure social health, through prevention of learning difficulties, behavioral problems, school failure and delinquency in children (Boss et al., 1995).

Contemporary services have limited resources and as such are increasingly targeting services to at risk populations. This approach has become particularly evident in the past two decades as there has been a general questioning of the need to provide extensive services to clients without risk markers, a position supported by a paucity of research to demonstrate positive outcomes from such services. Alternatively, prior to this time all mothers and babies were eligible for free access to services regardless of need. The challenge now, as families ‘at risk’ are being targeted, is to ensure that families without risk factors do not develop problems as a result of limited services and support for this group.
Current services have focused screening and surveillance roles more sharply, following recommended guidelines and encouraging more parent responsibility for identifying problems (for example the Personal Health Record outlines milestones for growth and development). This shift reflects a move away from traditional surveillance roles to a more selected and enabling process, involving parents in and encouraging responsibility for their children’s health.

There is a perception in the early literature (for example, MacFarlane, 1968) that child health nurses were valued community members. In contrast, child health nurses in this study felt that their image was not prominent in the community and that the services provided were not valued. Indeed the parallel was drawn between the value placed on motherhood within contemporary society and the value placed on the professionals who provided care and support. As the emphasis shifts from reducing mortality to preventing morbidity, the crucial nature of the child health service is perceived differently. Increasing mobility and social isolation has led to less formal and sustained relationships being built between families and health agencies.

**Challenges to changes in service provision**

The most significant challenge facing child health nurses, identified in the study, is that of dealing with constant change itself. Participants interviewed felt that their input into new initiatives and services was limited and that they had limited impact on decision making. In addition the shift from universal to targeted programs is causing unease amongst a professional group who value their relationship with families and consider the relationship as central to the provision of quality services. This finding reflects those of Reutter et al’s (1998) study of perceptions of changes in public health nursing in Canada. In this qualitative study nurses perceived that their roles had changed significantly, in particular they mentioned less time for nurse-client encounters with more emphasis on ‘mandated’ programs and a shift from direct modes of involvement with clients, and an emphasis on group rather than individual consultation.
As the client profile and mode of service delivery changes, so does the knowledge and skill required. Participants in the case study identified a number of areas in which their practice has broadened and expanded, with accompanying support and education for such changes, varying depending on resources available.

CONCLUSION

A number of elements of the original infant welfare service have remained throughout the 84 year history in Queensland. Surveillance, screening, and the underlying tenet to ‘educate mothers’ remain as the mainstay of child health services. While the rationale and method have changed, in many ways, despite immense social change, the service continues to provide support and information for families as they adapt to their new role.

This study has found that the role of child health nursing is changing as services develop to meet the contemporary priorities of the health services. In drawing historical and contemporary comparisons, both similarities and differences are identified. In essence the main focus of child health service to provide support and guidance to families with children remains the same but the way in which this is enacted is vastly different. Population health approaches aim to ensure that scarce resources are directed to areas of need, but this approach has meant a challenge to the traditional child health nursing role, in particular in the way in which the relationship between nurse and client has changed. A major challenge in the future will be balancing individual and population health approaches to meet the health needs of all clients and in providing appropriate education and support for nurses working in this area.
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<th>Service</th>
<th>Primary Prevention &amp; Health Promotion</th>
<th>Secondary Prevention Strategies</th>
<th>Tertiary Prevention Strategies</th>
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<td><strong>Home visiting</strong></td>
<td>- Provision of quality information/education following birth</td>
<td>- Enrol and engage clients from priority populations</td>
<td>- Extended home visiting</td>
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<td>- Supporting parenting</td>
<td>- Screen for indicators with the potential to impact the child's wellbeing</td>
<td>- Provide extended services using multiple strategies</td>
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<td>- Promoting mental health</td>
<td>- Individual consultation</td>
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<td>- Prevention of child abuse and neglect</td>
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<td>- Promoting positive parenting</td>
<td>- Case coordination</td>
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<td>- Providing universal home visiting to first-time mothers</td>
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<td><strong>One-on-one consultations</strong></td>
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<td>- Enrol and engage clients from priority populations</td>
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