The perceived impact of the National Changes to Registration and Service Provision on the Victorian Maternal Child and Family Health Nurses:

A Qualitative approach.

Rayleen P. Breach

A Thesis Presented in Fulfilment Of the Requirements for the Degree of Doctor of Philosophy

March 2014

School of Health Sciences

Royal Melbourne Institute of Technology University
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Declaration

I, the researcher, undertook all aspects of this study under the guidance of my supervisors. This involved choosing an appropriate study design and arranging for the recruitment of participants. I personally performed all data collection (interviews) with the participants, undertook all the analysis and drew appropriate conclusions.

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature:

Date:
I dedicate this study to my husband Russell with thanks for his unwavering belief and support of me in so many ways. To my wonderful children Michael and Jenniffer I say thank you, for inspiring me to achieve my very best. Thank you, to my family and friends for your patience, love, friendship and for being there and understanding what this achievement has meant.

To my Father Max, Mother Verlie and Sister Ann who offered encouragement from above.

It is all done; not bad for an old tin miner’s daughter, you can be proud.

Finally to my little companion who stayed by my side each and every night keeping me company.

Cuddles for “Molly”
Acknowledgments

To my primary supervisor, Dr Linda Jones, I say thank you, for your patience, guidance and unwavering support over the past four years in accomplishing my Doctorate. Every challenge along the way has been met with a positive attitude and a willing to give ‘above and beyond the call of duty’. Thank you for knowing when to bring me back and for letting me go when I needed you to. Your unique professional and academic aptitude has enabled many to succeed where otherwise they would have struggled. Thank you once again for your untiring support. It has been much appreciated. Your belief and trust in me has meant the world.

I would like to sincerely thank the participants for giving their time and their wisdom for this study. Without you this research would not have been possible. I believe we have done justice and given you the ‘voice’ you all asked for.

The success and final production of this project required a lot of support, guidance, assistance and encouragement along the way, and I am very fortunate to have received all of this. There are too many people to list here to whom I owe my sincere gratitude.

I acknowledge with thanks to the Victorian Association of Maternal and Child Health Nurses for their support of an Academic Scholarship to support this research.

Finally I am thankful for the academic and financial support that I have been fortunate enough to receive from the RMIT University. I would like to extend my sincere thanks to the staff for their endless efforts and professionalism.
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<td>AHCN</td>
<td>Australian Health Ministers' Advisory Council</td>
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<td>Australian Health Practitioners Regulation Authority</td>
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<td>AHCN</td>
<td>Australian Health Ministers' Advisory Council</td>
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<td>AHPRA</td>
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<td>Australian Institute of Health Workforce</td>
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<td>ANMF</td>
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<td>APHDPC</td>
<td>Australian Population Health and Development Principal Committee</td>
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<td>CFHN</td>
<td>Child and Family Health Nurse</td>
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<td>COAG</td>
<td>Council of Australian Governments</td>
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<td>DEECD</td>
<td>Department of Education and Early Childhood</td>
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<td>DEEWR</td>
<td>Department of Employment, Education and Workplace Relations</td>
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<td>DHS</td>
<td>Department of Human Services</td>
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<td>EHD</td>
<td>Early Childhood Development</td>
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<td>EHV</td>
<td>Enhanced Home Visiting</td>
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<td>EMCFH</td>
<td>Enhanced Maternal Child and Family Health</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>IGA</td>
<td>Inter-Governmental Agreement</td>
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<td>KAS</td>
<td>Key Ages and Stages</td>
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<td>KPMG</td>
<td>Klynveld, Peat Marwick Goergeler</td>
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<td>KSH</td>
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<td>LGA</td>
<td>Local Government Authority</td>
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<td>MAV</td>
<td>Municipal Association of Victoria</td>
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<td>MCFHNA</td>
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<td>NMDA</td>
<td>Nursing and Midwifery Board of Australia</td>
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<td>National Relay Service</td>
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<td>QUIT</td>
<td>Stop Smoking Campaign</td>
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<td>RIS</td>
<td>Regulatory Impact Statement</td>
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<td>SUIDS</td>
<td>Sudden Unexplained Infant Death Syndrome</td>
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<td>UMCFH</td>
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<td>UNMCFH</td>
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<td>UWS</td>
<td>University of Western Sydney</td>
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<td>VAMCFHN</td>
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<td>VBHCA</td>
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<td>VET</td>
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<td>WHO</td>
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Abstract

Background

The Australian Productivity Commission’s position in 2006 was to improve the nation’s productivity, workforce participation and broaden the national scope of health services. This was a national approach to establish a safe, consistent, evidence-based approach to providing universal services across Australia. Previously eight jurisdictions, consisting of six states and two territories across Australia, had their own registration requirements. Under the national proposal, all health professionals would be registered with individual professional boards under one organization, that is, the Australian Health Practitioners Regulation Agency (AHPRA). This resulted in national registration and regulation of professional health services to take effect on July 1st 2010. This would allow for the workforce to identify and plan a more collaborative, transparent and transferable pathway for specialist nursing services across the jurisdictions of Australia. However in order to disseminate and implement a national approach to Early Childhood Services, significant changes would be required across professional practice, policy, programs and service delivery. These reforms included a national Child and Family Health service framework that would enact national consistency with standards of practice, qualifications and education requirements for the Child Health workforce. A significant change of this proportion could have the potential to substantially change the current role of the MCH service in Victoria.

However, the extent of the diversity between the jurisdictions in their education programs and registration requirements has been highlighted in the literature. This diversity was significant to the Victorian Maternal and Child Health (MCH) nurses as they require both midwifery and a Graduate Diploma in Child and Family Health qualifications to practice in Victoria. Other jurisdictions across Australia do not have the same pre-requisite to practice in this field of nursing. There is currently a paucity of published literature concerning the Victoria MCH nurses
knowledge, attitudes and beliefs regarding the national changes to registration and a proposed service framework.

**Purpose**

The primary purpose of this study was to fill the gap in knowledge regarding the knowledge, attitudes and beliefs of the perceived impact of the national change to registration and a proposed national framework for service provision on the Victorian MCH nurses. This current study draws on the specific characteristics and demographic composition of the Victorian Maternal and Child Health Nurses related to their education and service requirement to practice in Victoria.

**Significance**

The significance of this study lies with understanding the gaps in current knowledge of MCH nurses to the national changes and the process of organisational change. This is the first known study to be conducted in Victoria and one of the few studies to be conducted to explore the knowledge, attitudes and beliefs of the Maternal and Child Health nurses in Victoria Australia. The findings will assist in informing the future development of the National Universal Maternal, Child and Family Health service in Australia.

**Design and method**

An exploratory descriptive design study was employed using qualitative methodology for this study. Semi structured interviews were employed to gather data from two separate groups. Interviews for Group One consisted of 12 Key stakeholders who were either in management, academia or service coordination from different influencing positions for example; University program coordinators, the Department of Education and Early Childhood Development, Municipal Association of Victoria, or Coordinators of Family and Children’s Services from local government
jurisdictions across Victoria. Group Two interviews were undertaken with 36 MCH nurses across Victoria. These interviews were then grouped into three categories of years of experience for data collection purposes. In both groups the participants interviews were digitally recorded then coded using Nvivo 9.2 software.

**Analysis**

Content analysis was the chosen method for the analysis of the data in this study because it enabled the researcher to include large amounts of recorded textual information and systematically identify its properties. The same qualitative analysis strategies were used for both the groups. Following the analysis of the two groups the data was then triangulated as a means of cross validation.

**Results**

Categories were developed by identifying recurrent patterns from the data and organized into groups through a process of inductive reasoning. Category labels were then chosen that reflected the participants own words and included the following. Firstly identified was the category of ‘common standard’ which included the subcategories ‘competent and capable’, ‘losing our identity’ and ‘future pathways’. The second category extrapolated from the data was ‘universal service’ with a single subcategory of ‘integrated services’. The third category of the data was ‘we do it well’ with a subcategory titled ‘we sit in between both’. Finally the last category identified from the data was ‘imposed from above’ with the final subcategory ‘change is inevitable’.

It is anticipated that these results will assist with informing future practice, policy and education initiatives between governments, educationalists, nursing, midwifery and governing authorities in conjunction with professional groups assisting with the transition to a national platform. The overwhelming message from this study is the fundamental need for respectful and significant engagement between governments, communities, and professional leaders from all jurisdictions to collaborate on the future services because the decisions they make today will have a long-
lasting impact on the services and on communities of the future Maternal and Child Health service.

**Recommendations**

The overarching recommendation from this study is that a comprehensive review of the proposed changes and their implications to practice and service be attended prior to any of the changes being implemented. This would enable due consideration to be given to all the jurisdictions across Australia. As the move to a national registration has already happened the above mentioned recommendation refers to the implementation of the proposed service framework. Future research is, therefore, recommended.

**Conclusion**

This study identified what the knowledge, attitudes and beliefs of the Victorian KSH and the MCH nurses were to the perceived impact of the national changes to registration, service provision and organisational change.

**Keywords:** Australia, Maternal and Child Health, National Registration, National Framework, Organisational Change, Knowledge, Attitudes and Beliefs, Perceptions.
Publications and Presentations


Chapter One

Introduction

Introduction

This chapter provides an overview of the thesis structure including the significance of the research and research aims as well as the methods that were used to undertake the qualitative study. The overarching aim of this study was to explore and describe the knowledge attitudes and beliefs of the Key Stakeholders (KSH) and the Maternal Child and Family Health (MCH) nurses from Victoria to the perceived impact of the national changes to registration and service provision. Throughout this thesis the term jurisdiction will be used which refers to the 6 states and 2 territories that exist in Australia. In addition, the Maternal and Child Health (MCH) nomenclature will be used to collectively refer to the health professionals working in the speciality area of child and family health nursing across the jurisdiction.

Background

This study has explored current contemporary issues relating to the introduction of a National Registration and a proposed Service Framework for a Universal National Maternal Child and Family Health (UNMCH) service. The Council of Australian Governments (COAG) position in 2006 on broadening the national scope of health services was a national approach to establish a consistent, sustainable, evidence-based approach to providing universal services across Australia. The early childhood development sector in particular the Early Childhood Education and Care services, were the subject of significant national reforms. These reforms have substantial implications for the related workforces including the MCH workforce and their services.
In keeping with the national reform agenda the Allen Consulting Group (2009) was commissioned to provide a (draft) national framework for universal child health services. This report was commissioned by the Child Health and Wellbeing Subcommittee (CHWS) of the Australian Population Health and Development Principal Committee (APHDPC) of the Australian Health Ministers’ Advisory Council (AHMAC). Additionally the report was to critically review the evidence base and identify processes that informed the provision of best practice by the respective jurisdictional child and family health services across Australia This report proposed a national framework that would reduce the reported wide variation between states and territories in some areas of service delivery for child and family health service provision and assist in the delivery of consistent services while continuing to maintain national standards across all jurisdictions. In addition the evidence base supporting the national service was believed to assist with the governance of services and support national performance monitoring along with the appropriate and effective distribution of workforce personnel. In 2009 the draft report for a National Framework for Universal Child and Family Health Services was released.

The National Framework for Universal Child and Family Health developed by the Allen Consultancy Group (2009) set out the core services that all Australian children and families should receive, irrespective of location and where they access the service. This framework was intended to cover children and families from birth to eight years with added attention on the antenatal period recognising this as an important stage for a child’s future health and development. The report further identified the principal services required for optimum health outcomes for children and families which also included services for the vulnerable and disadvantaged families.

The Productivity Commission is the Australian Government’s independent research and advisory body for a range of economic, social and environmental issues affecting the welfare of Australians. Its role, is to assist governments in make better policies, in the long term interest of all Australians (Productivity Commission Report, 2011a). Therefore, COAG requested that the Productivity Commission undertake further research examining early childhood development, schooling and Vocational Education and Training (VET) across Australia with the intention of increasing the capability and effectiveness of quality of early childhood education and care services particularly for vulnerable, the disadvantaged, children with additional needs, the Indigenous community and children in rural and remote locations. This in part could be due to the
fact the complexity of the governances in the jurisdictions required further clarification and quantification.

The scope of the Productivity Commission research was identified as, providing advice and recommendations on workforce planning, development and structure of the early childhood development and care, schooling and VET workforces for the development of short, medium and long-term service frameworks (Productivity Commission Report, 2011a). The Commission’s recommendations and findings further supported the future development of the early childhood workforce that underpins the national reforms. However, in order to disseminate and implement a national approach, significant change would be required across professional practice, policy, governances, programs and service delivery throughout Australia.

Of particular interest and concern to the MCH nurses were the Productivity Commission’s draft findings and recommendations. One such finding of the Commission was that; ‘There was little evidence to suggest that a midwifery requirement leads to better outcomes for children and that it creates an additional hurdle to workforce recruitment’ (Productivity Commission Report, 2011a). The Commission recommended that the midwifery qualification requirement should be removed. Following a significant number of submissions from Victoria and communications between the Department of Education and Early Childhood Development (DEECD), the Municipal Association of Victoria (MAV) and the Victorian Association of Maternal and Child Health Nurses (VAMCHN) the Productivity Commission reversed their initial assessment and found the MCH service to be unique to Victoria and that the midwifery qualification was to remain as a prerequisite for the qualification to practice as a MCHN in Victoria. The commission, however, also indicated in the final report (Productivity Commission Report, 2011a) that there was insufficient evidence of the impact of this additional qualification on child health outcomes to justify extending compulsory midwifery qualifications to other jurisdictions (Productivity Commission Report, 2011a).

The MCH workforce has been regarded as a speciality field of nursing in Victoria for many years with their increased level of complex care and client responsibility (Edgecombe, 2009; Scott, 2011; Schmied, Donovan, Kruske, Kemp, Homer & Fowler, 2011). It has been recognised in the literature that the early years provide the foundation for lifelong physical, social and emotional wellbeing (Shonkoff & Meisels, 2000), with MCH nurses being uniquely placed to influence these critical periods in a child’s life by promoting consistency of service. MCH nurses are internationally recognised highly skilled independent specialist nurses who take a holistic approach to health care along with being at the fore front of Early Childhood service contribution.
in the community. There was a large amount of change occurring for the MCH nurses at the time of the introduction to national registration. To complicate this time further many of the MCH nurses were feeling disenfranchised due to the loss of their speciality notation on their registration certificates being removed in the process of national registration.

**Statement of Rationale**

To date, no published studies have investigated the knowledge, attitudes and beliefs of the KSH and MCH nurses to the impact of the national changes to registration and proposed service provision on the Victorian MCH nurses. This research highlights the need for further investment in quality research on the impact of the national changes on the MCH services to inform future policy and practice.

**Significance and Purpose of the Study**

The current study is the first to investigate the knowledge, attitudes and beliefs of the KSH and MCH nurses to the impact of the national changes to registration and service provision on the Victorian MCH nurses. The significance of this research lies in the realisation of its aims and in developing new knowledge that can be used to inform future practice, policy and educational initiatives pertinent to the development of a National Universal MCH service. The literature review for this study indicated that little was currently known regarding the individual roles of the Universal Child and Family networks of professionals across the Australian jurisdictions as to how they collaborate, work in partnership with other services, networks, or the educational preparation, competencies and skills required for delivery of an effective service (Schmied, Kruske, Homer, Barclay, Wilson & Fowler, 2010).

The national changes resulted from a number of recommendations and reports from the National Nursing and Nursing Education Taskforce (N3ET, 2006). The final report from the N3ET report indicated the need for a taskforce to undertake work in an environment of challenge and change, with a national focus on developing a more sustainable and responsive health workforce through
efficient and effective national arrangements (National Health Workforce Taskforce Update, 2009). In addition, solutions to ensure the continued delivery of quality healthcare were proposed from the National Health Workforce, (2006), research report. The main aim of the commission was to facilitate workforce mobility and enhance safety and quality, in the provision of healthcare with the establishment of a National Scheme for health practitioner registration and accreditation. However, achieving change at a national level would be an intricate and prolonged process due to the Australian federation of states and territories having policy frameworks and services that are fragmented and differ across disciplines and sectors in each jurisdiction. To achieve this it would require closer collaboration between governments, education, nursing and midwifery regulatory authorities and professional groups to effectively facilitate this level of national change (NHWT, 2009).

Similarly to New Zealand, the UK, Northern European and Scandinavian countries, Australia has a well-accepted system of supported and free, universal health services for children and families. Victorian early childhood health and social policy reforms are well placed within international research findings on child development and the knowledge that events during pregnancy and the early years influences behaviour, learning and health (McCain & Mustard, 1999; Shonkoff & Phillips, 2000; DEECD, 2013).

**Location of study**

The research was located in Victoria Australia. This study commenced at the time of the introduction of the National Registration and was completed in early 2014. Participants were recruited from metropolitan, semi-rural, rural and remote areas of Victoria to obtain a cross sectional representation from the KSH and MCH nurse workforce for the richness of data. The study was situated only in Victoria Australia.

**Maternal and Child Health Nurses**

The Victorian MCH nurses are currently the only jurisdiction in Australia that require the MCH nurses to have a minimum of a graduate diploma in Child and Family Health or equivalent to work in the area of Maternal and Child Health. They are also required to be registered nurses and registered midwives.
The Victorian MCH service is currently located within the State Government’s Department of Education and Early Childhood Development (DEECD) portfolio. The DEECD is accountable for the planning and provision of early childhood services in partnership with local government (DEECD, 2011). Unlike in the other jurisdictions, the services offered to Victorian families are provided in partnership with the Municipal Association of Victoria (MAV), the Local Government Authority (LGA) and the DEECD. There are 79 LGA councils supporting the community with Universal Maternal Child and Family Health service in Victoria. The attendance at the MCH services is voluntary for families with no expectation that the family must attend. In Victoria, MCH nurses are employed by the LGA in respective council areas. The MCH workforce that provides assistance and support to the MCH nurses to deliver the service includes, coordinators and team leaders usually MCH nurses themselves. In addition there are a number of support personnel such as clerical and additional workers other than nursing, such as parent support workers (PSW) and midwives in some local government areas involved in the delivery and management of the service (DEECD, 2011).

MCH services support families with children aged 0-6 years by the use of a universal primary health-care platform. Additionally MCH nurses offer support and advice that enables families to develop and build resilience, while promoting parenting confidence, self-efficacy and social connectedness. Furthermore the MCH nurses promote the health of children and families through the use of a partnership which supports the development of responsive and sensitive parenting to facilitate the parent-child relationship. The MCH nurses are responsible for identifying deviations from the normal and assist families to identify their strengths and weakness with their parenting capacities. Additionally the MCH nurses facilitate equity and access through universal and targeted services by incorporating community capacity building within their practice to sustain and improve health outcomes especially with vulnerable and disadvantaged families (DEECD, 2011). The knowledge and expertise required for MCH nursing practice today has developed significantly and continues to evolve as a consequence of research contributing to wider integrated evidence base practices (DEECD, 2011). The Victorian MCH is well placed in the community to identify and consider the needs of families and to apply their extensive nursing knowledge and skills in the promotion of their practice. MCH nurses achieve this through a population health approach, which focuses on outcomes, influencing the social determinants of health. The Victorian MCH service has been lauded as ‘world class ‘by Professor Gay Edgecombe (Edgecombe, 2009). Professor Dorothy Scott, OAM, has similarly described it as ‘the
envy of the rest of the country and well beyond the shores of this country, as some of us have long known …’ (Scott, 2011:7).

There is evidence supporting the universal services which indicates that the health outcomes for families and young children across Victoria are above the national average in a number of headline indicators (AIHW, 2011). It is further documented in the literature that the early years provide the foundation for lifelong physical, social and emotional wellbeing (Shonkoff & Phillips 2000: Shonkoff, Boyce, & McEwen 2009). The MCH nurses in Victoria are uniquely placed in the community to influence these critical periods in a child’s life while promoting consistency of service. In addition, the MCH service in Victoria is highly regarded across Australia and internationally. The education levels and experience of the highly skilled independent specialist nurses delivering the service in the community is believed to contribute to this (Edgecombe, 2009: Scott, 2011).

Moreover, DEECD has committed to providing Victorian families with a well prepared MCH service to effectively respond to new and emerging family and community needs (DEECD, 2011). This comprehensive educational platform delivers significant inherent strengths to the MCH service resulting in; increased continuity, decreased fragmentation of care, an increased focus on preventative care and improved opportunities to develop client practitioner relationships. This in turn is believed to increase the MCH nurses capacity to provide timely referrals for intervention where necessary. Current literature supports and emphasises the importance of quality timely care and the increased outcomes for healthy mothers, babies and families (Schmied, Homer, Kemp, Fowler & Kruske, 2008; Briggs, 2007).

Current evidence in the literature indicates that, countries that support child health with policies regarding child health and wellbeing factors can expect comparatively high levels of overall health and well-being. These indicators are measured by material, relational and educational well-being, health and safety (Kuo et al., 2006). According to the Australian Institute of Health Workforce (AIHW 2010), however, there is increasing evidence that there is a declining number of MCFHNs in Australia. Combine this with increasing demands being placed on the services by Policymakers and a shift in social determinants the necessity to research these specialty nursing areas such as the MCH service to validate the effectiveness of services and to provide evidence of the requirement for specialty nursing roles is imperative (Jerlock et al., 2003: Pulcini et al., 2010).
The MCH service is offered across the state by three service streams. These include: the universal MCH service, the MCH Line (24 hour telephone advice service) and the Enhanced MCH service as indicated in the 2011 service framework from the Department of Education and Early Childhood Development (DEECD, 2011).

**Universal MCH today**

Following the birth of a baby the local council is notified via the birth notification system from the hospital that a baby has been born from the local area. These babies are then allocated to a specific MCH centre close to the family home. The universal MCH nurse from that area then contacts the mother to initiate contact for a home visit and ongoing support and advice. The MCH nurses visit 95 to 98% of all Victorian mothers with newborns at home within two weeks following discharge from hospital (DEECD, 2011). After this home visit, women then attend the MCH center for their infants’ Key Ages and Stages (KAS) assessments. This means during the assessment of the baby the MCH nurse checks the baby’s gross and fine motor development, cognitive development and attends a physical assessment. The MCH services include health assessment, health promotion, preventative education, early detection and intervention. At the health reviews maternal screening for postnatal depression and family violence are routinely attended along with providing information and health education on topics such as basic postnatal physiotherapy and family planning. These visits also take into consideration the mother’s physical, social and emotional health as well. Other educational topics discussed also include, Sudden Unexplained Infant Death Syndrome (SUIDS), safe sleeping practices and QUIT initiatives (DEECD, 2011).
Enhanced MCH

The Enhanced Maternal & Child Health (EMCH) services are an extension of the universal MCH service. EMCH are fully funded by the Victorian State Government and offer a more intensive short-term support to families experiencing significant parenting difficulties, vulnerable families and families with young children who are considered at risk of harm. As with the Universal MCH service, the Enhanced service is a free, confidential and culturally-sensitive service for families who are experiencing early parenting difficulties. This means the Enhanced service responds to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. These families are likely to include families in which a parent is experiencing psychiatric debility, alcohol or substance abuse, intellectual or physical disability, family violence; families in which a child has low birth weight, fails to thrive, has a disability or has been involved with child protection services; families in which a member has a serious illness; or families with teenage parents (DEECD, 2011). Enhanced MCH nurses provide assistance with additional home visits to strengthen parenting roles, that support parents in their parenting, manage difficult and challenging infant and child behaviour by offering; practical parenting advise, increasing confidence in parenting skills, education to improve health and wellbeing outcomes, emotional and social health by attending supported group meetings and referral to other appropriate professionals at external services when required, such as; mental health practitioners and family support agencies. Referrals to the Enhanced service are generally directed by the Universal MCH nurse. The funding for Enhanced MCH is allocated according to the percentage of socioeconomic disadvantage families in an area. The hours allotted to the Enhanced MCH in the metropolitan area are fifteen hours for client contact, whereas the rural areas receive an additional two hours for the purpose of travel (DEECD, 2011).

Maternal and Child Health Line

The MCH line was established in 1973 on a voluntary basis operating from 6pm to midnight. This is now a 24 hour 7 day a week state wide telephone advice and support service available to all
Victorian families. This service is staffed by qualified MCH nurses who provide information, support and guidance regarding child health, parenting, nutrition, breast feeding, maternal and family health. The service is fully funded by DEECD and operates anonymously and functions as an extension of the universal MCH Service. With the caller’s permission, the MCH line can refer to other appropriate professional services such as; General Practitioner, hospital emergency, Domestic Violence help lines and family support agencies. The MCH line refers back to the MCH nurse in the centre for ongoing and further supports. As with the universal MCH service, the use of interpreters is encouraged for the culturally and linguistically diverse families. This also includes the National Relay Service (NRS) for hearing or speech impaired callers (DEECD, 2011).

**Research Aim and Research Questions**

The study design was developed from the aims of the research. The aim of the research was to explore and describe the knowledge, attitudes and beliefs of the KSH and the MCH nurses to the perceived impact of the national changes to registration and service provision on the MCH nurses in Victoria and organisational change.

**Research Objectives**

The research objectives underpinning this study were the following;

- Explore and describe the knowledge, attitudes and beliefs of the key stake holders implementing the national changes to registration, qualifications, educational requirements and proposed service provision.

- Critically examine, explore and describe the knowledge, attitudes and beliefs of the Maternal and Child Health Nurses to the national changes to
registration, qualifications, educational requirements and proposed service provision.

- Critically examine the knowledge, attitudes and beliefs of the Maternal and Child Health Nurses to organisational change.

- Examine and identify key emerging issues and encourage wider discussion between relevant bodies to facilitate the removal of constraints to change.

**Overview of Research Method**

A qualitative exploratory descriptive (QED) research methodology informed by Patton (2002) and Sandelowski (2000) was employed for this study. This approach was undertaken as it is an appropriate methodology for collecting information when little is known about the phenomena and where data is too complex to be captured using other methods (Patton 2002; Maxwell 2006). Furthermore, using QED was appropriate for the contemporary nature of this study and was suited for retaining the individual realities of the participants through their narratives, and capturing their own stories (Brink & Wood, 2001).

In addition, a theoretical framework is the underlying structure of a study and informs the research (Maxwell, 2012). There are many approaches to studying organisational change. Having reviewed the literature on organisational change, it became clear that a common theme existed regarding the components that must be present in order to achieve and sustain change within an organisation according to Kotter (1996). These components included the following 8 steps: creating a sense of urgency; empowering broad based action; developing a vision and strategy for change; creating the guiding coalition, generating gains; communicating the change; consolidating gains and producing more change; and anchoring new approaches in the organisational culture.
The aim of this study was to explore the knowledge, attitudes and beliefs of the KSH and MCH nurses in Victoria to the perceived impact of national changes to registration and service provision. Interviews were undertaken firstly with 12 KSH who were either in management, academia or service coordination from different influencing positions for example; DEECD, MAV or Coordinators of Family and Children’s Services from local government jurisdictions across Victoria. Secondly, interviews were undertaken with MCH nurses who provided the service across Victoria. These interviews were then grouped into three categories of years of experience for data collection purposes.

The participants were recruited using purposive sampling through advertising in the Victorian Association of Maternal and Child Health Nurses (VAMCHN) journal and at DEECD state conferences. Interested participants contacted the researcher with their expression of interest in participating. Recruitment continued until data saturation was reached (Patton, 2002). Participants were interviewed and audio recorded which lasted approximately 45 minutes for completion. The interviews comprised of 6 categories of questions related to national registration, national framework, qualifications, service provision, professional development and organisational change.

Full ethics approval from RMIT University’s Human Research Ethics Committee and DEECD was granted. Prior to being interviewed each participant was given a consent form and a plain language statement to read and sign. Transcripts were identified alphabetically and numerically to ensure confidentiality and anonymity. All National Health and Medical Research Council (NHMRC) ethical guidelines were adhered to.

Analysis

Qualitative content analysis and data triangulation were the methods used for the analysis of this study. Interviews were transcribed; coded and emergent categories identified using NVIVO 9.2 software. Sandelowski, (2000), describes content analysis as a dynamic form of analysis of verbal and visual data that is orientated towards summarising and informing the data content. While Maxwell, (1998), indicates data triangulation involves the collection of data from multiple sources with the same foci from the same study which will give diverse views of the phenomenon.
for the purpose of validation. Triangulation of the data then became a device for enhancing the credibility and persuasiveness for this study.

Results

Categories were developed by identifying recurrent patterns from the data and organized into groups through a process of inductive reasoning. Category labels were then chosen that reflected the participants own words and included the following. Firstly identified was the category of ‘common standard’ which included the subcategories ‘competent and capable’, ‘losing our identity’ and ‘future pathways’. The second category extrapolated from the data was ‘universal service’ with a single subcategory of ‘integrated services’. The third category of the data was ‘we do it well’ with a subcategory titled ‘we sit in between both’. Finally the last category identified from the data was ‘imposed from above’ with the final subcategory ‘change is inevitable’.

Overall the results from the two groups were very similar. Group One included the KSH who were found to be more focused on the strategic and managerial direction of MCH service. Whereas, Group Two which included the MCH nurses, were more concerned regarding the implications of the changes to national registration and service delivery.

Recommendations

As a result of this study it is recommended that further research be undertaken to firstly fully investigate the education and qualifications of MCH practitioners across Australia. In addition to fully investigate the MCH services across Australia. Then to have a round table discussion between key people from the service of each jurisdiction to analyse this information obtained from the investigation and develop a future direction platform for a national MCH portfolio.
Limitations

This is a small qualitative study situated only in Victoria and limited to the Victorian MCH nurses. Although the data has been collected from multiple areas in this jurisdiction, the findings cannot be generalised to include the other jurisdictions across Australia. The final limitation recognised by the researcher was that potential for bias from the researcher as the researcher has identified herself as a MCH nurse in Victoria. These limitations do not undermine the value of this research, however, being unable to generalise with the other jurisdictions due to legislation and governance differences may be seen as a constraint.

Organisation of the Thesis

This thesis has been divided into 8 chapters. Chapter 1 introduces the research topic by providing a brief overview of the study by including the context, rational and brief description of the study setting. Chapter 2 offers insight into the background literature supporting the study through a review of the relevant literature for the topic of investigation. This review highlights the lack of literature on the knowledge, attitudes and beliefs of the Victorian Maternal, Child and Family Health nurses to the perceived impact from the move to national registration and the proposed change to service provision.

In Chapter 3, attention is given to discussing the methodology and the method used for the chosen research approach for this study. This chapter includes a discussion of the theoretical framework of the qualitative methodology and a discussion of the steps taken for the qualitative exploratory descriptive method and instrument used. In addition the sample size and selection, data collection, analysis, research rigor, validity and ethical considerations were included.

Chapter 4 and 5 discuss the analysis of the data obtained from the study participant's semi structured interviews. Chapter 6 further discusses the triangulation of the analysed data from the two participant groups. The data has been triangulated between the KSH and MCH as well as between the three MCH nurses groups. Chapter 7 discusses the key findings of the study. An
emerging realisation was that in principal the Victorian MCH nurses believed that National Registration was a perceived to be good idea, however, the MCH nurses believed that further research was required around the disparity of qualifications, education preparedness and service provision. Chapter 8 summarises by drawing conclusions, and providing broad recommendations for the implementation of a Universal Maternal Child and Family Health service in the process of delivering primary health care in Australia, and outlines future research directions.

Conclusion

This chapter introduced the research problem and its purpose. In addition, it sets the context for the study by outlining what a MCH nurse is, how they practice and their qualifications. Following on then is an overview of the aims, methodology and methods used to undertake the study. The rationale was presented for engaging Kotter’s 8 step Organisational Change framework as the theoretical framework to guide the research. Finally an overview of the thesis is provided. The next chapter presents relevant literature and identifies gaps in the available literature, knowledge, and the purpose and significance of this study.
Chapter Two

Literature Review

Introduction

The previous chapter provided an overview of the thesis structure including the significance of the research and research aims as well as the methods that were used to undertake the qualitative study. The aim of this chapter is to examine the literature related to the perceived impact to the Victorian Maternal and Child Health (MCH) nurses from the national changes to registration, a proposed national framework and service provision. In this chapter a review of relevant literature is presented to situate the study in order to present relevant knowledge regarding the research focus and also justify the study. Background knowledge to this thesis will also be discussed including what initiated the change from jurisdiction based to national registration for the nursing workforce.

Purpose of Research

Research is a way of answering the question ‘why’ and at the same time understanding the issues and applying the scientific methods to gain knowledge (Patton, 2002). Research gives nurses the knowledge and ability to support nursing practice, it allows for clear thinking and decision making. There is a paucity of current published literature regarding the knowledge, attitudes and beliefs of the Victorian MCH in relation to the perceived impact of the national changes to registration and service provision. A detailed description and exploration of the perceived issues was, therefore, warranted. In addition, research offers the community the advantages of standardized evidence based practices in Victoria, which endorses optimal quality and increased positive family outcomes (DEECD, 2012).
Search Strategy

The literature search strategy focused on the purpose of the research; that is to explore and describe the knowledge, attitudes and beliefs of the Victorian Maternal and Child Health to the perceived impact from the national changes to registration and service provision. To facilitate a review of literature pertinent to this research, appropriate literature was identified from multiple sources, including searching electronic databases, and relevant reference lists. Electronic databases accessed included: Scopus, Web of Science, ProQuest, Pub Med, CINAHL, Medline and Google Scholar. In addition, the Electronic digital library data base was accessed for dissertations and thesis related to the topic and methodology. The same key words were used for all data bases, that is; Maternal Child Health, knowledge, attitudes, beliefs, organisational change, impact, perceptions, education, health, national registration, communication, health management, service management, service funding, and early childhood reform. Reference lists of retrieved papers were manually scanned to identify other relevant literature not located in initial electronic searches, and these articles were retrieved and accessed for currency and pertinence to study interests. A paucity of related literature to the study topic on the Victorian Maternal and Child Health was identified.

History of Infant Welfare and the transition to a Maternal and Child Health service in Victoria.

Much of the landscape has changed over the past 100 years with regard to the professional field of MCH nursing, where the service is delivered and how MCH nurses deliver their services. The demographics of societies have changed considerably not only through globalization but through international migration as well. This change in society is not only through migration and globalisation but technology as well. According to Castles, Miller, & Ammendola, (2005) the current large population movements around the world has brought about a growing ethnic diversity to host countries. The impact from the immigration and to a degree ethnic diversity, has presented a challenge for health workers and especially immigrants without common ethnic origins. The MCH are aware of these challenges and are working towards achieving positive
outcomes for the ethnic groups along with the Australian policymakers to enhance the transitions and reduce vulnerability. Given these societal shifts over the past century, changes to health professional education and how they educate and deliver services to the community has also had a number of progressive changes.

According to Sheard (2007) the Victorian MCH service emerged from the Infant Welfare movement following the early initiatives of Doctor W.G Armstrong, a prominent Sydney public health reformer. The movement originated from concerns related to infant mortality early in the twentieth century, predominantly from infectious diseases such as infantile diarrhoea. The emphasis, however, on saving infants from unnecessary deaths soon became a wider public health issue which included the mother and subsequent family members in health outcomes. This was further construed in a humanitarian need from the British Empire that the new Australia should be larger and have an increasing healthy population (Cahill, 2001; Reiger, 2000). Population growth and the preservation of infant life was further seen as essential following the awareness of falling birth rates and the high mortality rates as a result of World War 1 (Victorian Year Book, 1973:38 - 46).

In 1914, the year before the Great War began, the Victorian Year Book recorded that 2,835 babies died before they turned one (Victorian Year Book, 1913–14:34 - 346). This was approximated to 10 out of every 100 babies dying. In addition the rate of illegitimate babies was thought to be 3 times higher than the 10 to 100 ratio (Broome, 1987). Women were becoming increasingly concerned with the death of so many babies from diarrheal diseases and believed that prevention was essential. This concern was believed to be one of the contributing factors that lead to the establishment of the first Baby Health Centre in Richmond in 1917 (Sheard, 2007).

According to Kelynak (1917), the war was responsible for increasing the profile of child welfare as a serious national concern. Slogans such as 'the race marches forward on the feet of little children’ highlighted the value of new life as a necessity for the future (Kelynak, 1917). Around this time the international slogan of ‘save the baby’ also gave urgency to the child welfare movement (Winter, 1977).

Women had become more independent following the war and began to be more assertive politically after gaining the right to vote in 1910. They were then able to influence the political agenda on social welfare reform and advocate for improved conditions to decrease infant mortality (Sheard, 2007). The validation for the need of the Infant Welfare movement came with the collecting and publishing of the statistics on the mortality rates of babies and children in the
yearly recorded book of records and statistics. This information was freely available in the local
libraries, categorising the cause of death and indicating which of these were preventable
communicable diseases. The Victorian Year book from 1913 to 1914 provided the evidence that
education of the mothers was seen to reduce the infant mortality rates which was a significant
concern at that time (Victorian Year Book, 1913–14:346 - 344).

The Infant Welfare movement was seen to grow rapidly between 1917 and 1926. This period was
characterised by an intensification of efforts by the welfare movement to educate parents and to
become an accepted integral cornerstone for the community supporting the welfare of women
and children (Younger, 1940). The social significance of these early endeavours is an example of
twentieth century shift in attitudes to women and the significance of providing advice on child
health issues to women. This progressiveness was seen to have notable consequence for the
mothers and their families due to the emphasis that was put on the importance of health services
for women and young children (Sheard, 2007).

Women and children were beginning to be seen as important to the economic outcomes. In order
to increase the awareness of health outcomes, Doctors Scantlebury Brown and Main in 1925
were recruited to undertake an inquiry into the welfare of women and children in Victoria and New
Zealand in an attempt to lower the mortality rate of babies and infants in Victoria (Scantlebury
Brown, 1917–1939:48). This inquiry was the prelude to a number of recommendations that are
still in place today. These recommendations included the qualification requirements for health
centre sisters to practice in the field of child and family health and the mandatory notification of all
recorded births throughout the state to the local council areas for dissemination to the MCH
services.
The establishment of the Department of Infant Welfare and the appointment of Doctor Vera Scantlebury Brown in 1926 as the Director of the new Department of Infant Welfare in Victoria was seen as significant advancement for the Infant Welfare movement and elevated the importance of healthy outcomes further (Sheard, 2007). Doctor Vera [as she was commonly known] then presided over the new government department that became the authoritative body for funding, co-ordinating and planning the Infant Welfare services. This was to also include the development of uniform education and training requirements for the Infant Welfare nurses (Sheard, 2007).

Doctor Vera was seen as being visionary, recognising the importance of education for the care of mothers and their babies through the development stages from birth to preschool. In 1938 Doctor Vera further increased her portfolio, together with the Lady Gowrie Child Centres, to include preschool education as she believed this to be an extension of the work of baby health centres (Heywood, 2002). The lobbying of the Government for additional funds for preschool education and her report to the National Health and Research Council in 1937 was responsible for additional Government funding for preschool education (Scantlebury Brown, 1917–1939). New centres with toddler playgrounds and equipment were opened in 1939 (Scantlebury Brown, 1917–1939). Further expansion of the services to the rural areas in the Mallee and Wimmera districts also included the mail service from a correspondence sister that made regular contact with mothers from the isolated areas of the outback (Scantlebury Brown, 1917–1939). The integration of MCH services with kindergarten, day care and community groups in centre complexes can be seen further today as a legacy from the Scantlebury Brown era. Doctor Vera remained in the position for a further 20 years giving the Victorian Infant Welfare Movement a clear vision and framework to work with (Sheard, 2007). The efforts from the Infant Welfare Sisters Peck and Cook in establishing the early centres have contributed to the principal and vision of today in that the service is free and accessible to all parents with young babies, infants, toddlers and children.

A number of the initiatives Doctor Vera had instigated were continued by the new Department of Infant Welfare within the Victoria Public Health department when it was formed in 1945. Other recommendations, including increased breastfeeding knowledge and the improvement of human milk substitutes were also carried forward (Scantlebury Brown, 1917–1939:48). Furthermore there were Infant Welfare centre centres established by Sister Peck initially, and the efforts of Sister Cook, have contributed to the principal and vision of today in that the service was free and
accessible to all parents with young babies, infants, toddlers and children. In addition, the number of centres and MCH nurses working in the community currently emphasises the importance and value of the service in the community of today. The significance of the service in the late 1950’s was highlighted by the increased number of birth notifications which was subsequently capped at 200 to ensure a consistent quality service offered by the Infant Welfare Sisters (Sheard, 2007:77).

The baby boom in the 1950’s provided significant challenges for the service especially with the post war trauma and increased migrant socioeconomic issues (Sheard, 2007). Training and funding of Baby Health Centre Sister also came under review in the early 1950’s with the acknowledgement of the need for more extensive training to cope with the changing social welfare needs. Education of the baby health centre sisters was attended by the Victorian Baby Health Centre Association, Tweddle Baby Hospital, the Presbyterian Babies home and Tandarra Foundling Hospital. All Sisters required General Nursing and Midwifery education prior to attending the training to become a centre Sister (Sheard, 2007:76). The Baby Health Centre service was evolving from the 1950’s with new approaches to training which reflected the importance of having the nurses educated in behavioural sciences. This meant that the shorter hospital based courses offered for MCH nursing students were to be phased out with the last intake being in November of 1979. With the education of MCH nurses moving the then into the universities in 1980, the education standards to qualify as a MCH nurses were set at a minimum Graduate Diploma in Child and Family Health or a Master of Nursing Sciences in Child and Family Health (Sheard, 2007:79). This was also a time of change of nomenclature from Baby Health Centre Sister to Infant Welfare Sister.

Along with the changes to the education requirements, the MCH service was to go through a turbulent time with the re-organisation and rationalisation of council shires with amalgamations and changes in jurisdictional policy directions in the 1990’s. The re focusing of the MCH service with administrative, and funding accountability within councils was a turbulent time. Many of the changes to state government policy came at a time of significant social change being experienced in the community (Reiger, 2000). For example; many of the women were and are still choosing, to have their families later in life due to the women’s increased participation in the workforce. There was also an increasing awareness of the effects on families from family breakdowns, child abuse, domestic violence and drug and alcohol abuse. The growing recognition that a healthy and stable early childhood is essential for healthy families was another factor for family’s to contend with. How the family dynamics are perceived determines how the
MCH services are situated in the community today (DEECD, 2011). This meant that the MCH nurses were dealing with complex families. Dealing with complex families means that MCH nurses require a broader knowledge base to be able to assess and care appropriately for the families. This includes what and how other disciplines may be able to assist with in order to refer to the appropriate practitioner for healthy outcomes with long term economic value.

While the community demographics have changed considerably since 1926, the fundamentals of MCH have not. The MCH nurse today encompasses more of a flexible, multicultural diverse service delivery to families with cultural and linguistic differences, single parent families, the vulnerable and disabled along with the working families. The MCH nurses offer more of a family centred practice today based on the family being the central focus. This results in the family’s attention being drawn more to their strengths rather than their deficits in a culturally sensitive manner. (DEECD, 2012) The importance of providing an equitable service lies with the government of the day and their governances. As reported by the Productivity Commissions report into the early childhood workforce in 2011, the Victorian MCH service is unique to Victoria in that it provides services to the Mother and the family as well as the baby (Productivity Commission Report, 2011b).

**Before the National Reform**

Prior to the National Reform early childhood provision in Australia was complex due to the three tiers of government which consisted of Commonwealth, State and Territory and Local Government. In addition, across Australia there are six states and two territories. Each of these jurisdictions was responsible for different aspects of the services provided and had their own boards that were responsible for all matters pertaining to the health professions. For example the Nurses Board in the individual jurisdictions across Australia was responsible for all policy decisions related to registrations, education requirements and service provision. This resulted in a very complex structure and meant that if any health professional, especially nurses, moved jurisdictions or had to work in more than one jurisdiction at the same time, had to be registered with two boards. Each board had its own registration requirements which were not necessarily the same as others.
For the MCH, the qualifications and education requirements varied considerably across the jurisdictions. Kruske and Grant (2012) in their study identified that the programs in the individual jurisdictions varied from a Graduate Certificate in Children and Young People’s Health to a Master of Nursing: Child and Family Health and Graduate Diploma in other jurisdictions. The lengths of the programs also varied from a graduate certificate being completed within 0.5 years full time or 1 year part time and a graduate diploma taking 1 year full time or 2 years part time (AQFC 2011). There were also differences identified in where the programs were conducted varying from university to one being provided by a professional organisation. The other difference identified in this report related to the amount of clinical that the programs contained, varying from 40 to 320 hours (Kruske and Grant 2012).

This disparity goes even further than this to the extent that the nomenclatures used by the nurses across Australia are different. Collective titles include Maternal and Child Health nurses in Victoria and the Australian Capital Territory, Child and Family Health nurses in Western Australia, Queensland, and the Northern Territory, Child and Youth Health nurses in South Australia and Child and Family Health nurses New South Wales and Tasmania (Kruske, Barclay and Schmied 2006; Kruske and Grant, 2012). In Tasmania, however, there is an even further disparity identified, in that practitioners are referred to as either Child and Family Health Nurses (CFHN) or Child Health and Parenting Service (CHAPS) nurses. (Tasmanian Department of Health and Human Services 2009) This was further identified by two separate submissions tabled to the Productivity Commission (Tasmanian College of Child and Family Health Nurses Inc. Sub. No 149 ; Tasmanian Government. Sub. No 77). Generally across Australia these nurses are referred to as either MCH nurse or CFH nurses despite the nuances identified above. Recently a decision was made by the National Association of Maternal Child and Family Health Nurses Australia (MCaFHNA) to collectively use the nomenclature Maternal, Child and Family Health Nurses across Australia (Maternal Child and Family Health Nurses Australia, 2013). The term Maternal and Child Health nurse has been used for consistency throughout this thesis as the study involved the MCH nurses situated in Victoria.

The Allen report (2009) and Kruske and Grant (2012) found that there was also no consistency between jurisdictions in family and child health services and that service delivery varied considerably between states and territories. There was a growing body of knowledge related to outcomes of good quality early childhood programs that not only promote a young child’s health, learning and skill
development, but also positively influence their longer-term health, educational and social outcomes (Shonkoff, 2011).

**The COAG National Reform Agenda**

The Productivity Commission was appointed in 2005 by Council of Australian Governments (COAG) to undertake a research study of Australia’s health workforce. The purpose of the study was to examine issues impacting on the health workforce including the supply of, and demand for health workforce professionals, and to propose solutions to ensure the continued delivery of quality health care was maintained over the next decade (Australian Health Ministers’ Advisory Council, Governance Committee, 2009). This study led to COAG in February 2006, agreeing to new national reforms in relation to health professional registration and regulation, referred to as the COAG National Reform Agenda. It was believed that due to the ageing population and the increasing competitiveness of the global market, Australia would face increasing challenges in the future to workforce access and availability. Previous reforms focused on making Australia’s economy more competitive and to reduce the burden of bureaucracy on businesses. While this continues to be a focus in the national reform agenda, there is continued ongoing emphasis on providing Australians with opportunities and choices to lead active, healthy and productive lives (COAG, 2006).

COAG recognised that to guarantee the national reform agendas success, a skilled and motivated population was essential to improve workforce participation and productivity. COAG further indicated that human capital reform was about improving health, learning and work outcomes for all Australians. Achieving change, however, at a national level was thought to be an intricate and prolonged process because this would be challenging conventional thinking while acknowledging the differences across the jurisdictions. Maintaining a focus on nursing and midwifery was seen as a significant component for the jurisdictions. The importance of the National Health Workforce Taskforce (NHWT) research exploring ways of overcoming these barriers and the resistance to change along with proposing new initiatives, therefore, was required for the eventual introduction of the national scheme. Closer collaboration between governments, education, nursing and midwifery regulatory authorities and professional groups would be further required for facilitation of the national reform agenda (NHWT, 2008).
The reforms proposed by COAG aimed to include a sustainable transparent health care system that would provide accessible and affordable health care for all Australians into the future. Due to the disparity across Australia with governances, legislation and design of the jurisdictions health care systems, the COAG reforms were thought to significantly improve and modernize Australia's health system. This would be achieved by reforming governance and financing arrangements, increasing accountability and ensuring the focus was on primary health care. Additionally, there would be a focus on delivery of services to meet the local needs of care outside of hospital, with a greater focus on prevention, early intervention and improvement in the quality of care. To support these changes, what would be required from the workforce was a culture of teamwork and innovation. The many programmes offered across Australia in the early years settings were thought to be unlikely to work without the genuine co-operation and collaboration of the people involved. This kind of affinity required a united organisational culture to support it. Future directions for the early year’s services would depend to a greater extent on innovation and service quality, which in turn depends also on workforce capabilities (COAG, 2009).

In January 2006, the Australian Government Productivity Commission published a research report titled Australia's Health Workforce (AHW) (COAG, 2009:11). This report presented the findings of the above mentioned commissioned study of the Health Workforce, which explored issues impacting on the effectiveness of health workforce, including supply and demand of health professionals, and proposed solutions to ensure the continued delivery of quality healthcare throughout the jurisdictions. Originally the recommendation for national registration and accreditation by COAG were to facilitate workforce mobility, improve safety and quality, and reduce the bureaucracy (COAG, 2009:5). The plan was to establish a single national registration scheme for health professionals by July 2008. This was to include initially the nine professions that were subject to statutory registration in all jurisdictions. As indicated in the initial report, there were two options made available for consideration by COAG. The first option was to stay with the status quo of registrations on a state by state and profession by profession basis. This would mean that jurisdiction based registration boards would continue to register health practitioners for practice. If practitioners wished to practise in another jurisdiction they must also register and pay a registration fee in that jurisdiction. (COAG, 2009: 10).

A second option proposed by COAG (2009) was a single cross-profession national registration with a single national registration board. This would then include the Health Ministers in individual
jurisdictions maintaining a presence with the responsibility for setting primary policy, governances and the implementation of the specific roles pertaining to their jurisdictions. COAG acknowledged that to facilitate this, and to ensure input from professional experts, professional peak bodies and key stakeholders on matters regarding the development of a preferred model, would be essential to the success of the changes initiatives. This was thought to be important in ensuring the viability of the new registration along with accreditation activities in retaining essential health profession detailed expertise (COAG, 2009: 2-4). In making the decision as to which option to proceed with, the Productivity Commission identified a number of bureaucratic issues that needed to be taken into consideration.

First there were a diverse range of statutory schemes and regulatory bodies operating under the jurisdiction laws which included 65 separate laws. These 65 laws in fact established 83 separate statutory bodies that had the responsibility for regulating the health professions across Australia (COAG, 2009:10). The Productivity Commission further identified that the jurisdiction based boards were fragmented and unco-ordinated. The registration of health practitioners was previously undertaken across Australia on a jurisdiction by jurisdiction and profession by profession basis. The jurisdiction also had the responsibility for developing the professional standards required for registration in their jurisdiction. It was believed that due to the diversity of the boards and the inconsistent standards between jurisdictions, the workforce efficiency and effectiveness was in fact impacting on the efficiency of the economy and thus increasing the administrative and compliance expenditures (COAG, 2009:8). An in-principle Regulatory Impact Statement (RIS) was approved on 10 April 2007 which led to COAG signing the Inter-Governmental Agreement (IGA) which set out the framework for a single national system of registration and accreditation of health practitioners in Australia on the 26 March 2008 (COAG, 2009:4).

Following the RIS agreement, a National Registration and Accreditation Implementation Project (NRAIP) was commenced to further address the issues related to the National reform agenda. According to the NRAIP (COAG, 2009:4), there were a number of concerns expressed by stakeholders. This included that registration standards should remain with the professions to develop in order to ensure that the national standards remained at a consistent high quality across all jurisdictions. Complaints and discipline issues, previously addressed by the jurisdictional boards, continue to be seen as a top priority and dealt with in a timely and professional manner by the national body. The clear role identified for the national, and
jurisdiction committees was then established to ensure the Health Ministers were up to date with all the issues related to the reform agenda (AHPRA, 2011-2012 report: 9). In accordance with the principles and objectives of the National Law that underpinned the national agency, the Commission was required to focus on public protection with openness and transparency. This was to include the establishment of best practice guidelines by the national boards following the implementation of national registration for all professional services in the health workforce (AHPRA, 2011-2012 report: 9).

Under the national proposal, all health professionals would be registered with individual specialty boards under one organization, that being the Australian Health Practitioners Regulation Agency (AHPRA). As a result national registration and regulation of professional health services commenced on July 1st 2010 (AHPRA 2010-11). This new national regulation was established to standardize the individual health professions (AHPRA Report, 2010-2011). The Nursing and Midwifery Board of Australia (NMBA) is responsible for the regulation of all the nurses and midwives registered in Australia. AHPRA oversees the running of the individual boards which includes the NMBA (AHPRA Report, 2011-2012). The MCH service guidelines set by the DEECD indicate that the requirements to practice in Victoria are in fact unaffected by the change to a national registration (DEECD, 2011:21). This means that, the qualifications to practice in Victoria remains the same regardless of the establishment of the one national registration.

Nine professional bodies previously regulated in each jurisdiction were included in the initial implementation phase which included; chiropractors, dental practitioners [dentists, dental therapists, dental hygienists and dental prosthetics], medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists and psychologists(COAG 2009:8). Each board are responsible for the registration of the practitioners and ongoing monitoring of the individual professions. For example the functions of the Nursing and Midwifery Board of Australia include: Registering of nursing and midwifery practitioners and students, the development of standards, codes and guidelines for the nursing and midwifery profession. The board is also responsible for handling notifications, complaints, investigations and disciplinary hearings. In addition the board approves accreditation standards and accredited courses of study and assesses overseas trained practitioners who wish to practice in Australia.
The Australian Health Practitioners Regulation Authority (AHPRA) is widely recognised as an internationally significant health reform, bringing together multiple jurisdictions and professions into a single regulatory system. AHPRA assumed one of the most ambitious reforms of health practitioner regulation anywhere in the world by bringing together 14 professions into a national regulatory framework (AHPRA Report, 2013). AHPRA was established as a new national organisation with responsibility for implementing a complex range of regulatory functions for the eventual 14 individual registered health professionals National Boards. AHPRA is the organisation responsible for the implementation of the National Registration and Accreditation Scheme across Australia. AHPRA’s operations are governed by the Health Practitioner Regulation National Law Act 2009, in each jurisdiction. This National Law came into effect on 1 July 2010 except in Western Australia who came on board on 18 October 2010 (AHPRA, 2010-11 Report). The new law meant for the first time in Australian history, health professions are regulated by a nationally consistent legislation. AHPRA supports the 14 National Health Practitioner Boards that are responsible for regulating registered health practitioners. The National Law was shaped by 65 acts of parliament which now has a consistent benchmark for patient safety to be guided by AHPRA, (2011-2012 Report).

The initial implementation of AHPRA proved challenging in a number of areas. In the beginning there was a significant demand for information from the services with limited access to the AHPRA online site. This resulted in the service needing to hastily improve the support network to reduce the impact of the change from jurisdictional to a national body. Uncertainty among a number of practitioners regarding the implications of a national registration developed from the initial implementation issues and remains a concern today (Breach & Jones 2014a).

In addition for the first time, the embedding of national consistency with standards that all practitioners are expected to meet has been one of AHPRA’s key priorities. The framework provided by the National Law sets tougher requirements designed for greater public protection. Most health practitioners can register once and practise Australia wide, as can be seen in the AHPRA (2010-11 Report; 11) annual report. Presumably, it is believed that National registration
meant better and more consistent practitioner data collected across Australia to assist with workforce policy and planning.

A Key feature of the National scheme is that AHPRA administers the National Scheme and provides operational and administrative support to the National Boards. While the primary role of the Professional Boards is to protect the public and set standards and policies that all registered health practitioners must meet (AHPRA, 2010-2011 Report: 9).

**National Boards and AHPRA.**

AHPRA manages the registration processes for health practitioners and students around Australia. In addition, AHPRA supports the Boards in the development of registration standards, codes and guidelines along with providing advice to the Australian Health Workforce Ministerial Council about the administration of the national registration and accreditation scheme. The National Scheme is responsible for publishing the national registers of practitioners to ensure all relevant information is available nationally regarding the registration of individual health practitioners is available nationally to the public on behalf of the National Boards. AHPRA in turn has its own Management Committee that oversees the functions of AHPRA at a National level (AHPRA, 2010-2011 Report).

To assist in managing this, AHPRA has offices in each jurisdiction which have a number of functions including where the public can make notifications about a registered health practitioner or students (AHPRA, 2012-2013 Report: 18). A significant function for AHPRA at the National level is to work with the Health Complaints Commission in each jurisdiction to make sure the appropriate organisation investigates community concerns about individual registered health practitioners in the management of investigations into the unprofessional conduct or questionable performance of registered health practitioners. There is an exception in New South Wales, however, where the investigations are undertaken by the Health Professional Councils Authority and the Health Care Complaints Commission (AHPRA, 2012-2013 Report: 183). Queensland has also put a motion forward to begin the process to undertake investigations in their jurisdiction as well (AHPRA, 2012-2013:13).
At present in Victoria, the Victorian Legal and Social Issues Legislation Committee of the Victorian Parliament is inquiring into the performance of AHPRA. This inquiry is expected to continue throughout the 2013-14 reporting year. In addition, the review of the National Scheme is expected to start in 2014 as scheduled by the government (AHPRA, 2012-2013 Report: 14)

**Key benefits of AHPRA**

The initial key benefits suggested by AHPRA in 2010 are that the National Scheme would offer a careful balance between public safety and the supply of a flexible qualified health workforce. In association with stability of the workforces and flexibility of where professionals can work, other significant advantages are mobility with the one registration to practice anywhere in Australia. This in turn, along with increased transparency with the registering of all health practitioners and their limitations on practice if applicable, assists workforce planning. With the significant changes to the registration, a new uniformity with consistent national standards in relation to registration and professional standards for each profession also assists with mobility and staffs cross border transfers. The bureaucratic processes that once hindered the professions to work in another jurisdictions have been significantly reduced and now been streamlined to increase the efficiency of the registration and notification processes. Collaborative practices between the key professional bodies, jurisdictions and AHPRA have produced significant levels of understanding, innovation and regulatory practices within the changing face of professional regulation in Australia (AHPRA, 2011-2012 Report).

As previously mentioned the Universal MCH services are staffed by MCH nurses that meet the DEECD qualification criteria to practice in Victoria. The MCH nurses are required, as per the standards of practice, to have the following qualification; Registered Nurse, Registered Midwife and hold additional postgraduate qualifications in Child and Family Health (DEECD, 2011: 11). According to the MCH service guidelines set by DEECD ‘these requirements are unaffected by the change to the national registration’ (DEECD, 2011: 11). This appeared to be in line with the commitment of DEECD to provide Victorian families with a well prepared Maternal and Child Health service to effectively respond to new and emerging family and community needs (DEECD, 2011). This comprehensive educational platform for MCH nurses delivers significant inherent strengths to the service resulting in; increased continuity, decreased fragmentation of care, an
increased focus on preventative care and improved opportunities to develop client practitioner relationships. This in turn is believed to increase the MCH nurses capacity to provide timely referrals for intervention where necessary. Current literature supports and emphasises the importance of quality timely care and the increased outcomes for healthy mothers, babies and families (Schmied, Kruske, Homer, Barclay, Wilson & Fowler, 2010; Briggs, 2007).

A significant result from the introduction of the National Registration was that a number of speciality areas of nursing had the recognition of being a speciality area on their National Registration removed (Australian Nursing & Midwifery Federation, 2011 [Victorian Branch] Submission, No: Dr 165., Productivity Commission Report, 2011a). The Victorian MCH nurses were one of the speciality groups to be affected (Productivity Commission Report, 2011a).

**Productivity Commission review**

The Productivity Commission is the Australian Government’s independent research and advisory body on economic, social and environmental issues affecting the welfare of all Australians. An Act of Parliament underpins the Commission which publishes all the outcomes from their studies, open for public scrutiny. In addition, the Productivity Commission assists governments to make policies with the long term interest of the Australian population utmost in mind (Productivity Commission Report, 2011a).

The study initiated by COAG was to be undertaken in the context that the Productivity Commission would embark on research examining workforce issues in the Early Childhood sectors. To achieve this, the Commission consulted widely with the early childhood development sector, governments, non-government organisations and individuals. The Productivity Commission's Draft report (June 2011) was then released for public consultation which resulted in a number of submissions from various organisations and individuals. The final report was released in November 2011.

From this COAG agreed on a common strategic framework to guide government action on early childhood development, which would encompass schooling and Vocational Education and Training (VET) across Australia. It was thought that by building the capability and effectiveness of
the workforces in the early year's areas, predominantly for Indigenous and the vulnerable populaces, it would achieve better overall outcomes especially for these groups.

The main aim of the Productivity Commission's research was to examine the economic viability of a national registration and to look at initiatives that better support the wellbeing of children and families across Australia. A further aim was to facilitate workforce mobility and enhance safety and quality, in the provision of healthcare with the establishment of a National Scheme for health practitioner registration and accreditation. To achieve this it would require closer collaboration between governments, education, nursing and midwifery regulatory authorities and professional groups to effectively facilitate this level of national change (NHWT, 2009).

The current service arrangements in the jurisdictions were identified to have a number of weaknesses in the coordination and implementation of their services. COAG wanted to increase the education and care profile from the historical distinction to a more modern outlook that encompassed the belief that learning and development begins at birth. In particular, high quality early childhood education and care can significantly improve outcomes for vulnerable and disadvantaged children. It has been reported that the attendances of the vulnerable and disadvantaged children receiving high quality care and education have higher prospects in later life (Productivity Commission Report, 2011a).

According to the Productivity Commission draft report (Productivity Commission Report, 2011a) the scope of this research was to consider and provide advice on the short, medium and long-term demand for the workforces along with the mix of knowledge and skills required to meet the national service needs. The extent to which sectoral and jurisdictional boundaries limited innovation and flexibility in workforce planning, development and practices was a further key specific issue for consideration in the Terms of Reference from the Productivity Commission Report (Productivity Commission Report, 2011a). This study considered population distribution and demographic trends, including significant shifts in skill requirements and policy regulation. In addition, the current and future supply for the workforces, including demographic, socio-cultural mix and composition of the existing workforces, and jurisdictional and regional analysis. Further elements that were reviewed in the study included recompense, pay disparities, working conditions, professional status and standing, retention, roles and responsibilities, professional development, along with training and support structures. Of interest to the MCH nurses in Victoria were the qualification pathways, in particularly those that would ensure accessibility and appropriateness of training to meet the qualifications and competencies required.
At the time this research was undertaken Australia had a complex interconnected multi-layered early childhood system which had been identified as being fragmented due to the services being provided by a number of different organisations in the jurisdictions. These services were of high quality however, they were not all consistent between jurisdictions or with the national policy for the Early Childhood Development (COAG, 2009). A national registration would enable a platform for consistency of registration. However, with the establishment of a national registration there became the need to develop a national framework for service delivery to maintain the consistency of care to reduce fragmentation and disparity between jurisdictions. Fragmentation and disparity between the jurisdictional services contributed considerably to the lack of intervention being delivered to the most disadvantaged and vulnerable (Primary Health Care Reform in Australia Report, 2009). In order to achieve this reform in service delivery, the Allen Consultancy Group was commissioned to review child and family health services across Australia.

The Allen Report

The brief of the Allen Consultancy Report (2009) was to critically review the evidence informing the provision of best practice and develop a draft national service framework. In order to achieve this, a comprehensive assessment of the current service in Australia, as well as national and international frameworks, review of literature on evidence base for universal provision and stakeholder consultations were undertaken. This report (Allen Consultancy Report, 2009) found wide variation between jurisdictions in some areas of child and family health service provision yet high levels of consistency in other areas. A draft framework was then developed (Allen Consultancy Report, 2009).

Despite the overall findings from the Allen Consultancy Report (2009), the need for further broader comprehensive consultation with stakeholder groups to prepare the final draft of the framework was than required. In order to assess the feasibility of implementing the draft service framework proposed by Allen Consultancy Report (2009), consultation forums occurred in each jurisdiction consisting of a variety of different practitioners as well as consumers (Schmied et al 2009). The aim was to identify the potential challenges which jurisdiction and health professionals may face as they considered implementation of the draft national service framework.
Following the development of the final draft of the framework, further clarification was required about the feasibility of implementing the national service framework from the perspective and experiences of those directly involved in service provision (CHoRUS, 2010). With this in mind, surveys and focus groups were undertaken in five jurisdictions starting in 2010. This excluded SA, ACT and Tasmania (CHoRUS 2010). The surveys and focus groups occurred with MCH nurses, General Practitioners, practice nurses, midwives and consumers. This also included some specialist service providers such as paediatricians, psychologists, and social workers as well as the early childhood education sector and family support services. The aim of the focus groups extended to determining the changes required for professional practice to be implemented nationally, the necessary workforce qualifications and skills to provide a comprehensive universal along with strategies to address workforce recruitment. In addition the focus groups were looking for the participants to describe classic local service models, particularly those that reflected strong cooperation and collaboration. It was envisaged that this CHoRUS study would highlight areas of overlapping and gaps in service provision. The results from this study has the potential to inform the development of the national universal services along with competencies for the professionals providing MCH services and continued opportunities for inter-professional learning. To date the outcome of this feasibility exercise has not been published.

The Allen Consulting Group was commissioned by the Child Health and Wellbeing Subcommittee of the Australian Population Health and Development Principal Committee (APHDPC) of the Australian Health Ministers' Advisory Council (AHMAC) in 2008 to develop a draft national framework for child and family health services. Additionally the report was to critically review the evidence base and identify processes that informed the provision of best practice by the respective jurisdictional child and family health services across Australia. This report proposed a draft national framework that would reduce the reported wide variation between jurisdictions in the areas of service delivery for child and family health service provision and assist in the delivery of consistent services while continuing to maintain national standards across all jurisdictions. In addition the evidence base supporting the national service was believed to assist with the governance of services and support national performance monitoring along with the appropriate and effective distribution of workforce personnel (Allen Consulting Report, 2009).

This draft National Framework for Universal Child and Family Health set out the universal services required for positive health outcomes for Australian families including services for vulnerable and disadvantaged families (Allen Consulting Report, 2009). While this report focused...
on the service needs of children and families rather than on the professionals groups who provide these services, there were a number of populations such as Indigenous, rural and remote along with the culturally and linguistic diverse communities that required unique care and opportunities.

Despite the overall broad findings from the Allen report, the need for further comprehensive consultation with stakeholder groups to prepare the final draft for the National Framework for Universal Child and Family Health Services was required. A University of Western Sydney (UWS) project team was then appointed in November 2009 on behalf of the National Child Health and Wellbeing Subcommittee (NCHWS) of the Australian Population Health Development Principal Committee of the Australian Health Ministers’ Advisory Council (AHMAC) to seek broader consultation with stakeholders to prepare the final draft of the Framework for Universal Maternal, Child and Family Health Services (Schmied, Kruske, Barclay, & Fowler, 2011). To date there has not been a Framework for a Universal National Maternal, Child and Family Health Services implemented.

**The Early Childhood Development Workforce**

The MCH services are situated within the Early Childhood Development sector in Victoria. According to the scope of the Productivity Commissions study, the Early Childhood Development workforce includes, but is not limited to, coordinators and managers, early childhood teachers, teaching assistants and para-professionals, childcare workers for pre-primary and primary aged children, early childhood intervention professionals, administrative staff, community service workers and relevant health and social welfare professionals (Productivity Commission Report, 2011a). As indicated in the Productivity Commissions Report (2011a), the Early Childhood Development sector contributes to the positive early life outcomes experienced by the majority of young children in Australia. The report further identified that the Early Childhood Development sector provides early childhood education, care, plus child health and family support services to over 1.5 million children (Productivity Commission Report, 2011b). Due to the increasing concerns with workforces planning for the future, the Australian Government decided to examine the feasibility of implementing a range of significant reforms to early childhood education and care with the aim of providing every child the best start in life (Productivity Commission Report, 2011a). The majority of Australian children meet developmental milestones and are well
prepared to enter primary school. However, the need for significant change in the Early Childhood Development sector has been identified by a number of reports sent to the Australian Health Ministers’ Advisory Council, Governance Committee (2009). What was concerning for the Nation was that there was a quarter of Australian population of children entering the primary school system with vulnerabilities in one or more of five key developmental milestones. These included literacy and numeracy (Productivity Commission Report, 2011a). While efforts to give children the best start possible in life are supported by early childhood development services that include maternal and child health and family support services, followed by childhood education and care, more is required to reduce these vulnerabilities. It has been further identified that the services for children with additional needs, including Indigenous, vulnerable and disadvantaged children, are not being met compared with the results seen of other children across Australia. COAG is looking at what changes were required to minimise the gaps between these groups of children. It is envisaged that these reforms will have far-reaching implications for the early childhood workforces if the reforms are implement (Productivity Commission Report, 2011a).

**Justification of the research**

As can be seen from the literature in this chapter, there has been a great deal of change occurring in the early year’s sector in relation to national registration and proposed national service framework. No research has been undertaken to assess the effect of these changes on the Victorian MCH nurses to date. More importantly, no published studies were found that have been undertaken to examine the knowledge, attitudes and beliefs of the Victorian MCH nurses to these national changes. The paucity of published literature regarding this contemporary area, therefore, highlighted the need for further research. This study aimed to rectify the lack of published literature regarding the Victorian MCH nurses perceptions of the introduction of a national registration and service provision.
Conclusion

This chapter presented the background to the study, including the context and identified the gap in the literature in which this research is situated. This included the reasons for the changes that occurred in national registration and service provision. The next chapter outlines the methodology, theoretical framework and the methods used for this study.
Chapter Three

Methodology and Method

Introduction

The previous chapter presented the literature identifying the significance to the perceived impact of the changes to national registration, service provision and a proposed national framework on the Victorian Maternal and Child Health Nurses. The focus of this chapter is to discuss the Qualitative Exploratory Descriptive (QED) research methodology chosen for this study together with its theoretical framework. Emphasis will be given the exploratory descriptive method and to providing the justification for choosing this methodology. Consideration is then given to discussing and describing the method used for this study, including the sample selection process, accessing the participants, limitations of the method and the analysis process. The strengths and weaknesses of the study, limitations of the method and ethical considerations will also be discussed. In finishing, the strategies employed to ensure research rigor, credibility, confirmability, fittingness and auditability will be further discussed.

Methodology

Qualitative methodology was selected as the preferred method instead of a quantitative method because qualitative methods give both depth and detail of what the participants reveal (Patton, 2002). This is further supported by Maxwell (2006; 2012) with this interpretation, in that qualitative researchers are interested in understanding how people interpret their experiences, how they construct their world and what meaning they attribute to their experiences. Patton (2002) defines the differences between the two methods indicating that quantitative research offers a broader generalized set of statistical findings presented in a concise mode. Whereas qualitative research
produces a wealth of detailed information with increased understanding around a smaller cohort (Merriam, 2009). Other characterisation of qualitative research identified by Merriam (2009) that it is an inductive process. Using an inductive process is believed to be important in that it adds to theory development with themes or categories, whereas quantitative research is a deductive process of hypotheses and testing of concepts. Findings in qualitative research are not arrived at by means of statistical procedures or quantification of data (Corbin and Strauss 2008). Traditional use of qualitative methods arose as a direct consequence of quantitative methods not always being able to describe aspects of human values, culture and relationship (Streubert and Carpenter 2003).

Qualitative research has emerged with some debate surrounding the title of ‘Qualitative’ as the best term to use as its title. Preissle (2006) recognises the shortcomings of this title, however, stating that in fact the label of qualitative has worked because of its vagueness but it is also broad and inclusive enough to cover the variety of research practices that have been developed. Denzin and Lincoln (2008) further indicated that qualitative research is a well-positioned activity that locates the observer in the world and that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of meanings people bring to them. A more defined interpretation is offered by Van Maanen (1979:520) who describes it as an umbrella term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world. In other words, many researchers are interested in how people make senses of their world and how they construct meaning for themselves. Patton further adds to this by describing how people make sense out of their lives and how they interpret their experiences;

[Qualitative research] … is an effort to understand situations in their uniqueness as part of a context and the interactions there. This understanding is an end in itself, so that it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting, what their lives are like, what’s going on for them, what their meanings are, what the world looks like in that particular setting and in the analysis to be able to communicate that faithfully to others who are interested in that setting… The analysis strives for depth of understanding (Patton 1985:1)
Qualitative researchers can therefore be described as study entities in their natural settings, attempting to make sense of or interpret phenomenon in terms of the meanings people bring to them (Denzin & Lincoln, 2008). What is more, it is from the participants perspectives that the phenomena are understood. This is supported by Bogdan and Biklen (2007:9 -10.) suggesting that Chicago sociologists’ in the 1920s emphasised ‘the intersections of social context and biography’ that lies at ‘the roots of contemporary descriptions of qualitative research.’ These authors knew they were ‘giving voice’ to points of view of people marginalised in the society. In addition to this, professional fields such as education, law, counselling and health were becoming interested in specific cases for understanding phenomenon and so began to use qualitative methods. The humanities began to portray people’s experiences in specific social contexts. Merriam (2009) alludes to two important mid-twentieth-century publications that contributed to the emergence of and increased popularity of qualitative inquiry. These being Discovery of Grounded Theory: Strategies for Qualitative Research by Glaser and Straus in 1967 and in 1987 by Guba titled, Towards a Methodology of Naturalistic Inquiry in Educational Evaluation.

Philosophical Perspective of Qualitative Inquiry

There are a number of philosophical perspectives to qualitative research. The most commonly referred to are positivist, interpretive, and critical. According to Patton (2002) a positivist orientation assumes that reality exists and is observable, stable and measurable. Whereas, the interpretive assumes that reality is socially constructed with no single or observable reality. In other words, there are multiple realities or interpretations of a single event. Interpretive inquiry is where qualitative research is most commonly located (Patton, 2002). Critical inquiry draws from a number of theories one being the feminist theory. Critical inquiry aims to critique and challenge, and to transform and empower (Crotty, 1998). Lather (1992: 2006) further adds post-structural or postmodernism to the typology which indicates that there is no single truth but multiple truths.

In addition, understanding the nature of qualitative research according to Merriam (2009) can be gained by looking at its philosophical foundations. Merriam (2009) further states that there is almost no consistency between writers in how the philosophical perspective of qualitative inquiry is deliberated. Likewise, Bogdan and Biklen (2007) talk about traditions and theoretical underpinnings while Patton (2002) refers to theoretical traditions and orientations. Denzin and
Lincoln, (2000) refers to theoretical paradigms, whereas Creswell (2013: 2007) uses worldviews and Crotty (1998) refers to the epistemology and theoretical perspectives when referring to the philosophical perspective. Furthermore, Creswell (2013:2007) identifies the paradigms as alternative knowledge claims. Denzin and Lincoln (1994, 2000, 2005 & 2011) have further described the philosophical assumptions over the years as the ‘axiomatic’ guiding philosophy behind qualitative research.

A central focus for researchers before choosing a methodology in any research is the consideration of its ontological and epistemological underpinnings. These concepts are interrelated in that knowledge of what exists cannot be separated from the process of acquiring knowledge about what exists.

**Ontological Considerations**

Ontology is the philosophical study of the nature of reality or the idea of multiple realities as seen through many views (Merriam 2009). Traditionally ontology deals with questions concerning what objects exist or can be said to exist, and how such entities can be grouped. In qualitative research, the researcher and the researched embrace different realities. Whereas according to Patton (2002), research is conducted with the intent to look at the perspective of multiple realities which in turn answers the question of what is believed about the nature of reality. Streubert and Carpenter (1993) further assert that human beings are cogitative, psychological beings and have multiple realities. Their thoughts and ideas therefore, are subjective not objective. The naturalistic paradigm within which this study is situated, takes the ontological position that the world is seen as basically a function of human thought, analysis and perception (Oliver, 2004:29).

In this study the researcher aimed to discover what the participants’ perceptions were to the perceived impact from the national change to a national registration and proposed service provision on the Victorian MCH nurses. In this instance, the information obtained will be subjective and unique for each individual participant that is their own reality, their truth. The question arises as to what it means in this context to call these epistemic judgements ‘objective’ or ‘subjective’. Mandik (2001) proposes that the difference is positioned on truth and that objective judgements are absolutely true, whereas the truth of subjective judgements is relative to the person making the judgement call.
Epistemological Considerations

Epistemology according Creswell (2013) are beliefs about knowledge or theory of knowledge and learning how knowledge is produced. This means the researcher is required to situate themselves within the participants' environment while conducting the study to collect subjective evidence from the participants to construct their own perceptions of what is being studied. Epistemology questions what knowledge is and how it can be acquired, and the extent to which any given subject or thing can be known. This is why epistemology is fundamental to how people think and understand, how knowledge is acquired, and concepts are developed. A sound epistemology is, therefore, necessary for the existence of sound thinking and reasoning according to Creswell (2013).

Axiological Considerations

Creswell (2013) indicates that all researchers bring values to their research, however, points out that the qualitative researcher in particular makes their tenets known in their research. In other words, the axiological assumptions typify qualitative research by the researcher admitting the value laden nature of the research and reporting any biases. The researcher while positioning themselves in the study openly discusses values that shape the accounts of the participants’ experiences in conjunction with their own interpretations of the data.

Pragmatic and Utilitarian research

A pragmatic, utilitarian framework can guide qualitative inquires on their practical and applied underpinnings without having to be attached to, or derived from, a ‘grand’ or ‘master’ theoretical tradition (Patton 2002:145). Pragmatism in research deals with the practical issues rather that in testing theory or developing theory. Utilitarianism ensures practicality and usefulness.
Selection of methodology

There are a number of paradigms associated with qualitative research, including critical social and naturalistic. Qualitative research allows for a rich descriptive or interpretive, naturalistic approach to viewing the world. It is, therefore, situated in a paradigm that views things in their natural settings, while attempting to make sense of, or interpret, phenomena in terms of the values and meanings that people bring to them (Denzin and Lincoln 2003:5). In other words, qualitative research concentrates on the values, meanings, thoughts, and beliefs of the event and is based on the naturalistic paradigm (Liamputtong and Ezzy 2005). Naturalistic research is undertaken in the 'real world' about a 'real world' issue where the researcher does not influence the phenomenon. The phenomenon unfolds 'naturally' in that it has no destined course established by and for the researcher (Patton 2002:39). In other words, it is 'situated in a paradigm that views situations or language in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings that people bring to them' (Denzin and Lincoln 2003:5). A study is believed to be 'naturalistic' when taken place in real world rather than in a test site and the researcher does not control what is being studied. In other words, the findings are discovery orientated not predetermined. The methodologies located in the naturalistic paradigm include, but are not limited to grounded theory, phenomenology, heuristics, ethnography and qualitative exploratory descriptive. The various methodologies are based on the 'specific methodological frameworks emerging from distinctive disciplinary traditions' (Sandelowski 2000: 337).

Patton (2000) explains that qualitative descriptive studies are the least theoretical of the qualitative approaches, in that researchers are the 'least encumbered by pre-existing theoretical and philosophical commitments' (Patton 2000:337). This method allows for the collection of data as they are presented without being a requisite by the philosophical underpinnings related to other methodology designs. The studies do not require researchers 'to move as far from or into their data' but rather require 'the presentation of facts of the case in everyday language' (Sandelowski 2000:336). This can be described as being a pragmatic approach which is just as reliable as other theory based approaches. In other words;
Not all questions are theory based. The value and legitimacy of qualitative inquiry, it is not necessary, in my option, to swear vows of allegiance of any single epistemological perspective to use qualitative methods. Indeed I would go further (at the risk of being heretical) and suggest that one need not even be concerned about theory. While students writing dissertations and academic scholars will necessarily be concerned with theoretical frameworks and theory generation, Patton suggests that there is a practical side to qualitative methods that involves asking opened ended questions of people and observing matters of interest in real world settings in order to solve problems, improve programs, or develop policies. In short, in real world practice, methods can be separated from the epistemology out of which they have emerged (Patton 2002:135-136).

The focus of this research project was the exploration and description of the knowledge attitudes and beliefs of the KSH and MCH nurses to the national changes following COAG’s decision that the Productivity Commission investigate and make changes to the health workforce registration and in turn service delivery. The perceptions of the MCH nurses along with their knowledge, attitudes and beliefs has been a phenomenon that has had no exploration, hence the requirement for further investigation. This study was undertaken using a QED research approach, informed by the works of (Patton 2002) and Sandelowski (2000). An exploratory descriptive approach was chosen for this study as it is an appropriate method for the task of gathering new information on a phenomenon where little is known about the nature of a particular problem and the data is too complex to be captured using a survey method (Patton 2002). This is supported by, Domegan and Fleming (2007), who suggests that QED research aims to explore and to discover an issue around the problem on hand, when there is little known about the problem. This study is, therefore, well suited to the QED methodology chosen. Therefore, the QED method was chosen following the consideration of a number of factors that included the nature of the phenomenon being considered, how much previous investigation had been done into the phenomenon and the extent of knowledge already known about the phenomenon (Morse and Field 1995). In addition, in selecting the method, the researcher was required to consider her own abilities and agenda in regards to the chosen phenomenon for investigation (Schneider, Whitehead & Elliott 2013)

Furthermore, QED method is the method of choice where little is known about the nature of a particular problem (Patton 2002:193) and where ‘what’ types of questions are asked. In addition, a QED approach is ideally suited for capturing the subjective realities of the participants’ through their narratives, it captures their stories through their voice. This descriptive study stayed close to
the original data and, while was coded and categorized to create order from the raw data obtained, the techniques used allowed the information to present itself as if it were not under study, that is, ‘in as natural a state as possible’ (Sandelowski 2000:337). It is therefore, appropriate to use a QED approach where it is important to ‘explore the participants’ views of reality rather than that of the researcher’ (Streubert and Carpenter 1995:11). This information can then be used to significantly inform further research into why and how participants feel a certain way and what can be done to improve the problem under investigation.

While exploratory research emphasises gaining ideas and insights, Strauss and Corbin (1990) suggest that this is not meant to solve problems. This exploratory research instead provided insight on individual representation of the population, but not the opinion of an entire population.

**Theoretical Framework**

Theoretical frameworks are the underlying structure of a study. According to Maxwell (2012) the theoretical frameworks are the system of concepts, assumptions, expectations, beliefs, and theories that supports and informs research. The theoretical frameworks that informed this study were resultant from the national changes occurring due to the move to a national registration. The knowledge, attitudes and beliefs of the KSH and MCH nurses to these changes directs the theoretical assumptions which in turn assist in addressing questions of what, why and how. This allowed the researcher to move from simply describing a phenomenon observed to taking a broad view about various aspects of that phenomenon being studied. This study provided additional validation as well as corroborative evidence for the need of further research in this contemporary area of primary health and change.

The collection of forces, which underpins behaviour in organisations, is so formidable that, it is surprising that any change ever manages to be planned, let alone implemented (Mangham 1979). As Flint (1993) notes, change in maternity care is both hard to initiate and hard to live through. Senior (1997) considers that it is too risky to blindly follow a change recipe in the hope that it will work. For change to be successful, the path has to be appropriate for the situation in hand. A health service, as with any complex institution, finds change difficult for many reasons. This includes the fact that the situations are often complex, involving deep-seated, systems issues, which are embedded with complex social systems (Braithwaite, Hindle, Ledema and Westbrook.
Using some sort of organisational change framework can assist in understanding the change process and assess what needs to be in place to make it more achievable as others have found (McCourt and Page 1996). Consequently, the organisational change framework informs the research and, therefore, is the theoretical framework for this study.

Organisational change can be defined as transforming an organisation from its current state to one that is improved and more desirable (Ragsdell 2000). Change can also be stimulated by major policy reviews, for example, the decision to move to a National Registration by COAG (2006) for all the Health professionals. The important aspects of implementing organisational change contributed to a number of different aspects from both the KSH and MCH nurses data.

Over the last 20 years the study of organisational change has increased in magnitude, particularly the number of conceptual approaches available (Coram and Burnes 2001). These approaches can be categorised as planned and emergent. The planned approach originated with Lewin’s (1951) work, which describes three phases of organisational change. Phase one is about unfreezing past behaviours and attitudes in order to heighten awareness for the need to change. Moving is the second phase and involves making the changes that takes the organisation to its new state. The final phase is refreezing or securing the change. Senior (1997) criticised the refreezing phase as ignoring the increasingly turbulent environment of an organisation and the need for ongoing change.

Hendry (1996) believes most organisational change has followed these stages in some form or another. Lewin’s (1951) work, termed soft systems model of change (Senior 1997), became the central focus of organisational development and action research in the 1960s (Chapman 2002; Dunford 1997). An organisational development approach cares about people who are crucial as both drivers and participants of change (French and Bell 1995). Change is achieved with organisational development through processes of facilitation that moves an organisation from one state to a new state through a set of activities (Senior, 1997). It is a collaborative process directed to change through developing problem awareness and problem solving skills among people in the organisation (Dunford 1997). The process involves collecting data and making a diagnosis, followed by discussion of these by the group who, in turn, develop action plans for implementation. An evaluation is carried out, followed by more action and subsequent evaluation, and action, and so forth. These processes involve an ongoing, interactive process as change occurs in incremental steps as opposed to a sudden event. Organisational development then becomes the research approach.
Dunford (1997) refutes the effectiveness of organisational development as a change strategy. This criticism is based on the assumption that participation and incremental change are not always appropriate. Further, Dunford (1997) believed that organisational development neglects the significance of power. In addition, Senior (1997) maintained that organisational development neglects to face up to the harsh realities of change and, therefore, has limited scope. Consequently, organisational development is appropriate for transformational change, which results in significant alterations to an organisation (Connor and Lake 1994).

Planned change, in general, was developed for a top down, rigid, autocratic organisation. This has been strongly criticised in an increasingly more chaotic and turbulent organisational world (Coram and Burnes 2001). A top down approach neglects the professional development of the employees through which change can occur more readily (Clarke and Meldrum 1998). There is also an assumption with planned change that one method suffices for all organisations, situations and times (Dunphy and Stace 1993). The focus is primarily on individual or group level interventions, which supports gradual or incremental organisational change (Chapman 2002).

As a consequence of the increasing criticism of a planned approach to organisational change, the emergent approach came about (Coram and Burnes 2001). The emergent approach was seen as being more appropriate for dynamic and unpredictable organisations. In such organisations, continuous change was the focus in order to procure organisational transformation. The emergent approach was based on certain assumptions, that is, organisations operate in a dynamic, turbulent and unpredictable environment with organisations needing to appropriately respond (Coran and Burnes 2001). In summary, the emergent approach was an open ended, bottom up and continuous process. An example of an emergent approach is that developed by Kotter (1996).

The emergent approach is not without its criticisms, although these are really not substantial. Coran and Burnes (2001) believe that the emergent approach is not suitable in organisations operating in stable environments or where major change is required through rapid, coercive measures. Further, the emergent approach has been criticised for over emphasising politics and culture in change process (Hendry 1996). Certainly with this study, politics and culture were a major contributing factor to issues that developed during its planning. Over emphasising politics was therefore not a valid criticism in this circumstance.
What can be surmised from this brief overview of organisational change literature is that approaches vary. Further, there is no one best, all embracing, universally accepted way to achieve organisational change (Dunphy 1996). It could be argued that this is appropriate as there are many different situations that require change and many different types of organisations. Therefore, whichever method is used needs to be tailored to the individual organisation (Crom and Bertels 1999). Further, the organisational change approach needs to balance technical aspects with human factors (Bovey and Hede 2001). In other words, there is no one best way to achieve change and, in fact, Coran and Burnes (2001) suggest that a combination may be appropriate in some situations. For these reasons the framework described by Kotter initially in 1996, an emergent approach to organisational change was, therefore, deemed appropriate for this study.

Kotter (1996; 2012), initially, examined numerous initiatives aimed at producing organisational change over some 25 years and analysed why transformational change failed in these circumstances. More recent work follows the same principles of analysis of organisational change (Kotter and Cohen 2002). The result was a list of common errors and reasons why change does not easily happen and may fail. This list was useful in assisting leaders of change to understand specific instances of resistance to change in order to develop approaches relevant for a particular situation (Senior 1997). Kotter (1996; 2012; Kotter and Cohen 2002) turned this list of errors around, resulting in identifying eight stages that must be present for achieving major change. Each stage was associated with one of the fundamental errors preventing transformational change. These eight steps are likened to strategies that are about unfreezing the participants to plan the change, aiming to embed the change in the organisational culture. Other organisational change authors refer to frameworks very similar to that of Kotter (1996), describing what is necessary to succeed with change (Dunford 1997; Eccles 1994; Senior (1997). The framework provided in this thesis uses predominantly Kotter’s (1996) work with some input from the other authors, such as Dunford (1997), Eccles (1994) and Senior (1997), to add to or clarify that developed by Kotter (1996). Kotter (1996; Kotter and Cohen, 2002; Kotter 2012) believe that the eight steps do not necessarily need to be followed step by step, however, they all need to be in place. This framework is useful for indicating where organisations err in the attempt to achieve change. Senior (1997) described Kotter’s change framework as being more directive and all-encompassing than other change process and is more adaptive, therefore, to individual circumstances. For all these reasons, the eight steps presented by
Kotter (1996; Kotter and Cohen, 2002; Kotter 2012) were deemed appropriate for this study. What follows is an overview of the elements of the framework presented by Kotter (1996; 2012).

**Creating a sense of urgency**

Achieving change within an organisation involves people stepping outside of their normal role and comfort zones, to have initiative and a willingness to make sacrifices. Further, achieving change requires great cooperation from colleagues (Kotter 1996; 2012; Kotter and Cohen 2002). This cooperation can be achieved by creating a sense of urgency to achieve change. Without a sense of urgency people are not interested in planning to change or to form a group to gain enough power and credibility to guide the planning. This sense of urgency is achieved by believing that what exists is unacceptable and, therefore, needs changing (Kotter 1996; 2012; Kotter and Cohen 2002), thereby creating the pressure to change (Eccles 1994). To increase the sense of urgency, removing or minimising the sources of complacency is necessary (Kotter 1996; 2012). People then become motivated to plan for change.
Empowering broad based action

Empowering broad based action is about empowering people to have a sense of urgency by removing as many obstacles to change as possible (Kotter 1996; 2012; Kotter and Cohen 2002). With the introduction of any change there is an expectation that certain obstacles to change will occur in an attempt to undermine and obstruct the change. People are moved outside their comfort zone with the advent of change and creating obstacles is often a consequence of this resistance. It is, therefore, important to remove as many obstacles as possible to empower broad based action and thereby create a sense of urgency. According to Kotter (1996; 2012) ways that these obstacles can be removed include communicating the change, making structures suitable, providing training opportunities and confronting people. Other stages of the framework further assist with this process of removing obstacles.

It is important to note, however, that it is impossible to remove every barrier from all individuals who are required to change. Consequently, not all people will support the change entirely or consistently. It is important, therefore, that researchers as change agents firstly identify the participants and their reasons for creating obstacles and work around them (Kotter 1996; 2012; Kotter and Cohen 2002).

Developing a vision and strategy

Having a vision for how something could be in the future is the first step in achieving change (see for example, Clarke and Meldrum 1998; Kotter 1996; 2012; Kotter &Cohen 2002). Senge and colleagues (1999) argue that leadership is indeed critical in achieving change. Leadership, then, is about having a vision about which one is passionate and the ability to motivate others to bring about that vision. An effective change agent, in being a leader, is able to achieve a vision for change. Having a good and clear vision ensures a number of important purposes to the change process. The purposes in having a vision means the direction of change is clarified, others are motivated towards the change and coordination of other’s actions is assisted in order to be fast and efficient (Kotter 1996; Kotter and Cohen 2002). Managing change is necessary, but leadership is crucial (Dunford 1997; Eccles 1994; Kotter 1996; 2012).
The characteristics necessary to be a successful leader are also relevant for leaders of change (Dunford 1997; Eccles 1994). Eccles (1994) believes that different styles of leadership may be suited to different types of change. There is little in the literature, Eccles ads, to recommend which style of leadership is most suited for which type of change, with one exception. There is evidence to suggest that transformational leadership is ideal for leading transformational change (Eccles 1994; Senge, Kleiner, Roberts, Ross, Roth and Smith 1999). Transformational leadership concerns challenge the status quo and encouraging others to do the same, resulting in a motivated workforce that adapts well to the effects of change (Dunford 1997). Transformational change results in significant alterations to an organisation (Connor and Lake 1994), an apt description for this research project. With transformational change every person affected by the change becomes change agents (Chapman 2002). Dunford (1997) adds, however, that achieving change requires more than the qualities of transformational leadership. The change agent needs also to have position power, expertise, credibility and leadership (Dunford 1997; Eccles 1994; Kotter 1996; 2012).

Creating the guiding coalition

It is important for change agents to align themselves with powerful others. This group of powerful people then become a guiding coalition. The alignment with others further facilitates development of support from key stakeholders. The guiding coalition needs a vision and able to motivate others to accept that vision and, therefore, are leaders themselves with the necessary characteristics. By working together and presenting a united front, the guiding coalition is able to lead and sustain the change process. It is vital that the guiding coalition is not only united, but is seen to be united and committed to implement change (Dunford 1997; Eccles 1994; Kotter 1996; 2012).

Communicating the change

Part of identifying change is to communicate that change to as many people as possible, and not just through a top down approach. Mander, Gomes and Castle (2002) believe that communication is vital in organisational change. Using different forms of communication frequently is important in
encouraging others to share the vision, support it and be motivated to change (Kotter 1996; Kotter and Cohen 2002). Further, communication is about listening to other’s opinions and feelings about change and ascertaining whether they understand it or not (Eccles 1994). Effective communication needs to be in a manner that will increase receptiveness of the information and not create barriers (Dunford 1997). Identifying the range of acceptable points of discussion and presenting this information in a non-threatening manner can therefore, achieve good communication. It is important to have an understanding of what it is that motivates different people and not assume it will be the same as one’s own motivation. Communication needs to facilitate a two-way discussion to allow people to voice their concerns and be responded to in order to allay their concerns and break down barriers (Kotter 1996; 2012; Kotter and Cohen 2002).

**Generating gains**

Kotter (1996:2012) defines generating gains as achieving short-term gains that are visible and unambiguous, which serve as a reward and motivation to continue. These gains are about rewarding commitment and success regarding the change (Eccles 1994). Short term gains help undermine those who resist, making it more difficult for those opposed to change to block it. Further, gains can help move people, who may have been previously neutral about the change, into active supporters. Short-term gains do a lot to reassure and motivate the change agent/s to push ahead with change as they are rewarded for pursuing the appropriate goal. Achieving short-term gains gives positive feedback to the change agent about the viability of the change (Kotter 1996:2012; Kotter and Cohen 2002). These gains also demonstrate to the researchers that the planning is progressing.

**Consolidating gains and producing more change**

Even when gains have been achieved, it is important not to let the momentum go, keeping the pressure on by continuing to lead the change. Further, it is important to continue to make adjustments as necessary and move forward to achieve more gains (Kotter 1996:2012; Kotter and Cohen 2002). This process of continually making adjustments to the plan makes the progress of change slow, steady but continuous (Eccles 1994). Part of the planning process is learning from the
unintended consequences of planning and adjusting accordingly. If the momentum is not kept going the change process may regress, making rebuilding of the momentum difficult and potentially allowing resistors to gain a foothold (Kotter 1996:2012 Kotter and Cohen 2002).

**Anchoring new approaches in the organisational culture**

Embedding the change into the organisational culture is crucial to achieving change (Kotter 1996:2012; Kotter and Cohen 2002). This involves anchoring the change into the organisations norms and values so that it becomes so much a part of the organization that it is the organisation. The reason for this is that the culture of the organisation plays a dominant role in trying to achieve substantial change (Senior 1997).

**Research Aim and Research Questions**

From the aim of the research the study design was developed. The aim of the research was to explore and describe the knowledge, attitudes and beliefs of the KSH and the MCH nurses to the perceived impact of the national changes to registration and service provision on the Maternal and Child Health nurses in Victoria and organisational change.

**Research Objectives**

The research objectives underpinning this study were the following:

- Explore and describe the knowledge, attitudes and beliefs of the Key stakeholders implementing the national changes to registration, qualifications, educational requirements and proposed service provision.
• Critically examine explore and describe the knowledge, attitudes and beliefs of the MCH nurses to the national changes to registration, qualifications, educational requirements and proposed service provision.

• Critically examine the knowledge, attitudes and beliefs of the MCH nurses to organisational change.

• Examine and identify key emerging issues and encourage wider discussion between relevant bodies to facilitate the removal of constraints to change.

Method

Location of study

The research was located in Victoria Australia. This study commenced at the time of the introduction of the national registration in 2010 and was completed in early 2014. Participants were recruited from metropolitan, semi-rural, rural and remote areas of Victoria to obtain a cross sectional representation from the KSH and MCH nurse workforce for the richness of data.

Accessing Participants

Participants were purposefully sampled and to a degree the snowballing technique was used. According to Patton (2002) snowball and purposive sampling techniques are used for locating information from rich key informants recruited via professional networking (Patton, 2000). Purposeful sampling is a strategy in which the researchers knowledge of a population and its elements are used to hand pick the cases to be included in the sample. The researcher usually selects subjects who are considered to be typical of the population (Schneider, Elliott, LoBiondo-
Wood and Haber, 2003). Patton (2002) explains that using this process enables the researcher to learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling. In addition, according to Patton (2002) more can be learnt from a carefully selected group who share a common experience or perspective rather than a large representative sample. Purposeful sampling focuses on selecting a population who will focus on the questions under study and as a result offer data rich in information (Patton, 2002).

For example, this study explored the knowledge, attitudes and beliefs of Victorian Key stakeholders (KSH) and Maternal and Child Health nurses (MCH) to the perceived impact of the national changes following the move to a national registration. For this study, the recruitment process began by asking suitable people who were KSH and MCH nurses working in the field across the state of Victoria to participate as they were characteristic of the population under consideration. Each participant, however, was unaware as to whether a person in their network had been chosen to participate by the researcher, thereby ensuring that anonymity and confidentiality was maintained.

Participants were recruited from metropolitan, semi-rural, rural and remote areas of Victoria to obtain a cross sectional representation from the KSH and MCH nurse workforce for the richness of data. The recruitment process occurred through advertising in the Victorian Association of Maternal and Child Health Nurses (VAMCHN) journal, the DEECD state conferences in 2010 (Appendix A) and with a degree of snowball recruiting. Interested KSH and MCH nurses then contacted the researcher with their expression of interest in participating. If the interested participant passed the selection criteria an interview place, date and time was then scheduled. Recruitment continued with participants that met the inclusion criteria until data saturation was reached. This resulted in 48 interviews being completed which included 12 KSH and 36 MCH nurses.

**Sample size**

Sandelowski (1986) explains sample sizes in qualitative research as being generally small because of the large volume of verbal data that must be analysed and due to the prolonged contacts with participants at times. In addition, sampling with qualitative research is theoretical rather than statistical. According to Whitehead and Annells (2007) the number of participants...
required for a qualitative study is between eight and fifteen or until data saturation has been achieved. In interview studies, sample size is often justified by interviewing participants until reaching ‘data saturation’. These requirements not only emphasize the importance of reaching saturation but also of providing documentary evidence that saturation had been reached. Sandelowski (2000) indicates that sample size is dependent on when data saturation is achieved. Data saturation in qualitative research according to Patton (2002) is reached when no new information emerges. The final number of participants is dependent on when informational redundancy has been achieved. Whereas, Patton (2002:246) also recommends specifying a minimum sample size “based on expected reasonable coverage of the phenomena given the purpose of the study”. Merriam (2009) further adds that in actual fact there is no real answer to this. The actual sample size instead depends on the questions being asked, the data being collected and the analysis processes as well as the number of participants to adequately answer the research question in the first place. With all of this in mind, data was collected from 12 KSH and 36 MCH participants. At this point no new information or insights were being obtained from the data and the decision to stop sampling was, therefore, made.

Group One for the study consisted of KSH. These individuals were selected from management, academia or service coordination and came from different influencing positions for example; DEECD, the MAV or Coordinators of Family and Children’s Services from LGA’s across Victoria. Data saturation in group one was achieved following 12 interviews.

Group Two consisted of MCH nurses. These individuals were selected from metropolitan and country areas across Victoria. Data saturation in Group Two was achieved following 36 interviews. The MCH participants were divided into three groups in Group Two. These groups were identified by their years of experience working as a MCH nurse. This included:

Group A: one to five years of experience
Group B: six to fourteen years of experience
Group C: fifteen years and over of experience

The number of interviews attended in group two is indicated by group classification A, B or C.

Group A: 13
Inclusion Criteria

Participants were required to meet the study selection criteria. This included:

Group One
- KSH currently working as manages in the field related to the MCH service
- Willing to participate in an individual audio digital recorded semi structured interview

Group Two
- MCH nurses practicing in Victoria
- MCH nurses currently working in the MCH service
- Minimum 12 months experience
- Willing to participate in an individual audio digital recorded semi structured interview

Exclusion Criteria

Participants were excluded from the study if they did not meet the selection criteria. This included:

Group One
- KSH working in a seconded position
- KSH not working currently in the field related to Maternal and Child Health
Group Two

- MCH nurses working in a seconded position
- MCH nurses with less than 12 months experience.
- MCH nurses not working currently in the field related to Maternal and Child Health.

Ethical Considerations

In keeping with the ethical standards of research prescribed by the National Health and Medical Research Council (NHMRC), approval was sought and obtained from the RMIT Human Research and Ethics committee (HREC) (ASEHAPP73 – 10) and permission from the Department of Education and Early Child Development (DEECD) was obtained prior to commencement of the study. Permission was also requested and received from the Local Council areas for staff to participate in the study; therefore ethical standards of research were maintained. The ethical issues addressed in this study that will be discussed are: informed consent, confidentiality and anonymity, classification of risk, participant vulnerability, risk classification, data security.

Participant Information and Informed Consent

All research is subject to forms of consent which involves the ethical and legal requirements of the researcher informing the participants of the requirements enabling them to make an informed choice whether to participate or not. Informed consent is the principle that individuals should not be pressured, have undue influence applied to participate in research against their will, and that their participation should be voluntary, and on a full understanding of the implications of participation (Green and Thorogood 2013). When participants initially expressed interest in this study, they were given a copy of the plain language statement and a consent form to sign (See appendix: C,F). This plain language statement explained to participants what the research was about prior to signing the consent form. The information included that the interviews would be digitally recorded, then transcribed with the use of codes and pseudonyms to maintain anonymity and the final report would not contain any identifying information. The participants were also
advised that they would be free to withdraw their consent to participate at any time and they could withdraw their data from the study even after the interview had taken place. A copy of the plain language statement and consent forms were offered to each participant on request.

Confidentiality and Privacy

Confidentiality for the participants was maintained by de-identifying the data and removing any personal information. This included not providing a breakdown of the number of participants accessed in metropolitan, semi-rural, rural and remote as this may potentially identify some of the participants. The data was individually coded and numbered in both groups of the study. Keys to the codes were known only by the researcher and stored in a password protected file on the computer hard drive. In the final report participants were referred to as: KSH 1-12; MCHA 1-13; MCHB 1-11; MCHC 1-12. In addition the participant’s workplace was not identified in the final report. The digital recordings of the interviews were stored in a password protected file on the computer hard drive when transcribing was completed. The transcripts were access only by the researcher and the primary supervisor.

Risk Classification

A Level 2 minimal risk classification was awarded to this research study by RMIT University HREC as the participants were considered not to be exposed to physical, psychological or social risks above the everyday norm. Their participation in the project involved discussing knowledge, attitudes and beliefs of the national changes. There was, however, a slight possibility of participants becoming emotional when reencountering experience at the time that were a source of stress or distress. If a participant became emotional or distressed while discussing their experiences, the interview would have been stopped for a period of time. The interview would be recommenced when the participant felt ready and was happy to do so. If the participant by any chance could not continue, the interview would be stopped immediately and the participant would
have access to appropriate persons for assistance. No participants required such assistance and all interviews were completed as scheduled.

**Data Security**

All printed data collected during the course of the study is stored in a locked filing cabinet in the primary supervisor's office in the Division of Nursing and Midwifery, RMIT University. Only the researcher and the researchers' primary supervisor have access to the information. Electronic copies are held by the researcher on a password protected laptop in a secure location at the researcher’s home. Additional copies are kept on Universal Serial Bus (USB) for transportation purposes to university. Following the completion of the study, all material relating to the study will be archived in accordance with RMIT University policy. All stored materials will be destroyed after five years.

**Participant Vulnerability**

The participants' in this study were not from a vulnerable population, as classified by the National Health and Medical Research Council. Further, participants of this study were not in a dependant relationship with the researcher, and were not asked any questions that they would not ordinarily discuss in a professional conversation at any time. Some of the participants would have been known to the researcher, however, only on a professional basis due to the researcher being professionally active. The participants were advised prior to the interview that if they found themselves in a future professional relationship with the researcher, the principles of confidentiality would remain in place. Mindfulness and respect for the participants' private space and cultural sensitivity while interviewing was paramount for the researcher to uphold. Locke, Spirduso, Waneen, and Silverman (2013) further indicates that the development of a relationship between the researcher and the subject during an interview needs to be considered in terms of the values of the researcher and the cultural aspects relating to any ethical issues.
While the researcher was particularly satisfied with the results of the interviews and was genuinely interested in the experiences of others, giving a voice to the Victorian MCH was a guiding force behind the research. The researcher is humbled by the participant’s willingness to be interviewed although troubled by the possibility of exploiting them for her doctorate. Patai (1987) expressed similar views when interviewing participants for her scholarship. Brinkman (2012) further stated that exploitation of interviewees is a serious concern for many researchers. It has been further suggested that research is often done by people in relative positions of power with their own personal interests of advancement being served (Seidman 2012). It is therefore important, that research processes remain equitable to all concerned.

Data Collection

Interview questions

The approach to interview questions can be either instrumental or realist (Minichiello, Aroni & Hays, 2008). The difference between these two is that instrumentalis develop their questions in terms of observable or measureable data and prefer to continue with what they can directly verify. Whereas the realists treat the unobserved phenomena as real and their data as evidence to develop and test ideas in regards to the existence and nature of the phenomena (Maxwell, 2004). According to Linde (1993) both the realist and the instrumental approaches have their inherent difficulties. The main threat of the instrumentalist questions is that the study can be constricted and exclude theorizing about the phenomena that is not directly observable. As a result what is investigated can become rigorous with an uninteresting conclusion. In contrast if the realist relies too heavily on inference this in turn may lead to the drawing of unwarranted conclusions or assumptions to influence the results (Linde, 1993).

Linde (1993) further states the decision to use either the realist or the instrumentalist questions should not be based around the seriousness of the risks to validity but on what the researcher wants to understand from the outcomes of the research. What is also needed is how the participants make sense of the phenomena and what perceptions inform their actions versus what really happened or with what they did. For this thesis, the researcher used the realist
approach for the participants by using a perception and beliefs frame for the questions in relation to what the participants perceive has or will happen with the phenomena.

Additionally, Patton (2002) suggests the interview process be developed with different types of questions to stimulate the responses from the participants. Patton (2002) has recommended that the ‘why’ questions be limited as they may divert the flow, or lead to dead end responses. Interestingly though, Merriam (2009) agrees but reports that the ‘why’ can also assist in uncovering insights that may suggest new avenues of questioning. It is the interviewer’s responsibility to ask questions in a clear understandable manner which in turn develops a good rapport and enhances the quality of responses (Patton 2005). The language used at the interview or terms need to be phrased as near to what is commonly used by the participants being interviewed to ensure the truth of the phenomena under study is truly identified and understood by both interviewer and the participant.

The focus of the interview tool for this study was on the knowledge, attitudes and beliefs related to the perceived impact of the national changes to registration and service provision. These interview questions for this study were developed to reflect the theoretical framework of organisational change with knowledge, attitudes and belief questions. The majority of questions asked were structured with a mixture of “Ideal position”, “Interpretive”, “Devil’s advocate” and “Hypothetical” question (Merriam 2009:97). Leading questions were avoided to prevent interviewer bias or assumptions being portrayed to the participants.

The researcher met with KSH and MCH nurses in the study setting to determine what they perceived as important to investigate in regards to the national changes to registration and service provision. After identifying the focus of the study and the area of knowledge, attitudes and beliefs that were to be investigated the researcher then interacted with the KSH and MCH nurses again to formulate the interview questions. These were related to national registration, national framework, qualifications, service provision, professional development and organisational change. There were 36 questions in total. These questions were assembled by the researcher and reviewed by an expert panel to comment on content, design and appropriateness along with any ethical and cultural concerns. Following the expert panel review of the questions comments and recommendations were incorporated into the question design. The question design was firstly assembled for the Group One KSH interviews. Group Two interview questions were then informed by the results of Group One interviews. Both sets of interview questions were then
Piloted. There was a slight variance with the questions between Group One and Two. Interview questions for both groups are available in the appendices (Appendix D and E).

**Pilot study**

According to Maxwell (2012) a pilot study or prior research serve the same function as both are focused more precisely on pre-testing of a particular research instrument such as the interview questions. In addition, it is useful to pilot the questions in order to ascertain the length of time the interviews would take. Other advantages of conducting pilot studies is that it may well give advance warning about where the main research project could fail, where research protocols may not be followed, or whether proposed methods or instruments are inappropriate or too complicated (Seidman 2012). The pilot study of the interview questions is believed to be essential for early researchers in that it offers them insight into, not only their instrument, but also their interviewing design and can further alert the researcher to any elements that do not support their objectives (Seidman, 2012). Pilot studies are generally done with a small number of participants.

**Group One Pilot study**

Group one pilot study was conducted with three KSH who met the inclusion criteria for participation and were kept independent of the main study to ascertain content validity, and the appropriateness of the interview questions. The pilot study provided an opportunity to determine the appropriateness of the structured interview questions in terms of its scope, length, and clarity. These participants identified the need for further development of the questions to enable more in-depth rich data to be collected. All of the comments, suggestions and corrections were taken in to consideration to improve and upgrade the level of reliability of the questions. The researcher as a consequence of the pilot study changed the structure of the questions by increasing the number of questions for ease of participants’ to answer. The questions were then re-piloted with another participant who met the criteria and that was separate to the main study. This KSH was asked if she believed there was anything else that should be included in the interview questions. The
response was no, the questions covered the scope of the study. This resulted in no further changes being required.

**Group Two Pilot study**

The questions from Group One informed the questions for Group Two of the study. The questions were piloted again with two MCH nurses that met the inclusion criteria and again were not included in the main study. The MCH nurses following the pilot interviews were asked their opinion on the structure, content, scope, length, and clarity of the interviews. Both participants found the interviews pertinent to the current study. The MCH nurses were also asked if they believed there was anything else that should be included in the interview questions. The researcher did not have to change the interview questions for group two.

**Interview style**

Qualitative Interviewing is a powerful way to gain insight into the understanding of individuals whose lives reflect those issues being studied. Patton (2002) suggests that as a method, interviewing is the most consistent for people to make meaning through language. The researcher as the instrument is able to adapt and affirm the importance of the individual without being critical of their cooperation and community beliefs.

“One of the major differences between qualitative and quantitative research is that with interviewing the researcher is recognised as the human instrument with the ability to adapt and respond to situations with skill and understanding to minimise distortions that can occur because of their position as interviewer (Patton, 1989:157)”.

Interviewing, therefore, provides the necessary avenues of enquiry for the researcher to understand the meaning of the participant's experiences. The importance of structure is relative to maintaining the ability for the participants to reconstruct and reflect within the context of their experiences. Seidman (2012) advises that the governing principles of interviewing are to strive for processes that are repeatable and documentable.
Interviews

Data collection in qualitative studies is typically directed toward discovering who, what and where of events or experiences, in their basic nature and shape (Sandelowski 2000). Qualitative data was obtained for this study via semi-structured interviews of approximately 45 to 50 minutes in length. The interviews were conducted at locations and times mutually agreed upon by the participants and researcher.

All participants interviewed for this study were advised of the technique for digitally recording of the interviews prior to the commencement and signing of the consent form. The literature regarding the recording of interview offers varied opinions on the process (Bogdan and Taylor, 1975; Briggs, 1986; Lincoln and Guba, 1985; Patton. 1989; Maxwell, 2012). Seidman (2012), however, suggests for reliability of the participant’s words, the researcher has the responsibility to transform those spoken words into written text accurately in order to study them effectively. Vygotsky further suggests that the participant’s words reflect their consciousness to the questions asked at the interview (Vygotsky 1987). In other words the participant’s thoughts are alive in their words.

All the interviews began with the same framework of questions for the participants utilising questions from a number of categories to best determine the depth and breadth of the knowledge, attitudes and beliefs of the KSH and MCH nurses to the national changes. The semi-structured question format was used to invite discussion without providing an opinion from the researcher. Kvale (1996) suggests the researcher use a set of predetermined questions for all participants’ in the two groups. This is to ensure that all the participants understood the questions and to endeavour to capture the meaning of peoples’ experiences and to uncover their lived world. The questions for this study, however, differed slightly in between the two groups due to the nature of the participants’ position. In addition, the questions were short, clearly worded and able to be explored further with ‘what’, ‘why’ and ‘how’ questions if the researcher was unsure of the participants’ meaning in their replies at the time of interview (Krueger and Casey 2000).

The researcher invited any further discussion about the topic at the end of each category and the participants were asked at the completion of the interview if they had any further comments.
to add on the research topic and the content of the questions. Participants were asked to contact the researcher in the following week of their interview if they believed they had anything further to add to their interviewed session. In addition, the participants were given the opportunity of having a hard copy of their interview if requested at interview. The participants declined as they expressed confidence in the researcher and felt that by having their interviews digitally recorded that their words would be treated conscientiously and with respect by the researcher.

**Transcribing of the Interviews**

Individual sessions were transcribed verbatim by an independent, experienced transcriber as the researcher found the transcribing of the interviews a time consuming exercise and wanted to keep the enthusiasm for further interviewing. In addition, the researcher did not want to lose the context of the interview or to precipitate judgements on the importance of statements. Specific instructions on the researcher’s requirements concerning the transcriptions to ensure consistency especially with punctuation as suggested by Kvale (1996) were given for the transcription (Sandelowski 2000).

The accuracy of the transcriptions was checked by the researcher by listening to the digital recordings against the typed transcripts. Seidman (2012) also suggests that it is unavoidable for the researcher’s consciousness not to play a significant role in the interpretation of the interview data, that consciousness must interact with the words of the participant recorded as fully and as accurately as possible. Researchers by preserving the original recorded data have the ability to return to the source and check for accuracy in turn demonstrating accountability if ever questioned or accused of mishandling the interview material. The researcher found returning to the data a valuable process for checking and keeping focus while immersed with what the participants were expressing and identifying in the data.
Data Analysis

There are a number of approaches for qualitative data analysis with thematic analysis being one of the most common forms. Thematic analysis focuses on examining themes within data. The coding in thematic analysis is the primary process for developing themes and encoding them prior to interpretation. This form of analysis tends to be less descriptive overall because the analysis is limited to the preconceived frames (Guest, Namey and Mitchell, 2012).

The second approach for data analysis is through content analysis. Burnard (1996) points out that initially content analysis dealt with the objective, systematic and quantitative description of the obvious with communication, however, over time, content analysis has expanded to also include interpretations of content. Downe-Wamboldt (1992) further describes content analysis as having external validity as a goal. As a result of its focus on human communication, content analysis offers practical applicability, promise, and relevance for research involving the practice and education of nurses and other helping professionals. Currently, the two principal uses of content analysis is with the quantitative approach which is often used in media research, and the qualitative approach that is used in nursing research and education.

Qualitative content analysis in nursing research and education has been applied to a variety of data and to various depths of interpretation (Latter, 2000; Sandelowski, 1998& Burnard, 1996). According to Patton (2002) the analysis technique is required to be chosen early in the process of designing the study. This is because it is important during the data analysis process that the qualitative richness of the data is not lost. To limit the loss of data, the researcher is required to put the data through a systematic and rigorous analysis that will not distort or reduce the richness of the data, or fragment participants’ stories and experiences.

Additionally, Babbie (2010), states that content analysis is primarily used in the social sciences and further defines content analysis as the study of recorded human communications. Whereas, Altheide (1987) indicates that content analysis basically looks for situations, settings, styles, images, meanings and nuances in data. Furthermore, Sandelowski (2000) refers to qualitative content analysis as analysis of verbal data that is orientated toward summarizing the informational contents of the data collected. On the other hand Merriam (2009) states that content
analysis is one of the less common data analysis techniques along with analytic induction used in qualitative research. Merriam (2009) further adds that all data analysis is in fact content being that it is actually the content of interviews and documents that are analysed. Content analysis was chosen for this study by the researcher because it enabled the researcher to include large amounts of recorded textual information and systematically identify its properties. This textual information is then categorized to provide a meaningful reading of the content under scrutiny.

In this study to reduce the prospects of the richness of the qualitative data being lost, the data was analysed using the following steps described by Dey (2003):

- Transcription of the digitally recorded interviews and field notes
- Active reading of the data- asking questions while the transcripts are being read
- Annotating notes and memoing
- Creating categories and assigning categories

The analysis techniques in qualitative studies and the reduction of data are important processes to be considered during the analysis process. Data reduction refers to the process of selecting, focusing, simplifying, abstracting, and transforming the data. Data reduction occurs continuously throughout the qualitative research. This is often seen prior to data collection in that the researcher decides which research questions to ask and what approaches to data collection to use. According to Miles and Huberman (1994), data reduction is part of the analysis process and continues until the final report is written. The process of data reduction emphasises, discards and organises data in such a way that final conclusions can be drawn and verified. Tesch (1991) also suggests that data reduction can be seen as data consolidation. Data reduction and consolidation for this study was seen firstly in the selection of the questions and secondly with reduction in volume of verbal data, with the coding and for the data analysis.

**Computer Assisted Qualitative Data Analysis Software (CAQDAS) system**

**Nvivo**

The computer has evolved as a tool for assisting the qualitative researcher in data managing and storage. In particular, the Computer Assisted Qualitative Data Analysis Software (CAQDAS)
system Nvivo has gained prominence with qualitative researchers. This program assists the researcher in separating the data management from the data analysis. The process of coding involves the labelling of passages of text according to content then providing a means to retrieve similarly labelled passages (Richards and Richards 1999). The CAQDAS system is time saving, however as Bogdan and Biklen (2007) identified, this only assists the researcher in organising concepts and nodes, it does not do the analysis for the researcher. Additionally, Seale, Charteris-Black, MacFarlane and McPherson (2010) add that the researcher in fact has more time to closely examine the data with the time saved with the organisation of data and storage methods which adds to the rigour of the study. Furthermore, Creswell, (2012) adds that the visualisation of concepts assists the researcher to see the relationship of the codes and categories with the computer assisted structure of concept models.

Qualitative Social Research (QSR) Nvivo 9.2 qualitative analysis software was used to assist in the analysis process for the storing of the data following summarising and classifying of the transcripts in to categories of primary and secondary nodes (Richards, 1999). Each individual transcript was coded in turn using content analysis. Concepts were identified by exploring code patterns and relationships in the data (Rice and Ezzy 1999; Patton, 2002; Bazeley, 2007). The coding framework of nodes increased up to 66 nodes and with an additional 26 sub nodes. The concepts were then coded into nine categories during the coding process so as not to limit the generation of ideas (Pope, Ziebland and Mays, 2000). Coding was found by the researcher to assist with the building of knowledge about what the data was saying. Once the data had been coded to a node, the researcher was able to further code from the node without returning to the original document. In conjunction with the coding, the researcher used annotated notes and memoing to assist with the analysis process.

The analysis process is inherently the researcher’s responsibility to determine the coding and classification of categories. In other words, the analysis processes further involved the transcripts being summarised and classified into categories grounded from the participants own accounts as soon as possible following transcription. The qualitative interviews for this study produced a large volume of material that required transcribing then being condensed, categorized and coded to be made meaningful. Due to the volume of data received the researcher attempted to, as far as possible, analyse simultaneously with the data collection. Each transcript was analysed line by line systematically to capture relevant characteristics of the interview content to enhance the reliability and validity of the interpreted findings.

Chapter 3 – Methodology and Method
The assigned concepts in the category nodes were then reviewed by the researcher again to identify similar classifications which resulted in further inductive analysis processes. This process refined the category node number to 37, as six category nodes were seen as a redundant source of information or the frequency was not seen as relevant from the data so were able to be grouped or deleted. These 37 category nodes were then collectively grouped under five broad themes. Both positive and negative aspects of each topic were considered. Pattern quotes for each category were independently selected by the researcher to illustrate the key study findings.

**Participants Demographic Information**

Appropriate identification of research participants is essential to create a clear and complete picture of their characteristics. Additionally, a thorough description of participants allows readers and researchers to determine to whom research findings generalize and allows for comparisons to be made across replicated studies. The inclusion of such information greatly added to the knowledge base and understanding of the universal service and its variations.

Demographics are statistical data collected about the characteristics of a particular population under inquiry to determine individual features. For example, participants information regarding; age, qualification levels attained, years of experience as a MCH nurse and position held. All of this was collected from the participants prior to being interviewed for this study. The reasons for collecting the demographics of the participants was to establish whether there was any corresponding factors to be identified between the KSH and the MCH nurses.

The demographics for Group One indicated that the KSH were MCH qualified and worked either in management, academia or service coordination. The participants from Group One came from different influencing organisations for example; DEECD the MAV or the Coordinators of the Family and Children’s Services from local government jurisdictions across Victoria. The participant’s range of experience in this group was 1-20 years. Most of the participants in Group One had a Graduate Diploma qualification with four having a Masters of Business management.
All had extensive nursing experience and a midwifery qualification. The age range of participants was 46 - 55 years young (See Table: 3.1).

### Group One: Demographic Data

<table>
<thead>
<tr>
<th>Key Stakeholders n = 12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>46y – 55y = 7</td>
</tr>
<tr>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>56y- 65y = 5</td>
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</tbody>
</table>

Table 3.1 KSH; Age, Qualifications, Years of Experience and Identified Position
Group Two: Demographic Data

The demographics for Group Two of this study consisted of 36 MCH nurses who were MCH qualified and worked in the MCH service. These participants were selected from metropolitan and country areas across Victoria. A more detailed breakdown of the number of participants from metropolitan, semi-rural, rural and remote is not provided, however, as this may potentially identify them. The participant's range of experience was 1-35 plus years. The majority of the participants in Group Two had a Graduate Diploma qualification with ten having a Masters of Child and Family Health. All were nurses with extensive nursing experience and a midwifery qualification. The age range for the participants was: 24 years - 65 plus years young (See Tables: 3.2; 3.3 & 3.4). The three sub groups in Group Two varied only with their years of experience.

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Qualification</th>
<th>Years of Experience</th>
<th>Identified Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>20y – 24y</td>
<td>n = 1</td>
<td>Grad. Dip = 0&lt;br&gt;Masters = 1</td>
<td>&lt;=1y = 0&lt;br&gt;2-5yrs = 1</td>
<td>Enhanced = 1</td>
</tr>
<tr>
<td>25y – 35y</td>
<td>n = 1</td>
<td>Grad. Dip = 1&lt;br&gt;Masters = 0</td>
<td>&lt;=1y = 1&lt;br&gt;2-5yrs = 0</td>
<td>Universal = 1</td>
</tr>
<tr>
<td>36y – 45y</td>
<td>n = 5</td>
<td>Grad. Dip = 3&lt;br&gt;Masters = 2</td>
<td>&lt;=1y = 0&lt;br&gt;2-5yrs = 5</td>
<td>Enhanced = 1&lt;br&gt;Universal = 3&lt;br&gt;Outreach = 1</td>
</tr>
<tr>
<td>46y – 55y</td>
<td>n = 5</td>
<td>Grad. Dip = 4&lt;br&gt;Masters = 1</td>
<td>&lt;=1y = 1&lt;br&gt;2-5yrs = 4</td>
<td>Enhanced = 0&lt;br&gt;Universal = 5&lt;br&gt;Outreach = 0</td>
</tr>
<tr>
<td>56y – 65y</td>
<td>n = 1</td>
<td>Grad. Dip = 1&lt;br&gt;Masters = 0</td>
<td>&lt;=1y = 0&lt;br&gt;2-5yrs = 1</td>
<td>Universal = 1</td>
</tr>
</tbody>
</table>

Table 3.2 MCH A; Age, Qualifications, Years of Experience and Identified Position
### Maternal and Child Health B n = 11

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Qualification</th>
<th>Years of Experience</th>
<th>Identified Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>36y – 45y</td>
<td>n = 3</td>
<td>Grad. Dip = 2, Masters = 1</td>
<td>6 - 10 = 3, 11 - 15 = 0</td>
<td>Enhanced = 0, Universal = 2, Outreach = 1</td>
</tr>
<tr>
<td>46y – 55y</td>
<td>n = 6</td>
<td>Grad. Dip = 0, Masters = 1</td>
<td>6 - 10 = 3, 11 - 15 = 3</td>
<td>Enhanced = 0, Universal = 5, Outreach = 1</td>
</tr>
<tr>
<td>56y – 65y</td>
<td>n = 2</td>
<td>Grad. Dip = 0, Masters = 1</td>
<td>6 - 10 = 1, 11 - 15 = 2</td>
<td>Enhanced = 0, Universal = 2, Outreach = 0</td>
</tr>
</tbody>
</table>

Table 3.3 MCH B; Age, Qualifications, Years of Experience and Identified Position

### Maternal and Child Health C n = 12

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Qualification</th>
<th>Years of Experience</th>
<th>Identified Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>36y – 45y</td>
<td>n = 1</td>
<td>Grad. Dip = 0, Masters = 1</td>
<td>16 – 20 = 1, &gt;21 = 1</td>
<td>Enhanced = 0, Universal = 0, Outreach = 1</td>
</tr>
<tr>
<td>46y – 55y</td>
<td>n = 4</td>
<td>Grad. Dip = 0, Masters = 1</td>
<td>16 – 20 = 1, &gt;21 = 2</td>
<td>Enhanced = 1, Universal = 2, Outreach = 0</td>
</tr>
<tr>
<td>56y – 65y</td>
<td>n = 7</td>
<td>Grad. Dip = 0, Masters = 1</td>
<td>16 – 20 = 1, &gt;21 = 6</td>
<td>Enhanced = 1, Universal = 7, Outreach = 0</td>
</tr>
</tbody>
</table>

Table 3.4 MCH C; Age, Qualifications, Years of Experience and Identified Position
Research Rigour and Validity

In both qualitative and quantitative research rigour is strived for to ensure trustworthiness and the interpretation of the data. According to Boswell and Cannon (2012) rigour and validity are intricately linked with reliability and validity checks. In addition, Carpenter and Speziale (2003) state that rigour in qualitative research is validated through the researchers' attention to and confirmation of information discovery. Trustworthiness is the term used by qualitative researchers to demonstrate rigour. To maintain rigour in this research project, during the interview process the researcher made use of established techniques of effective interviewing such as, engaging in a conversational style of interview and using carefully developed knowledge, attitudes and belief questions in a structured format. During the interview the researcher was respectful not to impose personal points of view on the respondents. All interviews were digitally recorded to ensure accuracy of data collection.

Both Patton (2002) and Sandelowski (2000) state the criterion for research rigour in qualitative research is creditability, fittingness, auditability and confirmability. Each of these will be discussed in detail.

Credibility

Credibility relates to the trustworthiness of findings and is demonstrated when participants recognize the reported research findings as their own experiences. In addition, a study is said to be credible when other people with similar experiences can recognize the descriptions and interpretations of the participants as 'one's own' after reading about it in the study (Sandelowski 1986). According to Patton (2002:14) 'the researcher is the instrument'. In other words the credibility of qualitative methods relies on the researcher’s skills, competences and rigour when doing the field work. Patton (2002) further argues that credibility is related to the integrity of the researcher and that credibility in qualitative research can be defined as the extent to which the data and data analysis are believable and trustworthy. In addition, the researcher's reflectivity as the instrument, further adds to the credibility when they reflect critically on themselves as a researcher and explain their biases (Lincoln 1995). Although it has its own disadvantages, Lincoln
and Guba (1985:314) also consider member checking into the findings as the most critical
technique for establishing credibility.

Furthermore, by including the views, values and expectations of the researcher that influence the conduct and conclusions of the study, allows the reader a deeper understanding of the perspective from the researcher in the study results (Maxwell 2005). At the time of commencing this research project, the researcher was a MCH nurse herself and was able to add rigour to the study by having a strong knowledge of the phenomena being studied. To maintain credibility of this study, the researcher was aware of having formed personal opinions of the perceived impact of the national changes, however, ensured not to neither reveal any bias either way nor contribute personal beliefs during the interviews. Commitment to representing the participants’ views was strongly adhered too.

**Fittingness**

The criterion of fittingness is met when its findings ‘fit’ into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences (Sandelowski 1986). Fittingness is also achieved when the findings are ‘well-grounded in the life experiences studied and reflect their typical and atypical elements’ (Sandelowski 1986). To achieve fittingness in this study, all elements obtained from the data were included in the discussion if it reflected the majority of the participants’ experiences.

**Auditability**

Polit, Beck and Hungler (2006) indicate that auditability refers to another researcher’s ability to follow the thinking, decisions and methods used by the original researcher. In other words, a study and the findings are described to be auditable when another researcher can clearly follow the decision making processes used by the researcher in the study (Sandelowski 1986:33). Furthermore, auditability can be acclaimed when another researcher arrives at the same or comparable conclusions. In qualitative research there needs to be a thorough audit trail which marks the path for other researchers to follow in order to have them arrive at a similar end result.
This study has provided an audit trail by detailing the process followed, describing what was done, why it was done, and how it was achieved. Another researcher therefore could follow the same trail and arrive at a comparable conclusion.

**Confirmability**

Confirmability refers to the 'objectivity' or neutrality of the data within the study. That is, the extent to which a researcher is aware of, or accounts for, individual subjectivity or bias. (Polit, Beck and Hungler 2006), Sandelowski (1986) regards confirmability to be achieved when auditability, truth value, and applicability are established and can only be ensured when the other criteria have been met. It is well documented that qualitative researchers recognize the existence of multiple realities (Merriam 2009). As well, it is further recognized and acknowledged that the person’s perceptions are influenced by where they are positioned in relation to the phenomena (Schneider, Elliott, and LoBiondo-Wood and Haber 2003). Streubert and Carpenter (1995) indicate that to provide confirmability, there is a requirement to clearly illustrate evidence and thought processes which directed the study’s conclusions. Keeping and maintaining records of the study is essential for ensuring objectivity of the report itself.

**Transferability**

Research findings are transferable or generalizable only if they fit into new contexts outside the actual study context. Transferability is analogous to external validity, that is, the extent to which findings can be generalized. Generalizability refers to the extent to which one can extend the account of a particular situation or population to other persons, times or setting than those directly studied (Maxwell 2006; 2012). Transferability is considered a major challenge in qualitative research due to the subjectivity from the researcher as the key instrument, and is a threat to valid interpretations in its traditional thinking about research data. However, a qualitative researcher can enhance transferability by detailing the research methods, contexts, and assumptions underlying the study. According to Seale (1999) transferability is achieved by providing a detailed,
rich description of the study to provide the reader with sufficient information to be able to judge if the study the findings are applicable to other settings that they know.

**Dependability**

Dependability is similar to reliability, that is, the consistency of observing the same finding under similar circumstances. According to Merriam (2009:220) it refers to the extent to which research findings can be replicated with similar subjects in a similar context. It emphasises the importance of the researcher accounting for, or describing, the changing contexts and circumstances that are fundamental to consistency of the research outcome. Dependability was maintained for this study as there was only one researcher that conducted all the interviews. Therefore, having consistency of interview techniques throughout the study interviews is important.

Reliability is practically impossible to achieve as human behaviour is not inert, it is contextual and changes continuously depending on many influencing factors. It is, however, further compounded by the possibility of multiple interpretations of reality by the study participants. In other words, a similar study with a different researcher, cultures and context may in fact have very different results. The quality of inferences also depends on the personal construction of meanings based on individual experience of the researcher and how skilled the researcher is at gathering the data and interpreting it. As a result of all these, reliability in the traditional sense is not practical in a qualitative study. Merriam (2009) suggests that reliability in this type of research should be determined by whether the results are consistent with the data collected. The reliability was maintained with this study by the use of the NVIVO software for the analysis process.

**Trustworthiness of the Study**

Trustworthiness is the equivalent term used in qualitative research as a measure of the quality or validity of the research. This is the extent to which the data and data analysis is believable and trustworthy. In other words, the insights and conclusions needed to ring true to the readers instilling confidence in the researcher's ability to conduct the investigation (Merriam, 2009:210). The four main strategies to establish and maintain trustworthiness of qualitative research include:
credibility, transferability, dependability and conformability (Guba and Lincoln, 1981; Krefting
1991). The traditional criteria for ensuring the credibility of research data includes: objectivity, reliability and validity (Patton 2002:546). These terms are used in scientific and experimental studies because these are based on standardized instruments and can be assessed in a comparatively straightforward manner. In contrast, qualitative studies are usually not based upon standardized instruments and they often employ smaller, non-random samples. These evaluation criteria, therefore, cannot be strictly applied to the qualitative paradigm, particularly when the researcher is more interested in questioning and understanding the meaning and interpretation of a phenomenon (Merriam 2009).

**Triangulation**

According to Patton (2002), triangulation is an approach that utilizes multiple data sources, multiple informants or multiple methods in order to gather perspectives on the same issue so as to gain a more complete understanding of the phenomena. The purpose of triangulation is to increase the validity of a study by cross verification from more than one source. This is achieved by collecting different views of the same phenomena. Thus finding an opportunity to explore what the experience is from different sources (Burns and Grove 2005).

In social research, the term triangulation is used in a less specific sense, it involves the use of multiple methods and measures of an empirical phenomenon in order to ‘overcome problems of bias and validity’ (Blaikie 2000; Scandura and Williams 2000). Merriam (2009:215), however, states that triangulation is possibly one of the best known approaches to quantify internal validity concerns and one of the most important ways to improve the trustworthiness of qualitative research findings. In addition, triangulation can be used for ethical concerns requiring validation of processes (Yin 2003). Basically, triangulation is used to compare data to decide if it substantiates and validates research findings (Patton 2002; Creswell 2007). There is much debate, however, as to whether triangulation offers qualitative researchers a satisfactory method of verifying their findings. Many viewpoints have been expressed, resulting in the argument that the worth of triangulation is the provision of broader insights. For example, Richie and Lewis (2003:44) state that the ‘security’ that triangulation provides is through giving a fuller picture of phenomena, not necessarily a more certain one. Triangulation is the major approach used to
evaluate the outcome of this study. It was used in this study as a way of validating the results and to uncover any unreported biases due to there being only one researcher investigating the phenomenon. For the purpose of this study, triangulation was performed using multiple informants for the collection of data on this particular phenomenon to gain a more complete understanding of the perceived impact from the national changes. The outcomes of the individual interviews were triangulated with the views of the participants in Group One and Group Two as well as between the three different groups of MCH nurses in Group Two. Triangulation was, therefore, done at various levels to focus on a final outcome based on the various perspectives of the participants.

In order to ensure rigour in this research a number of steps were undertaken. These included: use of expert panel; pilot questions; standardised questions for each participant; one researcher conducting all interviews; digital recording of interviews; interview until data saturation; review transcripts to digital recordings; member checking; analysis reflected the majority of the participants experienced; use of NVIVO; triangulation of data; audit trail and reveal any researcher bias.

Conclusion

This chapter outlined the research methodologies, theoretical framework and research method for this study. The research design for this study is a qualitative exploratory descriptive design that was analysed through content analysis. The following chapter will discuss the KSH interviews and the analysis of the data from Group One of the study.
Chapter Four

Key Stakeholders Analysis

Introduction

The previous chapter discussed the methodology, methods and the theoretical framework selected for this research. The intention of this chapter is to present the findings from Group One of a qualitative study exploring the knowledge, attitudes and beliefs of the Key stakeholders (KSH) to the perceived impact from the national changes to registration, a proposed national framework and service provision to the Victorian Maternal and Child Health (MCH) nurses. A brief review of the characteristics of this group will be presented first followed by the key categories identified from the data. These findings will be detailed and supported by the interview data.

Demographics

Interviews from Group One were undertaken with the KSH who were MCH qualified and either in management, academia or service coordination and came from different influencing organisations for example; Department of Education and Early Childhood Development (DEECD), the Municipal Association of Victoria (MAV) or the Coordinators of the Family and Children’s Services from local government jurisdictions across Victoria. Participant’s range of experience in this group was 1-20 years in either upper management or higher service delivery and education, with the majority having more than 10 years’ experience. Most of the participants in this group had a Graduate Diploma qualification with four having a Masters of business management. All had extensive nursing experience and a midwifery qualification. The age range of participants was 46 – 55 years young.
Categories

Categories were developed by identifying recurrent patterns from the data and organized into
groups through a process of inductive reasoning. Category labels were then chosen that reflected
the participants own words. These were: ‘Common standard’, ‘Universal service’, ‘We do it well’
and ‘Imposed from above’.

‘common standard’

This category includes the following subcategories; ‘competent and capable’, ‘losing our identity’
and ‘future pathways’. The notion of having one registration body across all jurisdictions in
Australia, as opposed to eight separate registration bodies, was seen by the majority of KSH to
be of benefit. This was because it provided;

“… a common standard across all of Australia…”KSH1

In addition, because all nurses were registered under one national body it was thought that a
reduction of the bureaucratic process of registration would be achieved. This is because;

“… they are not required to register in individual states…”KSH5

One of the major changes that occurred as a result of national registration was that a distinction
was made between nursing and midwifery, which then became two separate registrations. The
implication of this was that registration requirements were then necessary to be achieved for both
registrations. This was recognised by the KSH as a significant change, as identified in the
following;

“… the significant ones for nursing were… they actually split nursing and
midwifery…”KSH10

The majority of KSH as indicated from the data had a good grasp of national registration. Not all
KSH, however, did understand. This is illustrated by the following KSH who was obviously very
confused and believed that all the health professions would be together under the same register,
instead of separate registrations, boards and so forth, for each profession;
“... because they have got so many professionals all mixed together... nursing should keep to nursing... GP’s should keep to the medical profession... Allied health... you’ve got everybody mishmash... it’s too big...” KSH11

With the move to National Registration a number of advantages were identified by the KSH. This included the fact that it was envisaged the workforce numbers would be able to be accurately determined, thereby improving workforce planning for the future;

“... it is giving an actual figure of how many are across Australia... helps job movement... it’s cheaper... it’s just easier...” KSH8

From the data one of the other advantages of having national registration highlighted by the KSH was the ability of health professionals to work in different jurisdictions without having to have separate registration for each. This was particularly an issue for MCH nurses whose practices are situated in border towns. A number of participants commented that national registration, therefore, assisted with;

“... minimising of border to border discrepancies and difficulties...” KSH9

“... acknowledges the difficulty to move from state to state... streamline the process... enable people to move and work in different areas...” KSH8

This last quote highlights one of the other advantages of national registration. That is, to offer easier movement between jurisdictions and thereby increase employment opportunities by being able to work anywhere. This was also believed to help ease nursing shortages by streamlining recruiting from other jurisdictions. In fact this was also considered to be part of the justification for going to a national registration);

“... a standard registration board... should make it easier to recruit from other states...” KSH6

“... potentially it’s going to increase the ease with which people gain employment in other states...” KSH7

“... makes it easier for people moving from overseas to Australia...” KSH1

National registration was initially assumed by the KSH to be a constructive change however, when the implications were realised it was then considered a barrier to movement across jurisdictions. This was especially for nurses without the required qualifications to work in MCH in Victoria, which were very different to the other jurisdictions. It therefore became;

Chapter 4 – Key Stakeholders Analysis
“… harder to check what people’s qualifications are when they apply…” KSH9

In other words, interstate applicants must have;

“… a MCH qualification that meets the Victorian standard…” KSH3

The issue here was that this equivalency was not always the case. Despite one of the aims of the national registration to facilitate the ability of movement of nurses between jurisdictions, the reality, however, was that “… not many people move interstate…” KSH6. The reasons for this varied from “… because I like the way we practice here” KSH4 to “No… I have family commitments here…” KSH11

From the data one of the prominent reasons the participants indicated as to why they would not move was the significant concern regarding the disparity that existed between the qualifications and practice standards between jurisdictions. There was a strong belief expressed among the participants that Victorian MCH nurses were highly qualified and provided a comprehensive service compared to other jurisdictions. This was perceived to not necessarily be the case in other jurisdictions, hence the quote seen below;

“… I work in the service that best meets my requirements and I have the best qualifications… I don’t think it would be a positive move…” KSH8

In support of the previous comment, the following KSH stated that she would not move because she was committed here and if she did move interstate;

“… I would want to change the service… ” KSH10

The disparity between jurisdictions in fact was seen to actually impede cross border transferees from applying to work in Victoria. This was thought to be because they may not have the qualifications required to practice in certain professional areas. In turn this then negated the purpose of national registration. On the other hand;

“… nurses are more likely to look for work interstate for brief stints particularly across boarder if they are working on the boarders…” KSH5

The ability to move jurisdictions however, created issues in themselves. Due to the loss of the MCH notation in Victoria it was virtually impossible to verify qualification equivalency. This was evident from the KSH data where a number identified that they had issues with interpreting the qualifications of interstate applicants for such equivalency. The KSH believed that this was a significant issue and not a straight forward process. To employ interstate workers in fact required
a more complex process of examining at each applicant on an individual basis. Furthermore, the KSH needed to be aware not to reject the applicants because they did not have what looked like the full package;

“… some may just need to do a couple of extra units at university so that they will be up to the same level…”KSH2

Needless to say, the review process for interstate applicants was discussed by the KSH at length during the interviews. These KSH believed that there should be a collective criteria set up with support from the universities who offer the MCH program in Victoria to assess the equivalency of the qualification of the applicants;

“… universities in Victoria need to look at what qualifications an interstate person might have… then discuss the educational equivalent… they will only do the educational equivalent assessment of people that are general and midwifery registered…”KSH7

This process, however, was not seen as a feasible answer to this issue of qualification equivalency. A suggested strategy by one KSH to assist with this process was the development of a flow chart of how the other jurisdictions qualifications would articulate with the Victorian qualifications and a way to limit confusion and create consistency;

“… we’ve had issues with what we do with people that have got different qualifications… so a flow chart was developed…”KSH5

In addition to the flow chart, a key factor that made the checking process easier was the fact that there was a clear position description for MCH in Victoria that required them to have nursing, midwifery and MCH qualifications. This was because:

“… there has been an agreement by DEECD and MAV as part of the MOU… and the majority of councils equally that we will only employ people that are midwives and have a recognised MCH qualification…”KSH1

Despite the fact that national registration had been implemented within six months of the interviews, a significant number of KSH had not the foresight to anticipate the need to put in place any review processes for interstate applicants. For instance, when asked whether they had a review process they replied; “Not as yet”KSH9 to “… not as such…”KSH6 and “… it remains up in the air”KSH4. Though in defence “… we have not had any interstate applicants…”KSH3
One of the other issues highlighted in the data from the KSH relates to the lack of information given to people. Some nurses and new graduates had been misinformed regarding their qualifications and requirements to work in some other jurisdictions as seen with these KSH comments;

“… people that have just completed their education were told they would be able to work anywhere in the country with their Maternal Child and Family qualifications… they’re not able to…”KSH5

“… with people coming from interstate who don’t have midwifery or MCH qualifications… they think they are qualified and they’re not…”KSH8

These comments could be explained by the fact that the registration change was fairly new at the time of the interviews. The KSH did reflect that there were advantages to the move to a national registration. That is, an economic advantage for the nurses who previously had to maintain more than one registration in order to work for example in border areas. In other words;

“… financially it will be better…”KSH5

The problem was that this in reality was opposite due to the disparity in education and qualifications between jurisdictions. In other words, this translated to additional expense because;

“… in Victoria… the standards require particular educational pathway…” KSH7

As previously identified the prerequisite to practice MCH in Victoria are general, midwifery and a qualification in Child and Family Health. Other jurisdictions across Australia do not require the midwifery qualification to practice in Child and Family Health. Therefore;

“… it is going to be an added cost to those coming from interstate who don’t have midwifery or their MCH qualifications…”KSH8

The disparity of qualifications between jurisdictions was the essence of the concerns articulated by the KSH’s regarding the perceived impact from the change to a national registration. This in itself was one of the rationales behind the change in the first place to national registration. The disparity previously was the different registration requirements which then translated into disparity in qualifications and service standards. Many KSH could appreciate the rationale behind the changes but were also realistic about the impact, as can be seen here;

“… while there are some advantages out of it… it has raised a lot of disadvantages not the least the impact on MCH nurse’s in Victoria…” KSH8
In other words, as this KSH suggested in the long term;

“... it may change the qualification that people need to have to practice...” KSH1

This is supported to a degree by the following KSH who commented on what the impact in the short and long term to employment opportunities would be;

“... none in the short term... people are required to have midwifery before they are MCH nurses... perhaps in the long term that pre-requisite for the midwifery qualification will go...” KSH12

Needless to say a number of KSH were concerned about this disparity between the jurisdictions. More importantly they were cautious about how this would be resolved. The majority of KSH believed that this disparity could be resolved in a number of ways;

“... the training and expertise required in Victoria could infiltrate to other states where there is not that higher an expectation of practice...” KSH12

“... we might drag up the rest of Australia to actually reflect Victoria...” KSH1

There was concern, however, that the later would not happen and that the alternative would in fact be the reality. The reason for this concern is reflected in the second quote;

“... we go to a minimum standard” KSH1.

“... a shame to bring it down to a minimum level... be dumbed down... we won't have the level of education that we have had in the past” KSH2.

In other words;

“... the Federal Government goes for the lowest common denominator...” KSH12

The KSH strongly believed, however, that the Victorian qualification should be the benchmark standard. Certainly the feeling among the KSH was that this;

“... is something that we can aim towards...” KSH6

There was, however, one suggested strategy to help reduce this disparity from the following KSH;

“... we all have different qualifications... if the Federal Government and universities got themselves together on the same page... we all had exactly the same course and competencies to meet the criteria to register it would be great... people could move through the state... we would have a better workforce... to achieve good child and family outcomes... I think in Victoria we have got that...” KSH11
Following on from this identified disparity, the KSH were asked what impact they perceived that national registration could have on the service in Victoria. There were a number of differing responses from those KSH who had a positive, in the middle or a negative point of view in regards to the perceived impact, as shown with the following quotes;

“… at present none because we have the program standards… if there is a shift of government policy away from that… then that’s a huge problem… we may not do it perfectly but we have mechanisms in place… if employers see it as an opportunity to employ other categories… it could dumb down the system…”KSH8

“Yes it will impact…we are terrified we are going to lose the additional qualification and that will really undermine all the work that Victorian nurses have done…”KSH11

“… we are always at risk of somebody who is not a MCH or who doesn’t have the background of making decisions… saying that it is no longer necessary… it’s always going to be under threat…”KSH10

On the other hand, the majority of KSH indicated that, regardless of the change to national registration, they believed that the move would not influence their current practice. An explanation as to why is suggested in the second quote;

“I don’t think it will change… I would like to think that they would continue practicing at the same standard…”KSH1

“I can’t see how that will change how we practice… we have quite comprehensive guidelines and standards around our program…”KSH6

In contrast, a number of KSH believed that the service would in fact be impacted by the move to a national registration and what this could translate to;

“Yes… but I’m not quite sure how at the moment...” KSH4

“In the short term No… In the long term possibly… there could be a move towards what’s happening in the Northern Territory at the moment… workers who are not nurses who do allegedly MCH type work… hopefully they’ll raise the bar and make a higher education expectation...”KSH12

The KSH indicated in the data that they believed that there had not been a thorough enough examination of the options and the current jurisdictional situation before introducing the change to a national registration. Furthermore the KSH believed that the system behind the national change...
failed to identify the ramifications of the changes prior to implementation, as indicated in the quote below;

“... it’s been really badly handled… in setting up they haven’t looked at the implications… it’s been rushed and poorly investigated prior to implementation…” KSH5

The KSH, therefore concluded that they believed national registration was implemented without due respect and consultation with the workforce;

“... they’ve done it around the wrong way… brought it in too quickly…” KSH 11

‘competent and capable’

The first subcategory under ‘common standard’ is ‘competent and capable’. Part of maintaining registration is that practitioners have to declare that they are competent to practice each year before they sign their registration renewal. Recency of practice refers to the practitioner being competent to work in a given area of practice (AHPRA, 2010). In order to achieve this, according to the AHPRA, practitioners must have maintained an adequate connection with the profession since gaining qualification or the equivalent of three months full time within a five year period (AHPRA, 2010). Prior to the introduction of national registration in 2010 there was some resemblance to this requirement but was not so formal. Unexpected results were noted from the KSH regarding the question related to their understanding of recency of practice. There were some KSH who had a good understanding of what this meant as can be seen from the following;

“... recency of practice means as a professional that I am competent and capable of doing the work as part of my competency and my capability… I have practised sufficient hours with sufficient number of client contacts to be competent in the work…” KSH1

“... recency of practice is related to how recently you were involved in activities related to your qualification…” KSH7

Then there were a number of KSH that had a vague understanding of the significance of recency of practice. This was puzzling considering recency of practice has been aligned with national registration and is a requirement for registration renewal each year;
“... I can’t tell you the specifics... but I do know there are a number of hours over 3 - 5 years... in terms of practice hours that meet the needs of your qualification...” KSH6

In contrast to the previous comment, other KSH expressed limited to no knowledge at all in regards to recency of practice. Referring to it as; “...it’s a bit vague” KSH11 to even saying “That’s the first time I have heard the term” KSH9 and “... it must be a term from the register... I have never heard it.” KSH3. This is somewhat surprising considering the fact that the KSH were in management positions and therefore, should be better informed.

As part of recency of practice, MCH have a professional responsibility to be current with midwifery as well as nursing clinical experience. The problem was that this was being taken too literally. That is, believing that a person need undertake practice in nursing and midwifery to be deemed competent. Instead of not understanding that practicing as a MCH nurse translates to being competent in both nursing and midwifery as this is what the role entails. This in turn contributed to a lack of clarity on the meaning of recency of practice, confusing it with professional development;

“I think sadly we are already losing some of the good midwifery practice... when some go to professional development they tend to focus more on child things without realising that we should also be focusing on the mother...” KSH1

Despite those that were not totally aware of recency of practice, there were KSH that had a thorough understanding of recency of practice. The majority of KSH believed that recency of practice was a positive move for the future of the profession. So much so that it was stated by the KSH that recency of practice and evidentiary currency in practice should be included as a major component of the review process for assessing employability skills and currency of practice. There were, however, other issues identified from the KSH data about recency of practice;

 “… recency of practice should have a major quality component with a 360 review... not only a self-assessment but also an assessment by peers of practice competency... I might have practiced as a MCH nurse for years but never changed my practice... so sadly some people could claim that they have recency of practice but ethically they then cannot say my practice is best practice, research based, modern, up-to-date, reflects current thinking... sadly recency of practice doesn't address those issues...” KSH1
In other words, recency of practice is only half of the issue here. This highlights that there needs to be more than just recency of practice, there needs to be a commitment to professional development as well. Plus there should be various ways to assess recency not just self-assessment.

Another component of national registration is professional development, a standard requirement for all nurses and midwives to maintain their knowledge in order to be registered. Professional development standards were applied as a national law in 2010 and effective from 1st July 2010 (Nursing and Midwifery Boards, 2013). According to AHPRA (2011) there are a minimum number of hours required for professional development to be recognised as sufficient for registration. The current requirement is that both a registered nurse and a registered midwife complete 20 hours in each area per year. That is, 40 hours in total. However, where the education was relevant to both the nursing and midwifery professions, the hours undertaken could then be used for both fields of practice (AHPRA, 2011). The responsibility for recording and maintaining proof of professional development hours is with the professional themselves. This record can be audited in the process for renewal of registration.

When the KSH were asked if they considered the MCH nurses had any difficulties completing their professional development hours within their organisations, the majority indicated;

“Absolutely none… we already give over and above what they need…” KSH1

“No… not at all… I think there is so much information out there available electronically now that there are no excuses…”KSH10

The reason they perceived that there was no difficulty was that professional development was part of their award;

“As part of our enterprise agreement we already have 5 professional development days per year allocated… the team have it planned for the year…”KSH6

There was, however, a sense of the need for professional accountability regarding achieving the necessary professional development. In other words, MCH practitioners should be undertaking professional development outside of the organisations. It is evident from the data that this is not a common scenario. As one KSH stated therefore, that the responsibility for providing professional development should not be, “… just ours” KSH2 indicating that the nurses had a responsibility for a degree of their professional development as well. In other words;
“... some people feel that their employing body should provide everything at all cost and are not willing to take ownership of their own professional development...” KSH12

The reality of professional development, however, was that it should be relevant to the requirements and not just the hours clocked up, as seen in the comment below from this particular KSH;

“... there does need to be some consideration that the essential topics to keep people up skilled are a mix of practical, clinical and contemporary parenting... a balance at forums...” KAH10

With the obvious concern in regards to the disparity of qualifications between jurisdictions, the KSH were asked if they believed professional development hours should be increased to reflect the level of their qualifications. Not surprisingly the majority answered to the negative, as seen in the following quote;

“No... I don’t think so... most MCH nurses are so motivated they learn continually...” KSH8

This particular KSH agreed that the hours did not need to be necessarily increased in her view, however, she expressed that in her opinion there were limitations with this particular structure of undertaking professional development, as seen below;

“...every professional person has a responsibility to maintain their knowledge and skills... having said that there are people that haven’t opened a book or read a journal since the day they finished their course... forcing people to attend or keep a diary doesn’t necessarily mean they have learnt anything...” KSH10

This again emphasises that professional development should be more than what the organisation provide. In addition, some KSH indicated in the data that they believed that every professional has a personal responsibility to maintain their knowledge and skills in other ways. In other words;

“... we should be self-reflective practitioners... but there are people who don’t think further than what is for lunch...” KSH10

There were, however, issues that were identified by the KSH regarding professional development. This acknowledges that it is more than just doing the hours in order to meet the requirements;
“... just going and attending professional development really does nothing... it’s how you actually bring that back and introduce it into your practice...” KSH1

Another issue identified related to the knowledge and understanding of the processes involved with the required documenting of professional development hours and that there would be random audits undertaken. To some extent this was not surprising as this was a new process. Auditing occurred in other jurisdictions prior to national registration, however, and is noted in the AHPRA documentation. The concern expressed by KSH was that;

“... it very much relies on the honesty of the practitioner ...” KSH2

‘losing our identity’

The second subcategory under ‘common standard’ is ‘losing our identity’. There was a great deal of discussion from the KSH regarding their knowledge, attitude and belief about the loss of MCH notation and the threat to remove the midwifery qualification. What surprised many of the KSH with the move to a national registration was the failure to recognise MCH as an additional qualification. The KSH data indicated that a number of KSH believed that the loss of the notation on their registration resulted in a loss of speciality recognition. This study captured participants at a time when many were questioning their value and worth in their work environment following this loss of acknowledgment of their speciality. It was clear from the data that this had a huge impact with the consequences of their loss being reflected by many KSH in the following comments;

“I am a little bit anxious that my MCH nurse registration is not recognised...” KSH11

“... it is the saddest thing out... it was understood that we were actually endorsed... we had recognition of additional qualifications... this is a specialty area of nursing... to remove recognition of the qualification means lowering the standard... I think it will diminish the service considerably...” KSH8

“... the impact of not being an acknowledged speciality .... is a negative for Victoria... if it is not recognised by AHPRA ... it is not a requirement to practice...” KSH10

“... my biggest concern is that we don't reduce the qualification requirements...” KSH6
As can be seen from the last of these quotes, of greater concern was the impact that this could have. The KSH believed that the time and effort given to pursuing post graduate studies was not acknowledged. To then have these qualifications dismissed was distressing;

“… doing midwifery is a long hard slog… to have it taken off my bit of paper was really offensive”KSH9

In addition, a number of KSH questioned the purpose of having the MCH qualification as an additional qualification if they were not acknowledged by the governing bodies as stated below;

“… why would people put that investment and time into a qualification that wasn’t recognised” KSH3

The additional qualification requirement and recognition was one of the biggest concerns raised by the KSH during the interviews. Also, from the data the KSH perceived that their qualifications were not the same as they previously had following the loss of their notation. Furthermore, the KSH found it difficult to understand how the notation could be removed if they had the qualification endorsed by the program standards as a requirement to practice as a MCH nurse in Victoria. In other words;

“… we have program standards and position descriptions that specifically state the requirements for midwifery, general nursing and postgraduate qualifications in Maternal and Child Health…”KSH6

The KSH believed that the safety net offered by these program standards, and the memorandum of understanding (MOU) between MAV and DEECD, could possibly be under threat if there was a change in Government or portfolios for MCH;

“… while DEECD defends the qualification… we are safe but we cannot rest on our laurels because the midwifery qualification is always going to be at risk…”KSH10

Furthermore, the majority of KSH were concerned with the reported instances of some managers from inside councils making statements that suggest;

“… to get more MCH they might drop midwifery…”KSH9.

In short, the KSH believed that if some of the managers were making such statements they obviously did not have a comprehensive understanding of the standards or the implications of the MOU.
The implication expressed here by many of the KSH was that people from other jurisdictions seeking employment in Victoria who did not have the same qualifications or requirements could impact greatly on what was perceived to be a successful service. The implication being that employing lesser qualified people could result in a decrease in service provided. Moreover one of the biggest impacts at this time was identified by the Productivity Commission’s draft findings and recommendations from the review of the Early Childhood Development Workforce (ECDW). This report found that ‘there was little evidence to suggest that a midwifery requirement leads to better outcomes for children and that it creates an additional hurdle to workforce recruitment, (Productivity Commission Report, 2011a). It was clear from the data that the KSH strongly disagreed and supported midwifery as an integral part of the service they provide for a number of reasons;

“… we see them very soon after birth … you cannot have the same understanding without midwifery… it gives you the skills and knowledge to deal with any post birth problems the mother might experience…” KSH 6

The ultimate impact could be that;

“… if we lose the midwifery qualifications requirement that could impact on our pay… our prestige the way you feel about being a MCH… less attractive… at the moment I think it is something quiet special…”KSH9

Further comments that support and provides reasons for the importance of keeping midwifery as a requirement for the practice of MCH nursing;

“… you need to understand the process… the echo system for the mother and baby. If people haven’t had that sort of background before they come to observe the next stage… you are throwing the baby out with the bath water…” KSH3

“… if you haven’t got the background you are just not going to do the job as well as you should…”KSH9

The KSH identified a number of other reasons why midwifery was so integral to their practice. This included the ability to continue to offer the complex care necessary following traumatic births;
"Maternal & Child Health is very much an extension of midwifery… you need the delivery, antenatal and postnatal knowledge… it’s not just physical it’s all the psychological factors you take in… the family issues, the social issues…”KSH 11

It was obvious from the data that the majority of KSH strongly believed the midwifery qualification was integral to the wellbeing of the family unit. This then assisted them in offering a holistic service that had the potential to influence the developmental trajectories for children. In other words;

"Midwifery is important … we are concentrating on maternal health because that has a big impact on the development of the child… to loose midwifery and concentrate solely on the child you actually lose one of the biggest influences on the child’s development…” KSH10

In addition, being a midwife was not just needed for the first six weeks after birth. It was considered essential beyond six weeks because;

“… how many women do we de-brief up to six months down the track from birthing issues… if you do not have any concept of what physically could have occurred for that woman… how on earth are you going to do it…”KSH8

Furthermore it was indicated by the following quotes that midwifery gives the MCH nurse an added perspective to their care in that;

“… unless you have been a midwife you don’t appreciate some of the issues mother’s go through” KSH1

“… we are not just working with children and their families we are also working with women that are birthing and the connection that midwives have antenatal and postpartum are absolutely vital…”KSH5

In contrast, one KSH indicated that midwifery per se may not be necessary. The MCH course, however, would need to have a compilation of midwifery components to enable the course to bridge the gap of knowledge required to effectively care for the clients;

“… perhaps not having the midwifery qualification but there needs to be something that can be a bridging gap…”KSH12

A different perspective, however, was offered by other KSH who reflected that this was more about what the person brings to the role, not the reverse as seen below;
“I would like the qualification maintained… but in practice what works is not the qualification it’s the person…” KSH12

Not all KSH however, supported the need to be a midwife to practice as a MCH nurse. The participants were realistic though to point out that there was a need to evaluate this thoroughly before making a decision;

“… we really need some compelling evidence as to why we need to be midwives… currently there is not enough research going on… people say we need to be midwives but are not putting forward the data or the evidence’ KSH1

There were some KSH who questioned the usefulness of the midwifery qualification past the immediate postnatal period. This was because if any problems did arise in the first 6 weeks the client could be sent back to the hospital under the hospital postnatal follow up policy. Midwifery was therefore, not essential;

“… you can send them back to the hospital in the first six weeks… I don’t really know if you need midwifery to do the rest… how much of your midwifery are you actually using…” KSH2.

In addition to this comment, it was identified by some of the KSH that midwifery was not everything and should not be the only consideration in the postgraduate qualifications. Other areas for deliberation were agreed as being mental health and increased counselling components. These were identified by the KSH as necessary because;

“…in the complexity of our society nurses now need to be equipped to deal with mental health issues, anxiety, substance abuse…” KSH2

There were other discussions about what else should be included into the MCH program during the interviews. One of these included;

“… I think they all should have to do the infant mental health course as well…” KSH3

In other words, the KSH identified that there was a need for the new graduates to have adequate preparation to be able to exit the program into the community. This included a knowledge base equal to the complexity of cases that they will be caring for. There was also a belief that;

“… new nurses are coming out with a pretty limited practical experience… I think it would be useful for them to do a lot more practical placements so that they understand the nature of the work which for me is about relationships…” KSH3
Further to the debate surrounding a national qualification, the KSH were asked if they believed that the current qualifications to practice as MCH in Victoria should be adopted by all jurisdictions. These qualifications were seen by many to be an important aspect of the broader service necessary to support the national early childhood population;

“... there could be ways to transition over a period of time so that either a full midwifery qualification was required... or some bridging midwifery course... I don’t advocate for that... the future might just be that in fact...”KSH10

“... we need to be looking at what minimum educational requirements that we need and whether there are different levels within that...”KSH6

The data provided an unexpected degree of ambivalence from a very small number of KSH regarding the national changes. This is supported by the fact there will always be people that are content to continue with what they are doing because that is what they have always done. It was surprising that this was reflected at the management level;

“... I really don’t care... if they are going to adopt something it should be the Victorian model... I am just happy if they just leave us alone really...”KSH3

Part of the discussion regarding the educational pathways to become a MCH was whether Bachelor of Midwifery graduates could then directly undertake the MCH qualification without first completing a Bachelor of Nursing. There were an increasing number of Bachelor of Midwifery graduates across Australia since its introduction in 2002. Some jurisdictions were in fact already admitting Bachelor of Midwifery graduates into their programs, which was creating pressure on Victoria to do the same (Kruske and Grant, 2012). The prospects of a Bachelor of Midwifery graduate entering into the postgraduate MCH qualification program was put to the KSH for consideration. Many KSH were passionate about the inappropriateness of this option due to the fact that they perceived the Bachelor of Midwifery would not have the nursing background to support the need in the community. In other words;

“No... they don’t have the requisite knowledge of being a general nurse... you need to recognize abnormal from normal before it happens rather than... woops too late...”KSH8

“No... because they are not nurses... they don’t have the breadth and depth of knowledge required...”KSH10
One of the other concerns regarding this was that the Bachelor of Midwifery graduates may lack life experience. This reflected more the fact that doing a Bachelor of Midwifery would mean some would be young as they have come straight from school and not undertaken nursing and then midwifery prior;

“… No… being a 23 year old MCH is just way too young… you need to have experience and life experiences…”KSH11

Added to this one KSH reflected that the concern with this was that inexperience did not mix well with autonomy;

“No… you need to be general trained just to get the breadth of knowledge… we are sole practitioners… you really a wide breadth of knowledge…”KSH9

In other words;

“… working autonomously they need experience and if having more experience means doing general nursing and midwifery then Maternal and Child Health… that person has more experience by default…” KSH 6

Realistically, however, another KSH commented that the Bachelor of Midwifery course components were not something she was familiar with so in turn lacked the knowledge to contribute to the discussion. The difficult position expressed here again, however; is their age;

“I haven’t been in a position where I have really looked at what it is the Bachelor of Midwifery do… so I don’t feel qualified to answer the question… my gut feeling is No because they haven’t had the life experiences…”KSH12

While the Bachelor of Midwifery may be an option under consideration for the future of the MCH service, the number of postgraduate midwives applying to undertake these additional qualifications supports the viability of the current MCH qualification. The expectation, however, to do the qualification without the recognition of MCH qualification on their registration is thought to be unrealistic by the majority of KSH;

“…it’s hard for them to envisage an end in sight because it’s a lot of study to get there…”KSH6

An additional aspect to the lack of recognition identified by the KSH was the cost incurred to undertake the course. Scholarships are available from a number of different avenues to assist with the costs however their value does not go anyway near to covering the cost of the postgraduate course. The service, therefore, needs to be made more attractive for the midwives with salary and pathway alternatives. In other words why would;
“...young people do three separate qualifications when they can earn $60,000 or $70,000 in marketing after a three year degree...” KSH2

Attracting midwives to become MCH nurses did not appear to be an issue. It would appear from the data, however, that some KSH believed that some midwives were attracted to do the MCH course because of the preferred convenient hours; “...a job that is 9-5 Monday to Friday” KSH1. This could, however, also be seen as an alternative to the overwhelming hospital work scenarios which had become so busy with the increased birth rate and decrease in the staff due to government cut backs. Whatever the reason, there appeared to be no shortage of midwives wanting to enter MCH nursing.

‘future pathways’

The final subcategory under ‘common standard’ category is ‘future pathways’. The future direction for the MCH nurses has been discussed on a number of platforms over the past decade. Likewise with this study the KSH were asked for their point of view on the future pathway for the Victorian MCH nurses. While their responses were mixed the majority of the KSH agreed that the future pathway for MCH nurses was the Nurse Practitioner role. A number of reasons why this should be the case as well as the fact that the majority of KSH have supported this move for some time is illustrated below;

“Absolutely Yes... we are independent and we've got the evidence based screening tools that we can use to support that...” KSH11

“... I have been lobbying for some years for this... it would serve the community really well to have MCH nurse practitioner...” KSH4

There were a number of advantages identified by the KSH, including the fact that being a Nurse Practitioner would ease the stress on the public health service by offering alternatives. For one thing this Nurse Practitioner role was considered by the KSH to be fundamental in helping reduce the overload on the GP service in regards to the family and early childhood areas of health, social planning and preventative education This was especially the case for the rural and outback areas;

“I think to have one Nurse Practitioner for each council would be great... it would take the load off doctors especially in the rural community...” KSH9
“… sending the mother to the GP to get a referral to the paediatrician is just the most ridiculous thing…” KSH1

Despite the positive responses for the Nurse Practitioner role, not all supported or believed this was a direction that MCH nursing would, or should take. A minority group of KSH believed that because a large number of the workforce were nearing retirement they would not have the level of education necessary to pursue the qualification required. This is because there were some practitioners that had qualifications such as the Infant Welfare certificate, which was hospital based and not at the same level as the Graduate Diploma currently required. This would inhibit them, therefore, in attaining qualification level required before being able to pursue the Nurse Practitioner status;

“I cannot see the entire workforce even envisaging that… there is no way they could get to that level of qualification…” KSH6

The following KSH concurred to a degree with the previous comments however adds another layer of complexity to the scenario of what would need to be considered first;

“Academically yes… in theory it works… but there is no financial recognition yet… a lot of workplaces would be scared without actually realising the scope of what they are going to get…” KSH8

In contrast, some KSH believed that the service needed to be built on the strengths that were already there, not necessarily move in the direction of a Nurse Practitioner role;

“My ideal is that MCH becomes stronger, more widely recognised, that the education levels stay improving… we don’t lose that expectation of quality that we now have… the Nurse Practitioner would only work for the enhanced service realistically…” KSH5

“… I’d like to think we would maintain similar to what we have got … but move the focus a bit more to the first six weeks and the mother… I don’t think we focus on the mother enough during the all the key ages and stages visits…” KSH1

This was supported by the following quote from another KSH;

“… I still see us working in the community… the way in which we work and what we offer might however change…” KSH6

Despite the mixed responses to the Nurse Practitioner role, the majority of KSH stated that they would support the MCH nurses to achieve the additional postgraduate studies required for the
Nurse Practitioner role; “Yes I’d love to” KSH3 to “Absolutely… if they could find a way to make it work yes…”

In addition to the role of Nurse Practitioner one KSH believed that e-health was another pathway that should be included into the MCH role. The electronic patient history is a personal health record which the client has control over with who they allow to have access to. Essentially e-health is in the early stages of being rolled out across the jurisdictions. It has reportedly been used successfully in the Northern Territory for a number of years;

“… absolutely vital we get incorporated into e-health… a transition from midwifery in hospital through domiciliary to community midwifery into MCH then into school nursing… a path that links all…” KSH5

‘universal service’

This is the second category developed from the data analysis and includes the subcategory of ‘integrated service model’. As a consequence of national registration there was a need to develop a national service framework. What currently existed was disparity of practice across all jurisdictions that coexisted with the disparity of qualifications. With the plan to make the qualifications uniform across Australia with national registration, the services provided by the MCH nurses have to be made uniform, that is, the development of a national service framework. The majority of KSH’s indicated that this was in principle a necessary change to provide universal child and family health services across Australia. At the time of the interviews, a draft framework (Allen Report, 2009) only had been developed, therefore, little development of the service framework had occurred. Consequently a number of KSH’s were confused as to what this framework would constitute, considering the current diversity that existed between jurisdictions. This varied from those that had a good understanding of the framework in that they accepted it in principle, for example;

“… from an idealistic view point… a national framework with care would be fantastic … to have standardised care across Australia is a really good idea …” KSH 8
“… a standard that ensures quality… you never stand still… far more research for our practice to become more professional…” KSH1

Interestingly some KSH saw the development of a national service framework as an opportunity to develop a better service as illustrated;

“… it’s a huge opportunity to improve services across Australia…” KSH3

“Universality… capacity for increased service to higher risk, higher needs communities like enhanced… flexibility because environments are different…” KSH5

It was evident from the data that the KSH were in agreeance with the concepts of a national framework, but were, however, hesitant;

“… in principle it looks good… things look good on paper but what that looks like on the ground is another thing… I guess how it is carried out will tell what that will look like…” KSH2

In contrast, there were those KSH who did not have a grasp of what a proposed national framework would consist of, or the fundamentals. For instance, some KSH openly stated they had inadequate understanding of what was meant by a national framework. This is seen here, when the KSH were asked what their understanding was, they replied “not good” KSH9 or “I have limited understanding” KSH6.

This was seen further by other KSH who, despite admitting to keeping up to date with MCH nursing professional issues, stated that;

“… I can’t honestly say that I am aware of what they are talking about in terms of the national framework at all…” KSH3

“I find that a really hard question… I’m not sure what goes into most frameworks… I guess the level of service by the most qualified people and the funding to go with it…” KSH4

Further highlighting the lack of understanding was that it appeared some KSH were confused about the difference between national registration and the framework. For instance, one KSH when asked the question ‘Do you believe national registration will change how the Victorian MCH will practice’ replied;
“… possibly… at the moment we have a framework I think is excellent… what the framework will look like in the future I don’t know… a shame if it puts us back to antiquated practices…” KSH2

Another example of this can be seen when another KSH was asked a question related to whether they had set up any review processes for implementing a national framework. The response was directed more to discussing how staff would be audited for registration and professional development hours;

“… the nurses are meant to be maintaining their own… audit to maintain their registration…” KSH1

An additional example of the confusion between registration and framework can be seen here with this answer to the same question;

“… I don’t think there is a lot of information yet disbursed about the implications of the national registration…” KSH2

Despite there being a number of workshops, including the CHORUS focus groups, and papers being developed, these KSH believed there continued to be a limited understanding of the proposed national framework. In their defence, however, the framework was thought by other KSH to be so far away and could be used as a plausible excuse to why there was a lack of information circulating;

“I don’t have enough information about it… my instinct is there about five years away from coming up with what they’re going to do…” KSH5

At the time of the interviews the CHoRUS study was currently examining the feasibility of a national Child and Family Health service and, therefore, the beginnings of the national framework. There were a number of KSH interviewed for this study who had participated in the CHoRUS study. The KSH indicated that this lack of feedback had in fact limited their understanding of what was being proposed for a national framework;

“… there was a series of meetings in Victoria with the CHoRUS study… we actually didn’t ever get any feedback on that…” KSH10

It was evident from the data that generally there had been limited communication to the field on the progress to a national framework;
“…there are discussions starting to happen… we are aware that something will come… that’s as much as we have…” KSH5

There were contrasting results from the KSH replies to the question regarding whether they believed the proposed framework would influence their current position. The majority of KSH indicated that they felt the proposed national framework would to a degree influence their current position in a number of ways;

“Yes… it will impact in terms of consultation and coming to an agreed position… it will be very much related to funding and there-in lies a political and economic argument or discussion for the future…” KSH7

In contrast, while another KSH acknowledged the need for a national framework she also believed that such a move;

“…shouldn’t influence my current position apart from how we manage the staff coming into the service…” KSH1

Whereas another KSH also acknowledged the national framework but was a little disillusioned with the progress and her colleagues commitment to the process;

“I hope a lot of my colleagues at the same level and above will also open their eyes to other opportunities … I don’t get that sense when I attend state wide forums… they think our way is the only way… that’s really sad” KSH2

Interestingly there were KSH that expressed that the national framework should not influence their current positions if they all had input into the development. This emphasises the need for this to be a collaborative process;

“…not if I am prepared to get on board and have enough to say it shouldn’t.…just because it’s gone national doesn’t mean we shouldn’t be having an input… what it will do is make me work harder… I intend to make sure that further changes are in the best interests of families…” KSH3

There was however, a great deal of discussion from the KSH about what the framework should consist of. This was again partly due to the fact that the framework was evolving at the time this study was being undertaken. The KSH articulated that there were a number of important aspects that needed to be considered for inclusion in the national framework in order to ensure a quality service, with appropriately qualified staff. From the KSH point of view the service, therefore,
needed to be research based, have effective evaluation processes to change ineffectual practices and be aligned with best practice outcomes. In other words;

“A framework with evidence-based practice and an acceptable minimum standard… with the complexity of our society nurses need to be equipped to deal with mental health issues, anxiety and substance abuse… a parent driven strength based approach with a minimum grad dip… I don’t think we should go back to the Stone Age and apprenticeship style training…” KSH 2

There was acknowledgement from the KSH that the proposed framework could look at areas around the underpinning principles of the vulnerable families, as seen in the following quotes below;

“… accessibility, universality and availability… a service that doesn’t exclude people… a component of outreach to seek out the non-attender or poor attender…” KSH7

The majority of KSH, as with the national registration, believed that the transition to a national framework in principle was a positive move for the families of Australia. However the majority of KSH, indicated they had concerns for the continuance of the service at its present level because they believed a national service framework would be different;

“… my fear is that the opportunity will be taken to reduce services and that the quality of services will suffer because of funding…” KSH3

The following comment from another KSH supports the fears of many regarding the possible direction of the service as clearly stated below;

“I am terrified that we are going to the lowest common denominator and the cheapest options… absolutely devastated if that happens…” KSH5

In other words;

“… I am anxious that the quality of the service in a national framework will be quite different and I am not prepared to acquiesce to that yet” KSH3

What was compounding this further and contributing more to the confusion, however, was that the KSH believed the depth and significance of the national changes to the Victorian MCH nurses had yet to be fully comprehended by the organising authorities or the MCH nurses themselves;

“I don’t think people appreciated the depth of what was being proposed” KSH 1
Furthermore, it was perceived by a number of KSH that there was a need for a common ground for compromise and negotiation, in other words;

“… we meet in the middle… but whether we get there or not will wait to be seen” KSH2

It was obvious from the data that one of the confounding contributors to the confusion was the lack of communication and consultation that appeared to have occurred around this. This was compounded by the perception it was more of a political issue driven by a few with invested interests;

“…from a confusion point of view….. we have National Registration coming out… a National Framework… the Productivity Commission sitting there… there is not enough clarity with what they are actually looking at… there is a lack of clarity in the framework that is Federally driven… a lot of people with their fingers in many pies... that confuses practitioners because they don't know who's driving what for what reason... it's too political at the moment …” KSH8

This KSH comments further add to the fundamental confusion and lack of confidence for a number of KSH in the professional standing and processes being employed for the move to a national framework. In other words, the KSH felt there was an additional underlying agenda involving significant others pushing their own invested interests;

“… possibly some of where it has been driven from is not necessarily from the Victorian framework and so the platform they are moving from is of a lower standard from where we are…”KSH8

‘Integrated service model’

A subcategory of the data under ‘universal service’ is ‘integrated service model’. Notwithstanding the underlying perceived hidden agendas, the majority of KSH believed that the integral steps to the evolution of an integrated service model were needed to navigate the pathway of the national changes. Following the move to a national platform for early childhood services the services being offered by the jurisdictions need to be reconfigured to be effective at a national level. For this to take place, communities and services must become better integrated to a more inclusive community-based service with a cohesive interdisciplinary approach. This is thought to be
achievable by sharing a common ground with core values, knowledge and skills instead of the segregated centre-based silo services previously being offered under the semblance of integration. An integrated service can be defined as the management and delivery of health services to ensure families receive a variety of preventive and curative services, according to their health care needs in a timely manner and across the broad spectrum of the health system (WHO 2007). This variety of services would then be organised in one facility to enable a seamless referral process from one practitioner to another for women and her family as the need arises. This is a beginning concept currently being established in Victoria with few being available at present time and the desire to establish more. Needless to say these integrated services would be ideal for the MCH nurse to be situated, in order to more easily refer the women and her family to the other health practitioners within the service. These integrated services could include such practitioners as; GP, dietician, speech therapy, chiropractor and so forth.

The KSH were asked the question related to their understanding of what they thought an integrated service was. Here again the replies to the question were surprisingly varied and different. There was a group of KSH who had a reasonable understanding of what an integrated service entails and the advantages of such a service;

“… mothers telling their story once… there is so much more to their stories… we record the biomedical… but we don’t often record a lot of the other…”KSH10

“… looking at a one stop shop for families across the ages… be it kindergarten… MCH or allied health…”KSH8

“… part of a co-located building with long day care and allied health… where mothers only have to tell their stories once… a soft entry flow through…”KSH9

There were other KSH who believed that it was more than about the one stop shop and that there were other possibilities with an integrated service;

“It’s just a one stop shop… Electronic e-histories… would be great… having a decent data base that you could measure outcomes… not just how many consultations but what’s happening to these children we refer…”KSH11

Another clearly articulated advantage of the integrated service identified from the data was that there could be partnerships working together for a common goal;
“...it’s lots of partnerships happening... I think we all need to work together because MCH knows what they do... others know what they do... but no one knows what each other is doing... working with complex families with difficult needs... we need to work together...”KSH11

Despite the fact the majority of KSH were in agreement to what they believed an integrated service model was, there were KSH who could see a number of obstacles to the implementation;

“... an integrated service model could work well in theory... it’s something that lip service can be paid to but there are still a lot of barriers that need to be broken down...”KSH12

‘we do it well’

The third category extrapolated from the data was ‘we do it well’ which includes the subcategory ‘we sit in between both’. The majority of the KSH indicated that they believed the Victorian framework was operating very successfully and, therefore, should be considered in principle for a national framework. This was initially alluded to in the previous category. One of the reasons why the service was identified by the KSH as being worthy of forming the national framework was because Victoria has a history of “… the strongest evidence-based practise…” KSH8 and the strong evidence based philosophy behind the service. The following quote illustrates that it is not only Victoria that believed it is an exemplary service;

"We actually do it very well and the feedback we get from other states is excellent"

KSH11.

Why the Victorian framework should be a consideration in principle for the proposed national framework was highlighted by the following KSH;

“... the Victorian framework has benefits and outcomes for children... the evidence based feeling safe in practice has given me the big picture outlook...”KSH11

Another part of the reason identified by the KSH as to why the Victorian service was exemplary was because it had the infrastructure along with legislated birth notifications and independent
funding from the state and local government to support the service. This meant the service was streamlined;

“...there are a few things in Victoria that make our service so good ... one is the birth notification... 98%-99% of our families engage with the service...” KSH10

For the KSH, they believed that this all contributed to the fact that;

“... the service can operate at a level which is excellent rather than good…” KSH10

Furthermore, the KSH indicated that they felt the service in Victoria was strengthened by the education pathways required for MCH nurses to practice. In addition, the service has had many reviews and evaluations related to service delivery and outcomes for children. The majority of KSH varied, however, to the degree that they believed the Victorian framework should in fact be a consideration for the national benchmark. As suggested in the following quote this varied from being realistic about the possibility;

“... the Victorian model certainly needs to be a consideration... I don't necessarily agree with adopting everything... but we have to investigate what's working and bring that in... I think we do pretty well…” KSH5

In other words, while acknowledging it was comprehensive, the Victorian model may not transpire to a national workable framework;

“I think the Victorian model is a very comprehensive and successful model... it offers families so much more than any other state... but nationally I don't know if that can work...” KSH6

In contrast, a number of KSH felt the current framework in Victoria was a little prescriptive with the focus being more on the child. As indicated in the following quote, it is the mother in the early postnatal period that required more attention than was given;

“... I would actually like to move the focus a bit more to the first six weeks and to the mothers health...we are not supporting women when they really need the most support... more care often benefits greatly…” KSH1
“I think the Victorian model certainly needs to be looked at carefully as a consideration... I don't necessarily agree with adopting everything just because that's the package but I do think we have to investigate what's working and bring that in... yes I think we do it pretty well” KSH5

In fact the KSH realistically stated they believed that they needed to know more about what the other jurisdictions actually did before they could make the claim that Victoria had the best service model to offer. The KSH were not saying that the Victorian service was lacking, but that they wanted more evidence from the other states of what they offered in respect to services;

“I don't believe it can be presented as the national model even though it is good... I haven't adequately explored the other models... we need to look at what other jurisdictions can bring to the table... for that to be done it needs to be adequately funded and resourced...” KSH12

Despite these above comments, surprising results came from the KSH responses when asked how familiar they were with the services the other jurisdictions offered compared to the services provided in Victoria. It was evident from the data that the KSH had some knowledge of the services provided in certain jurisdictions but did not have a comprehensive knowledge of all the jurisdictions. In some cases the information was only secondary for instance;

“...my sister is a nurse up there and I check out the MCH nurses when I go to see her...”
KSH2

Other KSH admitted that they knew little;

“Not terribly... I haven't really kept up with what they're doing... I gather that it's much more hit and miss in the other states... much more driven by someone who might seek out... rather than comes looking for them...”KSH3

To a minimal knowledge;

“Not terribly... No...”KSH11

This further highlights that when there is discussion about a national service framework, there was limited understanding of what Victoria actually does by other jurisdictions or the government of the day. From the data it was evident that the KSH felt that this could very well be the fault of the MCH nurses themselves since they did not emphasise the service enough politically or use the evidence they had from the mothers that reinforced the Victorian model as being invaluable;
“...I don’t think there is a good understanding of what Victoria actually does... part of that is our problem... we don’t emphasise that enough... we have evidence from the mothers... I don’t think government understand it enough either... we need to get better at being political...” KSH1

Another explanation for the limited understanding of what Victoria does was articulated by one KSH who commented that;

“...our era was too busy doing rather than evaluating... that is why we are in the position we are in now... we can’t prove why we are better in Victoria...” KSH2

‘we sit in between both’

The subcategory of the data under the category ‘we do it well’ is ‘we sit in between both’. Part of the reasons as to why the service was deemed the best was which department the service was attached to, as this influenced policy direction and the service framework. Many of the KSH have experienced the changes in departmental portfolios for the MCH service over the years. At the time of the interviews Victoria was under the DEECD portfolio and had been for the past six years. Prior to that period it was in the Department of Health. This made Victoria the only jurisdiction that was not under a health portfolio. Due to this fact it was considered relevant to ascertain the knowledge, attitude and beliefs of the KSH as to where they believed the Victorian MCH service should be situated. The results from the KSH data were unforeseen and diverse. It was a widely held opinion of the KSH that the MCH service worked cooperatively with primary health and the early intervention services. The majority of KSH, however, believed that it was difficult to position themselves within either portfolio, as the quotes below identify;

“I struggle with this one... Education is one of our roles... as primary health and preventative health with anticipating family needs... I’ve always felt that we were a little bit on the outer since we have been under the Department of Education and Early Childhood Services... when we sat under the Department of Human Services it just seemed to fit and flow better... so I am divided on that one...” KSH2

“... this is a tricky one... I think the education system values what we do ... I don’t know... undecided... yes undecided...” KSH9
This is supported by a number of other KSH who expressed that they were unsure whether they should be situated in education or health;

“… I don’t know… it depends whether you see us as a holistic view of the early years or whether we are totally focused on health…”KSH6

“… I think we get lost in education unfortunately… we have to keep a connection with either education or health… we need to think health rather than education... because that is actually losing the nursing and health promotion element…”KSH5

Being under the education portfolio, however, was seen by a number of KSH to be an issue that was causing concerns with practitioners for a number of reasons;

“… at the moment the focus is remained on education and MCH has become a secondary thing… I don’t think it really matters which portfolio it’s in… education and health are both lively important for children… health is dominated by the hospitals and education dominated by the schools… maybe we need some community service department…”KSH4

The problem was that there are advantages and disadvantages to being situated in either portfolio, as reflected in the following;

“… pluses and minuses with both of them… the danger of it staying with health was adopting the medical model… it could stay with education provided the department really take us on board not just as an afterthought…”KSH12

“… it can stay with education if there is a new department created… at the minute we are a health service in an education department and it’s not working… the language is wrong… I don’t think going back to a health model or the Department of Human Services is necessarily right either… “KSH3

A number of the KSH stated that the decision as to which portfolio was more dependent on the personnel promoting the service, especially if the leaders were not strong champions. This is clearly supported by this quote;

“… there are advantages and disadvantages in both… we need to be under the public health sector… not under the acute health… if it’s the transplants, wiz bang machines… we could be forgotten… the difficulty is health doesn’t understand the early years really well and education doesn’t understand the health…”KSH10
One final solution to this dilemma was suggested by a KSH who believed that the 80/20 rule should apply for the aligning of services, as explained below;

“… the Department of Human Services have a major part to play within MCH in the needs of children… if we are talking about the 80/20 rule 80% of children not needing child protection therefore need education… we are also focusing on their brain development… learning… we need to be in that agenda if not we are almost superfluous…”KSH1

‘imposed from above’

The final category of data presented in this chapter is ‘imposed from above’ which has one subcategory ‘change is inevitable’. As previously identified, the KSH knowledge and understanding of what a proposed national service framework for MCH nurses would look like offered surprising results. This is because the number of stakeholders who had limited knowledge was significantly more compared to the stakeholders who had a more comprehensive understanding. To date there have been a number of issues identified by the KSH in the data that may have attributed to this. One of the major concerns identified by the participants was the lack of involvement and consultation that had occurred between the governing bodies and the KSH with what was happening at the national level prior and during the national changes. In other words, there was a perception from the KSH that;

“… if it is something that is imposed from above it’s not going to work…it has to come from the bottom up as well as from the top down…” KSH12

“… change can be positive… it is how it’s implemented… if it’s just sort of dumped on people they become more resentful…”KSH2

It became apparent from the interview data that the KSH further believed the decisions regarding the service were being made by policy makers who had not thought through the implications of the change thoroughly enough. In addition, there was also a perception by the KSH that the policy makers and governing bodies did not have good knowledge and clarity of what the
Victorian service offered. A further reasons why this was perceived as being problematic was expressed by one of the KSH in the following;

“… policy people bring one set of glasses when they are looking at things …they just don’t seem to know what the grassroots stuff is all about…” KSH12

In other words, the KSH believed that;

“… there needs to be more consultation with the grassroots practice and that’s not happening…” KSH 12

Other reasons identified by the KSH as to why it was important that the practitioners themselves should have been included in the planning process was because;

“… many decisions are made when there isn’t anybody around who has a practical view of what’s happening on the ground … unless you incorporate their point of view you are always going to have to drag the service along…” KSH3

While policy makers may have the vision for change, it is important to have good leadership for executing change as identified in the following;

“… change can be positive… it is how it’s implemented… if it’s just sort of dumped on people they become more resentful…”KSH2

This is not only about having the KSH on board, there needed to be consultation with the MCH practitioner themselves. More importantly this was identified as one of the main concerns highlighted by the KSH as something that in fact was not happening. In other words, from the KSH perspective there had been a lack of consultation and involvement in the national agenda of the Victorian MCH with the policy makers and service reviewers, as illustrated;

“… I think we have not had enough consultation as stakeholders in the national agenda…” KSH3.

“… getting people in right from the word go... grass roots involvement because if the grass roots don’t accept it, that’s the end of it… you have to be involved all the way up the line…”KSH10

The necessity of the importance of collaboration is outlined by the following KSH;
“… it needs to be relevant for people to feel that they own it… come to the table with goodwill… be prepared to give and take… we have an excellent service in Victoria but we could learn from the other states with things they do well…” KSH12

This is supported by other KSH;

“… getting people to come around in terms of where they were and where we have got to change to… not just change for change sake”KSH4

“… just because it’s gone national doesn’t mean we shouldn’t be having an input…”KSH3

In contrast, there was a small number of KSH that believed that in fact there was adequate consultation regarding the evolving framework. Instead that many practitioners ignored what was happening believing that Victoria would be immune because;

“In Victoria … people thought we had the gold standard and therefore we would be fine without realising that we didn’t have the research to back up and the data to say well yes a child in Victoria is much better off because of our service” KSH1

While the above quote has highlighted to some degree the KSH complacency it is also indicative of the opinion of only a small number of KSH. It was also indicated by some responses that they believed there was adequate consultation and that people had not necessarily availed themselves of these opportunities;

“... if people haven’t read the changes and the proposed new framework… I don’t think it is any fault of the people that have put it out there…”KSH2

Policy makers may have had the vision for change, however, the importance of having good leadership for executing change was identified as vital by the KSH. The KSH believed, furthermore, that leadership on its own was not enough to ensure successful change. The effect on the leadership champions from the change to a national platform was, however, that the change was still imposed from above and resulted in the KSH feeling disenfranchised with the lack of guidance on what was happening. In other words;

“… we don’t know enough… we are doing this in the dark… I certainly feel ill prepared to lead a change in our team around this…”KSH4
It was obvious from this KSH perspective there needed to be more than what had been delivered. More specifically what were needed were the background and the lead up documentation to support the reasoning behind the decision for the national changes:

“… I like to see the rationale behind why we are changing… so I don’t feel threatened by the change… “KSH2

Leaders cannot implement new change strategies on their own. They require a partnership of senior leaders which includes leaders from the different levels of management to establish and gain the cooperation of others;

“… you need to … get the stakeholders on board…. if they understand why then they’re much more likely to be involved… it has to help the process… pre-anticipating anxieties and addressing the anxieties is essential…”KSH5

The responsibility of this guiding senior leadership is also to empower and encourage others to embrace the change effort and keep it on target. Success of the change effort primarily depends on the quality and attention senior leadership gives to its structure. In turn this is thought to minimize unsuccessful change efforts;

“… I am sick of the coordinators discussing this whole thing and no- body really knowing anything about it… it’s really hard to discuss the whole thing when you really don’t know…”KSH 4

More importantly the KSH indicated in the data that they believed there needed to be a more comprehensive and inclusive working leadership group to progress with the national service framework. It was clear from the following quote the KSH perceived the opposite was the case;

“…there needs to be a broader representation …. it is certainly being led by two states and they have given good leadership…. but it would be good now to create a leadership group of academics from all states… as there’s good wisdom in all states…”KSH7

In addition, it became clear from the data that the KSH also believed there had not been adequate communication between the organising bodies nor the leaders implementing the changes about what was happening. The KSH further believed that good communication is essential for change processes to be effective and to have the desired transformations. Instead the KSH felt that;
“… we are reliant on gossip and hearsay… the odd comment at a conference or a paper… there is nothing structured… unless you get that you really cannot make a decision on what works or doesn’t work…”KSH10

Furthermore the majority of KSH believed that communication is much more powerful and effective if it is delivered within a multi focus arena;

“… communication and letting people know what the change is… how they are going to be supported… having change leaders around… champions for people…”KSH10

More to the point the KSH indicated that keeping the message and communiqué pathways simple would assist therefore;

“… making sure the chains of communication are set up so that it is easy…”KSH8

A suggested strategy offered by the KSH to support communication was;

“… there needs to be funded seminars for people to come and give their opinions…”KSH12

In addition, the KSH recognised that to assist with major change there needs to be a vast amount of honest communication to address inconsistencies and eliminate mixed messages. Plus there was a need to gather as much information about what happened elsewhere and to be fully informed;

“… we should have a roundtable to work out what does happen in the other states…”KSH10

‘change is inevitable’

The subcategory under ‘imposed from above’ is ‘change is inevitable’. As a consequence of the substantive change that was occurring, the KSH were asked if they were comfortable with change. Realistically the KSH indicated that in fact;

“… you cannot avoid death, taxes or change… if you don’t change you become stunted…”KSH10
The majority of KSH indicated that they believed the advantages of change were considerable in
that it establishes renewed concepts and often opens up new avenues previously unexplored. In
other words;

“… providing people with opportunities that perhaps they may not have realised…
change keeps things fresh, keeps people on their toes…”KSH8

“… sometimes change can make your practice much more efficient…”KSH2

In addition, to the previous comment, the KSH also expressed the importance of personal and
professional development that occurs from change and that therefore, it was good;

“… I think you grow professionally… you evolve with more challenges…”KSH11

The reason that this personal and professional development occurs is explained in the following;

“… it makes us review what we are doing otherwise we continue doing what we have
always done… when you always do the same thing you will always have what you
always got…”KSH10

The KSH indicated in the data that change is often not recognised as a continual phenomenon. In
other words;

“… change is not intrinsically about change itself… it’s about what you do with what you
are doing and how you do what you used to do…” KSH3

“… our whole society is changing so we need to keep up to date with change…”KSH6

As a consequence of change the KSH believed that there is a better overall perception and
understanding of the benefits of change. In other words;

“… the advantage of change is review… people stop and think… without change you are
not evaluating… you are not having people consider alternatives…”KSH5

This particular KSH believed, however, that change can bring new beginnings to the work
environment and that in fact change is often seen to trigger progress. In other words, KSH have
to feel comfortable with change because they themselves to some extent create change;

“… I have to… I create it…”KSH8
While the majority of KSH understood that change is progressive and inevitable, they also believed that there are good aspects of what was done previously that have worked well and need to be kept;

“You need to change to ensure your relativeness… at the same time you shouldn’t be throwing the baby out with the bath water either…”KSH12

In contrast to the advantages of change, the KSH believed that in fact not all change is pleasant. Unfortunately for some, one of the disadvantages of change is that it may cause a significant degree of stress. This then may derail the change process because people believe they cannot accomplish the task of making a vast or immediate change;

“… some people don’t cope easily with change… it will be difficult to bring them along to see the big picture…”KSH6

“… people get scared … to be out of their comfort zone”KSH8

The following KSH, however, conveyed a different position on the disadvantages of change reflecting that the inability for some to accept change can be a strong barrier to progress;

“… there is a danger in MCH that it has always been done this way so therefore we need to continue to do it that way…”KSH12

Furthermore, some KSH acknowledged that they were not very supportive of change but could accept that change has occurred if they understand why they needed to change;

“… change isn’t all that easy for me but if someone can give me a good reason why we should change then I’m on it…”KSH3

“… making changes gradually and providing lots of evidence of why changes are necessary … changes for a reason not for change sake…”KSH9

In conclusion a number of KSH believed that one never really knows what each change may bring, but a huge disadvantage of change is if it is just;

“… change for change sake…”KSH2
Conclusion

This chapter presented the data analysis that emerged following the analysis of Group One. There were 12 key stakeholder interviews conducted for this section of the study. Findings related to the participants knowledge, attitudes and beliefs regarding the perceived impact from the national changes to registration and service provision on the Victorian Maternal and Child Health Nurses. The key categories identified from the data were; ‘Common standard’, ‘Universal service’, ‘We do it well’ and ‘Imposed from above’. The next chapter will discuss the findings from Group Two of this study which consists of 39 interviews from the Victorian Maternal and Child Health Nurses.
Chapter Five

Maternal and Child Health Nurses Analysis

Introduction

The previous chapter presented the finding from the Group One the Key Stakeholder analysis for this study. The intention of this chapter is to present the findings from Group Two of a qualitative study exploring the knowledge, attitudes and beliefs of the Victorian Maternal and Child Health nurses to the perceived impact of the national changes to registration, a proposed national framework and service provision. A brief review of the characteristics of this group will be presented first followed by the key categories identified from the data. These findings will be detailed and supported by the interview data. In some cases, in order to situate the data, recapping of information already discussed in Chapter Four occurs in this chapter.

Demographics

Group Two of this study consisted of 36 MCH nurses who were MCH qualified and worked in the universal service. These participants were purposively selected from metropolitan and country areas across Victoria. The participant’s range of experience in the three groups was 1-35 plus years. The majority of the MCH nurses in this group had a Graduate Diploma qualification with ten having a Masters of Child and Family Health. All were nurses with extensive nursing experience and a midwifery qualification. The age range for the participants were; 24 to 65 plus years. This group were divided into three sub groups depending on their years of experience and includes; Group A: one to five years’ experience, B: six to fourteen years’ of experience, and C: fifteen years’ and over of experience.
Categories

Categories were developed by identifying recurrent patterns from the data and organised into groups through a process of inductive reasoning. Category labels were then chosen that reflected the participants own words and were the same as the KSH group (Chapter 4). These included; ‘common standard’, ‘universal service’, ‘we do it well’ and ‘imposed from above’. Participants who met the selection criteria were divided into three groups as identified above. Where possible, quotes have been used from each of the three groups to demonstrate the group perspective. In cases where there was a difference in opinion between the groups, a separation of the quotes occurs.

‘common standard’

This category includes the following sub-categories; ‘competent and capable’, losing our identity’ and future pathways’. An Australia wide registration was seen by the majority of Maternal and Child Health (MCH) nurses to provide a consistent streamlined process that enabled links between all the jurisdictions across Australia of the Maternal and Child Health nurse’s practices and services. National registration was, therefore, seen by a number of MCH nurses as an improvement to the task of registering because it reduced the bureaucratic process of registration and staff movement interstate. This was particularly for those who needed to register across borders. In addition, the requirements for national registration were consequently thought by the MCH nurses to be further contemporized to fit with the national workplace change agenda;

“... National registration consistent throughout Australia...... instead of having registrations particular for each state... " MCHA7

“National Registration is about ensuring that all nurses across Australia have similar requirements for registration so that you do not have to register separately in different States to work in the different States..." MCHB1

“... no matter where you go in Australia you will still be registered so you can practice throughout Australia rather than just state wide registration..." MCHC4
“... it allows people to move seamlessly from state to state if they have similar qualifications…” MCHB3

Although the majority of the MCH nurses had a good understanding of the changes to registration, there was a representative number that did not as illustrated;

“… to be honest I am not quite sure… I can’t say you know…” MCHA4

“… I don’t know that I can answer that question sorry…” MCHA7

The reasons why there was a limited understanding could be explained by the fact that a number of the MCH nurses were still new to the role as these comments were from Group A. These MCH nurses were concentrating more on putting into practice their newly gained skills and, therefore, had not fully grasped the national agenda. On the other hand, they were still registered nurses and midwives and so should have still been aware of national registration. Some MCH nurses did, however, demonstrate that they did understand to some extent because they were more focused on the loss of the recognition of the qualification on their registration than the actual process of national registration;

“I must say I am a bit fuzzy about it but I know pretty much that we’re losing our Maternal and Child Health component of it…” MCHB2

More importantly regarding the National changes was the possible impact of this to the required qualifications of the Victorian MCH nurses. It was, however, not fully understood whether there was a lack of understanding or in fact a degree of complacency. This is illustrated in the following;

“Very little… my understanding is that they wish to change it so that the qualifications of MCH will not need midwifery… so that the people trained in other areas including a childcare worker, a family support worker, a mother craft nurse, or a general nurse trained briefly can do this job…” MCHC6

In addition to the previous comments, it was further thought that another reason for the limited understanding was the lack of experience and perceptions of change. While this quote demonstrates someone who is new to being a MCH nurse, it clearly indicates the shortage of information that had been supplied by the outgoing Victorian Nurses Board and the new governing body AHPRA, which could also be seen as another reason for the limited understanding;
“... initially when the changes were happening I didn’t know a lot about it because I had only just started... when they were actually talking about that prelude to the first lot of registrations... the six-month one... that was really the first I’d heard of it... I didn’t realise until then what it was going to entail... we were actually going to lose it... not really lose a qualification but lose a registration for it...” MCHA8

The majority of MCH nurses believed that national registration was an advantage for a number of reasons. This was mainly because of the various difficulties that they had encountered with the individual jurisdiction registration boards previously. This was particularly an issue for the MCH who worked in border towns and had to, therefore, maintain multiple registrations. Further to this it was acknowledged by a number of MCH nurses as a further advantage, particularly for the immigrating and international workers;

“...nurses can go from one state to another and practice particularly nurses that work close to the border of certain states...” MCHA1

“... a one-stop shopping... you only have to apply to be registered once to work throughout Australia. The different qualifications need to be recognised but standardisation is also vital...” MCHB6.

“...one peak body organising registrations could be seen as an advantage for people coming from overseas wanting to register here in Australia...” MCHC7.

In principle the concept of having a national registration was thought to be a good idea. The big issue for the Victorian MCH nurses is, however, that there were a number of concerns that needed to be addressed in order for this to work. This was indicated in the data to be because of the current disparity in qualifications that existed between jurisdictions;

“... in general it would need an agreement amongst the states on maintaining levels of qualifications and standards of practice...” MCHA6

The majority of MCH nurses believed that national registration provided a significant advantage as it provided an impetus to realise the inequalities;

“... it does bring under review the inequities of other states by their lack of career pathway...”MCHC12

In other words, the services offered by all jurisdictions nationwide would be;

“... a standard service available for families who move interstate ...” MCHB4
Although this was clearly seen as an advantage, the MCH acknowledged that this in itself creates problems;

“… it can be a really good thing but change costs money…” MCHC9

In contrast to the previous comments, the data also indicated that there were a number of MCH nurses that were in fact ambivalent about the move to a national registration and could not see the advantages;

“… it is hard to see any at the minute…” MCHC3

This was further indicated in the following comment which acknowledged that national registration has some good, points but for the Victorian MCH nurses;

“… there are advantages obviously for practising all over Australia but I think for MCH nurses… we will be disadvantaged… we have lost our recognition as a qualification…” MCHC10

As discussed previously in Chapter Four, one of the advantages of a national registration was that this would make the process of moving interstate more streamlined. There were, however, a small number of MCH nurses that indicated they would not consider moving for a number of reasons;

“… the Victorian MCH nurses have the best standards of practice so one would be a bit reserved in working interstate where the conditions are not as well preserved or as stringent as we have as a safety net…” MCHC1

“Victoria offers the highest level and that's the way it should stay… I don't believe that I could get any better than what I have here.” MCHA9

“No… I wouldn’t like to work interstate... I would be very frustrated at the lack of service to families... I would not like to work in a service where I couldn't adequately support families and offer a comprehensive service that would allow me sufficient work satisfaction…” MCHB3

In contrast to the above comment, a small number of MCH nurses believed they would be more employable interstate with their skill sets. This meant, therefore, that they could easily move into any position and be sort after for their skills;
“… as a Victorian nurse if I travelled interstate I believe that I would be a more desirable employee because of my qualifications…” MCHB5

“… I have considered at some stage that I would like to work interstate… my employability I guess is pretty good…” MCHA13

More importantly the majority of MCH nurses were concerned with the disparity of required qualifications for the service provision in the different jurisdictions and that in fact there may not be work available for them interstate. This meant that the level of service provided elsewhere was not equivalent to Victoria;

“I probably wouldn’t because… I think I would be very frustrated working with colleagues that may not have the same knowledge base and the level of service provision in other states…” MCHC7

“… it’s a bit worrying for us MCH nurses in Victoria because we are the only State to have such a qualification… and the only state to have this service… I’m a bit worried that… we can’t move to other states to work because there actually aren’t any jobs for us…” MCHB11

“No… I wouldn’t apply because I’m really not sure that I would be working for the same type of service and I think I would be really relegated to the role of a baby weigher …” MCHA3

One of the outcomes from the draft report into the Early Childhood Workforce in June 2011 (COAG, 2011a) commissioned by COAG and conducted by the Productivity Commission could have in part contributed to a number of MCH nurses despondency and a degree of disempowerment. With the implied removal of the midwifery qualification this, therefore, was thought to influence whether they would move jurisdictions;

“If we lose midwifery… why stay here… I think other states are actually more highly paid than what we are in Victoria… we can go and work for them for more money and don’t have to worry about our qualifications…” MCHB6

The majority of MCH nurses when asked if they believed that the national registration would impact on employment opportunities in Victoria, replied in the negative. In other words, the Victorian MCH nurses would be able to gain employment anywhere in Victoria because they have the qualifications required to meet the standards. Practitioners from other jurisdictions would not
have such employment opportunities in Victoria, however, unless they had the qualifications necessary. This was because of the MOU or standards of practice which safeguards the qualifications required;

“... I don’t think National Registration will have any impact on employment in Victoria ... it will remain the same whether we had State or National Registration... the issue would be if people from other states wanted to practice MCH in Victoria and they didn't have midwifery qualification...” MCHB3

It was obvious from the data there were a small number of MCH nurses that did not have a good understanding of the Victorian standards to practice. There also appears to be a lack of comprehension of the required qualifications for employment to work as a MCH nurse in Victoria;

“... for people already with our qualifications it will minimise what employment opportunities we have... if people can employ someone with less qualifications, less experience... someone who will cost less, that's who will be employed... it will definitely decrease our employment options...” MCHB1

“... it will be open to interstate people coming down for the better rates, the pay rate, without actually having the qualifications that we have... it will detract people perhaps from moving around and changing jobs... if they leave a position they may not get the same recognition for re-employment... it will increase dissatisfaction...” MCHB4

Despite there being identified advantages, the majority of MCH nurses identified more disadvantages than advantages to national registration, especially as far as Victoria was concerned. The qualifications of the Victorian MCH nurses have been previously identified as contentious due to the disparity in qualifications across jurisdictions. The Victorian MCH nurses interviewed, however, believed that the threat to their qualifications was greater. In other words;

“... clearly there is a big disadvantage for Victoria with a National Registration... I think there has been a very strong push for Victoria to review what qualifications would be necessary to practice as a MCH nurse...” MCHB3

“No advantage at all... it will be a bad thing for Victoria...” MCHA2

One of the reasons identified by many MCH as to why this was disadvantageous was the aim of national registration was to create equivalency across all professions. The problem was that by doing this the MCH believed that AHPRA were;
“… lumping professionals into categories that are not necessarily similar in terms of their qualification and the service they provide…” MCHC7

This could then result in;

“… the potential of disharmony amongst the various different systems and standards that are in place at the moment…” MCHA6

A concern expressed by the MCH nurses was, how this disparity would be resolved was uncertain. This disparity needed to be resolved because the qualification of the workforce and service provided in Victoria are so different to any other jurisdictions. The MCH nurses indicated from the data that this could be resolved in a number of ways. Predominantly, however, the MCH nurses anticipated that this would result in a negative outcome for Victoria;

“… it’s really unknown because of how the political and industrial issue will be resolved… so potentially it could be a loss of recognition and of qualifications… from my perspective it could be seen as a downgrading of my role…” MCHA12

The end result, therefore, could be;

“… a group of nurses that don’t quite fit anywhere so they just get lost… I think we were one of those…” MCHA8

In addition, the majority of MCH nurses believed it appeared that the introduction of the national registration had been implemented too quickly before the processes had been thought through thoroughly. As a result there were a number of difficulties encountered by the MCH nurses regarding accessing and processing registration. This was clearly causing a great deal of confusion. In other words;

“…they really haven’t ironed out all the little process errors… we are all expected to register and the website did not work … wait and watch this space really isn’t good enough when we are talking about our employment… this is a copout… a joke… what sort of guarantee is that …” MCHA1

“Obviously there are a lot of teething problems in just the practicalities of getting onto the Website… I didn’t get any feedback… it didn’t set off on the right foot really… you didn’t have a lot of confidence in what was happening…” MCHC7
“… I don’t think it’s been very well handled... not much infrastructure behind it… all left to the last minute… no one seems to really know what’s going on… if you ring up to ask a question no one seems to know the answer…” MCHB1

Part of the reason why national registration was identified by the MCH nurses as a problem was that AHPRA appeared to not have been adequately prepared for implementation of the system prior to the start date;

“…they needed to be more organised… there is no point in saying to all the nurses across Australia we are going to change into a National Registration and then going oh no… we haven’t organised the website… we are not sure what to do …” MCHA1

“…If the whole thing had been better organised… it took so long for paperwork to come through… you didn’t get any registration acknowledgement till later… it was really messy… you didn’t know whether it worked… it would have made the biggest difference if it was a much more streamlined transition…” MCHB8

The aim of AHPRA was to become one organisation for registered health professionals. This resulted in what the MCH nurses believed was to be inefficient in regards to their processes. What was meant to be streamlined actually became quite awkward and time consuming to access;

“… the organisation is too big and cumbersome… it has been proven that errors are being made by AHPRA in terms of registration and notification of information… the bigger the organisation the more prone to error…” MCHC1

There was evidence from the data supporting the fact that the MCH group could see beyond the process. More to the point the majority of MCH nurses believed that they should have been more informed about the possible outcomes and significance of what they could expect. In other words;

“… we all knew that it was coming but people really didn't have a chance to look at the impact or saw it as a big thing… we just looked at… ‘Oh it will be great you'll be able to work in any state’… but nobody realised the implications…” MCHC9

“…they could have informed us before that this was what they were thinking of doing because I knew nothing of it until I actually started practising… If this is the way they were going to go it would have been nice to be told…” MCHA10
This was in part thought to be blamed on bureaucracy of implementation of change and that this is what happens;

“… I think it’s typical of government… it looks like a good idea… but was there enough thought put into it countrywide… “MCHB11

As a consequence of the introduction of the national changes, there were a number of aspects regarding the potential pathways to becoming a MCH nurse that needed to be addressed. Prior to national registration there was only one pathway to become a MCH nurse in Victoria. With the introduction of these changes, however, the reality of different pathways needed to be considered. This was particularly an issue for the people from other jurisdictions;

“… there are people that have come from interstate that want to work in Victoria and are unable to at the moment… there are also people within Victoria who would like to do MCH but haven’t got a Midwifery qualification… we also have Midwives who are Direct Entry who are not registered nurses so… so that’s another consideration…” MCHA13

With this change to national registration it was important to assess if this would impact on their employment opportunities. This question was seen to be answered positively by the majority of MCH nurses in the short term. What was highlighted in the data, however, was the numbers that were quite apprehensive about their future employment opportunities;

“… at the moment we don’t have any major trouble getting employment… with the introduction of National registration that may change because… they will have other nurses being able to do the job that we do without the qualification so it could negatively impact on our potential employment…” MCHA2

This point was taken further by another MCH nurse who added that Victoria may well attract more health professionals who want to work in a service that has been positively evaluated. In addition, that Victorian MCH nurses would be sought after in other jurisdictions because of their higher qualifications;

“… in terms of Victoria it will probably open up the employment market… to nurses who just have midwifery… I actually think it will improve our employability interstate… we will be seen as quite well-qualified and an asset to work in a similar position interstate but… we are kind of dumbing down the service by not having that MCH qualification…” MCHA3
The biggest concern expressed by the MCH nurses here was that because they were more qualified than anywhere else in the country, they would need to be paid accordingly. This then had a big implication for the future of the profession and the service as it could mean that a cheaper workforce would replace them. In the short term, the majority believed that there would not be a significant impact, however, they also believed their positions were not entirely safe in the future federal or state political arenas. In other words;

“… that people will start to see us as expensive… they are going to employ other people without the qualifications for less money… how will we keep our jobs at the current level if there is cheaper, less qualified employment…” MCHB11

In fact the majority of the MCH nurses believed that in time, the economics for the local government areas could come into play and the impact on the younger MCH nurses would be significant;

“… I will be retiring soon… but in time the Victorian Local Government will end up saying if it is cheaper to get someone less qualified…” MCHC2

When asked if the national registration would change how they practiced, the majority of MCH nurses indicated that they perceived there would be no significant impact. There were a number of reasons identified from the data as to why this was so. This is illustrated in the following;

“No… I don’t… I have a high work ethic and a high work moral and belief… I could never reduce the level of care that I was to give to my families to meet the requirements of other staff that may not have the same level of qualification…” MCHA9

“No… I will continue to practice as I practice… I don’t think registration will make any difference whatsoever to me in my practice…” MCHB1

“No… the work is still the same… while we are still called Maternal and Child Health nurses and they still want that qualification that we have even though it is not on our registration, I think the work will stay the same…” MCHC4

In contrast, there was a small number of MCH nurses who believed that National Registration would in fact impact on the way they practiced and why this was the case;

“National Registration will change how we practice if our service is in fact disbanded… or if we do lose our midwifery qualifications…” MCHA1

“… I think that our service will be severely compromised…” MCHC6
Interestingly though it became clear from the data that there were some MCH nurses who, recognised that some changes were inevitable. These changes, however, will not necessarily change how they themselves practice. In other words;

“… it will change how I practice by regulation… it won’t change how I have always personally chosen to practice…” MCHC12

In contrast, some MCH nurses indicated that they would only do what the service policy directed them to do. This was because there are different factors that impinge on what is involved with how they practice. Whether this meant that for some it was just a job or not was unclear;

“… the way I practice is governed by what the state decides I have to do in my work… you’re only funded for what they want you to do…” MCHC11

There were, however, a number of MCH nurses that felt so disfranchised about the potential future outcomes of the national changes, that they would not continue to work as a MCH nurse in the future;

“… it could determine whether I practice at all… I might decide that I will not continue if the role of MCH is significantly altered… it could have quite serious ramifications…”

MCHA12

“… if we lose Midwifery… I will probably go into forensics full-time as a result of that…”

MCHB6

‘competent and capable’

The first subcategory under ‘common standard’ is ‘competent and capable’. Part of the requirements of national registration is that each practitioner when re-registering each year declares they are competent to practice, otherwise termed as recency of practice. Recency of practice refers to practitioner being competent to work in a given area of practice. In order to achieve this, the practitioner must have maintained an adequate connection with the profession since gaining qualification, or the equivalent of three months full time within a five year period (AHPRA Annual Report, 2011). Unexpected results were noted from the question asked of the MCH nurses understanding of recency of practice. There were diverse responses regarding the
MCH nurses understanding of the meaning of recency of practice. The number of MCH nurses that had little knowledge, understanding or awareness of the significance of recency of practice compared to those that had adequate to in depth understanding was surprising. This was surprising considering some resemblance of recency of practice existed prior to national registration but was not such a formal requirement. The following demonstrates good understanding;

“… if you haven’t practiced within a certain period of time that you are not going to be able to maintain your registration…” MCHB3

“Recency of practice is when you sign up to say that you should keep your registration for the next 12 months… that you have actually been working as a Maternal and Child Health nurse…” MCHA2

“Recency of practice under the current registration requirement… I believe you have to prove and maintain a good database to demonstrate practice…” MCHC12

Despite the fact that national registration was implemented around four to six months prior to interviews, there were a number of MCH nurses that had no knowledge of the requirements of recency of practice. This is illustrated in the following;

“You got more information on that…” MCHB6

“No I am not familiar with that concept….the recency of practice…” MCHA3

“I’m not very clear on that… I have haven’t had to go into it…” MCHC11.

The second requirement of the national registration, is that MCH nurses have to undertake a certain amount of professional development) each year in order to re-register as a practicing nurse and midwife. The current requirement for registration is that a person who is both a registered nurse and a midwife must complete 20 hours of nursing and 20 hours of midwifery professional development per year. Importantly the professional development must be directly relevant to the nurse or midwife’s context of practice. The scope of application as stated by the NMBA (2010) for professional development is that when the education is related to both nursing and midwifery, the education can then be used for both fields of practice. Considering this is a substantial number of hours to achieve, the MCH nurses were asked at their interviews if they had any difficulties completing their professional development hours to meet the requirements for registration. The majority indicated;
“… it's not hard… we have great opportunity for professional development with our
council who really values it…” MCHC2

“… I think there's plenty of access these days... plenty of opportunities for accessing
hands on training… online courses that you can do and the requirement for continued
practice is certainly available through relieving positions in the rural areas…” MCHA6

“…there is so many conferences out there… in many different fields that could be
interesting…” MCHB8

The reasons why the MCH nurses believed that there was no difficulty in achieving the
professional development hours was that they felt supported by their respective organisations;

“… I think they do very well… listening to other councils and what they provide I think that
it is exceptional…” MCHB5

“… their always encouraging us to further the education… I think it is very much an
emphasis on education within the organisation in terms of meetings and conference
days…” MCHA3

“... you have the freedom to choose within the framework of what is funded…” MCHC12

In contrast to those MCH nurses that believed they had no difficulties with their
professional
development, however, there were some that expressed concerns related to the processes
required for professional development to be attended or organised, in some cases. The various
reasons are outlined in the following;

“… normally we can complete our professional development hours each year… living in
the country it's always an issue with travelling, the cost, the accommodation… it's far
more difficult for rural nurses than it is for their city counterparts…” MCHB7

“… it is difficult in our daily work practice schedule… it's virtually impossible… we haven't
got time… the hours in the day don't add up to being able to…”MCHC1

“… depending on where you work... you may not always have that time to allocate for
professional development…” MCHA4

An interesting side to this issue was the concern expressed by some MCH nurses regarding the
need to keep a record of their professional development attendance. In other words;
“...what bothers me about completing professional development is the fact that...many people are quite stressed and worried about whether they are going to be audited or not so yes I think it is a bit of an issue...” MCHA1

Despite a number of MCH nurses indicating that they were happy with the professional development that was being offered, there were some that expressed dissatisfaction. This referred to what was in fact actually being offered for professional development by their council or DEECD on certain allocated professional development days;

“...we don't always get professional development that relates to MCH...there are many topics that could be covered but are not...” MCHC10

“...it is a bit prescribed as to what DEECD wants us to learn...allowing us that bit more freedom...learning may be more fun and might be more stimulating for some people...” MCHA1

“...I don't think that all avenues are appropriate because it is more focused on education like school education...or preschool education rather than on the health side of it...” MCHB10

The following MCH nurse also agreed that the relevance of professional development should be a consideration when organising bodies were developing programs to ensure it was beneficial to all;

“...it's really difficult when you have been in the service for a long time because I have a good knowledge base...those professional development hours that are often provided are things that I have already done...you need something that's more refined...sustaining...higher impact giving more information...it should be geared to your level of knowledge rather than across the board...” MCHC11

Additionally when the MCH nurses were asked in their interviews if they believed that professional development hours should be increased to reflect their qualifications, a number stated that;

“...I'm not sure about increasing the hour but I think the quality of your learning should be reflecting what you learn...and where you work...” MCHA5

“Not necessarily increased just smartened up. I think the hours are fine, but again lots of our professional development is pretty third grade...” MCHB9
The majority of the MCH nurses stated that the hours were an adequate amount for professional development and should not be increased as illustrated;

“… I think they are adequate as they are…” MCHC10

“I don't think they need to be increased personally… I think we do a heap of personal study days already… we cover a large amount… the amount of e-mails that are sent to us to read is phenomenal… I think if you put too many hours of study in you are actually taking away from the service you are providing…” MCHB11

“… I think its ok although we tend to get more than what they say anyway…” MCHA8

Despite the majority of MCH nurses stating that they did not believe professional development hours should be increased there were a number that disagreed and indicated that the hours should in fact be increased. Alternatively, the MCH nurses expressed that there should be the opportunity for more hours if the MCH nurses wanted it;

“… the opportunity should be increased definitely especially within our role as Maternal and Child Health nurses… there is so much information that we need to be able to tap into… currently the hours that we are allocated really don't cover nearly what we are expected to do… you are constantly researching things that have come up…” MCHA1

“… anyone who thinks that they don't need professional development shouldn't be in the job because everything changes and there is always new research that we should listen to … there is always new developments… you would be a fool not to think that you can't learn more…” MCHC6

“…I would like to get more but it doesn't work that way…” MCHB8

These are interesting comments as there is no one stopping the MCH nurses undertaking more professional development hours if they wanted to. All they needed to do was to seek out other education opportunities. In other words the MCH stated that professional development was not just the responsibility of the employer to provide. It should be shared, as seen in the quote below;

“I believe that professional development should be 50/50… 50% on the employer and 50% on the practitioner… you can't expect professional development just to be handed to you…” MCHB5
‘losing our identity’

This was the second subcategory under ‘common standard’. There was a great deal of discussion from the MCH nurses regarding their knowledge, attitude, and beliefs about the loss of the MCH qualification notation and the threat to remove the midwifery qualification. What surprised many of the MCH nurses with the move to national registration was the failure to recognise MCH as an additional qualification.

The removal of the MCH speciality notation on their registration was seen as a significant loss and the perceived beginning of the required qualifications to potentially be reduced to practice as a MCH in Victoria. Their exasperation of what this meant to them and the belief of being let down was obvious, as was the strength of the emotion they felt about this;

“I am gutted by it... because I think it was a really important to qualify for... I don't think I could have done the job adequately without it...” MCHA3

“... the nurses themselves feel disenfranchised without their qualifications being noted on their registration...” MCHB3

“... under recognised and probably undervalued...” MCHC3

The big part of this exasperation was that the MCH nurses had undertaken a substantial amount of education in order to gain the qualifications to practice as an MCH nurse. This included nursing, midwifery and a minimum Graduate Diploma in Child and Family Health. The impact of this is clearly illustrated here;

“... it is quite sad actually because for people who have studied so long to get that status to think that it means nothing... I don't think it was a waste of time... I think it was absolutely vital...” MCHA4

“... we have lost the endorsement of MCH... it's General nursing, Midwifery and the MCH course we have done... they are all degrees at university... so therefore it should have been awarded on that principle... the fact that it hasn't been recognised or ratified is inconceivable...” MCHB10

“... they have not recognised the extra training and experience Victorian MCH nurses have...” MCHC8
Furthermore, it was not just about the extra study this involved. Taking this point further the MCH nurses commented on what was significantly more important to them, as can be seen in the following quote:

“… going to Uni to do the graduate diploma was a massive undertaking, emotionally, financially, time wise, travel wise… I did it, I conquered it… I was so proud of having done what I’d done and then they took it off my registration… it was quite disappointing…” MCHA7

“… we are sort of losing our identity almost… our experience and everything you worked for to get where you are is being take away… it doesn’t make sense… I don’t know who’s deciding on that…” MCHB2

What had contributed to the MCH nurses feeling exacerbated was the fact they believed that they had not been informed prior to implementation of what was going to happen. This was despite the fact that AHPRA had sent out information notifying them of what changes were happening. It was articulated by the MCH nurses that it was not clear in this information what the impact would be on the MCH workforce;

“… I think that they should have told us a long time ago that this was on the cards. I mean they may not have wasted our time doing a uni study and paying all that money…” MCHA2

“We weren’t informed about MCH not being recognised… we didn’t have any right of reply to that or any way to prevent that from occurring… it just happened overnight almost…” MCHC10

There was also a belief expressed through the data that there should have been more discussion with the MCH practitioners in Victoria in order to examine the options prior to implementation. This is another aspect that comes through strongly in the data that in fact this had not occurred adequately. Such was the angst of the MCH nurses regarding the national changes that they believed the end result had occurred from one of two possibilities;

“Pathetic, absent minded, ill informed… obviously they have never been to Victoria… they have never used our service and they have no idea what it is about…” MCHB6

“… what they were proposing was really a fait accompli… they really didn’t ask anyone in Victoria do you want this … it was like here it is and suck it up basically…” MCHA3
Furthermore, there was a feeling among the MCH nurses that other professionals would not be treated in such a manner;

“I see it as an insult professionally that MCH is not notated… You wouldn’t see teachers having their qualifications deleted… so why should this be deleted off our registration…” MCHB7

From the data the MCH nurses feared the impact of the loss of notation had far reaching implications beyond this. These implications then could be that;

“…it puts additional qualifications at risk and once you lower the standard… you also lower the value of the service and the nurses who work within that service… the MCH qualification was something that enhanced our role in the community and without it I think they may as well just employ a Div. 2 [Enrolled nurse] basically…” MCHA3

“It diminished what I had done… to me it leaves it open for just anyone to come in and say well you don’t require an endorsement to work… it minimises the work involved… we are not just general nurses… we are not just Midwives… We are more than that…” MCHB8

“… they have not recognised the extra training and experience Victorian MCH nurses have… it has been a requirement for their work… my concern is that if DEECD change their criteria then people without the qualifications that we have will be able to apply for our jobs and they will be inadequately trained to do the work…” MCHC8

As can be seen from these quotes, this study captured participants at a time when many were questioning their value and worth following the loss of speciality. The degree and depth of many of the MCH nurses feelings was obvious with these comments highlighting the significance of how the MCH nurses felt regarding the lack of recognition that resulted;

“…betrayed, angry and fearful I suppose of my employment opportunities…” MCHC11

“… horrified… I felt quite devalued and a bit like I have wasted my time…” MCHB1

“… it could be the thin end of the wedge… a change in nomenclature is a change of position and power…” MCHA12

The impact of the issue of loss of recognition of the additional qualification was a significant concern for the MCH nurses and more importantly, that the implications of this were not considered. This also alludes to the issue of disparity in jurisdictions;
“… it has caused a lot of disharmony… the qualifications standard that we have achieved for the role is fairly challenging… it is disappointing that other states are given the same title when they have to reach the same level of qualification… it reflects the amount of training that we have had for the role and the complex nature of the role really…” MCHB4

The degree of discussion in the transcripts around this angst is indicative of the level of concern expressed by the MCH nurses regarding the qualification disparity between jurisdictions and the impact this may have on the Victorian MCH nurses themselves;

“… there is a lot of inequality in the qualifications… from a minimum in some states to what we have in Victoria … that is quite a concern how we bring that together and maintain a high standard…” MCHC9

“… It’s in a bit of a mess… I didn’t agree to it when I first heard about it because of the discrepancies between all the States…” MCHB6

Despite identifying that there are disparities in qualifications between jurisdictions, when the MCH were asked specifically how familiar they were with the qualifications required in the other jurisdictions, the response was quite surprising. This indicated that the majority of MCH had limited understanding of other jurisdictions qualifications;

“No, not familiar…” MCHB5

“Not very… I really don’t know much about what is available…” MCHA8

“I have no knowledge of that at all…” MCHC10

There were, however, some MCH nurses who had a vague understanding of what qualifications were required in other jurisdictions;

“I know that they are not the same but besides that I know nothing…” MCHB11

“Not very familiar… my understanding is that they don’t need to have the same level of education as we do…” MCHA2

It was clear from the data, however, that this group of MCH nurses have some knowledge of what the requirements were in other jurisdictions. Firstly, that no other jurisdiction required a qualification in midwifery;

“… as far as I know no other state in Australia requires MCH nurses to be Midwives…” MCHB7
“I am aware that no other state requires midwifery…” MCHC7

The other area that the MCH nurses did have some knowledge about was the fact that all of the jurisdictions had different qualification requirements;

“… they are all very mixed… some states can do a health science degree… some a Community Health qualification… which bit are they going to take on working in the Community Health Section… which part of that holistic framework are they going to have to drop…” MCHB9

“…what’s offered seems to be quite variable all over the country… in the Northern Territory colleagues simply moved across into the role from being Midwives in the hospital without any further qualifications or training…” MCHA12

There were, however, some MCH nurses who had a limited understanding of what was happening across Australia in that they knew what was happening in one or two other jurisdictions. Certainly this was not comprehensive by any means;

“I am familiar with them… for example; In South Australia you only need to be a newly graduated general nurse… you require a 12 week course of study to practice as a child and family health nurse… that to me is totally inadequate… you are dealing with families with huge complex problems how can these nurses that have got such limited skills manage to deal with those issues…” MCHB3

“…in New South Wales you simply need to be a registered nurse and then you can do a Tresillian certificate or you can do a university Graduate Certificate… I’m not really sure about the other states…” MCHA1

“Reasonably familiar… I know in Western Australia they just do a bridging course for Midwifery and Victoria is the only one that needs Midwifery… I’m not sure about ACT… Tasmania just recently stopped it… Some of the other states encompass a wider age range… South Australia for example does Women’s Health, Women’s and Children’s Health and Tasmania does too… I know in Western Australia the Midwifery is a four-month Midwifery bridging course… I couldn’t tell you what their Child and Family Health Course is…” MCHC8

A number of MCH nurses acknowledged that their level of knowledge was limited but were, however, aware of the consequences to Victoria as a result of the disparity;
"I’m not very up with it... but I certainly have experienced the fall out of people coming from other states that take trips to relatives in Melbourne because they want to see a MCH nurse..." MCHC3

The real concern expressed by the MCH nurses from the data was that this disparity between jurisdictions had to be resolved somehow and how that would be undertaken was a concern. There was a belief that this discrepancy could be resolved in one of the two ways identified below;

“… if it is one qualification for all MCH nurses then depending on the qualifications of the other states they either have come up to Victoria’s level or Victoria has to dumb down to their level…” MCHB5

There were needless to say very strong opinions from the data that the former should be what resulted. The reason for this was identified in the following:

“… in an idealistic world the National Registration would mean that the highest denominator would be the one that everyone aspire to…” MCHB11

“Absolutely… they should come up to our standard not us lower to theirs…” MCHA2

“Yes I do… because I think that we obviously have the highest qualifications here and we should be aiming for the best not the least that's going to provide a better service for the whole of Australia... it would be lovely to be able to share that with other states…” MCHC9

The significance of what had been imposed on the Victorian MCH nurses with the loss of recognition of the additional qualifications, however, over shadowed any positive idealistic views of the future for these MCH nurses. There was a strong belief, therefore, that eventually the qualification would be reduced as indicated in the following;

“… National Registration will end up the lowest common denominator as far as qualifications are concerned…” MCHC2

“…my fear along with everyone else’s is that we will be undermined… because no one else is as qualified as us… there might be plenty of nurses who are as experienced and who actually have the knowledge… it is always going to go the lowest common denominator…” MCHB8
“… I think it's going to lower our standards dramatically… because we are the minority… I can't believe that it is going to happen…” MCHA11

The concern expressed by the MCH nurses in the data was what the impact of doing the above would have and why it was important to in fact do the opposite;

“… it's time to actually bring the qualifications levels up… once you lower them it is almost impossible to increase them again…” MCHB8

Such was the conviction of this group of MCH nurses that they expressed in the data that they would not let go without a fight;

“… if there was wind that the other states level of qualification is what the global level was going to be… then I would definitely argue against that… strongly argue against that…” MCHA9

One of the reasons why the MCH nurses so strongly supported the need for these qualifications was because these were believed to be imperative in order to provide the level of service that they did;

“Victoria has the best MCH service and delivery providers…” MCHC11

Following on then there was a belief expressed from the MCH nurses data that the loss of recognition of additional qualifications would, therefore, affect the level of service provided. This in turn would be detrimental to the quality of the Victorian service that they currently provided;

“… if the standard or qualifications were lowered it would have a huge impact on the service we provide… with our Midwifery and General training we have a good medical and maternal care background… that's who we are looking after not just babies… If you haven't got a healthy mother you don't have a healthy baby which impacts on the whole family…” MCHC9

In other words;

“… I do believe it's very much dumbing down of our service and it is very concerning especially as a new practitioner…” MCHA1

“… the way they are going they are going to desecrate our service… It's not only our service, it's our clients that are going to miss out… huge backward step… the other states need to get on-board with how good we are…” MCHB6

Chapter 5 – Maternal and Child Health Nurses Analysis
“...we’re being gradually grouped out or demoted... I believe the service will decrease in line with other states... the service will not be here as it is now in the next five years...”

MCHC11

As a consequence of all of the changes that were occurring, there was a strong opinion expressed by the MCH nurses in the data that this could result in attracting a different group of people to become MCH nurse to what it had in the past and not necessarily for the right reasons;

“...you might be looking at different sorts of people being attracted to the job... as it stands most MCH nurses have a deep passion of working with mothers, babies and families... as it changes a lot of the younger nurses will look at the ease of hours as they see it and not really focus on that holistic care of the families...” MCHA4

In other words, the MCH position had become increasingly attractive for a number of different reasons, partially identified above. This could be explained in part by the fact that maternity units had become so busy as a result of the increased birth rate and decrease in staff due to government cut backs. This then resulted in midwives leaving the hospital system to become MCH nurses and what they perceived to be a less demanding role. In addition, certain staffs were attracted to becoming a MCH because of the convenient hours of Monday to Friday, nine to five and not necessarily the profession per se. Consequently, becoming an MCH nurse had become a more attractive career pathway to younger MCH nurses with families who did not want to work rotation shifts;

“...there will be a lot of new people wanting to do MCH... because the hours are good... If you've got kids going to school it is very user-friendly for families so therefore you will get many more applicants but not necessarily with the knowledge...” MCHB9

The other aspect of the debate regarding the qualifications was whether the MCH nurses believed that midwifery should be a requirement to become an MCH nurse. This discussion followed on from the findings from the draft Productivity Commission report (2011a) which suggested that there was little evidence to support the need for midwifery. It was clear from the data that the MCH nurses strongly disagreed and very much supported the requirement to retain midwifery in order to fulfil part of the service they provided;

“...just looking at the draft report of the Productivity Commission which suggested that perhaps midwifery wasn’t necessary is a big concern... I think midwifery is a very..."
important component of our skill sets in terms of our practising and being a practising MCH nurse…” MCHB3

“Absolutely...you cannot do this job as a MCH nurse if you are not a Midwife... non-negotiable... half if not more of my daily practice is practising as a Midwife whilst working as a MCH nurse…” MCHA9

“Absolutely yes, yes, yes... I just can't think of a week that I have not used my Midwifery in practice in the last seven years that I have worked in this council…” MCHC3

The majority of MCH nurses believed in fact that the MCH qualification is an extension of midwifery and, therefore, are continuing the midwifery care into the community for the positive outcomes for the mothers. Many of the MCH nurses identified a number of reasons and rationales as to why the midwifery qualification was required for the services that they provided;

“...it is important... it's very hard to understand the full impact on families if you don't have a good understanding of what has happened to them antenatal, throughout the labour and in the early postpartum days... it helps the nurse to have credibility with that young family when they are first engaging in the service…” MCHA6

“...it is really important being able to relate to what’s happened to a woman during her birthing experience postpartum... to support her physically and emotionally after the birth... during the pregnancy some dramatic events can happen... so to have an understanding of that... supports a woman more…” MCHC11

“It's very important within the first seven days... often a woman having her first child hasn't a clue what's going on with her body and does need that little reminder that okay maybe this is not quite right we need to get this sorted out and we to do it now...” MCHB10

Not only did the MCH nurses believe that having midwifery was important for the first seven days of the postnatal period, but was also necessary beyond that period of time;

“Yes absolutely... the knowledge of the midwifery process and the birth makes it incredibly important in that first six weeks postnatal when people are going through huge changes and often post-traumatic stress from the delivery... we have to know and understand all principles of birth and the postnatal aspects…” MCHC6
An interesting side reason regarding the importance of having a midwifery qualification was identified by one MCH nurse who said that;

“… if I hadn’t been a Midwife and not able to read the notes… I picked up on the fact of probable retained products… I told her that if she was to start bleeding she must not think about anything else and just get an ambulance and that very night she did have a PPH at home and was rushed into the hospital… so from that point of view my extensive knowledge in Midwifery was put to good use…” MCHB9

Another reason identified by the MCH nurses from the data regarding the importance of having a midwifery qualification was in order to have knowledge and understanding of the impact of childbearing complications. This was becoming more vital due to the fact that the women appear to be increasingly experiencing complications during this period;

“Yes… I see it as mandatory…without the midwifery knowledge, the experiences of labour, childbirth and family dynamics, all the complications of obstetrical midwifery cannot be followed through to Maternal and Child Health…” MCHC1

“It’s essential for many reasons… I cannot understand how you could practice as a MCH nurse with no knowledge of Midwifery… we’re basically seeing pregnant women frequently throughout our daily practice… If you have no knowledge of the healthy pregnancy, the complicated pregnancy, the labour and delivery, premature babies, all the complications that can go with premature delivery… it would limit your practice enormously…” MCHB7

“… as Midwives we understand the vulnerability… how sometimes wonderful and sometimes distressing the labour and pregnancy can be… we have a very good understanding… it’s very reassuring for the mother to know that we do know…” MCHA10

Furthermore, a number of MCH nurses identified that their midwifery qualification was used and essential, therefore, for debriefing women at the home visit, especially if they had a traumatic birth or postnatal experience. The importance for women to debrief about these complications with someone who can have some level of empathy about what had occurred is clearly illustrated in the following quotes;

“You can debrief them easier because you know what happens in the labour ward and you know the things that might go wrong… you give them advice and the support they need post-natally…” MCHC8.
“... definitely... the fact that you have women who come to you talking about their experience in a midwifery hospital... her lack of support in the hospital... the fact that she had shoulder dystocia, the fact that she had a baby that was depressed at delivery... you have someone who has never done mid that cannot relate to that and sits there saying I can't talk to you about that... all I can talk to you about is quit and Peds safety and immunisation... the woman wants to talk about the experience that she had in the hospital... she doesn't want to talk about those things..." MCHB5

The importance of even just understanding the terminology used can be seen from this quote. MCH nurses are the first point of contact for a number of women following their delivery. The importance of having midwifery, therefore, is crucial for these practitioners. The MCH nurses, especially the rural and border nurses, believe their qualifications are essential as the demographics dictate the need for a broad skill set to cope with the demands and complexity that comes from living in rural areas;

“... we are one-stop shopping for families... rural areas do a lot more in universal which should be split up to enhance... we don't have the dollars... we don't have the support... we are jack of all trades here in the rural areas...” MCHB6

The ultimate reason as to why MCH nurses should have a midwifery qualification was identified from the data. This points to the great uncertainty that MCH nurses were feeling at the time the interviews were undertaken and is illustrated in the following;

“... I think it is very important given the uncertainty of MCH with what's being proposed with the National Framework. It is a real concern to me that we won't be employed in the same way that we are today... I just do not know what's going to happen so it is really important that I maintain my midwifery in case I need to leave and go back to the hospital to work... I don't really want to but... what choice have I got if it is not the sort of job that I want to be involved in...” MCHA1

Another aspect of the debate on midwifery is whether Bachelor of Midwifery graduates should be admitted into the MCH postgraduate programs. Some jurisdictions were in fact already admitting Bachelor of Midwifery graduates into their programs, which was creating pressure on Victoria to do the same. The prospects of a Bachelor of Midwifery qualification were put to the MCH nurses for reflection regarding the potential entry into the postgraduate MCH program The majority of
MCH nurses interviewed believed the Bachelor of Midwifery qualification was an inappropriate option as a pathway for the MCH profession, as can be seen in the comments below;

“No… if they’re not registered nurses…” MCHC10

“No to Bachelor of Midwifery … I don’t believe they have the basics that you get in those 3 years of General…” MCHA11

“No… I do not… I think that we need a very rounded education to become MCH nurses… a nursing education that means general nursing, midwifery and then qualifications in MCH... ” MCHB3

The MCH nurses stated in the data reasons why they believed the Bachelor of Midwifery was not the preferred pathway. This mainly included the fact that these graduates would not have the nursing background necessary;

“… they don’t have the general training… how are Midwives going to know about Pyloric stenosis and Perthes disease if they haven’t done general…” MCHC8

“… I don’t necessarily agree with Bachelor of Midwifery … I think that having foundation in general nursing as a background… I am concerned particularly with increasing older mums… mums delaying pregnancy and then having difficulties because there is underlying medical conditions… if you haven’t done your general nursing you have got very minimal knowledge and experience....” MCHB8

In contrast, there were some MCH nurses who believed that the Bachelor of Midwifery could in fact be an entry point for MCH nursing. This, however, was with some hesitancy but more because of the fact that they believed that midwifery, as opposed to nursing was an essential component;

“I don’t have a problem with that… the Midwifery qualification is probably the most relevant to the families at that stage the rest can be learnt over time…” MCHA6

“Yes I do… because I think midwifery as a basis is a very good starting position… you need something that has taught you how to be empathetic and sympathetic with the mothers and their babies… I don’t believe that general nursing as such is essential but I think midwifery is essential…” MCHB5
“If they had to have one or the other, I think it would have to be Midwifery… but to have General nursing practice just gives you so much more… people are much more competent to practice…” MCHC9

There were other MCH nurses who indicated that the Bachelor of Midwifery may be suitable but reflected that this would be a difficult pathway to enter the profession. This was because they would lack other necessary qualities gained through maturity and life experiences as a result of undertaking more education;

“… most of them are young girls coming out that have gone straight from high school into university and done the course that includes becoming a Midwife…” MCHA9

“Yes… I do think perhaps going straight from study and then into MCH without the experience of four or five years would be difficult… most of the nurses in our role are reasonably experienced with life… it is a totally different community nursing to working in the hospital… the hospital experience is essential for getting your skills, assessing people, assessing babies and talking to people…” MCHB4

Those MCH nurses who believed that graduates from Bachelor of Midwifery programs could be suitable commented that there would need to be adjustments made to the various programs accordingly though;

“I think Bachelor of Midwifery four years and 12 months MCH… I can see that working… if they know they are going to MCH bring in more of the childhood illnesses and diseases…” MCHB9

… for Bachelor of Midwifery … perhaps there needs to be some modifications of that course… it’s quite new and it is evolving… if you are going to look at them doing Maternal and Child Health qualification… you definite need to look at the program and elements that need to be included…” MCHA13

Part of the issue with the MCH nurses responses to this is thought to be a result of the general lack of understanding and knowledge that these practitioners had about the Bachelor of Midwifery curriculum. In other words, people do not know the amount of nursing and pathophysiology that the Bachelor of Midwifery curricula contains. This partly reflects the following quote;

“… I haven’t thought about that one…” MCHC11
‘future pathway’

The final subcategory under ‘common standard’ is ‘future pathways’. The future direction for the MCH nurses has been one of the other main concerns recognized by the majority of MCH nurses interviewed. This was partly due to the fact that they felt rather despondent about the loss of recognition they were experiencing. A number of opinions on what they believed the future direction for MCH nursing should be were identified. From the MCH nurses data it was obvious there was a small number that felt a degree of pessimism about the future and what direction the service should proceed with;

“… with the National Framework I don't know that there is one (a future)… I am not sure that there is one anymore…” MCHB1

“… it's looking pretty dicey…” MCHB9

In addition, there were a number of MCH nurses that expressed their opinions regarding the possibility of the service changing due to many factors, but were unsure how this in fact would happen;

“… I think the universal system will change… the days of people coming to visit us in an office are numbered… it will be directed more into the community… we will be looking at far more vulnerable families rather than the worried well… the work force is getting older and there’s not as many people coming in… we won’t have enough nurses to physically sit in centres either so something will have to change…” MCHB11

“… if we no longer are able to practice as MCH nurses because of the National Registration… we will probably go into a field of supervisory capacity which may be something like a nurse practitioner role overseeing other people who are less qualified…” MCHB10

The continued uncertainty about what the ultimate outcome would be, however, tended to dominate the responses, as illustrated in the following;

“… it depends on what happens… if we do adopt some sort of National Framework then we need to push to become nurse practitioners… maybe that’s the way we are only ever
going to hold on to our status of being highly qualified by going up the next rung of the ladder…” MCHA1

There were a number of other suggestions offered by the MCH nurses as to what direction they believed the MCH service could take. While the MCH nurses responses were mixed, they all indicated varying degrees of change associated with their future pathways;

“I would like to see it all at a Masters level and also perhaps even look into nurse practitioner…” MCHC7

“I would like to see midwifery as a definite pre-requisite… it gives you nurses who not only have done mid but it gives them that life experience… you cannot have someone coming into Maternal and Child Health whose 21 or 22 with no life experiences telling mothers basically how to look after their children…” MCHB5

I believe a future pathway is to make sure that we always have research to support the service… we would not be in this problem now if we had had the literature out there in the past that was research-based to support us to be able to challenge what National Registration is requiring…” MCHC12

Despite the uncertainty about the future, the majority of MCH nurses felt optimistic about what might occur. There were some MCH nurses, however, who just wanted to see the service remain the way it was and continue with the strengths that were already there not necessarily move in another direction. In other words, stay the same;

“I quite like the model that we are in now… the background in general nursing is certainly helpful… the qualification in Midwifery I think is vital in engaging with families and being able to work with them…” MCHA6

“I would like to see it continue as it was or has been the last 15 to 20 years with nurses who are practising with a lot of experience… when you’re dealing with families it’s really important to come from a background of experience not just a qualification… we need to considering the whole family including the male partner…” MCHC10

In contrast to the previous comments, the following MCH nurses believed that the service should in fact be more inclusive. This then brings another layer of complexity to the change platform;

“…education in counselling and those type of skills… given the complexity of the families and the communities that we’re dealing with now… it’s much broader than just
weighing and measuring the babies traditionally. We need to have a lot more knowledge around community health…” MCHA6

“… we need to get more proactive not reactive with our enhanced and young mum clients… get into the secondary schools… be seen to be educating these kids about with what we do… not all warm and fuzzy as they soon find out once they have had the baby… developing that reputation… like when you have a first-time mother that says we didn't know that you existed after making contact with them… we are not publicised enough for what we do…” MCHB6

There were a number of considerations identified by the MCH nurses as to why their role needed to be expanded. One of these was because of the increased complexities of families dynamics that would have to be incorporated into the service they provided;

“… our role has changed considerably in the last 10 years from simply paediatric measure and quote service to a baby education and information… more of a social worker, a psychologist, more of a family therapist, a nurse practitioner… we have numerous roles which are now incorporated into our limited timeframe… we have actually increased our skills and we need a solid knowledge base to do that adequately…” MCHC1

The majority of MCH nurses indicated in the data that the Nurse Practitioner role was in fact the pathway that would best situate the Victorian MCH nurses. This was because they believed they were autonomous practitioners already working in the role of Nurse Practitioner;

“Absolutely… because that is what we do now… we are independent practitioners who should be seen as professionals who provide a service… the fact that MCH is not being recognised with National Registration has decreased our professional integrity and standing…” MCHB5

“… we are basically doing it but without the recognition…” MCHC4.

“Absolutely… most of us would be happy to go or feel already really that we do have the qualifications to work as nurse practitioners especially those of us that have gone on and done Masters and gained those extra qualifications…” MCHA9.

In addition, the MCH nurses indicated in their interviews that they believed the level of service being given to the community by the MCH nurse should be recognised for the value it offers. They believed that becoming nurse practitioners would provide this recognition;
“... most nurses practice independently therefore they are entitled to have a nurse practitioner role…” MCHC5

“... be independent practitioner... we do have the right to be a practitioner…” MCHA5

The majority of MCH nurses, therefore, expressed in the data that Nurse practitioner was the direction they should proceed with in order to continue with the quality care already being provided in Victoria;

“... I believe that’s the way we will go as way of recognition... the need for our higher qualifications certainly should be revered... nurse practitioner is obviously the genuine pathway to take it to…” MCHC12

The following MCH nurse, however, was not sure if becoming a Nurse Practitioner was feasible for herself but believed that this was the possible direction MCH nursing would take;

“... maybe nurse practitioner... I don't know whether I want to be a nurse practitioner but I guess that's where it probably should go... I think our expertise is undervalued... I think there's a lot that we could be doing that we are not…” MCHA8

In contrast this particular MCH nurse expressed that she would in fact be interested in becoming a Nurse Practitioner but that this would only be under certain requirements. In other words;

“Yes... with the proviso that you are compensated accordingly..” MCHC4.

Interestingly, it became clear from the data that in fact the Nurse practitioner role in reality already exists, as stated by this MCH nurse;

“Yes... it's already in existence in some rural areas... I know of MCH nurses who are nurse practitioners... I don't think it'll take off in areas where you've got GPs available like in more urban areas but rural areas yes…” MCHB7

There were a number of advantages identified by the MCH nurses as to why the Nurse Practitioner role would be a preferred pathway. One of the reasons indicated in the data was that the Nurse Practitioner role would assist with reducing the workload on the primary health services especially in the rural and outback areas. This was for a number of reasons, as identified in the following;

“Yes... I think that could potentially happen... it could be good... it might give us a little bit more scope of practice and take the load off some of the general GP's…” MCHA2
“Yes obviously… absolutely… that would take a bit of the relief off the medical system because parents can’t get in to see doctors the same day so we could diagnose simple problems… it’s like all the other nurse practitioners, basic antibiotics… mothers with mastitis… all those sorts of things you could do it there and then… one-stop shop for the basic things that you see all the time…” MCHC11

“Yes… there is a big gap between the medical model and the nursing model… families especially in these rural communities are having trouble… it’s hard to access the medical system in the rural communities… there is a real role for nurse practitioners to be able to manage those clients and streamline the system…” MCHA6

In addition, there were a small number of MCH nurses that remained pessimistic of the future in regards to a move to the Nurse Practitioner role as seen below;

“… I can see that our vote is not going to count and it’s going to be overruled simply because it’s easier… most people take the easy path because they don’t like to do anything that is too hard… so yes we will probably, definitely be overruled…” MCHB10

Despite the positive responses of the MCH nurses in regards to the Nurse Practitioner being the role of choice, there remained a number that were still a little hesitant with looking at the possibilities of the role;

“Not if it isn’t free… people just won’t make that a priority unless they have a great understanding of what Maternal and Child Health actually does… the reality is it is a public service, it’s a free service, people who need it more than the affluent areas will miss out badly… the disparage between the rich and poor will grow… it will be more like working for the Department of Human Services in areas that are high needs… there is no way that people are going to worry about general health if they are worrying about putting food on their plates…” MCHC3

“… my idea of nurse practitioner has been more of a solitary workplace… I would worry that if there was that sort of structural change that the team work dynamics would change… there is so much in the different teams that is really important…” MCHC2
‘universal service’

This is the second category developed from the data analysis and includes the sub category of ‘integrated service model’. As previously mentioned, as a consequence of changes to national registration, there needed to be a reconceptualising of how the MCH service would operate nationally. The MCH nurses indicated in the data that Victoria could not see the need for the service to go national at some level. They were however, hesitant about the outcomes as a consequence of the disparity that currently existed between the jurisdictions regarding both services and qualifications of the providers. There were, therefore, a lot of provisos as far as the MCH nurses were concerned to the notion of the development of a national service framework;

“… if done properly having a level of education and infrastructure the same in every state does make sense… I strongly believe that it should be meeting and increasing requirements of the other states to meet Victoria’s… it should be bought up to the highest level possible…” MCHA9

“The Proposed National framework could be a good thing… I don’t think that it is necessarily a bad thing…” MCHB1

There were various reasons expressed in the MCH nurses data as to why they thought that the development of a national framework would be difficult to achieve, as illustrated in the following;

“… a huge heap of work for some committee somewhere… every state and territory will have their own framework at the moment… they are going to have to look at that and hopefully pull out the best from all of them and manage to make one that will be suitable Australia wide…” MCHB11

“I think for MCH it would be fairly complex and fairly broad… my concern is the services provided are very different in all the states… in Victoria we have legislated birth notifications which other states don’t have…” MCHC7
The development of a national service framework was in its emergent stage at the time the interviews were undertaken. Consequently, little was known by the MCH nurses regarding what would constitute a national framework. This was clearly illustrated in the data;

“It is very unclear… it really is very piecemeal… it’s not clear on what the framework is going to encompass…” MCHC12

“Everything is in transition as far as I’m concerned… I don’t know enough about it…” MCHC11

Needless to say, this contributed to a degree of confusion amongst the MCH nurses regarding their understanding of what the overarching service framework aimed to achieve. This varied from those that had a good understanding of the intention of the framework, for example;

“… be unified… all States to be the same…” MCHA5

“National Framework is around having… a similar framework for all the states in terms of the service that they offer…” MCHB3

“That’s a Federal Government initiative… the National Framework would be aiming to try to bring some uniformity amongst the services provided from the states and territories…” MCHC8

Then there were a number of the MCH nurses that had a limited understanding regarding the national framework, as illustrated;

“Not much… I have read a little bit but I am not up with it yet…” MCHA11

“I have heard the words but I am not entirely certain what they mean…” MCHB8

“… very little… but I assume it will make uniformity of practice between all states…” MCHC1

Not surprisingly from the data, there were MCH nurses that claimed to have had no knowledge of the national service framework whatsoever;

“I don’t know anything about a Proposed National Framework… I haven’t heard anything about it…” MCHC10

“I don’t know anything about it…” MCHC4
“… as a nurse working in the field… I really don't know that much about the National framework…” MCHC5

During the interviews, the MCH nurses were asked what they believed the most important aspects of a national framework would be. This resulted in a great deal of discussion, with many offering suggestions that needed to be considered for the development of the framework. This demonstrated that this group of MCH nurses did not really understand the concept of a national service framework;

“… that’s a tricky question… I guess it needs to cover all the Maternal and Child Health nurses… it needs to be the same for everybody… easy to understand…” MCHA4

“… it should reflect what we are and what our qualifications are… there was this mad rush for conformity… conformity is really important but they haven't stopped to really look at the big picture of what it takes to be what we are versus what they are allowing to happen in other states… this putting bums on seats, that’s how I see it for the other states with nursing… just because you have not got a Midwifery background it doesn’t matter if you've just got a piece of paper to say you’re a nurse you will do that’s their biggest mistake…” MCHB6

“… it should be universal across the board… be well resourced in every state… you could work in Victoria or you could go to Perth and have the same information at your fingertips to give out… and the same programs running everywhere… having said that I think in some areas there needs to be some flexibility with it too… all areas have different needs and there needs to be that ability to adapt to the local community…” MCHC9

The MCH nurses were, however, adamant that the national framework should look much like the service already provided in Victoria and this therefore should be the benchmark. The suggestions they made as to what should be in the national framework, therefore, reflected what already existed in the Victorian. This is not surprising, however, as it was obvious from the data that these MCH nurses knew little of what existed in other jurisdictions. It does, however, reflect their commitment to the services they provide;

“… should look much like it does at the moment… I think for MCH nurses… the key age and stage visits, the close monitoring of families and babies and children in the early years… because early intervention is a protective factor for children against later neglect
... so I think the framework should really build on what exists already in this state…”

MCHA12

“... to be the benchmark of Victoria being at the highest and having a base line of those other states to exist as they currently do with them being required over a period of time to raise their standards... the other states should be encouraged to put in a career pathway to replicate Victoria... another problem is inequities with state funding... Victoria is the only State that appears to have a clear framework of funding…” MCHC12.

“I imagined it to be a bit like a MCH framework where we have standards that we all have to maintain, education so that we are all on a similar level... so that if you are moving from state to state or place to place the work you are going to do will be similar to what you are already doing... other than that I don’t have any great insight into what that might mean…” MCHB1

The majority of MCH nurses indicated in the data what they believed needed be considered prior to the service framework being developed. This was in order that a thorough analysis of the services provided by the different jurisdictions across Australia was undertaken. These MCH nurses were, therefore, realistic about what the process should be and acknowledged that all jurisdictions services need to be evaluated in order to achieve the best outcome.;

“... it should be looking at the different services that are provided across nationally and how effective these services are... then going from there looking at the ones that are providing a very good effective service then perhaps looking towards modelling it on the education requirements after that…” MCHA13

“... what we need is to determine what it’s going to look like overall... look at everyone’s framework so that we can pick out the best of everyone... we should go to the best possible model for Australian families...” MCHB8

“... a National Framework needs to take into account the sort of people that are going to be providing the service and their qualifications, background and importantly experience in Nursing and Midwifery, both of which are really important to this service…” MCHC10
One of the issues that is highlighted in the data, however, is the disparity of qualifications across jurisdictions that had not been addressed prior to the implementation of national registration. On top of this then, they were trying to develop a national framework for service provision with such disparity. The MCH nurses indicated in the data that they believed that this disparity needed to be addressed first in order to achieve uniformity;

“… all the states should be the same… there is no point in having National Registration if everybody isn't practising the same… they have not thought it through enough…”

MCHB5

This is also evident from the quote below which illustrates the amount of confusion occurring because of the disparity in qualifications and services across jurisdictions. This then contributed to the ambivalence about the development of a national framework;

“I haven’t really thought about this… I don’t know… I don’t know how they can make it National… that is why I’m getting a bit confused about it… I don’t see how it would work the way it is now with people with different qualifications or not having the qualifications that we have… I don’t think it would…” MCHB2

On the whole, when asked if the proposed national framework would influence their current position, most MCH nurses were unsure. This could be attributed to the fact that little was known about what constituted the national framework. There needed to be more development of the framework first before they could express an opinion as to whether it would influence their current position or not;

“I have got no idea till we see what the National Framework is about... we need to have more information about where it’s coming from, what are the impetus for it and how it’s going to be implemented…” MCHC8

“That is an unusual question really… if the framework is based on what we are already using then no, but if it is something very different of course it would impact on my practice…” MCHB3

Despite this, it was evident from the data that some MCH nurses stated that they believed the development of a national framework may impact their current position. This was in part due to the disparity that currently existed between jurisdictions and that this disparity had to be reduced somehow;
“…Oh yes of course… because someone might decide that the qualifications can be changed… the pre-requisites can be altered and the role can be done by a less qualified person…” MCHA12

“Yes in capital letters… attending conferences in other states you hear what other people are doing…” MCHB6.

“I think it would have an impact… I am not sure how it’s really going to work… it could have an impact if funding is limited… that’s going to have a huge impact on the way we work and the way we provide for our families …” MCHC9

The real concern expressed throughout the MCH nurses interview data was that the service in Victoria may suffer as a result of the development of a national framework. This is illustrated in the following;

“… I believe there will be a real reduction in the amount of consultation time we have with clients… it’s going to mean that some of our high needs clients just completely miss out… they are not going to engage in a service that is prescriptive… who wants to come along and tick a few boxes…” MCHA1

In contrast, a number of MCH nurses were very unsure of the impact of the national service framework on their current position as practicing MCH nurses;

“I believe it could… lack of jobs… decreased hours because of decreased work requirements… I don’t know… I feel very unsure of the future…” MCHC11

“… I don’t think it will in the short term… I don’t know what will happen… yes perhaps in the future but I don’t think it will at this stage…” MCHA8

Another possible explanation for this uncertainty regarding the future relates to the newness of some practitioners to the service. The following quote comes from the group that has been practicing between 1 to 5 years;

“… I am so new to it I haven’t thought outside the box yet…” MCHA13

There were a number of the MCH nurses that stated in the data that they did not believe the proposed national framework would impact on the services they provided. This is partly explained by the security that they felt within their working environment;
“...I can't imagine it would really affect the way that I practice MCH... I think I will very much stay doing what I normally do...” MCHA3

“No... we feel well supported by the council and that our conditions will continue I hope...” MCHB4

“I can't see that happening... where I currently work no...” MCHC10

In addition the fact that the MCH nurses believed that the proposed national framework would not impact their service, could be partly explained by their naïve belief that their service was the best. Consequently believing the service would not be changed;

“No... because the way we are practising now I think is of a very high standard... it's very holistic...” MCHA10

Despite the fact of feeling secure in their current working environment, the MCH nurses were, however, realistic that future change was inevitable as a consequence of the proposed framework. In addition, it was obvious from the data that the MCH nurses were concerned regarding the significance of the impact to service provision in the future;

“... initially no... however long-term it may because of the proposed changes of not having Midwifery qualified MCH nurse... I don't essentially believe that it will affect my current position...” MCHA7

“... at the present it is not really affecting anything... in the future there will be huge ramifications... huge effects on what will happen within the workforce... I think we will have a work force of people with a lot less education and less qualifications... therefore you would have an inferior work force... I don't know that I would be happy practising like that... I can see a lot of us going out into private practice...” MCHB1

“No... but I have severe reservations for the future...” MCHC1.

On the other hand, however, there were a number of MCH nurses that expressed that they will always practice the same no matter what changes occur. It was, therefore, about how they practised and this then would not be influenced by any proposed national changes that might occur;
“… I don’t think it will at all because I do my job to the best of my ability… if things go down basically I think I probably will be retiring rather than being expected to do a lesser job… I don’t think I could ever do that…” MCHA11

“… in context to my work… my own knowledge base won’t change… I would continue to practice as I have done currently and in the past historically…” MCHC12

The MCH nurses were asked how they believed they could be better supported for a transition to a national framework. From the data the MCH nurses made a number of suggestions as to how they could be better supported for the transition. These varied from being optimistic regarding the framework to being totally pessimistic;

“I think information about the National Framework would be good and some discussion and debate about it… what it should include… and everyone have some input into it…” MCHC10

“… it certainly needs to come in over a longer period of time… more education about how that’s going to happen… not just be told this is what you are going to do from now… some follow up, to evaluate it…” MCHC9

“…I don’t think I could have been better supported… because basically… the National framework should not be encouraging a de-skilling of the workforce… It should be encouraging an up skilling…” MCHA3

There was, however, a level of uncertainty as to how they could be best supported because there was so much ambiguity regarding the constitution of the framework. From the data, it was obvious that the MCH nurses were overall pessimistic about the future of the service;

“… It depends on what they are going to do with us… we do need to know what their intentions are… I can’t see at the moment how we can make changes… I don’t see how the National Framework is going to allow us to keep our standards of practice at the moment the way they are… I just can’t see it…” MCHA11

“I really don’t know… if they are not going to dumb us down and they are going to wait for the oldies to retire then I guess the new people coming in won’t really know any different…” MCHB9
A subcategory under ‘universal service’ is ‘integrated service model’. The decision to move to a national platform by COAG identified a number of areas that required innovative change in the jurisdictions governance and service provision. It is believed for this to take place, communities and services must become better integrated in order to be a more inclusive community-based service, with a cohesive interdisciplinary approach. The suggestion, therefore, was the establishment of integrated services. As previously discussed in Chapter Four, an integrated service can be defined as the management and delivery of a variety of health services to ensure families receive a variety of anticipatory and therapeutic services, according to their health care needs in one facility (WHO 2007). A truly integrated service would be ideal for the MCH nurses to be situated in for referring families to other health practitioner within the service.

One of the questions asked of the MCH nurses during the interview was what their understanding of an integrated service model was. Here again their responses to this question were surprisingly varied. The majority had a reasonable understanding of what an integrated service was along with a comprehensive knowledge regarding what an integrated service comprises of and how it is situated within a community service. As can be seen from the following quotes;

“… a number of disciplines working with young families, babies and children…” MCHC9

“… an integrated service model would be with Doctors and Community Health, MCH nurses and midwifery working together to provide services for families…” MCHB3

“… an Integrated Service Model is as many services working under the same umbrella… under the same funding… I believe that there is a place for that if it is implemented properly… I don’t know how that would work in Maternal and Child Health nursing to be honest…” MCHA9.

There were, however, some MCH nurses who had limited understanding of what an integrated service was. Though as can be seen from the following quote, these MCH nurses had a vague notion of what this could be referring to;

“… it’s limited, however,… I do believe it to be having services that are easily accessible by families and it’s one stop shop…” MCHA7
In contrast, there were a group of MCH nurses that had no understanding at all as to what an integrated service was. As this was a beginning concept with not many established at the time of the interviews, this was not surprising. The concept of integrated services, however, was widely discussed in the health arena, including Federal and State politics at the time;

“I’m not really sure of the language of that…” MCHA13

“Don’t really know..” MCHC11

“No you will have to explain that one more…” MCHB6

This lack of understanding was further obvious from the MCH nurses data which indicated there were several MCH nurses who believed they already worked in an integrated service model;

“… we work in an integrated service now… we have our MCH nurse team, we have our enhanced team, our family support workers… we have access to a community health centre which has speech pathology and dental health… all the other aspects you need for children’s health but everything is fragmented… putting it all together would be the perfect solution…” MCHC6

This illustrates these MCH nurses have misinterpreted the meaning of integrated services. In other words interpreting integrated as being more than one MCH practitioner working together in one facility. Integrated service refers to a variety of health services being provided in one facility. For example: speech therapists, a General Practitioner or a chiropractor. Two possible reasons identified from the data illustrated why the MCH nurses believed an integrated service was in fact, a good idea were;

“… it would be a lot easier to have an Integrated Service Model with just one history… then all parties that have access to the mother-child dyad would have access to that history… so instead of mum telling the story 1 million times she tells it once… such a speech therapy, occupational therapy… so they know who’s doing what, where and how often..” MCHB10

“… different organisations to work together…” MCHA5

In addition integration is best seen as a continuum of services that organizations provide in order to equip communities with quality health services. The current challenge indicated by the MCH nurses, however, was what the integrated services were that needed to be delivered;
“… if it was truly integrated it would function like a Community Health Centre model where nurses and Allied Health Workers such as Physios, OTS, Speech Therapist work together co-located…” MCHA12

One MCH nurse indicated in her interview that she believed a sustained commitment from management and policy makers was required first in order for an integrated service to function. In other words;

“… lot of lip service is given to that but there’s not many integrated services around… it would be where there is more than one service working together seamlessly…” MCHB11

‘we do it well’

The third category extrapolated from the data is ‘we do it well’ and includes the subcategory ‘we sit in between both.’ The predominant belief among the MCH nurses was that the Victorian framework was operating very successfully and therefore should be considered in principle as the benchmark for the national framework. This was partially alluded to in the previous category;

“Absolutely… 110% non-negotiable” MCHA9

“Yes… I think most of us think that’s the highest standard across Australia and why would you settle for less than the best…” MCHB1

“… Victoria should be deemed the jewel in the crown of services… the rest should be trying to aspire to reach that…” MCHC12

It was clear from the MCH nurses data that it was not only Victoria that believed the service to be exemplary, as illustrated below;

“… they should certainly look at the Victorian model… it is a gold standard Australia wide and recognised worldwide… I have had that spoken about in England…” MCHB10

“… Yes I think so because… the Victorian services are looked upon as a model that has worked very well… I think that other states do look towards the Victorian services as a good model …” MCHA13
From the data it is clear that there is in fact evidence to support the claim that the MCH service in Victorian is exemplary. Over the years there have been a number of evaluations and reviews of the service have been undertaken as identified below;

“I believe we should be the aspired framework that other state should have at some point in the future… Victoria has had birthing reviews surveys… back in 1995 there was a birthing review across the State… the MCH rated the highest of client revered… their customer satisfaction surveys put MCH as one of the first on air as being the most supportive contact for them after the birth of their baby… It wasn’t the midwife in the hospital… there have been regular local government studies that have put MCH very highly revered in the local municipality…” MCHC12

There were a number of reasons why the service was identified by the MCH nurses as being worthy of forming the national framework. This was due to a number of factors that are identified below;

“Of course… it does offer the kinds of interventions that families need and require and those kinds of interventions where vulnerable families are identified early… I think it could be built to be even more expanded role for the vulnerable families… the core aspects of the work I think are strong…” MCHA12

“I certainly do… because it is very effective and we have universal enrolments, universal access, everybody is seen… Some of the other states don’t see the babies for several weeks after birth…” MCHC8.

“I like the way the system works in Victoria… I like what it does. I like the council provision of the service because it means that we are all singing from the same hymn sheet when it comes to the provision of service… with the current hierarchy I think it works…” MCHB8

In addition, the reason why the service was considered as exemplary, according to the MCH nurses data, was not just about the level of service that was provided. It was also about the level of qualification that the practitioners have who provide the service. The fact was also highlighted earlier in this chapter;

“Absolutely… I feel very strongly that the Victorian model should be adopted in principle… It’s superior because of the qualifications that our nurses have… they are essential qualifications that nurses need in working with families… Yes… MCH nurses
can do our job without general nursing and midwifery knowledge, however, they cannot practice as professionally or effectively and to the same standard as those of us who have got these qualifications…” MCHB7.

There was a major concern, however, expressed through the MCH nurse’s data regarding the disparity of services that existed at the time of the interviews between the jurisdictions. More importantly, the MCH nurses were cautious about how a common framework would be developed from this disparity;

“The disadvantage is that each state has got their own way of doing things and getting a consensus has been difficult… railroading us all into something that we are not happy with is not very good either…” MCHB4

The concern specifically was that the level of service in Victoria may be reduced as a consequence;

“Victoria, at this point in time, is probably able to provide the most comprehensive MCH service of all states in Australia… I think it would be unfortunate if Victoria was reduced to the level of service provided in other states…” MCHB3

“I feel that the level of care that we can offer here in Victoria, the global scope of our practice, covers the whole family, the mother, the child, the father and we have been trained in that way to be able to give the highest level of care possible… to have that reduced it just doesn't make sense…” MCHA9

On the other hand, the opposite could happen. In other words, the services in the other jurisdictions would be reflected more on what Victoria offered. The MCH nurses then believed, that this would be a positive outcome;

“Yes… I think it would be good to see that… it would improve what’s happening in the other states…” MCHB2

“… I think it would be valuable to bring people in other states up to the standard that we have… when you weigh up the health benefits overall surely the saving to the community must be huge…” MCHC9

“… and ideally if they could lift the other states up to what we have… I think we might have left our run a bit late…” MCHA8
It was evident from the data, however, that having all jurisdictions with the same services as Victoria is not necessarily a good idea. The problem with this outcome was that the service could cost more and as a result not be all encompassing of the best practice model. The other issue here is the disparity in qualifications that would need to be made the same as Victoria first;

“Yes I do… from what I have seen of the other states our service runs much more smoothly… It probably cost more to run but we support our families well… we are looking after a whole family not just a baby so why settle for less than the best…” MCHC9

It can be surmised from the above statements that the MCH nurses believed that the Victorian model of service was exemplary. The MCH nurses were, therefore, asked whether the national framework should be modelled on the Victorian service. Surprisingly the MCH nurses indicated that this would be in principle a positive move, however, with some provisos, as illustrated;

“... I think it will be a good idea in principle... personally I am not sure about the Key Ages and Stages framework ...” MCHA1

“I am probably biased because I'm working in Victoria and think that it is the best service... until you actually know what the other states have got to offer you can't really say that...” MCHC5

Part of the reason for their hesitancy in recommending the Victorian model be adopted in principle across Australia, was related to them not knowing what other jurisdictions offered. This response was realistic in that they first required all the pertinent information on which to base such a decision. Support for this can be seen below;

“Hard to say... I haven't got enough information about the other services but from the little reading that I have done I think that the Victorian Maternal and Child Health system seems to have a few advantages...” MCHA6

“I would have to say yes and no... what we do is incredibly good... but on the other hand I cannot compare it to what other states do because I have no comparison... take the best of both and take away the worst... National can therefore be of benefit because it is streamlined...” MCHB5

“...I think so... I would assume most states would want to know where we are at and what we are doing that way you come from a less biased opinion and all share knowledge of what we do better and what they do, then put that all together...” MCHC9
Taking this point further then, the MCH nurses were asked whether they knew what existed elsewhere. Surprising results emanated from the MCH nurses responses when asked how familiar they were with the services the other jurisdictions offered compared to the services provided in Victoria. It was evident from the data that the MCH nurses only had vague knowledge of what other jurisdictions offered and much of this was only antidotely;

“… I know that their services are not nearly as comprehensive as what we offer here… It is a huge problem… in New South Wales they have huge numbers of families that very rarely get to be seen before eight weeks of age… nurses up in Queensland were so… disappointed and frustrated with the support that they have been given both financially and professionally… unfortunately many of the families don't realise how useful a good Child and Family Health service would be because they have never had access to one…” MCHB3

“Fairly broad knowledge… I'm aware of course that there is no birth notification… they don't all have home visits… I am aware that there is no 24-hour MCH line service in other states although they have different telephone services but they operate out of early parenting services…” MCHC7

“My awareness is through people that I know who live in other states or who have worked in other states and also clients that come to the service who have been living interstate… the clients say that the service in Victoria is very good… they talk about the service that was quite sort of patchy where they were living and that it wasn't as thorough and as inclusive…” MCHA13

About the only fact the MCH nurses knew for certain was that the services were in fact different on many levels. In other words;

“I think the services are variable and there is no uniformity in the other states…” MCHA12

“Only recently I realised that it is quite different… I am surprised that they don't have everything a bit more organised rather than just rocking up somewhere and anyone seeing you…” MCHB4

Then there were those that were not familiar with the services that other jurisdictions provided at all;
“... probably not very familiar because I have never worked in another State only what I have read and they are similar but not the same...” MCHB1

“... I am not really that familiar...” MCHA7

“... I really don't understand a lot about what they do...” MCHC2

‘we sit in between both’

Under the category ‘we do it well’ is the subcategory ‘we sit in between both’. The MCH service had previously been situated in a number of Victorian government portfolios. With their move from Health to the Education portfolio in August 2007, the MCH service was then the only jurisdiction in Australia to have MCH services in the education portfolio. As a result of the move to the education portfolio, the Victorian MCH service has been seen to develop more of strength based research practice model. This belief, however, has not transpired in the data across the precipice between what is thought to be a health model in an education field by a number of MCH nurses.

The question the MCH nurses were asked in their interviews to elicit these responses was related to, whether they believed the MCH service should be in the education or health portfolio. A number of strong views were drawn from the data representing the views of the MCH nurses. Overall the facts in the data indicated that the MCH nurses were divided on where they believed the service should be located. There were a number of MCH that were adamant the service should return to the health portfolio for a number of reasons, as identified in the following quotes;

“I would like them back in the Health Portfolio... we get more recognition for what we do in the Health Portfolio... it is a community health-based program... I feel that our professional development is more appropriate to belong to a health based program... It doesn't mean that I don't think we could be linked to Education... I actually think it worked better when we were under the Health Portfolio...” MCHB3

“Health... we deal with the physical and mental health primarily of mothers and infants... while education is a big component of our workload I see that we are more providing education... to obtain healthy outcomes...” MCHC1
“… it should be in the Health Portfolio... because that is what we are all about... we are all about health... yes we do educate but we educate them on their health...” MCHA11

This last quote articulates why there was such a dilemma expressed by the MCH nurses as to which portfolio should be accountable for the service. Support for the health portfolio was acknowledged by other MCH nurses who identified why education was an inappropriate portfolio for the MCH service and, therefore, why health was more appropriate;

“... I don't think they have quite known what to do with us in Education... we are this funny little group that doesn't quite fit in... we fit under Health better than Education... I think it has taken a bit of the emphasis away from certain areas that are more health orientated...” MCHA8

Likewise, other MCH nurses supported that the service being in the health portfolio but for different reasons to that identified above. The MCH nurses were definite in what their position was as a health professional and that, therefore, this should be the basis on which to make the decision as to which portfolio the service be situated in;

“... we are health professionals providing a service that looks at the health and well-being of the mother, the baby and the family... I'm not a teacher... I'm a health professional...” MCHB5

“... if I wanted to be a teacher I would be a teacher... I am a nurse I belong where health belongs... the education department... we just don't fit there... we are like a round peg in a square hole...” MCHB6

Nevertheless, the education portfolio was supported by a number of MCH in the data who strongly believed this was the best position the service should be in. A number of reasons supported the argument with these convictions;

“... I like that it's in education... it's saying that this is the beginning of this child's foundations for their educational career... at the same time there has got to be the health element there because we are looking at typically developing behaviour...” MCHC2

“... we are primarily involved with the development of that child... in essence making sure that the child is prepared to enter the education system and that really depends a lot on the overall general health and well-being of the family unit...” MCHA3
Similarly the following MCH nurses believed the education portfolio was a political safety net because of the relative government spending on education that resulted compared to the uncertainty of funding for the health portfolio:

“… a tricky one... I think it is correct in the Education Portfolio because politically it is under less attack from politicians who always want to slash that health budget and who are less likely to want to destroy the service in the Education Portfolio because of the value of the undisputed value of the early years…” MCHA12.

Not only was the MCH nurses preference for education portfolio based on funding but also on the level of support provided to the service as illustrated;

“… we do mostly Education and we have been fairly well supported by DEECD since we have changed over… I wouldn't want to rush back into health…” MCHB4

Being under the education portfolio, however, was of little consequence to other MCH nurses. To some MCH nurses it did not matter which portfolio the service was situated in. Instead it was more important that the service was valued for its contribution to the community in which ever portfolio it was situated;

“… I haven't had any problems with it moving over to the DEECD...It doesn't matter... as long as it is well respected in whichever department it is that's okay…” MCHC8

“… I don't really have a preference... I guess for me it's now in the Education... I am a bit wary about having it in health... It may not get the recognition it deserves in health…” MCHA13

There were a number of MCH nurses, however, who were uncertain as to which portfolio the service should be situated. In addition, they perceived it to be a difficult decision to make as to where to position the service and were noticeably non-committal;

“I sit on the fence with this one because... Health is about education…”MCHA1

“I actually sit on the fence with that one... philosophically I believe there is a lot of education with Maternal and Child Health…” MCHC3

“It is an interesting blend... I was really quite startled when we did change portfolios... but I think there is value in both... Politicians answer…” MCHB8
In contrast, there were some MCH nurses who believed that it did not make any difference as to where the service was situated. There was a degree of frustration expressed by these MCH nurses regarding the lack of marketing of the service, which they perceived as being more important;

“... we have been with Education now, for nearly 3 years, and we have made very slow inroads... to be honest I don't think it matters where we sit... we could fit in both quite nicely... health does miss out in education... I think that it's more about building up our profile of what MCH nursing is all about...” MCHC7

Surprisingly not all MCH nurses had a clear understanding of the meaning of portfolio. This is evidenced by the following quote which is alternating from one to the other as she attempted to answer the question;

“Education... because I am not sure what health portfolio means... probably Health Portfolio change that... not Education because we are part of Health... Health promotion, health education...” MCHA2

Despite there being a number of MCH nurses that believed that the service should be either in the health or education portfolio, there were a number of MCH nurses that indicated that they would like to have the service remodelled into an amalgam of both portfolios or in fact a separate portfolio altogether. In other words, as indicated with these comments;

“... we sit in between both... we don't really sit it ether camp very well... we work with the well not the unwell... we also do anticipatory guidance... really we have a foot in both camps so where ever we sit it's not ideal and we always want to be in the other camp...” MCHB11

“... both... because I feel that we do both... we play a very big part in education and we are also a good advocate for health...” MCHA10

“I think it is a bit of both... but Health is more important for our role...” MCHC4.

‘imposed from above’
The final category of data presented in this chapter is ‘imposed from above’ which has one subcategory ‘change is inevitable’. The MCH nurses have experienced a considerable amount of change over the past years prior to and post introduction of the national registration by AHPRA and the respective boards. As previously identified in the data by the MCH nurses, the change to a national registration meant that there would need to be a reconceptualising of how the MCH service framework would operate nationally. It was clear from the data that the MCH nurses strongly believed that these changes were imposed on them and that others were in fact making decisions on how the service should function. In other words, top down change directives which rarely elicit long term success. As indicated;

“… governments bring in these ideas… they rush them through without much thought for the people that are implementing them or bringing them out… who in turn don’t really understand them… so how can they then pass it on down the chain… by the time it gets to us at the bottom it’s a nightmare because nobody has understood it properly… the instructions are so muddled that it makes it virtually impossible to implement something new… the majority of people give it lip service and then they continue to do what they have always done… it is so confusing…” MCHB1

What this quote also highlights is the strong need for involvement from the grassroots’ practitioners when planning the changes. This is in order to ensure all aspects of change are investigated to guarantee specifically a workable service framework thus reducing barriers to implementation of best practice at the coal face. A further reason identified from the data is illustrated in the following;

“Unfortunately it has been my experience that decisions made without actually consulting with practitioners… come up with a framework that is not going to work at a clinical level… such a waste of resources and time that creates enormous frustration for the MCH nurses who are actually trying to put the framework into practice… either they don’t use it at all or they use it badly because it doesn’t work in their practice…” MCHB3

The majority of MCH nurses in the data stated that they believed the most important aspects of organisational change were ensuring a culture of collaboration. This is where the fear and uncertainty of the unknown aspects of change are acknowledged and worked through with a collaborative process. They further stated that this should include the importance of a positive
culture behind both the barriers and the enablers for successful change initiatives in order to proceed. This then takes time but is important for success;

“… it has to be a gradual process… a slow process… informed… everyone needs to know what’s going on and when it is going to happen and why it needs to happen…” MCHA 2

“… making sure that people are aware of what’s going on… why there is change and of what the change is going to mean for them… allowing people time to understand the change and to ask questions… to feel comfortable with that… change should never be done in a hurry… it should be a process that takes time and gives people time to move with it rather than to be carried along…” MCHB1

In addition, the MCH nurses also stated that they believed it was important to take the time to consult with the workforce about what the change initiatives could look like and how the change was going to be implemented. In other words, keeping everyone informed each step of the way. The MCH nurses further highlighted in the data that they believed the consumers of the services were also a major consideration for the future direction of services and should be involved in the consultation process. There was no evidence at the time that this had happened. The majority of MCH nurses stated in the data that they strongly believed that imposing any decisions of change on people without due consultation generally elicits a negative response. A collaborative culture in an organization, however, indicates the trust the people have in that organisations ability to implement increasingly more complicated and important change initiatives in the future;

“… there needs to be wide spread consultation… staff need to be involved… there needs to be an investment from management in allowing the staff to own the change so it’s not top down driven… change has to be sold on the positive… it cannot be imposed it has to be through consultation… looking at what the community needs not just changing the service… it has to be well thought out…” MCHB11

“… people must be involved in the process of change and have input… an assessment of the benefits, as well as the disadvantages, there has to be consensus…” MCHC1

More importantly consultation with the workforce helps gain information about how the services work and could elicit ideas about how this could change. Specifically, there was a need for a process of consultation between the workforce and the Productivity Commission review panel prior to the implementation of national service framework;
“... more consulting with us... we have had no consultation group... they haven't even bothered to do their ground work and actually ask us what our thoughts and ideas are... what suggestions we can make...” MCHB6

“It would be nice if they had interviewed us like this beforehand or maybe focus groups with the MCH nurses to see what they thought of it ahead of time... if there were some way we could have some input on what was happening... and if there was another way about it...” MCHB2

“There should have been workshops, more printed information... it has been clandestine in its operation and the way it has been carried out...” MCHC1

This was supported by other MCH nurses who reflected that they should have been better informed and involved in the decision making about the change they were part of. MCH nurses identified that this should have been a major priority in the process of the reform, not to just be told this is how it is almost after the event;

“... I think we should have been involved more in how it was going to play out even before it got to that point with a bit of input from us because honestly...” MCHA11

“... talk to us... let us have a right to respond to what's actually going on...” MCHB6

“... I believe as a body of existing MCH nurses that this should have been discussed... you cannot nationalise something that has no uniformity unless there is a lot of discussion taking place at levels beyond... what has happened in my opinion it has not been sufficient...” MCHC12

Being part of the consultation process also had other benefits, as identified in the following. This further emphasises the importance of the consultation process;

“Involving the people from the beginning in the change... it shows respect... a feeling of being involved not leaving it to the last minute to tell them... there needs to be an atmosphere where people feel open to speaking about things and not being told or dictated to...” MCHC5

“... preparation, discussion, brainstorming... time to debrief and adjust... meetings to make sure that everyone’s on board... get everyone thinking on the same tune... respect individuals to that are working for you...” MCHA4
In defence of this lack of consultation, however, it was identified by one MCH nurses that it was more complicated than that and that they should take some responsibility for their own inactivity. In other words;

“… nurses are notoriously bad at actually galvanising themselves into action and I feel that perhaps we allowed them to sneak up on us and it sort of just got railroaded through…” MCHB11

As a result of the lack of consultation, it was obvious from the data that the MCH nurses felt totally disenfranchised from the whole process and consequently felt despondent by the end result;

“… we were blindsided… the decisions were made for us… it was just implemented… they could have possibly sent a questionnaire around… if they cared about what our thoughts and what we had to offer… make us feel like we were part of the change…” MCHA9

“… contributes to feeling incredibly undervalued when you are not asked for your opinion on something that is so important to the actual people at the coal face…” MCHC3

Another important aspect of the consultation process is creating the opportunity to identify how to improve their ability to change by providing the necessary education. This was thought to then increase the chances of success. In other words, a new policy direction would require pre education prior to implementation of the new policy;

“… if you are not part of the change and you are not kept up to date… not given enough information on the research then you’re left questioning change… there has to be a lot of support… when there is change the educational programs have to be timely with that change… it’s no use implementing the new change and up skilling your work base and then six months later the changes come in…” MCHC11

“… you have to be flexible… I don’t have a problem with change as long as we get enough training in the change or advice on the change…” MCHA11

An additional reason why consultation was identified as such an important component of the change process was that it provided an avenue for disseminating information. This dissemination of information was another part of this change process that many MCH nurses felt was lacking. As such the MCH nurses believed that all communiqué should have occurred at different levels.
through meetings. There were a number of suggestions made as to how this dissemination of information could have been done;

“… it could have been on the agenda at MCH meetings whether they were local or regional or state wide… knowledge is power as they say…” MCHC5

“… someone to actually tell us what the framework is going to be would be a good start… consultation with people within the areas…” MCHB1

“… I think it has to be transparent, clarity and in a timely manner… more educational support in different various levels rather than just one-off… workshops need to be a continue follow-on… there needs to be more consultation…” MCHA5

Furthermore, the MCH nurses believed that the communications should be timely, authentic, and credible. The need for constant updates was further highlighted as a must as this was thought to encourage an invested interest, foster acceptance and reduce the insecurity often perceived when people believe they have lost control over their territory;

“… we have our state conferences twice a year… no one talks about these things… you have got everyone from the state there… that’s a perfect opportunity… It doesn’t have to be fragmented… that’s always a difficulty with anything new if people aren’t getting adequate information then there’s a level of insecurity… then you get rumours and you are left less optimistic than others…” MCHC11

“… they would need to put the framework in very clear literature that people can understand…” MCHC12 and with a degree of “Consultation and Transparency…” MCHB8

“Communication… explanation… forums for discussion… the exercise of democracy so nurses need to be able to give an account and advocate for themselves…” MCHA12

In addition, the MCH nurses believed that candid, open discussion is fundamental to change, as it assists with the breaking down of barriers and reduces resistance. Without these influential conversations, the workforce often stays trapped in their current belief systems, unable to find new or different ways of promoting and achieving change;

“… formal discussions prior to them rolling it out… getting everyone on board… what they’re thinking… their rationales for making the changes… everyone feels a lot more
relaxed and reassured when they know that something is going to happen... they can prepare themselves for it...” MCHA4

The reasons why the dissemination of information is so important for the change process was clearly articulated in the following;

“… keep us all informed... keep us in the loop… there needs to be some timely consultations not just sprung upon us… set timeframes between aspects of change being introduced…” MCHA1

“… make sure everyone is on the same page... be informed about a proposed change and have the ability to have input if it is going to independently or individually affect them to then deal with it…” MCHC12

Despite the fact information had been disseminated prior to the national registration being implemented, it became obvious from the data that the MCH nurses believed that the information dissemination was neither sufficient nor timely. Though interestingly there was admission that it was the nurses fault to some extent;

“… we could have been given a lot more information and prior knowledge of the changes… the benefits were never spelt out to the nurses as to why this was a more suitable way to go... the introduction was very poorly planned... It just felt like a rushed process without any time for us to have thought or input…” MCHC1

“I knew nothing about it other than when AHPRA became our National Registration and that’s probably a bit my fault too… but I don’t think enough information was out there… I think it was kept secretive...” MCHA11

“I think advertising should have been a lot greater... so that all nurses being affected are going to be aware of what is happening and have a voice…” MCHB10

Admission to being their own fault was also expressed by other MCH nurses but for different reasons. There was, however, other MCH nurses who believed that information had been disseminated but they had difficulty comprehending exactly what was happening. This MCH nurse suggested some strategies as to how this information dissemination could have been undertaken;

“... more transparency... It could just be that I have not paid attention... the information we have received has been all in gobbledygook jargon which doesn't make any sense...
the information needs to be presented simply, frequently in a much more consultative fashion. So that we have got the opportunities to feedback to a person not just an e-mail address…” MCHB8

More to the point, a number of MCH nurses believed that there should have been greater dissemination of information from various organisations including the Nurses Board of Victoria. In addition the MCH nurses indicated that the Australian Nursing Federation (ANF) could have played a more proactive role in the initial discussions that occurred around the feasibility of the changes;

“… I was very disappointed in The Nurses Board Victoria… they sent out very little information about what was going on…. they quite happily took your money… your registration card had your other qualifications noted, but when it comes to National Registration nothing recognised… crazy… the ANF as a union didn’t push hard enough either to make sure that nurses with other qualifications were represented…” MCHB5

Overwhelmingly, however, the MCH nurses reflected that the change to national registration had almost happened over night and that there could have been more done to prepare them for the changes. Such as;

“… I feel that there wasn’t enough education…. it was like a bit of a surprise just as the National Registration started…” MCHA8

Furthermore the MCH nurses indicated that they believed it to be imperative that any Victorian leadership champions effectively represent them in the national political arena. This was thought to be particularly leaders that clearly understand the functionality that was required in order to move forward. In other words, have leadership and be an effective guiding coalition in any discussions working through the change processes;

“… I would like to see the main key stakeholders work together… by that I mean DEECD, MAV and VAMCHN to hopefully join in and lead the way…” MCHC7

“… having our co-ordinator have a presence in the decision making…” MCHA7

“… you need to get a large number of stakeholders together to work out what is the best option for the clients… you can’t have people making rules for everybody if they don’t know what people want…” MCHB5
Throughout the MCH nurses data there had been a positive atmosphere expressed regarding change, albeit they had recognised and acknowledged the disadvantages as well. The MCH nurses continually noted that there needed to be support and nurturing of good leadership along with the right resources in order to act. More significantly, they believed it was essential to get the right people driving the change management;

“… a lot of disadvantages are in the management of the change…” MCHC5.

‘change is inevitable’

The subcategory of the data under the category ‘imposed from above’ is ‘change is inevitable’. These MCH nurses were undergoing a good deal of change with National Registration and the probable development of a new service framework around the time of their interviews. The MCH nurses were therefore asked during the interviews how they felt about change per se. Their responses to the question offered an unforeseen result. This was because the number of MCH nurses who openly stated they had difficulty with change was a relatively small number;

“… I am terrible with change… If I feel supported in change I certainly manage it okay… I do get quite anxious about it… I tend to give 110% to something when I feel comfortable doing it… if things change sometimes it is hard to embrace change… I don’t see it as being a negative… I see it as being a positive… I’m not saying I don’t do change… when I believe that it is necessary change I do…” MCHA9

“I have gone through a lot of change and I haven’t always felt comfortable with that but I am still here…” MCHC5.

In contrast, the MCH nurses that responded in the affirmative of feeling comfortable with change offered surprising insight into change and how they perceived change. Evidence of this is offered in the following quotes;

“I do… change is inevitable… I don't necessarily see change as a bad thing… people go to a lot of thought before they put change in…” MCHC6

“… Yes sure… change is a time for you to step back a bit and look at what you are doing currently… if there’s anything you can be doing better… that's a bonus…” MCHA4
“... I welcome change because change can usually improve situations... I am willing to give things a go but if I find that I don’t like them then I like to let people know...” MCHB10

There were a number of MCH nurses that indicated in the data that they had no difficulties with change. They also include a ‘but’ into their scenarios which could be interpreted as having some degree of hesitation to moving out of their comfort zones completely. In other words;

“... change is always difficult... It’s having an awareness that change is difficult... but you have to embrace change... that can be a new learning curve for your own self... there are other ways of doing things so... change is good...” MCHC11

“Yes... I think change is a good thing... but I don’t think it’s good to be always doing the same thing all the time... but change should be for the better not for the detriment of the service...” MCHA1

“Yes... we have had so much of it... in the past we have seen change for the sake of change and in the end we have ended up reinventing the wheel and eventually we ended back at square one with a lot of pain and discomfort in between... but the world is changing so we need to be flexible and move with that otherwise you’re just going to be left behind...” MCHC9

In addition, there were a number of MCH nurses that replied that they had no difficulties with change but it depended on what the change was. Many of the reasons voiced by the MCH were valid and offered another layer to the change platform;

“... it depends what the change is... If I think that change has got good outcomes and it’s warranted yes... but if change has been made without consultation and not a good reason... no I’m not comfortable with that...” MCHB3

“I am quite happy with change if I could see an advantage in it...” MCHC8

“... it depends on what sort of change you are talking about... If we were talking about change in the National Registration to a lesser qualification then I cannot see a positive to that... if you see the change as being the other states meeting the requirements of the Victorian level of education then absolutely for the whole of Australia that could be a positive...” MCHA9
The majority of MCH nurses indicated that they believed the advantages of change depended on whether the change was internally or externally generated. They also admitted that while some change was inevitable, it was important to take positive steps to reduce the impact of change agendas by building the knowledge base of people in understanding the correct change process. Furthermore, the MCH nurses believed that effective and efficient change management can support a smooth transition from the old to the new process. This in turn creates the correct perceptions of change for staff and the public. In other words;

“… you may not necessarily see the advantage of change… change isn’t always positive… when positive change suits both the service provider as well as the client then it could be positive… when it is driven by a hidden agenda to justify someone else’s outcome then it is not necessarily positive… unfortunately in any state there is not enough research to support the running of programs that are piloted in name only… they are never reviewed so evaluation of change needs to be really credible…” MCHC12

“… over the years there’s lots of research and studies done so you would hope that change would evolve from the research… that change would benefit MCH families and improved outcomes…” MCHB7

“… that you have explored what is out there… you are open to new suggestions and new ways of doing things and that you are making the process a better process in the end…” MCHA6

These particular MCH nurses believed change was in fact valuable in enabling practitioners to further increase their potential and offer opportunities for self-development. This was also thought to include creating ‘best practices’ models in change. The following comments add to the previous comment by indicating the importance of having the ability to step outside a comfort zone. In addition, it is important to experience different behaviours to prevent practitioners from becoming too comfortable in their ways and therefore stop seeking new and alternative ways to achieve new outcomes;

“… you are never too old to learn… I think by change you can open yourself and embrace the possibilities of what might be and then with knowledge you can make an informed choice…” MCHA7
“... change helps you to be fresh... to develop yourself more... your skills... rather than sitting back and relying on what you've already done...” MCHB1

“It is always comfortable not to change... being comfortable is not necessarily a good thing... we should always be challenged, if you stop being challenged then I think that you should stop doing your job...” MCHC6

In contrast to the advantages of change, the MCH nurses believed that one of the significant disadvantages of change was when the change being implemented had no relation to what was actually required. In other words;

“... change occurring because it's perceived as necessary but not actually what is necessary...” MCHB5

Another disadvantage identified in the MCH nurses data was the negative impact of implementing an unsuccessful change. The MCH nurses believed that decisions imposed on people suddenly, with no time to get used to the idea or prepare for the consequences are disastrous to any proposed change. This comment reflects how the MCH felt in general about the lack of consultation that had occurred, as identified earlier;

“... I think sudden changes can draw in mistakes... it is a lot of effort sometimes to introduce change... then to find that they haven't been very effective... or not as good as the way you were doing it before...” MCHB4

In other words, the MCH nurses believed that too much change too quick removes the focus of the important issues and becomes overwhelming;

“... I don't mind change although last year in this job there was so many changes and they were implemented so quickly and so close together that it actually made the change very difficult not because I resisted the change but because I was taught so badly about the implementation of it...” MCHB11

Another common disadvantage of change identified by the MCH nurses was in relation to consequences of decisions. The first identified here in this quote was thought to commonly occur when there has not been enough research into why the change was necessary;

“... the disadvantages of change can sometimes be change for change sake in that it is not necessarily going to improve outcomes... if it's for financial reasons sometimes changes can be made which may not necessarily be good...” MCHA13
The second disadvantage identified by the MCH nurses was in relation to economic rationalising. This is another common drawback identified by the MCH nurses in the data; this is often seen when there are personalities wanting recognition. Again this disadvantage could possibly result in the change being unsuccessful in the long term with staff resisting. Then, when the person introducing the change moves on, the staff often return to their previous behaviours. In other words, people telling them to change not an organisational approach;

“… provided it is not just change where people are exercising power or needing to make their mark on an organisation… it doesn’t change without purpose…” MCHA12

More importantly, the MCH nurses expressed that it was important that the organisation ensures the purpose of the change is clear. That is, it is being done for the right reasons and for the right benefit;

“… if it’s change for reinventing the wheel it is sort of wasting everybody’s energies…” MCHC2.

“… it stresses a lot of people… some people feel quite threatened and I think some people do find it a bit scary to say no…” MCHA8

To summarise a number of MCH nurses indicated that change is inevitable and that change brings with it enormous prospects, however, the disadvantages can be abundant as well. In other words;

“…changing for the sake of change is not necessarily a good thing… change has to be for a valid reason…” MCHB1

“… as long as it is change not just for the sake of change… we all need to move forward… as long as there is a purpose behind it…” MCHC4

“… provided that the changes are good and you learn the reason of the change… you can eventually see the bright side of it…” MCHA5

Conclusion

This chapter presented the data that emerged following the analysis of Group Two responses. There were 36 MCH nurse interviews conducted for this group of the study. Findings related to
the participants knowledge, attitudes and beliefs regarding the perceived impact from the national changes to registration, a proposed national framework and service provision on the Victorian MCH nurses. The key categories identified in the data were; ‘Common standard’, ‘Universal service’, ‘We do it well’ and ‘Imposed from above’. The next chapter will discuss the significant findings including the triangulation of the groups and their commonalities and differences.
Chapter Six

Significant Findings and Triangulation

Introduction

The previous chapter outlined the analysis of the data from Group Two which were the MCH nurses. This chapter introduces the significant findings from the triangulated data from Group One and Group Two of the analysis data. For the purpose of this study triangulation has been performed using multiple informants from Group One and Two for the collection of data on this particular phenomenon to gain a more complete understanding of the perceived impact from the national changes. The triangulated data is presented using the five key categories and corresponding sub categories to indicating the direct comparison of analysis that was undertaken between the KSH and the MCH nurse participants. According to Patton (2002), triangulation is an approach that utilizes multiple data sources, multiple informants or multiple methods in order to gather perspectives on the same issue so as to gain a more complete understanding of the phenomena.

‘common standard’

A common standard regarding a national registration was thought by the KSH and MCH nurses to be in principal a good idea in that it provided a consistent streamlined process that enabled links between the jurisdictions across Australia of the Maternal Child and Family Health Nurses (MCaFHN). Both the KSH and MCH groups agreed that the national registration was especially beneficial for those who required cross border registration in turn alleviating the bureaucratic processes. Surprisingly though, there was a small number of both KSH and MCH nurses who did not have a comprehensive understanding of national registration.
When discussing the advantages of national registration the KSH answered the questions reflecting more on the national advantages such as staffing numbers across the jurisdictions, the overall management processes and a new national structure. In contrast, the MCH nurses discussed more of the fundamentals of service delivery and the possible impact the changes may have. The MCH nurses also expressed a degree of frustration especially with the management of the web site, the lack of communication from the web administrators and the processes required to go through to completing their registrations on line. The KSH commented on the ease of movement of staff across jurisdictions that would result and thereby increase employment opportunities by being able to work anywhere. When the implications, however, were realised regarding the qualification disparity and checking processes it was then considered by the KSH to be a significant barrier to the movement of staff across jurisdictions. Surprisingly for both the KSH and MCH nurses when asked if they would move interstate if a position became available the majority indicated that they would not move. Both the groups identified significant concerns regarding the disparity that existed between the qualifications and practice standards between all the jurisdictions across Australia. There was likewise a strong belief expressed among the participants that Victorian MCH nurses were more highly qualified and provided a more comprehensive service compared to the other jurisdictions. Significantly for the KSH was that despite the fact that national registration being implemented within six months of the interviews taking place for this study, there was a number of KSH that had not anticipated the need to put in place any review processes for interstate applicants.

The MCH nurses overall indicated that they believed the advantages of national registration were limited. They agreed in principle with the KSH, that the idea of a national registration was good and would provide a significant advantage in rectifying the inequalities between the jurisdictions. This was seen to be especially the case with services and educational requirements. The KSH had concerns with the fact that the checking process of the qualifications of interstate applicants was difficult due to the difference in educational pathways and lack of equivalency. On the other hand, the MCH nurses were concerned with the disparity of qualifications between jurisdictions in regards to the possible loss of employment opportunities. The MCH nurses further indicated their concerns related to the potential decrease in standard of service offered to the Victorian clients with the movement of staff across borders. A lack of clarity of the processes of national registration led both the KSH and MCH nurses to claim that the national registration had been
introduced before it was thoroughly thought through leaving them as a group that did not fit anywhere.

‘competent and capable’

Overall the majority of the KSH and MCH groups had a reasonable grasp of the meaning of recency of practice. Surprising results, however, were indicated by the number of both KSH and MCH nurses that had a limited, to no knowledge, of recency practice. This was perplexing considering recency of practice has been aligned with national registration and was a requirement for registration renewal and competency to practice. The KSH differed to the MCH group in that they believed that recency of practice was only part of what was necessary to become a competent practitioner.

The majority of KSH felt that they had provided adequate opportunities for professional development to be undertaken by their employees and identified that this needed to include a mix of practical, clinical and contemporary knowledge. In addition, the KSH identified that professional development was more than attending sessions, it was also a reflection of practices and how the professional development could be carried over to the MCH practice. Furthermore, the KSH believed that a number of MCH nurses had unrealistic expectation of the employer in that all professional development should be provided by the employer and be part of their workday.

A different perspective to professional development was provided by the MCH nurses. Surprisingly the MCH groups identified that the nature of the professional development offered at times was too prescriptive and did not necessarily meet practice requirements. In other words, professional development tendered to be focused more on what DEECD required rather than what was required for the MCH nurses role. This was further evidenced with the MCH nurses only looking at the processes of documenting the professional development rather than the overall concept of what professional development brought to their practice and the expectation for registration.
‘loss of identity’

The effect of the loss of the speciality notation on the registration was momentous throughout the data from both the KSH and MCH nurses. It was noted by the KSH that the loss of notation was not the only issue in regards to the qualifications. There was an element of anxiety in the KSH data related to internal managerial comments regarding the requirement of a midwifery qualification. This in fact would have significant implications to the MCH practice if this was to be altered in anyway. Both the KSH and MCH nurses were concerned with any lowering of the standard of qualifications and services.

These MCH nurses were particularly concerned not only with the disparity of qualifications, but also the possible impact the loss of notation would have on the service being offered in Victoria if the qualification requirement to practice was lowered. That is, it would lower the value of the service and the nurses that work in the service. In turn further adding to the MCH nurses feeling disenfranchised and undervalued as a result of the loss of the notation. The MCH nurses firmly believed the additional qualifications in fact enhanced their role in the community.

Furthermore, the MCH nurses indicated in the data that they should have been informed of what was going to happen prior to national registration being implemented and not what they believed was them being ‘blindsided’ with the decision to not recognise the speciality of MCH nurses. In reality they were in fact informed of the changes to registration albeit more by omission regarding the MCH speciality notation.

The data identified that both the KSH and MCH groups were aware of the disparity of qualifications across jurisdictions but yet were not familiar with the qualifications required in other jurisdictions to practice in Child and Family Health. They could only offer some knowledge of one or two jurisdictions requirements to practice. Both groups were equally concerned with how this disparity would be resolved and the implications of this.

There was very little difference between the two groups regarding their beliefs related to the importance of MCH nurses having the midwifery qualification. Both the KSH and the MCH groups stated categorically that midwifery was essential for the service they provided for a number of reasons. There was, however disagreement regarding the length of time post discharge from
hospital that midwifery was required post discharge. A small number of KSH referred to the relevance of midwifery following the first six weeks. The majority of KSH and the MCH nurses, however, were in agreement of the necessity of having the midwifery qualification to practice effectively in the early years in primary health.

For the KSH, however, it was more than about whether they should have midwifery. They instead were being strategic and looking at the wider representation. The KSH reflected on at how the MCH curriculum could be improved, having the evidence to support the program and changing the MCH nurse’s educational curriculum. For example, this would include such topics as mental health and enhanced counselling skills to further satisfy other aspects required for the MCH nurses to continue offering a successful relevant service.

The data indicated that the KSH had a good understanding of the fact that the requirements set down by the MOU between DEECD and MAV to practice as a MCH nurse in Victoria were safeguarded. On the other hand there was little evidence in the data of the MCH nurses having the same level of comprehension of the MOU and the implications this offered. Furthermore the implication expressed here by many of the KSH and MCH nurse, was that people from other jurisdictions, who did not have the required qualifications to work in Victoria and seeking employment in Victoria, could impact greatly on what was perceived to be a successful service.

Overall the KSH, and the majority of the MCH nurses, were in agreement that the Bachelor of Midwifery was not an option to be considered as an entry pathway for Child and Family Health (CFH) nurses. This was predominately because they were concerned that the Bachelor of Midwifery graduates were not nurses. The KSH added that they were concerned about the lack of experience the Bachelor of Midwifery would have and that this inexperience would not mix well with the autonomy of the position. There were, however, a small number of MCH nurses that indicated in the data that the Bachelor of Midwifery graduates may in fact be a suitable pathway, more because midwifery was an essential component compared to nursing. There was, however, acknowledgement by the MCH nurses that there would need to be a number of adjustments made accordingly to curricula and programs.
‘future pathways’

There was agreement between both groups regarding their concerns for the future direction of the MCH service. While it was agreed in principle by the KSH and the MCH nurses that a nurse practitioner was one of the ways the service could go in Victoria, there were those that had their reservations regarding this direction. The majority of KSH and MCH nurses believed that in fact the MCH nurses were working as nurse practitioners already so was a non-issue. Being a nurse practitioner in fact was seen to have the advantages of easing the burden on the public health service and to relieve the pressure on the General Practitioners in the community. Not all the KSH supported this, however, believing that the level of education required would be greater than a number of current near retirement MCH nurses would be able to achieve. The MCH nurses on the other hand, were more concerned that the service would possibly change and that this continued uncertainty tended to dominate the responses. Despite this there were a number of MCH nurses and a small number of KSH who believed the service should remain the same and that they should continue offering the strengths based service they were already offering and not necessarily move in another direction.

‘universal service’

Both the KSH and MCH nurses group stated that a national framework would be in reality a positive move and agreed in principle that having a national standard of service and education would be of benefit. Nonetheless both groups expressed concerns relating to how the service would be developed and implemented across the jurisdictions. The disparity in qualification, differences in governances and legislation were among these concerns expressed by the participants on the subject of a national framework. Interestingly, there were surprisingly a small number KSH who did not fully grasp the concepts of what a national framework would constitute and admitted to not having adequate knowledge of what was meant by the terminology of a national framework. This lack of understanding was also evident in the MCH nurses data and was contributed by some to the disparity between all the jurisdictions which limited their understanding.
of what a national framework was. The common reason between both groups for this lack of understanding was thought to be due to the lack of disseminated information from the governing boards in relation to what was being worked on to reduce the disparities of qualifications and working governances. This was further highlighted by both the KSH and MCH nurses with their acknowledging that the depth and significance of the national changes to the Victorian MCH nurses had yet to be fully comprehended by the organising authorities and the MCH nurses themselves.

The KSH and MCH nurses were similar in what they thought were important aspects to be included in of the national framework, however, once again in the fundamentals they differed in that the KSH spoke more regarding the managerial and implementation whereas the MCH nurses spoke about the practical implications to the workforce and clients. Both groups were clear with their concerns on what direction the service may take and that a lessening of what was already in Victoria would not be acceptable. In principle the KSH and MCH nurses agreed that the Victorian Framework could in fact be a benchmark from which to develop the national framework. In regards to the KSH and MCH nurse's perceptions of the impact to their current positions the majority of KSH believed that there would not be any significant impact. The majority of MCH nurses were unsure, however, a number believed that the service in Victoria would change as a result of the national framework changes. Once again the contributing factor was thought to be the lack of published information available and no clear pathways being offered to counter the disparity in qualifications and service provision. Overall there was not a significant difference in the area of the national framework between the KSH and the three MCH groups.

‘integrated service model’

There were varying degrees of understanding from both the KSH and the MCH nurses relating to the meaning of what an integrated service was. The majority of KSH and MCH nurses had a good understanding of what an integrated service would encompass. The MCH nurses also identified that there was a lot of ‘lip service’ given to the term integrated service but not many true integrated services in fact were around. From the data there were an unexpected number of MCH nurses that had little to no understanding of what an integrated service was.
‘we do it well’

From the data both the KSH and MCH nurses were in agreeance that the Victorian model was the most comprehensive and should be adopted in principle as the benchmark for the national universal service. This was thought to be because the service in Victoria was seen to be a successful model functioning with strong evidence based philosophies. The KSH believed the Victorian framework had benefits and outcomes for children while the MCH nurses added that the service had interventions in place to identify vulnerable families early. The MCH nurses considered that the Victorian service was a gold standard and believed the service to be recognised worldwide. Both the KSH and MCH nurses were in agreeance in that a contributing factor to the high attendance rates was the infrastructure and the legislated birth notifications. The MCH nurses further added they believed the independent funding from the state and local government to support the service assisted with the universal access and result in that everybody is seen.

Furthermore, the KSH indicated in the data that they believed the service in Victoria was strengthened by the education pathways required for MCH nurses to practice. While the MCH nurses agreed, they also added they believed that without general nursing and their midwifery knowledge they could not practice as professionally or effectively to the same standard.

As a consequence of the above reasons the KSH believed the Victorian model certainly needed to be a consideration for the national framework. They also indicated that there was a need to investigate what was working well in all the other jurisdictions and adopt that into the structure of the framework. In other words, ensure that the national framework can, therefore, be of benefit and processes streamlined to accommodate all the jurisdictions and their nuances. The MCH nurses agreed with the KSH regarding the framework but they were more realistic about how a common framework could be developed considering the disparity of services that currently existed between the jurisdictions. There was some KSH who believed there was a need to move the focus of the service more to the first six weeks and to the mothers health during this time when they need the most support. Again the MCH nurses were more realistic about the logistics of achieving this while agreed with the concept to give more support to the mothers early in the postnatal period. The MCH nurses, however, believed one of the constraints to this was in fact...
that each jurisdiction had their own way of doing things and getting a consensus would be difficult in the foreseeable future. The MCH nurses were optimistic that in fact the opposite may indeed happen and that the other jurisdictions would reflect more on what Victoria offered considering the overall health benefits. The MCH nurses were also realistic enough to see that this outcome also had issues to consider in that the service could cost more and as a result not be all encompassing of the best practice model. The MCH nurses had the belief that they are caring for the whole family not just a baby which is believed to be best practice.

It was evident from the data that both the KSH and MCH nurses had only vague knowledge of what other jurisdictions offered in regards to services and much of this was antidotely. In addition the KSH further believed that there was not a widespread understanding of what Victoria actually does by other professional and government bodies along with the other jurisdictions either. As a result the KSH indicated that this could very well be the fault of the MCH service themselves because it did not emphasise the service enough politically or use the evidence they had from the mothers that reinforced the Victorian model as being invaluable. The MCH nurses while admitting to their own lack of knowledge regarding what services the other jurisdictions offered were realistic and hesitant without all the pertinent information on the other jurisdictions to base such a decision in recommending that the Victorian model be adopted in principal across Australia. KSH data supported what the MCH nurses indicated but added that it was possible that the limited understanding of what Victoria does could be contributed to the era of leadership being too busy doing rather than evaluating. This is, therefore, why Victorian MCH nurses are in the position they are in, needing to provide the evidence of best practice.

‘we sit in between both’

The demographics of the question as to which portfolio the service should be situated gave a mixture of unexpected results in that the portfolio of choice being health or education did not differ significantly between the KSH and MCH nurses groups. The KSH were unsure which portfolio best situated the MCH service. Alternatively the MCH nurses indicated Health as the preferred portfolio by a small margin with a combination portfolio of both Health and Education equally as a second preferred option. What was unexpected in the data was that there were MCH nurses from the A and C groups that indicated that it held little relevance which portfolio the service was
situated in. Rather they believed that due diligence was important to be given to the MCH service by whatever portfolio they belonged. The KSH data overall expressed a need for a portfolio that encompassed both health and education or a separate portfolio altogether. Likewise a number of MCH nurses were unsure what portfolio they believed the service would be best situated in along with a smaller representation believing a separate portfolio as being preferable.

‘imposed from above’

It was clear from the KSH and MCH nurses data that both groups strongly believed that the change was imposed on them and that others were in fact making decisions on how the service should function without a great deal of communication and consultation with the workforce. The KSH data highlighted that many believed they should have been more involved with the managerial side of the change processes, instead they felt disenfranchised and ill-informed to precede with any implementation processes. The depth of this concern was seen with numerous comments regarding not being involved and the lack of consultation from the organising bodies. The MCH nurses data, however, indicated that they wanted to know more how the actual process of the change was going to be implemented on the ground and the impact of the change on the MCH nurses themselves and the service they provided.

The majority of KSH and MCH nurses indicated that they felt comfortable with change albeit with varying provisos for the acceptance of change. There was, however, a number of KSH that indicated that they had reservations regarding change and needed sound reasoning for the change with established processes for implementation before they would accept the change. With this in mind the KSH had more of an overall organisational change perspective whereas the MCH nurses were more concerned with the personal side of the change and the impact on the person. Furthermore the MCH nurses spoke more in their data than the KSH in that they believed change was inevitable, due to the fact they were continually experiencing change. In addition, it was evident in the MCH nurses data similarly to the KSH, a smaller number that did not feel comfortable with change and at times were left feeling anxious regarding the support they may get with all the aspects of change be it prior or post implementation. A number of MCH nurses expressed the attitude of go with the flow and see who survives at the end or what will be will be.
Despite the fact that the KSH should have been involved, with planning the changes the evidence from the data points to the fact that they were not. The MCH nurses were also in agreeance, believing that there was not enough communication with them regarding the national changes to registration and service provision. Both the KSH and MCH nurses specified that communication was essential to ensure that everyone was informed of the change and that the reasons for the change had been thoroughly explored and were in fact needed. Furthermore, both groups firmly believed that any organisational change requires a degree of communication, consultation and planning with the workers rather than the change just being imposed on them. In addition, the KSH and MCH nurses believed that they should have been updated regularly to ensure their knowledge and understanding was at the level required in order to embrace the changes being implemented. A lack of communication and conflicting information was identified by both the KSH and MCH nurses as being an influencing factor for them in the implementation of the national registration. There were, however, a small number of KSH from the data that believed there was adequate consultation. These KSH indicated that others did not take notice or ignored the communique which could be seen as a level of complacency towards the change process. It was also acknowledged by KSH that the information was disseminated however, it possibly not accessed. Similarly some of the MCH nurses also commented that the information was there, however, they did not understand it.

A number of KSH indicated in the data the importance of having a strong leadership of senior leaders to guide the change. This was thought to include leaders from different levels of management which in turn was expected to establish and gain the cooperation of others. One of the differences between the two groups was that the KSH group spoke more about the leadership roles expected of them where as the MCH nurse’s data continually noted that there needed to be support and nurturing of good leadership along with the right resources in order to proceed. More significantly, they believed it was essential to get the right people driving the change management. The MCH nurses further indicated that in fact management was required to invest more in the way of supporting the people to manage the change with a positive perspective. In addition, the majority of the MCH nurses believed that it was necessary to see the whole picture before they would commit to the change.
‘change is inevitable’

The majority of KSH and MCH nurses indicated that they believed the advantage of change was to ensure the practice remained relevant, efficient and evolved with progress. Whereas the MCH nurses added to this further by stating that change that evolves from a research base opens up new potential avenues for informed choices along with improved outcomes. In addition the KSH and MCH nurses agreed that an effective and efficient change management would support a smooth transition from the old process to the new in turn creating positive perceptions of change for staff and consumers. Both the KSH and MCH nurses admitted that while some change was inevitable, it was important to take positive steps to reduce the impact of change agendas by building the knowledge base of people in understanding the correct change process to prevent what they termed ‘throwing the baby out with the bath water’.

Despite recognising the advantages of change, the KSH and MCH nurses agreed that not all change was pleasant and does have disadvantages. The KSH expressed concerns related to the inability for some to accept change which can result in strong barriers to progress of the change process. Whereas the MCH nurses believed that another disadvantage of change could in fact be that the service risked becoming less predictable in turn unsettling the functionality of the service. Both the KSH and MCH nurses further indicated in the data that change that is instigated by people who were exercising power or needed to make their mark on an organisation, was inappropriate and less conducive to effective change processes.

The majority of KSH and MCH nurses believed that change was inevitable and that change brings with it enormous prospects. Although the KSH stated they were comfortable with change, there were a number that felt disenfranchised with the lack of guidance on what was actually happening in regards to the national changes. This lack of guidance could then be seen in the MCH nurses data indicating the lack of transparency and communication pathways being significant for the organisational change process related to national changes.
Conclusion

Triangulation of the data from Group One and Two indicated that there were both similarities and differences between the groups, however not major in relation to this study. This triangulated data was presented using the five key categories and corresponding sub categories to indicate the direct comparison of analysis that was undertaken between the KSH and the MCH participants. The following chapter takes these significant findings further by situating them within the literature in order to gain insights into these findings.
Chapter Seven
Discussion of the findings

Introduction

The previous chapter presented the triangulated data from the findings of the two groups participating in this study. This chapter provides an overview of the key findings from the data and analyses from the two participant groups.

The fundamental aim of this study was to explore and describe the knowledge, attitudes and beliefs of the Victorian MCH nurses to the perceived impact of the national changes to registration and service provision. Data analysis led to a rich description of the processes that influenced the perceived impact of the Victorian MCH nurses to the national changes. To achieve the discussion objectives, the categories associated with the topics as identified in Chapter 6 will not be used in this Chapter to prevent repetitive information from being presented. Instead this discussion chapter will include the significant findings from the analysis which were around the category ‘common standard’, ‘universal service’ and ‘imposed from above’. These were the areas that created the most discussion throughout the interviews. The aim of this chapter is dedicated to discussing the insights of this research project in terms of the literature.

‘common standard’

This study highlighted the understanding of the Victorian KSH and MCH nurses to the National changes to a national registration. Both groups indicated that a common standard regarding national registration was in principal a good idea in that it provided a consistent streamlined process for registrations across Australia, especially for cross border registrations. The principles behind the national registration were to alleviate the bureaucratic regulatory burden imposed by the jurisdictions. The aim of COAG was to have the jurisdictions work more efficiently with
increased output. The significance, however, of the national reform for the MCH service in Victoria was the Human Capital Reform component of the national agenda that was to improve health, learning and work outcomes for all Australians.

The ability to have cross border movement as a result of having one national registration was seen by the MCH nurses and KSH as a positive move. To enable this to happen, the idea of a national registration was that all jurisdictions would have the same education and qualifications (AHPRA Annual Report, 2010-2011; Allen Consultancy Report, 2009). The biggest concern identified in the data, however, was the fact there was disparity in education and qualifications across jurisdictions and that this required a resolution. The fact that the disparity between qualifications had not been addressed prior to the implementation of the national registration was seen as a barrier to this free flow across borders.

Similarly research undertaken by Kruske and Grant (2012) examining the educational preparation for MCH nurses in Australia, highlighted the educational and qualification disparities between the jurisdictions and continued the debate on entry criteria for the specialist programs. Kruske and Grant examined and compared the different education requirements and programs from all jurisdictions. This research identified that there was in fact great difference in program nomenclature, levels and content. In addition, there was such a wide variance in the content of the programs that Kruske and Grant reported that it was difficult to compare the quality or depth of program content because of this. They did comment, however, that out of the 12 programs reviewed, only 7 contained specific educations on child development tools.

In addition, Kruske and Grant (2012) further highlighted the differing qualifications to practice as an MCH nurse in the various jurisdictions and the consequent differences in service delivery that resulted. These differing qualifications to practice alluded to by Kruske and Grant has been identified as one of the major concerns of the Victorian MCH nurses and KSH in this study. In Victoria, for instance, the postgraduate programs for MCH nurses require applicants to hold midwifery and general nursing qualifications and a minimum of a Graduate Diploma in Child and Family Health or equivalent to work in the area. Other jurisdictions across Australia, however, do not have midwifery as a requirement. Kruske and Grant (2012) highlighted again that Victoria is the only state that requires the MCH nurses to have a minimum of a Graduate Diploma in Child and Family Health to work in the area of Maternal and Child Health nursing. The other jurisdictions across Australia, however, as previously stated recognize a graduate certificate qualification to work in the area of Child and Family Health. Significant concerns were expressed
in the data by both groups relating to the transferability of skills between jurisdictions. The Victorian MCH nurses and KSH expressed that the issue of transferability had the potential to impact the future of the service in Victoria. With the current scenarios of education and qualifications this in itself impacts on the transferability of skills across jurisdictions and provides a challenge for the educational content of the programs being offered.

Kruske and Grant (2012) have also highlighted that in some jurisdictions Bachelor of Nursing or Midwifery are accepted into the specialist study programs. In other words, the practitioners are either registered nurses or midwives and not both. There are an increasing number of Bachelor of Midwifery graduates across Australia since its introduction in 2002. The pressure to admit these graduates into the MCH postgraduate programs is increasing as a consequence. Some jurisdictions are in fact already admitting Bachelor of Midwifery graduates into their programs, which is creating pressure in Victoria to do the same (Kruske and Grant, 2012). From the data Bachelor of Midwifery graduates wanting to become MCH practitioners was identified as a contentious issue. This could partly be explained by the lack of knowledge from MCH nurses perspective as to what is in the Bachelor of Midwifery program, which in itself is not surprising. It is only by being involved in curriculum development that a person is aware of the contents. The biggest concern expressed by the participants in this study, however, was that Bachelor of Midwifery graduates do not have enough education or life experience skills to be able to practice in the autonomous role that MCH nurses are required to. This could be reflective of the level of service provided in Victoria compared to elsewhere which is a consequence of the greater qualification. To date there has been no published research literature providing accurate data on the number of Bachelor of Midwifery graduates working in MCH nurse speciality area of primary health in Australia, or their suitability to do so. There is no longer delineation between the types of midwifery qualification on the AHPRA site as the qualifications are all grouped under midwifery. This is an area that requires further research in order to identify the suitability of the Bachelor of Midwifery as an entry point for the MCH service.

Many requirements have changed since the research undertaken by Kruske and Grant (2012) was published. For example, programs have been changed as part of the normal five yearly review processes that occurs, as well as the introduction of the Australian Quality Framework (AQF) in requirements. By 2015 all the postgraduate tertiary programs will be required to meet the AQF standards and be equivalent to the minimum of a graduate diploma. Certificate courses will be considered as an undergraduate level (AQFC, 2013). The AQF requirements provide an
opportunity in fact to assist in resolving this disparity in that the educational level required would need to be the same. It does not, however, necessarily ensure the content or resolve the disparity completely. Kruske and Grant had already identified in their research that there was even disparity that existed in the programs that were at the same level. This report by Kruske and Grant (2012) had identified significant differences between the different jurisdictions. How the AQF changes to qualification requirements will impact and influence the future direction of MCH nurses and influence the future direction of the programs is yet to be identified.

This disparity in education and qualifications between jurisdictions was previously identified by the Allen Consultancy Report (2009). This report critically reviewed the evidence underpinning the provision of best practice for a universal child and family health services and to develop a draft national framework for the jurisdictions across Australia. The Allen Consultancy Report (2009) further provided a comprehensive examination of the status of child and family health services across the jurisdictions. This report identified wide variation and disparity of child and family health service provision between states and territories.

In addition, the disparity in qualifications between jurisdictions and how this should be resolved was identified as an issue in both the draft and final report of the Productivity Commission Research into the Early Childhood Development Workforce (2011b). The Productivity Commission (2011a) highlighted a number of differences in qualifications, education and titles between the jurisdictions, the information provided, however, was not necessarily comprehensive. This could have been because the evidence provided was not necessarily always current and comprehensive. For example, the competency standards for MCH nurses from 1999 were used as a reference on which to base the Victorian competency standards in Productivity Commission. There was in fact a more up to date version available from the Victorian Association of Maternal and Child Health Nurses (VAMCHN, 2010). This is significant because there was a substantial difference between the 1999 and 2010 competency standards. While the philosophical underpinnings of the responsibilities of the MCH practitioner to public health and family centred practice were the same, the 1999 standards were based on case studies and open to interpretation. Consequently these 1999 standards were more likely to be open to individual interpretation. In contrast, the 2010 standards were more structured in that they were orientated to four specific domains designed to be used as a framework for the individual nurses to assess practice, work performance levels and for the review of professional development requirements. With each domain there are elements to determine competencies and associated validation.
guidelines. The interpretation of these standards was, therefore, more directed because the standards were evidence based and had measurable outcomes, which the 1999 standards lacked.

In addition, there was no mention in the Productivity Commission report of the Professional Practice Framework and Guidelines (DEECD 2011) that were being used in Victoria. This professional practice framework is what is used to guide how the MCH service is provided, that is, when the visits occur and what occurs at each visit. It would appear, therefore, that the Productivity Commission draft report (2011a) did not have all the information necessary on which to make informed recommendations. Specifically related to this study, and of significance to the MCH nurses in Victoria, was the recommendation made by the Productivity Commission draft report (2011a), that they could not see the necessity for the midwifery qualification for MCH practitioners. The report does admit, however, that they were unable to gain comprehensive information of the qualified MCH workforce. Despite this claim, the recommendation to remove midwifery was made with what appears to be incomplete information. In addition, the information obtained by the Productivity Commission draft report appeared to be predominantly from a limited number of sources. This was made evident from one of the submission made to the Productivity Commission which stated that

“... a significant portion of data ... appears to have been gathered from one jurisdiction and a single professional body rather than through national representation ... raises concerns regarding the soundness of the information gathered” (Productivity Commission, 2011a:8 Sub. CHoRUS No. DR159).

The Productivity Commission draft report was then released for public consultation and a number of submissions were received from various people and organisations across Australia. Needless to say, there were a substantial number of submissions received from concerned practitioners and organisations in Victoria. As a consequence of these submissions, the initial recommendation to remove midwifery qualification was rescinded in the Productivity Commissions final report (2011b) presented to COAG. This report acknowledged that the Victorian services were in fact different to what other jurisdictions provided. In addition, the Productivity Commission Report (2011b) indicated that midwifery was necessary for MCH nurses to practice in Victoria, however, they believed that this requirement did not transpose to the other jurisdictions. This did little to resolve the disparity.

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This recommendation to remove the midwifery registration requirement for Victoria MCH nurses was believed to be a way of resolving the disparity in qualifications because this was not necessarily a requirement in the other jurisdictions. Currently the Memorandum of Understanding (MOU) between the Department of Education and Early Childhood Development (DEECD) and the Municipal Association of Victoria (MAV) that is in place until 2015, safeguards the MCH nurses qualifications and education levels. As already discussed to be a MCH practitioner in Victoria requires nurses to be Registered Nurses and have a current midwifery registration. A further postgraduate qualification in Child and Family Health at a minimum Graduate Diploma of Child and Family Health level (DEECD) is also part of the MOU in Victoria. The problem with the MOU being in place is that it safeguards the Victoria MCH nurses education and qualifications for now, however, does little to resolve the current disparity across jurisdictions. Despite the changes to registration there was still disparity which needed to be resolved. The participants in this thesis clearly articulated that they were concerned about how this would be resolved. This disparity could be resolved in a number of ways; either all jurisdictions have the same education and qualification standards as Victoria or the Victorian MCH nurses qualifications be reduced to the lowest common denominator or somewhere in the middle. In other words there is a need to develop a national qualification and education pathway for this cohort.

Furthermore, the MCH nurses were concerned about the disparity in qualification levels more because of the fact that lesser qualified personnel from other jurisdictions would be more employable outside Victoria than themselves. This would therefore, reduce the employment opportunities for the Victorian MCH nurses. In addition, a Victorian MCH nurses seeking employment in SA for example, may find themselves unemployable as they could be deemed to be over qualified for the position or being employed at a lesser qualified level with less remuneration. Further discussion on this point occurs later in this chapter. For the KSH, the biggest issue was the difficulties that they were experiencing assessing the qualifications of people from other jurisdictions that wanted to work in Victoria. This entailed checking not only the individual qualifications but also the specific program content in order to ensure equivalency to practice.

Similar issues have already occurred between doctors and nurses in Australia. As a result of the shortage of doctors, nurses are performing more and more of the doctor’s roles. This can be compared to the doctors voicing their concerns regarding nurses extending their roles and becoming cheap ‘mini doctors (Kernick 1999). Both doctors and nurses believe key elements of
their roles are being eroded, devalued and being used as ‘cheap alternatives’ in times of economic slumps.

Similar education and qualification disparity issues had occurred with the mental health nurses in Australia when the Federal Government supported the transfer of nursing education, including mental health into the tertiary education sector. This occurred in all jurisdictions except South Australia and Victoria who continued their existing hospital based programs until 1993 with the new nurse’s act was passed (Happell 2009). In other words, the mental health nurses went from a specific mental health hospital certificate to a Bachelor of Psychiatric Nursing in all the other jurisdictions of Australia. As a consequence the levels of qualifications were different. Further disparity then occurred when the new Nurses Act of Victoria was passed in 1993. At this time the decision was made to discontinue the separate undergraduate mental health nursing to mental health content being subsumed within a comprehensive Bachelor of Nursing qualification. The problem was though that the amount of mental health content varied somewhat between programs from minimal to acceptable. The issue here, however, was that the mental health nursing components were not seen to be increased in the undergraduate nursing courses and believed to not adequately prepare the undergraduate nurses for the complexity of care required for the care of psychiatric patients. In addition Happell (2009) indicated that there were considerable variations between the courses offered throughout the undergraduate programs as well. According to Happell (1997), these changes were believed to devalue the skills of the mental nurses to the extent that it was putting this professional speciality area of nursing in crisis and serious threat. The modifications imposed immense changes upon the mental health nursing education especially in Victoria.

One of the changes that occurred as a result of mental health education being in nursing programs was that it entitled all Registered Nurses to practice in the field of mental health nursing. The problem was, however, that working in mental health was not as attractive as other areas of nursing. This then resulted in staffing shortages in mental health. As Happell (2009) reported that even when there was an oversupply of nurses, staff shortages still resulted. Happell also suggested that because of this oversupply many nurses were forced into mental health nursing as their only opportunity for employment. This then meant that Registered Nurses were legally entitled to practice at the commencement level of nursing in all areas of nursing except midwifery (Happell 1997).
Clinton and Hazelton (2000) further highlight the disparity between the current programs offered such as, Postgraduate Certificate, Postgraduate Diploma, and at a Masters level. The disparity continues with the duration of the programs from being equivalent to 6 months to 2 years full time. Further differences can be seen with how the programs are conducted. Such as, face to face on campus, offered through online and internet based education or a combination of face to face or online models. This can also be seen with the current programs being offered across Australia in Child and Family Health as previously stated.

Despite the MOU that existed in Victoria to safeguard the qualifications, the MCH nurses lost their specialty notation of additional qualifications on their registration to practice as a MCH nurse. The effect of the loss of the specialty notation on the registration was momentous throughout the data. One of the concerns expressed in the data was, however, that the loss of notation may have been in reality part of the process to decrease the disparity in registration requirements across Australia. This was thought to be because Victoria was the only jurisdiction that had the requirement of both the Post Graduate Diploma in Child and Family Health and for a midwifery qualification to practice.

A number of practitioners who had been in the service for a number of years indicated during the interview that the MCH nurses were in fact endorsed as Maternal and Child Health nurse at one time. This is supported by the Standards of Professional Practice for Maternal and Child Health nurses (1999) where it states that;

“Nurses employed to undertake activities as maternal and child health nurses are registered by the Nurses Board of Victoria in Division 1 of the register with endorsements for both Midwifery and Maternal and Child Nursing qualifications (Department of Human Services, 1998:3)”

Despite this fact, at some stage the MCH qualification became a notation rather than an endorsement. It is unclear when this change occurred from endorsement to a notation as no record of this could be located. There is a substantial difference between these two terms which is of significance to this discussion. According to AHPRA the definition for endorsement is;

“An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board.”(AHPRA, 2013)

Whereas a notation can be defined as;
“A notation is used by the National Boards to describe and explain the scope of a practitioner’s practice by noting the limitations to practice. The notation does not change the practitioners’ scope of practice but may reflect the requirements of a registration standard.” (AHPRA, 2013)

The differences between having an endorsement and a notation are considerable as the endorsement indicates an additional qualification and an extended scope of practice, whereas the notation recognises a limitation on a registrants practice. For example, prior to having a separate midwifery register, the Bachelor of Midwifery graduates were registered as nurses with the notation of restricted practice as a midwife. Being recognised with a notation therefore, does not acknowledge the increased scope of practice that the MCH nurses have. This lack of acknowledgement is reflected in the data from both the KSH and MCH nurses groups.

The threat to remove midwifery registration requirement for Victorian MCH nurses as identified in the draft Productivity Report (2011a) was a concern expressed by the MCH nurses. The majority of KSH and MCH nurses believed that the midwifery qualification was fundamental to the unique service they provided. The majority of KSH and MCH nurses throughout the data were concerned that the Productivity Commission were using an economic reductionist model to remove midwifery from the required qualifications for the Victorian service. Removing midwifery as a requirement would help address the disparity and mean that the MCH nurses would be cheaper to employ as they were less qualified. This negates the positive outcomes that having midwifery qualified practitioners would otherwise achieve in making a difference to the primary health outcomes for families. It is not always possible to assess these outcomes in the short term which may take time to evolve and be evident. There appeared to be too much of a focus in the MCH service on through put on number of visits and clients seen rather than on long term trajectories. (Shonkoff, 2011).

There were numerous reasons offered from the KSH and MCH nurses throughout the data as to why midwifery was important. These were varied and offered a unique insight into a specialty of community nursing experienced by the families in Victorian. Midwifery involves the care of women during pregnancy, labour, birth and throughout the postpartum period (Pairman, Tracy, Thorogood and Pincombe, 2010). This entails the care of the newborn, including infants in neonatal Intensive Care Units that are sick or premature. Additional midwifery aspects integral to the MCH service for example are; counselling and debriefing the mother following a traumatic delivery where intervention either surgically or medically resulting in her expectations of a normal
vaginal delivery not being met. This component of the MCH services is often not given the significance it deserves because this is often spoken of but not documented to the full extent, only being recorded as 'client debriefed following delivery experience'. It has been well documented in the literature that childbirth can generate strong emotions that can eventuate with symptoms of depression, anxiety and trauma in some women. Debriefing and non-directive counselling has been used to reduce the prevalence of depression and post-traumatic stress disorders. While women have identified that having the opportunity to talk to someone in a supportive environment which includes an opportunity to explore her feelings about her experience and normalisation of the experience of birth was beneficial with facilitating recovery. Further studies, however, are required to investigate the timing, place of the intervention and if more than one episode is significant to recovery. (Gamble, Creedy, Webster and Moyle, 2002). To effectively debrief the mother following delivery the person debriefing requires an in depth knowledge and understanding of what happens during labour and birth process to help the mother understand what happened to her and why. A midwife has that knowledge, when the knowledge is used effectively it reduces the fear factor for subsequent pregnancies. The understanding that midwifery brings to the MCH practice underpins the basis of their practice. Common boundaries between midwifery and MCH nursing exist with much of the midwifery ethos built into the relationship the MCH nurses have with women and their infants. For example, by the midwife having the knowledge how physiological birth influences the neurological development of the newborn enables the midwife to decrease the anxiety of the mother in turn helping her labour more effectively reducing the catecholamine's which impede labour and cause foetal distress thus reduces a bad labour experience (Chau, McFadden, Bowen-Roberts, Synnes, Brant and Miller 2009: Fenwick, Gamble, Nathan, Bayes and Hauck, 2009)). In addition, a mothers mental health improves when her labour is progressing well which influences her parenting capacity and the production of oxytocin the love hormone (Gamble and Creedy, 2009).

In addition, the study of reproductive health, breast feeding and support are all areas the MCH nurses use that extend their midwifery knowledge and experience for client care and support.

Further examples of the collective experience of Maternal and Child Health Nurse’s and the extensive midwifery knowledge required as seen in the Productivity Commission sub; DR196 (Breach & Convery, 2011) is shown in the list below offering a number areas advice is given by the MCH nurses in their daily practice;
• Advice regarding birthing choices;
• Provide debriefing to women following traumatic births;
• Counselling to women who have experienced miscarriage, stillbirth or the death of a baby after birth. [All babies born after 20 weeks are notified to MCH nurses for follow up and counselling opportunities after discharge from hospital];
• Breast feeding advice, support and advice for those mothers unable to breastfeed;
• Assessment and support of the breastfeeding mother;
• Referral for lactation consultant support or medical support for issues concerned with breastfeeding such as mastitis, breast abscess, nipple thrush and nipple pain;
• Counselling of the breastfeeding mother around use of medications, drugs and alcohol;
• Care and monitoring of premature neonates following discharged home;
• Assessment of the jaundiced baby and care requirements;
• Contraception and women's health;
• Information on sexuality and sexual relationships after the birth of a baby;
• Assessment, information, support and referral for continence and pelvic floor issues post birth;
• Assessment, support and referral around any Mental Health issues, including antenatal depression, post natal depression, adjustment disorders, anxiety and recognition in MCH practice and response to puerperal psychiatric emergencies;
• Provide advice re discussing the birth of a baby with older children and managing strategies for coping/ managing when the new baby comes home;

The majority of KSH and MCH nurses believed that the nurses in Victoria are vital and highly educated professionals who are trained extensively to examine, consider and work with the collective influences that impact child health, development, and wellbeing from a social model of health (DEECD 2009). Having midwifery was very much a part of this. From the KSH and MCH nurses viewpoint they believed the service increased in value by recognising and appreciating the vulnerability of infants and young children especially around their reliance on quality relationships with primary carers (that is, the mother), who in turn rely on extended families, skilled community supports, and ‘good enough’ governmental policies and practices, to enable them to provide
‘good enough’ care for their infants and young children. This is supported by Winnicott who states that;

"With the care that it receives from its mother each infant is able to have a personal existence, and so begins to build up what might be called a continuity of being. On the basis of this continuity of being the inherited potential gradually develops into an individual infant. If maternal care is not good enough then the infant does not really come into existence, since there is no continuity of being; instead the personality becomes built on the basis of reactions to environmental impingement." (Winnicott, 1960)

The KSH and MCH nurses believed the value of the midwifery qualification is further supported by the MCH nurses having their general nursing qualification that has educated them in the normal anatomy and physiology compared to the abnormal giving them the added ability to assess and give appropriate advice. The MCH education programs are supported in the clinical expertise of the MCH nurses by offering comprehensive education specifically for infants and mothers from a health model. In addition, from a psychodynamic perspective which draws on the general contexts that influence normal processes through birth and into the early postnatal period of an infant’s life and throughout the transition to parenting for families (Pairman, Tracy, Thorogood and Pincombe, 2010).

One of the other advantages of midwifery education is that it shifts the focus from the task orientated therapeutic nursing role to the wellness and health promotion through an education role. This enables the MCH nurse to experientially begin to evolve from a therapeutic sickness nurse to a practitioner focusing on wellness that enables the parents to be guided through the natural process of parenting with, practical information and with minimal intervention (Pairman et al., 2010). The MCH nurses indicated in the data the importance of recognising their own value and that of their service plus being available for the families when they have difficulties in meeting their everyday struggles with parenting. This can either be with the parents building the capacity to recognise their infant’s dependency or autonomy, while also being able to support their own physical and emotional needs as individuals, couples and families. This, therefore, enables the speciality of MCH nurse to be able to watch, wait and share knowledge if needed and gently model and coach the families to parenting capacity. The KSH and MCH nurses believed the services they offer incorporate much more than just the medical model. Instead, the majority of KSH and MCH nurses indicated in the data that they offer insight, respect and a sense of the
normal psychodynamic processes, such as the interaction of the emotional and motivational forces that affect behaviour and mental states of the parents which in turn impacts on the transition for families.

Having the ability to respect and incorporate dealing with past, present trauma or disturbances for mother, infant, and families which can negatively impact the lives of a family, as well as normal developmental trajectories, is essential for MCH practice. This again emphasises the importance of MCH practitioners being midwifery qualified as highlighted in the research undertaken by Freiberg, Adelson and Shapiro (1975) on “ghosts in the nursery”. This study explored the effect of parents own childhood experiences and how they themselves were parented, on their ability to parent and the relationship they have with their baby. Midwives tend to be more attuned to these circumstances as they have the potential to affect how well the women will labour. This then transfers through to their bonding and confidence with parenting. For example; a women who has had an unstable childhood has not had the advantage of positive role modelling to enable her to parent herself. However, by taking a person’s genetic blueprint into consideration will enable practitioners to be able to interpret the inherent diversity in human biology and behaviours. Therefore, a mother’s sensory perception is the key to her physiology and behaviour (Fahy, Foureur and Hastie, 2008). The autonomic response to stress in women has been discussed by Geary and Flynn (2002). The fight and flight experienced by most men is interpreted to be an equally powerful stress response. Whereas in, women this is referred to as calm and connection which appears to provide women with an ability to react in an energy conserving manner. Oxytocin, one of the neuro-hormones has a major role in mediating a vast range of mind and body processes and is the key to the calm and connection system (Moberg, and Francis 2003). Since oxytocin is a neuro-hormone it acts centrally as well as locally which means it influences behaviour as well as having a localised impact on different body systems such as the uterus in labour and breast feeding. As a neuro transmitter oxytocin links messages throughout the nervous system influencing behaviour characteristically linked to the calm and connection system. In other words, oxytocin initiates love (Carter, 2003). Midwives are more aware of this and are continually updating their knowledge and are experienced in knowing what questions to ask women in order to illicit sensitive information such as childhood sexual abuse, domestic violence, and fear of labour. Such information, as well as the women’s relationship with her mother, can impact on how well she labours and parents (Foureur, 2008).
Furthermore, the families often debrief with the MCH nurse regarding their pre conception experiences as they encourage the parents to speak of their fears, grief, loss, trauma or even their exhilaration. Without midwifery, a number of KSH and MCH nurses indicated that they would not have the knowledge or capabilities to facilitate this process, nor would they have the knowledge to consider an infant’s possible experience of a particular situation and act appropriately. The KSH and MCH nurses believe that recognition is required of the work MCH nurses do with families within the broader framework of families and what infants, mothers and fathers in fact bring to the relationship as individuals. Unrecorded assistance given by the MCH nurses often allows parents to experience love, loss, trauma and grief in the context of family relationships which enables them to respond positively to their infants while dealing with their own journey to being emotionally available (Teti, Kim, Mayer and Countermine 2010). The KSH and MCH nurses indicated in the data that their clinical skills and professional evidenced based clinical guidelines (DEECD 2010) enable them to not only assist parents in understanding their infants but also in understanding the origins of their own emotional reactions to the experience of parenting. Unrecorded assistance given by the MCH nurses often allows parents to experience love, loss, trauma and grief in the context of family relationships which enables them to respond positively to their infants while dealing with their own journey to being emotionally available. The KSH and MCH nurses indicated in the data that their clinical skills and professional evidenced based clinical guidelines (DEECD 2010) enable them to not only assist parents in understanding their infants, but also in understanding the origins of their own emotional reactions to the experience of parenting.

In addition, the importance of midwifery is reflected by the international confederation of midwives Global competency standards for midwifery education (Thompson, Fullerton, & Sawyer, 2011). Their description of the midwife is one of advocacy within women centred, primary health care framework. The competency standards further indicate that the midwife is an advocate in protecting the rights of women, families and communities whilst respecting and supporting their right to autonomy. The standards inform the commitment of the midwife to cultural dignity and the integrity of others while informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood. In addition, as part of being a midwife and working collaboratively in public health the midwife actively promotes wellness not only for the woman, for her family and the community as well. These are all pertinent aspects within the scope of practice for MCH nurses and emphasise the importance of the midwifery qualification.
According to Kuo, Inkelas, Lotstein, Samson and Halfon (2006) maintaining midwifery for primary health care practitioners such as MCH nurses has merit. This is because, in countries where child health services are supported by this policy, children have relatively higher levels of well-being. Furthermore, research from Australia supports this suggesting that nurses with midwifery play a key role in providing universal maternal, child and family health services (Schmied, Donovan, Kruske, Kemp and Homer, 2011). This study conducted by Schmied and colleagues (2011) aimed to identify the commonalities and differences between the service frameworks for maternity and child health between the different jurisdictions. While this study found that the current policies were in line with international research and policy directions, the services were in fact fragmented. In addition, the study by Schmied and colleagues (2011) found there were commonalities between Australia and international research that emphasised prevention and early intervention, continuity of care, collaboration and integrated services. Schmied and colleagues (2011) further suggested from the results of the study, that the time was possibly right to consider the introduction of a national universal maternal, child and family health service. The study concluded that the services developed should be provided by a well-educated and skilled workforce able to work collaboratively across a variety of services and agencies to support the families and communities. Whether midwifery was to be a requirement for these practitioners was unclear from this work. An option to have Bachelor of Nursing or the Bachelor of midwifery needs to be explored. There was a general perception from the data that the Bachelor of Midwifery was more appropriate, however, this would involve the development of new curriculum content both in Bachelor of Midwifery and the Maternal and Child Health programs. However, there has been no research specifically undertaken to evaluate whether MCH nurses should be midwifery qualified. In addition, there has been no previous research that has explored the MCH nurses knowledge, attitudes and beliefs regarding the necessity for midwifery qualifications.

A number of MCH nurses further believed that there is a skill involved with developing parenting skills to empower confidence for parents to learn to care for their babies. This was further highlighted in the data with the MCH nurses indicating that the nurses may be educated in the general basics, but not specifically related to the complex areas often dealt with by MCH nurses, therefore, not have the understanding of the effects of their responses on the parents. The data indicated a number of senior MCH nurses referred to the skills and competences of the MCH that allow them to walk that fine line of trust, while enhancing the parents reflective capacities by
empowering the parents to guide the MCH nurse in order to meet their needs. In addition, the MCH nurses reflected that it was essential that they have the experience and ability to allow families to talk about whatever they might be experiencing in relation to their parenting capabilities, relationships between partners or children, the trauma of loss, mental health issues, past and current domestic abuse, financial hardship, emotional, cultural and social pressures at the visits.

The MCH nurses are often the first point of call for families divulging problems related to their physical and personal issues following experiences such as the joys of birth, and grief of death. The data identified the difference that the MCH nurse have made through the care and support they provide to parents experiencing crises which positively impacts on their capacity to be emotionally available for their child. This is supported by the research on infant sleep quality and the emotional availability of the mothers (Teti, et al., 2010). The mothers were observed to see what practices they used to settle the infants as well as their emotional availability for their infant. This study found that the mothers that were more available to the child attended for their needs quicker and had better results with sleep settling. Parenting capacities for families are a large component of the education and care MCH nurses provide. Consequently, better outcomes for children are linked to parenting capacity (Murray 1998; Shonkoff and Phillips 2000). Child health services are focussed on the child but simultaneously involve the whole family as clients, as it is in this context in which child health and development is nurtured. Supporting the family and in particular the primary carer, who is generally the mother, promotes healthy outcomes for the children. It is far more effective to support the mother in caring for the child in a primary prevention capacity than to refer and treat behavioural, mental health or developmental concerns after a difficulty has developed.

The literature supports the fact that Infant brain research has revealed the importance of positive early interaction and care with a primary caregiver (Shonkoff and Phillips 2000). Optimal infant health and development is intricately linked with maternal wellbeing. Promoting and supporting maternal health and wellbeing protects and promotes infant health and development. Furthermore, collaboration with families in clinical practice is a series of communications, agreements, and negotiations to ensure the best possible health care outcomes for children. Similarly with the family-centred practice here in Australia, the Bright Futures vision in America and the Nurse Family Partnership practice in the United Kingdom are all based on family-centred care where families are empowered as care participants. While the families have an irreplaceable
ability to choose what is best for their children, it also must be recognized that families endeavour to do all they can to protect their children. In addition health supervision policies and practices have not kept up with the widespread changes that have occurred in the family, the community, and society (Bethell, Peck and Schor, 2001; Nelson, Wissow, and Cheng 2003; Hagan, Shaw and Duncan 2008). The recent literature demonstrates that there is a need for new benchmarks for health supervision to confront firsthand the challenges of today’s children and families. Moreover, the literature surrounding the epidemiologic, sociologic, and genetic studies regarding the importance of a family-centred approach to child health have increasingly shown that the correlation between parental and child health is critically important to optimal outcomes (Bethell, et al., 2008).

Furthermore, while child health is the responsibility of government agencies, parents, child health professionals and communities the accountability needs to be shared by everyone for the future positive outcomes. Health supervision for children has evolved immensely in the past half century, when it first addressed concerns of nutrition, child rearing, and the prevention of infectious diseases.

Child health practices of today have been established and woven throughout child health care with the following principles;

- Partnership
- Communication
- Health promotion and anticipatory guidance
- Time management
- Education
- Advocacy

It is significantly easier to actively promote attachment with anticipatory guidance than to try and redress problems after they occur. Parents are often seen to be seeking support to respond to infant and child behaviour issues, such as: persistent crying, tantrums, sleeping difficulties, eating issues and aggressive or non-compliant behaviour. Support, education, normalisation of behaviour and clarification of age appropriate expectations enable families to respond positively and repair and promote relationships, rather than diverting to an adversarial interaction that can impair understanding and contribute to fractious relationships. With the MCH service being a relationship based service, the recognition of the importance of advocacy for continuity of care
for families wherever possible, is essential. Continuity promotes knowledge of child and family history and previous issues. It can also promote family confidence, enhance reassurance, reduce conflicting advice and promote comfort. This further evidence that supports the notion that supporting the new mother requires skilled assessment and intervention by highly qualified MCH nurses.

In addition, the KSH and MCH nurses believed the lack of understanding of the “well client care model” by the Productivity Commission appeared to infer the MCH nurses role could revert back to a medical model. This in turn would fragment, devaluing, and returning the service to the previously used production line of child health assessments attended by a cheaper less skilled workforce. The MCH nurses further indicated that they believed there was a growing possibility that the Victorian universal service would be downgraded even though the services was supported by a skilled workforce that is highly regarded by families. This is further evidenced in numerous evaluations and studies. For example, the 2006 KPMG review of the MCH service and the 2009 Allen Consultancy draft Report on a national MCH service framework.

Further support for the cost saving impetus behind the decision to remove the midwifery qualification to make the MCH service cheaper can be found in the unpublished final report from the DEECD and MAV review of MCH services (2013). This review indicated that the Parent Support Worker (PSW) role could possibly be changed to take on more of the MCH role in the future. Currently the PSW support the MCH nurses role by running various support groups, such as, first time parent groups and sleep settling education in the home. These PSW, however, are not regulated, their training is at the diploma level in Early Childhood Development and the majority of their continued learning is attained informally by way of on the job training and professional development education days. Inconsistencies in training and workplace employment agreements make regulation of the PSW difficult to achieve. According to the Allen Report (2009) many of the professional bodies were extremely concerned about the replacing of MCH with people such as PSW. The concern here is that the PSW could take on more and more of the role of MCH as they are less qualified and cheaper. The problem with employing lesser qualified people to undertake a more qualified role, however, is that there is a tendency then for the need, when it suits, for the lesser qualified person to undertake higher duties outside their scope of practice. This lesser qualified person than eventually assumes the higher role. The end result is a potential undermining of the service provided (Kernick 1999).
Furthermore, the other side to this is the issue of sustainability of the workforce. To become a MCH nurse in Victoria requires extensive education which takes some time to achieve. In addition there are the requirements to maintain registration in both nursing and midwifery. This is not only about the time it takes to become and maintain the qualification but also the cost to achieve this. Both of these factors are not necessarily going to attract people to undertake the necessary requirement to practice MCH in Victoria. This has further implications for the current ageing workforce and the potential to worsen due to the fact that there is a tendency for some midwives to be drawn to becoming MCH nurses because they wanted the lifestyle of nine to five and not the profession per se.

Therefore, it is essential to support highly qualified MCH nurses being comprehensively prepared with nursing, midwifery and maternal and child health qualifications. It is believed highly skilled MCH practitioners would provide a more comprehensive accurate assessment. Furthermore, the MCH nurse that is comprehensively educated and highly skilled is more likely to identify issues and provide an accurate and timely diagnosis. Through early identification interventions can be initiated in a timely and effective manner resulting in better outcomes (Pairman et al., 2010).

The current skill set of the MCH nurses is associated with professionals held in high esteem and with improved performance on outcome measures as evidenced by the child health indicators (AIHW 2011). The DEECD review (2013) of the MCH service concluded that a more differentiated model for universal MCH nursing was required; however, a shift from the current model to a more differentiated model for MCH nursing was thought to in fact increase fragmentation of the care provided by the MCH service ensuing additional burden for MCH nurses and families. The MCH nurses believed these circumstances would, therefore, contribute to a reduction in the services already provided and in turn make the identification of vulnerable and at risk families involved with Child First and the Child Protection Service more difficult. There has been no specific research found to date that has evaluated whether the MCH nurses should be as highly qualified as they are. In addition, there has also been no published research results found that has explored the MCH nurses knowledge, attitudes and beliefs regarding their qualification requirements.

While the Productivity Commission (2011a) indicated in their report that the vulnerable and disadvantaged families were falling through the cracks and not being adequately identified or using the service due to the inflexibility of the service to meet their needs in part. The CHoRUS, submission (DR159) in response to the Productivity Commissions draft report as well as the Allen report (2009), and Moore (2008), identified that the services for the vulnerable and disadvantaged
were in fact continually being overstretched. Therefore, the majority of the KSH and MCH nurses believe that to further fragment the universal service by reducing the qualifications and the skill requirements for the MCH nurses would have little economic value to the community especially the vulnerable and disadvantaged. Furthermore, the fragmentation and discontinuity can adversely affect the quality of care provided to families, risking dissatisfaction and further disengagement from the service.

Support for this claim can be found in the work undertaken by Gillen and Graffin (2010) in the UK. Gillen and Graffin (2010) explored what was happening with the role of the Health Care Assistant (HCA) and found that they have always been a key member of the nursing team in assisting the nurse to undertake their duties. These HCA operate with very little education requirement. In recent year, however, the role of the HCA has been evolving and extending further into the nursing field. The introduction of HCA’s in the UK and PSW here in Australia is seen as being progressive as well as problematic.

A similar scenario was seen in Australia when the National Mental Health Policy in 1992 with emphasizing the importance of employing adequate highly qualified professionals in order for the service to be effective. The consequences of the nurse’s act threatened this policy which aimed to improve mental health services across Australia (Happell 1997). Instead the down grading of qualifications and education was seen to decrease the level of service resulting in the mental health nursing numbers in fact decreasing. This remained the case until specific postgraduate programs in mental health were developed (Happell 2008). Happell (2000) further suggested that the decrease in services was more likely to be because of the lack of exposure and a perceived view of mental health nursing to be a lesser attractive field of nursing and a misunderstanding of the mental health patient’s needs. This is further supported by the literature (Happell 2007; Maude 2002), in that the mental health nurses frequently felt marginalized and disenfranchised by their diminished visibility in the overall nursing agendas. Data from both the KSH and MCH nurses concurs with this outlook indicating a number of the MCH nurses feeling disenfranchised with Victoria not appearing to be included in the national change agenda along with the lack of published literature being available regarding the changes to the new policy being implemented. This, however, is not supported by any published literature to date. Furthermore, the MCH nurse to a greater extent indicated that they believed the uniqueness of the Victorian MCH service was not well known in the other jurisdictions and that this in fact denied a potential source of valuable information to be explored further. In order for this information to be recognized and understood, it
This raises the question regarding whether the MCH nursing credibility as a recognised specialist field is significantly diminished by legislation and the nursing bodies themselves with the loss of MCH nurses notation on their practicing certificates. Similar progression of events occurred when the mental health nurses experienced a subsequent decline in popularity as a career choice with the introduction of an integrated curriculum and the subsequent decline in the proportion of mental health content in education programs. According to Happell (2009) opinions continue to be divided between the current systems of tertiary based comprehensive nursing education and the Bachelor of Psychiatry programs of the past. The argument, however, is in favour of retaining mental health educational models at postgraduate levels. (Sharrock and Happell 2000). This is further evidenced by the increase in the professional role of the mental health nurse to the level of nurse practitioner (O’Brien, Maude and Muir-Chocrane 2009)

Despite there being the development of world leading innovations in population based mental health policy and early intervention programs there has not been widespread implementation of these services (National mental health report, 2004). In 2001 alone less than 40% of people with a mental health condition received attention in a 12months period compared to almost 80% of other physical health care related problems (Andrews, Henderson and Hall 2001). This has led to major service gaps and poor experiences of care (Hickie, et.al., and Luscombe. 2005). Therefore, further research is required not only for the pursuit of additional knowledge, but also the discovery of solutions to enhance the standing of MCH nurses within the nursing profession. This further relates to the service for the vulnerable, mentally ill, disadvantaged and homeless.

Repeated searches of the literature have contributed no possibilities for a resolution as to how the disparities in education and qualifications for MCH nurses could be resolved between the jurisdictions. While these disparities have been acknowledged and identified by a number of sources such as Schmied et al. (2008), Kruske and Grant (2012) and the Allen Consultancy Report (2009), they have not presented a resolution for the disparities or discussed the implications, impact or concerns related to the disparity of qualifications and services.

The MCH nurses were particularly concerned about what impact the disparity of qualifications and education, especially with the loss of notation, would have on the services being offered in Victoria. That is, it would lower the value of the service and the nurses that work in the service. In
This added to the MCH nurses feeling disenfranchised and undervalued as a result of the loss of notation. The MCH nurses firmly believed that the additional qualifications in fact enhanced their role in the community.

Despite the fact that both groups identified significant concerns regarding the disparity in education and qualifications between jurisdictions across Australia, a number of the participants had limited and sometimes only anecdotal knowledge of what existed in the other jurisdictions. For instance, they may have been aware that other jurisdictions do not require midwifery to practice as MCH nurses but not aware of the education and qualification details. This is not surprising that they were not aware of other jurisdictions qualifications and education requirements, yet surprising that they expressed such strong opinions regarding the disparity that existed between jurisdictions. The KSH group not surprisingly had an additional awareness of the other jurisdictions, and the overall process of the national change to the national registration. However, were concerned more with the review processes for interstate applicants wanting to work in Victoria as MCH nurses. The review process for interstate applicants to date has not been assembled as the disparity between qualifications and educational standards do not equate between jurisdictions. Three years on and the process remains in limbo.

One of the other findings that were highlighted in this study was the fact that a number of the KSH and MCH nurses in fact had limited knowledge regarding the change to national registration. This was surprising as there was a big build up to the national registration with a continual barrage of literature being sent out from the Victorian Nurses Board and the Australian Nursing and Midwifery Federation (ANMF). Possible explanations for this was highlighted in the data and included that the information was neither sufficient nor timely, participants had difficulty comprehending the information or that the information for not easily accessible.

The limited knowledge was also evident in the fact that the participants were not fully aware of the registration requirements. Despite the amount of information made available for the MCH nurses to access, confusion remained evident from the interview data concerning the requirements to renew their registration each year. This involved two areas; recency of practice and professional development. Firstly, the overall understanding of recency of practice was evident; however, the fundamentals of recency of practice were limited in both the MCH nurses groups regarding the requirements for competency and continued registration. The meaning of recency of practice was at times confused by both the KSH and MCH nurses with professional development requirements in that the time frames for recency of practice was confused with the hours specified for
professional development that constituted eligibility for registration. The realisation that the professional development hours were in fact mandatory and interlinked with recency of practice for registration was not something a number of participants understood very well.

Confusion was also evident in the knowledge of the MCH nurses related to the positions that practising nursing or midwifery personnel could include as recency of practice when they worked in areas like coordination, management, education, policy and research. That is, they were taking the requirements too literally to being specifically for nursing and midwifery when in fact there can be overlap between the two.

Secondly the continuing professional development hour’s obligation was confusing to a number of participants concerning the hours required for both midwifery and nursing. The 20 hours of professional development each year that is relevant to the area of practice. This would mean that there are 20 hours for nursing and 20 hours for midwifery. AHPRA simplified this for the nursing profession in 2011 by stating that professional development incorporating both nursing and midwifery can be used for both areas (AHPRA report, 2011-2012). This confusion further indicated either that the KSH and MCH nurses were not accessing the information provided online by the Nursing and Midwifery Board of Australia or that the communication networks for the information dissemination were not being used or accessed effectively. On the other hand, not accessing available information can be seen as complacency or a passive resistance to change.

From the interview data of the MCH nurse groups there was a strong impression that the set professional development days tendered to be too focused on what DEECD required rather than what was required for the MCH nurses role. A number of the participants believed this could be developed and refined more to reflect learning more relevant to the role. Surprisingly a smaller number of KSH believed MCH nurse had unrealistic expectation of the employer in that the MCH nurses expected the employer to pay for and include all the professional development in their working hours tally. This was unexpected to find as the commitment identified from the MCH nurses to their positions and the community was significant. Similarly with current practices in the UK the issues relating to responsibility for professional development and the accountability of the employers and employees to update their skills to satisfy the regulatory body and the workplace have been identified as with this current study. The finding of this study agrees in that, the responsibility remains with practitioners to become more adept at identifying and utilizing educational opportunities in all their forms to satisfy the mandatory continuing professional development (Thomas, 2012).
This data could indicate that the MCH nurses were committed to their role as an MCH nurse but not necessarily to the profession and finding out what was going on. This is evident from the fact that the MCH nurse had a tendency to only undertake the professional development that was provided through their work place and undertake the content that is dictated to them from DEECD. Plus the fact that they were not aware of what education, qualification and services are offered in other jurisdictions. This all leads to the fact that, there were some MCH nurses that do not necessarily see themselves as being professionals. In other words, these MCH nurse are more focused on the task at hand and the job rather than being aware of the bigger picture of their profession (Chaska 1990). A professional views work as being central to their life which in turn becomes their life, as they make a commitment to the subculture of that work. To become professionals, therefore, the MCH nurses need to redirect their focus on achieving optimal outcomes for the clients and the service to move forward into the future in order to survive. Moving on from inconsequential tasks to better utilise the skill mix the MCH nurses have is essential in today’s paradox. In addition, embracing professionalism would mean that the MCH nurses would be less insular and instead be aware of what occurs in other jurisdictions and have more of a national focus.

The continued professionalism of the KSH and MCH nurses is essential especially with nursing practices becoming more diverse and the boundaries of inter- and intra-professional practices becoming increasingly blurred (Daly, and Carnwell, 2003). Chaska (1990) emphasized that to have successful resolutions regarding the health care predicaments both the professional and the organisational components must be satisfied. This can be related to the organisational changes of today from a professional perspective. Without a consensus between the professional and the organisational governances it would appear that only lip service can be given, which would result in failure to operationalize change resulting in organisational confusion, mistrust, and minimal progress between the parties involved. This is supported by Reilly and Orsak (1991) who found that the dimensions of commitment relevant to the nursing profession were based on age and professional occupations along with commitment which significantly increased with career stage. There has been no research undertaken to investigate whether the MCH workforce see themselves as professionals or not. Certainly increasing their investment into the MCH professional organisation would help work towards increasing their view of the world.
‘universal service’

This study highlighted that the participants believed that a National Framework would in reality be a positive move and agreed in principle that having a national standard of service would be of benefit. Nonetheless, both groups expressed concerns relating to how the service would be developed and implemented across the jurisdictions when there was such disparity in existing service. The disparity in qualification, differences in governances and legislation were among these concerns expressed on the subject of a national service framework. Interestingly, there were surprisingly a small number of KSH who did not fully grasp the concepts of what a national framework would constitute and admitted to not having adequate knowledge of what was meant by the terminology of a national framework. This was also evident in the MCH data and was contributed by some to the disparity between all the jurisdictions which limited their understanding of what a national framework was. This was further highlighted by both groups with their acknowledging that the depth and significance of the national changes to the Victorian MCH nurses had yet to be fully comprehended by the organising authorities and the MCH nurses themselves. This was also not surprising as at the time of the interviews, there was only beginning discussions about developing a national service framework. What this framework would look like was yet to be determined and hence contributed to the lack of knowledge on national framework. What is surprising, however, is the fact that there were KSH who had not grasped the meaning. These people were in management positions and therefore, should have been more informed.

What beginning discussions that had occurred at this time was a proposed draft framework complied by Allen Consultancy Report (2009).

This report identified a number of challenges to implementing a national service framework, including: the perceived lack of awareness among the public as well as other service providers about MCH service; the issue regarding disparity in education and qualifications of MCH nurses across jurisdictions; the fact that professional territorial boundaries were reported to be a barrier to effective collaboration between different professionals (midwives, GP, MCH) providing care which may provide tension; and the limited mechanism for sharing information and linking data about children and their families across professions (Schmied, Kruske, Barclay & Fowler 2011). It could be argued, however, that not all of the necessary information was available. For one thing,
this feasibility study was undertaken before the implementation of national registration. Kruske and Grant (2012), confer that there was a need to comprehensively investigate further the education levels, qualification requirements and service delivery offered by the different jurisdictions across Australia to determine the correct mix of services and qualifications to be offered in the public and primary health areas. Not surprisingly, the data indicated that the MCH nurses were concerned about how the disparity in services that existed across Australia could be resolved to form one common service framework. From the data both the groups were in agreement that the Victorian model was the most comprehensive and could in fact be adopted in principle as the benchmark for the national service framework. This was thought to be for a number of reasons.

In addition, the Victorian Legislated Birth Notification (LBN) system is an example of why Victoria could be used as a benchmark as it demonstrates the continuity of care between the midwifery departments and the MCH service in the community. This Birth Notification process ensures the appropriate MCH service where the woman resides, is notified of the birth soon after delivery. This process is responsible for facilitating approximately 95-98 % of family engagement with the MCH service for the initial first Home Visit within two weeks following discharge from hospital (DEECD, 2010) This is in contrast to other states where the family must initiate first contact and engagement rates are lower (Allen Consultancy Report, 2009).

Although a number of child health services identify with being universal, there are few services that can demonstrate effective engagement and truly call themselves universal. The majority of MCH service evaluations have shown that the services are more likely to be accessed by families with a higher level of social determinants than that of vulnerable families, in spite of the intent and efforts of staff delivering the services (Allen Consultancy Report, 2009). The exception, however, to this would be child health services and programs that achieve high coverage rates. In other words, these services are more likely to be seen to achieve better outcomes than seen with services that deliver targeted approaches to client loads such as the vulnerable.

Further evidence of the comprehensiveness of the Victorian service and its worth of being a consideration for the benchmark of the national framework can be found in the DEECD service guidelines (2009). These guidelines indicated that the evidence based MCH service Key Ages and Stages (KAS) program provides families with 10 visits at key developmental stages between birth and 4 years, which is funded for approximately 6.75 hours (DEECD 2011). Three hours of this allocation is provided in the first four KAS visits (at Home visit, 2 weeks, 4 week and 8
weeks). These early visits are believed to be critically important to the support given to families during the transition to parenthood. However, both the Allen Consultancy Report (2009) and Schmied (2010) identified that while these early visits have been found to be beneficial there has been no research published to support this claim.

The Victorian MCH service supports families with children aged 0-6 years. These services are offered in an evidence based framework by way of the three streams which are: the Universal service, the MCH Line (a 24 hour telephone parenting support and advice service) and the Enhanced MCH service (DEECD, 2011). The Victorian MCH service has been applauded as ‘a world class service’ by Edgecombe (2009). In addition, the Victorian service has been described as ‘the envy of the rest of the country and well beyond the shores of this country’ (Scott, 2011:7). This is also supported by current literature which emphasises the quality of care and health outcomes of mothers, babies and families (Briggs, 2007; Schmied, et al., 2008; Schmied, Donovan, Kruske, Kemp, Homer & Fowler; Thomas & Kruske, 2008).

The success of the Victorian MCH service is believed to be built on a long history of being a local service that supports families through their transition to parenting and often beyond with subsequent pregnancies and children. The respect and credibility given to the MCH service has developed over time. It was commonly identified in the data from both groups that the model of continuity of care and care provider, along with a family partnership model of care is what has made the service in Victoria the success it is today. This refers to the provision of a state wide MCH program by a local MCH nurse with whom the family has an ongoing relationship. Like traditional general practitioners, some MCH nurses have provided care to successive generations of the same family. The majority of participants believed that a trusting relationship aided them in their efforts to coordinate care for the family and facilitated continuity of care. This is supported in the literature by Appleton and Crowley, (2009) which indicated that MCH nurses preferred to work within the continuity of carer model as this enabled them to more accurately assess all the needs and requirements of the family.

An interesting point to note from the data was that the MCH group, compared to the KSH, discussed more from the perspective of the fundamentals of service delivery. This was not surprising as they were more focused on the job as opposed to the profession, as identified earlier (Chaska, 1990). Furthermore, despite the fact that the Victorian nurses believed they had a superior service, they in fact had limited knowledge of services offered by the other jurisdictions. In contrast, the MCH knowledge of the Victorian service framework was quite
comprehensive. An interesting point to make here, therefore, is that these MCH nurses believed that they provided the best service which should then be used as a benchmark to develop the national service, when they were mostly unaware of what was offered elsewhere. It was however, not surprising that they did not know how services were provided elsewhere in Australia. Keeping informed is difficult unless one belongs to the professional organisation which helps keep people informed through the network this creates. This is again part of being a professional (Chaska, 1990). Interestingly though the KSH group should have been more aware of what services were provided elsewhere as this was part of their role as managers to know. This was found in this study to be not necessarily so.

The fact that this group of MCH nurse had such a strong belief that the Victorian service framework should be used as the benchmark for the national framework, made them appear insular and ignorant of the other professional jurisdictions across Australia. This could be referred as having territorial traits as they strongly defend what they perceive is the best service provided despite not being fully aware of what other jurisdictions do. There is a possible explanation for these perceived territorial traits by some as indicated by the early works of Reiger and Kelleher (2003), with their study on the ‘The emerging leadership role of Victorian Maternal and Child Health coordinators’. Reiger and Kelleher indicated that the Victorian MCH nurses traditionally shared a strong sense of identity as independent professional practitioners. In addition, Reiger and Kelleher (2003) found that following the commencement of Compulsory Competitive Tendering (CCT) during the early 1990’s, the Coordination of the service and, in part the MCH nurses, became more developed. This tendering process was part of the municipal restructuring and opened up the possibilities for other organisations, apart from the current MAV, to coordinate the services instead (Reiger and Keldeher, 2002). For instance, some of the community health centres tendered for the MCH service and were successful. A by-product of this tendering process was that it tightened up the management and structure of the service in the name of efficiency. Basically MCH nurses had to reapply for their positions and account for what they did and how they spent their time (O’Connor 2000). This then directly challenged traditional notions of MCH nurses’ identity and practice that were based on claims to professional autonomy. Throughout all the changes the traditional role of MCH was beginning to change with demarcation of roles causing anxiety and fear which lead to a defensive climate even though professional identity, vision and commitment remained strong (Reiger and Kelleher 2003). With all the bureaucratic changes within councils, not all nurses were able to make the mental ‘leap’ into the new regime. Some remained caught in the culture of the traditional system, however, by the late
1990s, with the redefinition of the MCH nurses’ roles a sense of identity and collaborative working environments became evident with wider Human Service teams emerging, at least in most services (Considine 1999). The CCT was abolished in 1999. The consequence of the CCT was that the MCH nurses became more accountable but at the same time became very territorial, not wanting to lose their autonomy or identity.

It was evident from the data that both the KSH and MCH had only vague knowledge of what other jurisdictions offered in regards to services and much of this was anecdotal. There was a necessity, therefore, to increase professional awareness and collaboration between the specialised MCH jurisdictions. In addition the KSH further believed that there was not a widespread understanding of what Victoria actually does by other professional and government bodies along with the other jurisdictions either. As a result the KSH indicated that this could very well be the fault of the MCH service themselves because it had not emphasised the service enough politically or used the evidence they had from the mothers that reinforced the Victorian model as being invaluable. KSH data offered in support of what the MCH nurses indicated in regards to pertinent information, that it was possible that the limited understanding of what Victoria does, could have been contributed to the era of leadership being too busy doing rather than evaluating. This was therefore, why, Victoria was in the position it was in, needing to prove why they were in fact better in Victoria. This also could be a reflection of the lack of professionalism in this group, as identified earlier (Chaska, 1990).

Similar to the mental health nurses, the MCH nurses found their professional identity remains ambiguous and poorly communicated outside their practicing fields (Happell 2009). It appeared from the data that a number of KSH and MCH nurses believed that, regardless of the context of practice, the capacity to identify and communicate the role of the MCH nurse has always been indistinct because the practice of MCH nurses is complex and not easy to ‘see’. MCH nurses work in a variety of clinical contexts outside of the traditional acute and sub-acute care settings. As the KSH and MCH nurses reflected, the more generic the model of care delivery the greater the ambiguity in their role. This could be because there are a core set of skills seen as common and necessary for all the MCH nurses with little regard for, or recognition of, specialised skills required for their positions (Meadows, Singh, and Grigg, 2007).

The KSH and MCH nurses were asked during their interviews what they believed the future was for the Victorian MCH nurses. The majority expressed the need to move forward to a nurse practitioner role. However, the nurse practitioner role was also seen to have a number of barriers
to establishing the role and career path. Many of the barriers indicated in the data from both groups referred to the setting up of the nurse practitioner role which evolved around their scope of practice, the regulatory environment, comprehension of the nurse practitioner role, the work environment and the different governances. The majority of the KSH and MCH nurses believed that their roles and responsibilities in the community actually support the General Practitioner as they take on similar responsibilities in delivering primary health care services. The finding from this study is supported by a similar study that utilized qualitative descriptive design to investigate nurse practitioners roles and responsibilities as primary care providers in Massachusetts and their perceptions regarding the barriers and facilitators to their scope of practice. (Poghosyan, Nannini, Smaldone, Clarke, O'Rourke, Rosato, and Berkowitz, 2013) This study found when they revisited the scope of practice for nurse practitioners that the role of the nurse practitioner role encompassed very similar barriers to what the KSH and MCH nurses indicated in their interviews, such as the setting up of governing authorities, the regulatory environment and the billing practices, and the lack of comprehension of the nurse practitioner role all limited the success of the nurse practitioner practice. This was despite the fact that they also believed that the nurse practitioners take on similar responsibilities as physicians to deliver primary care services.

In Victoria, the MCH service is currently located within the State Government’s Department of Education and Early Childhood Development (DEECD) portfolio. This department is accountable for the planning and provision of early childhood services in partnership with local government. Over the years, the MCH service has experienced many changes in departmental portfolios. The latest being a move from the Department of Human Services [now Department of Health] to the DEECD portfolio in August 2007 (DEECD 2013). This placed the service in Victoria as the only jurisdiction in Australia to be located in the education portfolio. The MCH services in all the other jurisdictions are situated within a health portfolio. The majority of participants in this study were unsure as to which portfolio the service would be best situated in, suggesting a portfolio that encompassed both health and education or even a separate portfolio altogether. These results speak to the complexity of the service as it provides both health promotion, which is about education and surveillance which is ultimately about health.

The MCH service has been seen as very successful over the years (Edgecombe, 2009; Scott, 2011). Part of the reasons why the service was deemed successful could be associated with which department the service was attached to as this influences policy direction and the service framework. As a result of the move to the education portfolio, for instance, the Victorian MCH
service had been seen to develop more of a research based practice model. This belief, however, is not reflected in the data given the perception held by a number of the participants of the incongruence of a health service model being delivered by an education portfolio.

Furthermore, the way the respective portfolios define themselves highlights conclusive differences in reference to the MCH service. For instance, the Department of Health’s core objectives lie with ‘achieving the best health and wellbeing for all Victorians’ through planning, policy development, funding and regulating health services (Victorian Department of Health 2013). It is well documented in the literature that health promotion is a large component of the MCH service and that it is integral in the wellbeing of the early childhood population (DEECD 2013). The DEECD in contrast, offer in their mission statement to, ‘ensure a high quality and coherent birth to adulthood learning and development system to build the capacity of every Victorian’. This is followed by DEECD’s key responsibilities’ to; inform outcomes that the department strives to achieve within its birth to adulthood learning and development agenda with outcomes to reflect that children have the best start in life to achieve optimal health, development and wellbeing (DEECD 2013). This in itself, however, does not reflect the essence of the MCH service and their contribution to the health and wellbeing of Victorian families. Specifically, the MCH service contributes to public health through health promotion which entails assessment, offering the parents anticipatory guidance and preventative strategies to promote optimal health and wellbeing of families. In addition, the observation of families is routinely undertaken in order to identify deviations from normal and this enables the vulnerable families that require further support to be identified and engaged in early intervention. Health promotion empowers people to increase their control over their health and make changes to improve health outcomes, which are very much the role of the MCH service (Diener and Chan, 2011).

Despite the evidence of the nature and complexity of the MCH service, it would appear from the data that there is a perception that DEECD lacks an appreciation of what the service entails and therefore, the question remains whether this is the correct portfolio for the MCH service to be situated in. This is further evidenced by the Auditor General’s report on Access and Quality of the Early Childhood Development Services (Victorian Auditor General’s Report 2011). The report highlighted the importance of not only promoting the health and learning development of young children, but that the quality of the programs enhance and have a marked effect on the children’s longer-term health, educational and social outcomes. This is especially evident with the children from vulnerable and disadvantaged families. The DEECD has been accountable for planning and
providing MCH services since 2007 (DEECD 2012), which also includes enhanced MCH services for vulnerable children, disadvantaged families and universal kindergarten. The audit by the Auditor General examined whether access to early childhood services has improved over this time and if services were meeting the required standards.

The significant finding from the DEECD report (DEECD 2012) however, tabled were that access to universal MCH, vulnerable children, disadvantaged families and universal kindergarten had in fact improved, with records indicating increased participation rates over the past five year period to 2010. Despite this, the Auditor General’s Report (2011) identified that DEECD could not demonstrate that early childhood services were being offered especially for vulnerable children and families in areas of significant need. The audit further identified that the department’s inability to consistently identify all vulnerable children and disadvantaged families meant it did not know to what extent these children were missing out on the benefits of specific services developed and funded to meet their needs. In addition, the report indicated that DEECD does not sufficiently understand or effectively manage early childhood services (Auditor General’s Report 2011).

There is no doubt that DEECD has had a number of achievements since taking on the MCH service, such as refining the structure of the service as well as instigating professional development of 1,200 MCH nurses (DEECD, 2009) in key areas such as, domestic violence, postnatal depression, QUIT, SIDS and sleep settling. Part of the issue here is, however, whether the MCH nurses value being under DEECD or instead that the department does not recognize the complexity and uniqueness of the service that MCH nurses provide. The principle behind the MCH service is health, which could further explain this confusion. It is clear from this that MCH nurses do not see themselves as educators promoting early childhood development, when their role primarily encompasses health promotion. This reflects the general confusion regarding the definition of health promotion as identified in the literature. For instance, Dunkley (2000) suggested that health education is often confused with health promotion. Health promotion is actually about activities that seek to promote healthy lifestyles with education being a part of that process. These terms, however, are not interchangeable. Health promotion is all encompassing with the MCH service being in a unique position with families to guide the adoption of a healthy lifestyle while raising awareness of health and development issues. This study clearly demonstrated the need for further investigation of the most appropriate portfolio to manage the MCH service. The MCH nurses reflected in the data on how the MCH service could move forward to enhance the synchrony between the service providers and management in order to benefit the
community. However, for many MCH nurses the question remains; are the governing bodies trying to put a square peg in a round hole having the MCH service in the Education portfolio or are they trying to ‘round the pegs or square the holes’ with the MCH service to make it fit. A suggestion made from the participant’s data in this study was the development of a separate portfolio all together.

‘imposed from above’

It was clear from the MCH nurse data that both groups strongly believed the change was imposed on them and that others were in fact making decisions on how the service should function without a great deal of communication and consultation with the workforce. The essence of the comments from the MCH nurses was that they believed there was not enough consultation with them regarding the national changes to registration and service provision. The depth of this concern was seen with numerous comments regarding not being involved and the lack of consultation from the organising bodies. Despite the fact that the KSH should have been more involved, the evidence from the data points to the fact that they were not. Instead they felt disenfranchised and ill-informed to precede with any implementation processes. This was an unexpected result from the KSH due to the fact that they were managers and therefore should be responsible for the change processes being implemented down the line. The MCH nurses data, however, indicated that they in fact wanted to know more about how these changes would be implemented and the impact on the MCH nurses themselves and the service they provided. Furthermore, the participants highlighted the importance that communication played to ensure that everyone was informed of the changes with the reasons thoroughly explored and not change for change sake. In addition, the KSH data indicated the importance of having a strong leadership of senior managers in order to lead the change. This was thought to include leaders from different levels of management which in turn was expected to establish and gain the cooperation of others. More significantly, they believed it was essential to get the right people driving the change management.
The similarity of these comments from the participants about what they identified as lacking throughout the introduction of the change they were going through and the work undertaken by Kotter (2012) is exceptional. The biggest concern the participants identified in the data was that they felt that the changes were imposed upon them and that they were not informed or part of the process to plan what was happening. These national changes in registration and service framework involved large scale or transformational change, which had the potential to significantly affect the MCH themselves and the service. Such change needs to be introduced correctly.

Kotter (1996; 2012), initially, examined numerous initiatives aimed at producing organisational change over some 25 years and analysed why change failed in these circumstances. The result was a list of common errors and reasons why change does not easily happen and may fail. This list was useful in assisting leaders of change to understand specific instances of resistance to change in order to develop approaches relevant for a particular situation (Senior 1997). Kotter (1996; 2012; Kotter and Cohen 2002) turned this list of errors around, resulting in identifying eight stages that must be present for achieving major change. Each stage was associated with one of the fundamental errors preventing change. These eight steps are likened to strategies that are about unfreezing the participants to plan the change, aiming to embed the change in the organisational culture. This is about a framework that is necessary to succeed with change (Kotter, 1996; 2012; Kotter and Cohen 2002).

The strategies that the participants identified as being important to them were the need for collaboration and consultation in order for them to have input into how the change would be, in other words creating a sense of urgency and empowering broad based action (Kotter and Cohen 2002). In addition, the participants identified that there was not enough information being disseminated to them in order that they were informed about what was happening, in other words, communicating the change (Kotter, 1996; 2012; Kotter and Cohen 2002). Finally the participants identified that there was need for strong leadership of senior managers in order to lead the change, in other words, developing a vision and strategy and creating a guiding coalition (Kotter, 1996; 2012; Kotter and Cohen 2002). The concerns expressed by the MCH nurses in this study therefore, equated to what Kotter identified as what needed to be present for achieving such major change.

The collection of forces, which underpins behaviour in organisations, is so formidable that, it is surprising that any change ever manages to be planned, let alone implemented (Mangham 1979). As Flint (1993) notes, change in maternity care is both hard to initiate and hard to live through. For change to be successful, the path has to be appropriate for the situation in hand. A health
service, as with any complex institution, finds change difficult for many reasons. This includes the fact that the situations are often complex, involving deep-seated, systems issues, which are embedded with complex social systems (Braithwaite, Hindle, Ledema and Westbrook 2002). Using some sort of process can assist in making the change achievable as other have found (McCourt and Page 1996).

It is important to note here that the participants in this study had a positive atmosphere regarding change albeit they recognised and acknowledged not only the advantages but the disadvantages as well. As previously identified in the data, the change to a national registration meant that there would need to be a reconceptualising of how the MCH service framework would operate nationally. This was a substantive change to experience plus the fact that the data identified that there were many errors with the implementation process. Despite this generally the data reflected that the MCH workforce felt positive towards change.

**Critique of the theoretical framework utilised**

The theoretical framework for this study was based on Kotter’s eight step framework for organisational change and management. This originated from the management area. As previously discussed Kotter (1996), initially examined numerous initiatives aimed at producing organisational change over some 25 years and analysed why transformational change failed in these circumstances. From this analysis, a list that was found to be useful in assisting leaders of change to understand specific instances of resistance to change in order to develop approaches relevant for a particular situation was developed (Senior, 1997). The result was a list of eight steps that were likened to strategies that are about unfreezing the participants to plan the change, aiming to embed the change in the organisational culture. This eight step framework of Kotter’s was chosen as the theoretical framework for the study because the steps align with the process required for successful organisational change and further identifies the contributing factors and common reasons why change does not easily happen or in fact fails.

In the current investigation, Kotter’s framework was used to highlight what processes were lacking and what could have been undertaken to assist achieving this change. A change of such a magnitude as the national registration and development of a national framework had never
been undertaken previously. This framework helped explain why participants in this study were feeling so disenfranchised with these changes. Furthermore, this theoretical framework provides a platform for the research to link those influential factors together and evaluate behavioural decisions that inform change. Both the KSH and MCH nurses indicated in the data that they had concerns related to the organisational change process of the move to a national registration and the development of the national service framework. Part of this was the fact that they strongly believed the change was imposed on them. Furthermore, there was concern that decisions on how the service should function were being made without a great deal of consultation and collaboration with the workforce in Victoria to assist in the development of these changes. In addition, the participants identified that there was not enough information being disseminated to the MCH practitioners in order that they were informed about what was happening. There was, however, some acknowledgement that the information sessions, letters and emails sent out by AHPRA along with information on the web site being difficult to understand and access as the server kept overloading.

Finally the participants identified that there was a need for strong leadership of senior managers in order to lead the change and that there managers should align themselves with others. These all follow the change framework that Kotter developed. In other words, by creating a sense of urgency, empowering broad based action, communicating the change, developing a vision and creating a guiding coalition (Kotter and Cohen 2002). This framework was therefore an apt theoretical framework for this research as it provided a basis to help understand why the participants were so disenfranchised.

The process of change transformation is described by Kotter (1996) as being based on one fundamental insight that change will not happen easily. The central reason identified in this study as being a barrier for change was the differing jurisdictional governances and the lack of involvement of the practitioners in the process to plan the change. Kotter and Cohen (2002) model further embeds the change process with this study by stating that without credible communication and leadership the vision for change is never captured. It is obvious that the KSH and MCH nurses felt undermined in the change process due to the inconsistent communication and behaviour shown by the change leaders. Embedding change in organisational culture is crucial for achieving change (Kotter, 1996; 2012: Kotter and Cohen, 2002). This outcome involves anchoring change within an organization’s norms and values so that the change becomes so much a part of the organisation that it is the organisation (Kotter 1996; 2012: Kotter and Cohen
Kotter’s eight step change model assisted the development of the current research by enabling a comprehensive understanding of the change process. The use of Kotter’s model has therefore assisted in this current study by giving further dimension to the data by providing an insight as to why the participants felt so disenfranchised as a result of National registration and the development of a proposed national framework.

Summary

A National Registration for the Health professions across Australia was first agreed on by COAG on 10 February 2006. This agreement was part of COAG’s National Reform Agenda designed to reinforce major changes aiming to raise living standards and improve services by increasing the productivity and workforce participation for the future years. The principles behind the National changes were to alleviate the bureaucratic regulatory burden imposed by the three levels of government, these being, local, state and federal governments. The aim of COAG was to have the jurisdictions work more efficiently with increased output. The significance, however, of the National reform for the MCH service in Victoria was the Human Capital Reform component of the National agenda that was to improve health, learning and work outcomes for all Australians. Cross border movement as a result from having one national registration was seen by the MCH and KSH as a positive move, however disparity between qualifications that had not been addressed prior to the implementation of the national registration was to be seen as a barrier to the free flow of staff across borders. This was identified by the Allen Report (2009) regarding the feasibility of a National Child and Family Health service and again post National registration implementation in a review of the qualification and education requirements by Kruske and Grant (2011). The disparity between jurisdictions previously, however, was the different registrations and requirements to practice in the jurisdictions which in turn following National Registration translated into qualifications and service standards.

This study highlighted the limited knowledge of a number of the KSH and MCH nurses regarding national registration. This was surprising as the build-up to the national registration was well documented in the available literature from the Victorian Nurses board and the Australian Nursing Federation (ANF). One possible explanation for this was that the Victorian nurses believed they had a superior service to the other jurisdiction. This was further evidenced with a number of the
MCH nurses and KSH having a limited knowledge of services offered by the other jurisdictions when asked if they were aware of what services were offered. The MCH nurses across the 3 groups discussed more of the fundamentals of service delivery which was not surprising as their focus throughout the interviews was on the grassroots of the job rather than the bigger picture. This made them appear insular and ignorant at times of the other professional jurisdictions across Australia. The MCH knowledge of the Victorian service framework was, however, quite comprehensive. The KSH not surprisingly had an additional awareness of the other jurisdictions and the overall process of the national change to the national registration, but were concerned more with the review processes for interstate applicants wanting to work in Victoria as MCH nurses. The review process for interstate applicants to date has not been assembled as the disparity between qualifications and educational standards do not equate between jurisdictions.

While the KSH were concerned more with the management and governances the MCH nurses were in turn also concerned about the possible impact on service delivery from the lesser qualified staff from interstate assessing and advising the clients without the knowledge and experience level required. This was in particular to the interstate trained staff that did not have a midwifery background.

Like many other developed countries (for instance UK, NZ and Canada), Australia has a well-developed system of universal health services for young children provided by community based nurses, although the services vary between jurisdictions (Allen report 2009). These community based nurses provide health education to families to promote health and wellbeing. In addition, the services offer support and guidance to families while developing parenting skills, assess the child’s growth, development and behaviour at the scheduled key ages and stages visits. Other services offered to the families include guidance in relation to family health, breastfeeding, immunisations, nutrition, and accident prevention and provide access to up to date information on child and family services (DEECD 2010; Schmied et al. 2008). In addition, MCH nurses promote the parent–child relationship and parental social and emotional wellbeing, as well as participate in community capacity building activities in response to local needs such as parenting groups (CHoRUS, sub. DR159). This reflects the changing nature of the complex role of today from the concerns regarding malnutrition and infectious disease that prompted the establishment of child health services (Vimpani 2004).

The increasing scope of health supervision and health recommendations challenge universal MCH services in Australia and a number of other developed nations of today. A primary health
care framework is required to analyse structural and practices of universal MCH services unique features in all the jurisdictions across Australia. Although universal MCH service content in Australia is similar, there are marked differences in the definitions of universal MCH services, qualifications and the scope of practice of primary care professionals. The knowledge and expertise required for MCH nursing practice today has developed significantly and continues to evolve as a consequence of research contributing to wider integrated evidence base practices while keeping aligned with changes to policy and governances. There is a need for comparisons and to define the structural and practice features of the individual jurisdictions service systems. Participant’s knowledge, attitudes and beliefs were explored and captured in this study which reflected the level of commitment and belief in the Victorian MCH service that is offered to the communities across Victoria. The belief that the uniqueness of the service offered in Victoria which encapsulates the Mother as being integral to the wellbeing of a child in developing sound physical, social and emotional development is expressed at time with a notable territorial attitude by a number of MCH nurses and KSH participants.

Conclusion

This chapter has discussed the insights of the participant’s perceptions to the national changes in terms of the literature. To summarise, this chapter has discussed the study insights concerning the perceived impact of the national changes to registration and service provision and identified those that represent new knowledge, those that confirm existing knowledge and those that extend current knowledge. The following chapter concludes this thesis with a number of recommendations supported by this study.
Chapter Eight
Conclusion and Recommendations

Introduction

The previous chapter presented the discussion that emerged from the analysis and triangulation of the two groups participating in this study. This chapter provides the researchers conclusion and makes key recommendations in relation to the perceived impact from the National changes to Registration and service provision on the Victorian MCH nurses. The conclusion and key recommendations in turn provide what the knowledge, attitudes and beliefs of the KSH and MCH nurses to the perceived impact of the national changes to registrations and service provision on the MCH nurses in Victoria are.

Summary of the Study

This study has explored the knowledge attitudes and beliefs of the Victorian MCH nurses to the national changes to registration and service provision. Wide variations between jurisdictions across Australia in regard to qualifications and educational preparation were a major concern to the Victorian MCH nurses. The Victorian MCH nurses are the only jurisdiction that required a midwifery qualification and a minimum Postgraduate Graduate Diploma in Child and Family Health to practice in this area. The significance of these disparities between the jurisdictions was perceived by the MCH nurses to potentially impact on the services they provided in Victoria, especially to the mother in the early postnatal period. In addition, the absence of a national minimum standard left the benchmark for the services open to interpretation. Further research was, therefore, seen as essential to determine what level of qualifications and service provision would be universally accepted for MCH practice.
A qualitative explorative descriptive method was employed for this study with purposive sampling of 48 nurses. Purposive sampling was chosen to ensure information rich cases ‘from which one can learn a great deal about of central importance to the purpose of the inquiry. Participants were divided into two groups drawn from a variety of areas in Victoria. The participants in Group One were 12 KSH who were academics, managers and persons with significance to education and service provision; the Municipal Association of Victoria (MAV), Victorian Association of Maternal &Child Health Nurses (VAMCHN), the Department of Education and Early Childhood Development (DEECD) and Co-ordinators from the Local Government Councils. Group Two participants consisted of 36 MCH nurses from the Universal service in the metropolitan, rural and remote area councils. This group was then divided into three groups depending on years of service.

Semi structured interviews were conducted in order to ascertain the MCH nurses knowledge of the national changes plus the perceived impact of implementation that these changes may have on the MCH nurses in Victoria. Pilot studies were attended for both groups for confirmability, creditability and fittingness. Questions identified to be culturally inappropriate or ambiguous were rewritten or deleted. The pilot samples from both groups were independent of the main sample.

The uniqueness of this study was in the exploration of the knowledge, attitudes and beliefs of the perceived impact of the national changes to registration and proposed changes to service provision on the Victorian MCH nurses. This study offered a unique perspective of the MCH nurses that had not been previously explored before.

**Summary of Findings**

The findings indicate that the KSH’s believed there was a lack of consultation and communication with decisions regarding what changes were being proposed prior to implementation. It was further argued that the processes of organisational change were not followed, resulting in frustration and a lack of confidence in the national agenda. In addition the attempts from COAG to offer consistency between jurisdictions in fact appeared to be creating further disparity. Furthermore, the loss of the notation of the MCH nurse qualification appeared to have caused a considerable amount of concern to all participants interviewed. In regards to the national framework there was surprisingly limited knowledge regarding what would constitute a national
service framework. Likewise there was agreement that the framework from Victoria could be a significant benchmark for consideration for the national service framework to be based on.

**Limitations**

This is a small qualitative study conducted in a specific jurisdictional location. Although the data has been collected from multiple areas in the jurisdiction, the findings cannot be generalised to Victoria or to the other jurisdiction across Australia. The findings from this study provide strong support for further research in this contemporary area of primary health due to the research being situated in Victoria and limited to only the Victorian MCH. These limitations do not undermine the value of this research, however, being unable to generalise with other states due to legislation and governance differences may be seen as a constraint. For this study there was one researcher, therefore, the epistemological considerations of the one researchers’ interpretation of the data was acknowledged whereas there could in fact be multiple realities to the explanations of the data. The final limitation recognized by the researcher was the potential for bias from the researcher as the researcher has identified herself as a MCH nurse in Victoria.

Sample bias relating to the timing of this study requires consideration as those that agreed to participate in the study may have been more negative due to the timing of this study. Factors for further consideration in relation to the timing of this study were; loss of the MCH qualification notation on the practicing certificate and the proposed national framework being in an embryonic state. For these reasons, undertaking another study may have differing outcomes to this present study.

**Strengths of the study**

This study is characterised by a number of key strengths. Firstly, it gives voice to the Victorian MCH nurse’s perceptions related to the national changes to registration and service provision. In terms of the study itself there are a number of strengths in the research design that add to, and underpin, this benefit to the knowledge, attitudes and beliefs about the perceived impact of the
changes to the MCH nurses. This includes: the transparency of the study which is an indisputable strength. All elements of the research processes were audited and overseen by the researcher’s supervisor. A rigorous approach was adopted from the formulation of the research questions through to development of the proposal, seeking ethics approval, data collection, exploring data and the formulation of the research results. All stages of the research were conducted ethically and the resulting insights have a high level of integrity because of the research process.

In addition, this study involved two groups of MCH nurses. The first participant group was at management level from academia, policy and coordination levels. The second participant group was drawn from the practitioners. This provided the full scope of opinions of the MCH group as a whole with different perspectives of the research questions obtained offering rich, thick and detailed descriptions. These insights are pertinent to MCH and inform practice, policy and education initiatives. The final strength was that the use of purposively selected participants that were drawn from metropolitan, rural, semi-rural and remote areas across Victoria.

**Recommendations**

It is recommended to have the MCH nurses across the jurisdictions fully engage in their future to advance the MCH service to its true potential as they adapt to the complex world of public health in the 21st century. There is a further need to address; practitioner resistance to change, the challenge of an ageing workforce, the importance of partnerships and the need to develop the evidence base further if primary health is to realize its true potential.

From the analysis of the presenting data it became clear that in order to achieve an understanding of the perceived impact to the Victorian MCH nurses from the national changes to registration and service provision, a comprehensive study of the changes and the impact should be attended before any of the changes are implemented. The paucity of published literature regarding the knowledge attitudes and beliefs of the MCH nurses in Victoria to the perceived impact of the national changes to registrations and service provision is an important contributing factor for the further requirement of additional research into these issues.
The recommendations for this study have been informed from the KSH and MCH nurses data. It is envisaged that the contribution of the individual participants will build on current expertise and promote continuous improvement of a universal national MCH service. These recommendations have been based on the fundamental principle that, in order to provide a universal MCF healthcare system the fragmented approach currently in place will not be effective to resolve the current issues of governance and disparity between the jurisdictions. Setting a national direction for the future requires a more integrated planning process than has been evident in the past.

The study recommendations are extended to all the jurisdictions of Australia. That is, to have a comprehensive evaluation of each jurisdiction’s services, the qualification level that best suits the needs of the individual jurisdictional requirements and situations. Furthermore, it is essential that the specific service requirements in each jurisdiction are accommodated for. Additionally, services may be identified that would also be of benefit for other jurisdictions that have not been previously identified.

Recommendations drawn from the ‘The Perceived Impact of the National Changes to Registration and Service Provision on the Maternal and Child Health Nurses of Victoria study’ are presented for MCH nursing in the specific domains that integrate Practice, Education and Research. These recommendations are key elements that are central to MCH nurses in the areas of their clinical practice, education requirements and for further research.

To provide a national service that seeks to promote a collaborative approach in providing a high level of service and to maintain the expertise needed for the development and advancement of the profession there needs to be further investment in MCH nursing education, training and research to facilitate future long term growth.

**Recommendations for Practice**

The following recommendations are made for MCH nursing practice.

**Increase the professional profile and identity of MCH nurses**
• With the increasing emphasis on community-based primary health a systematic review of the Maternal and Child Health nurse’s role in the community is recommended with the intent to consider and increase the professional role of MCH nurses to a Nurse Practitioner position.

• Increase the National professional profile of MCH services by a number of means including; MCH nurses being involved and belonging with state and National professional bodies; ensuring that the professional bodies are consulted regarding any Child and Family Health matters that may arise, including policy, practice, education and research; member of the professional body being invited to participate as members of other related professional bodies committees (for example, college of GP’s), and comment on any discussion documents.

• Peak professional bodies and professional organisations are required to facilitate discussion on presenting a common voice on all subject matter pertaining to all professional areas of Child and Family Health; such as position statements.

• Promote and increase the awareness of the MCH service within Peak Professional Organisations of the potential of the MCH service in the community as it is currently underutilised to its full potential in the current contemporary primary health care systems across jurisdictions. The time is right to be inclusive and collaborative with the emerging influence of specialist nurses in community based care.

• Ensure that information transfer is relevant, timely and of the standard expected of a peak professional body. (for example, a national journal equal to international standards).

**Maintain the Qualification requirements for MCH nurses**

• Eliminate the disparity in qualifications, variability in educational requirements and conflicting role expectations between jurisdictions by increasing the qualification and
educational requirements to assist with clear role definitions and clarity of roles in the community.

**Support the MCH nurses to be more connected with organisational change**

- Increase the professionalism of the MCH nurses to better connect and articulate with contemporary social, political and economic trends in health care delivery.

- Increase and promote inter-jurisdictional relationships with overarching policy and decision making for the National Universal Service Framework.

**Increase awareness of the uptake of traditional nursing roles by non-nurses**

- Establishment of clear guidelines for the role of non-nurses working within the community health area to prevent the diminishing of the nursing professional roles.

**Increase awareness of family centred practice**

- With respects to fathers, single, lesbian and gay families. Increase awareness of cultural diversity with respect to refugee, CALD, Indigenous, the vulnerable, and the disadvantaged families.

**Recommendations for Education**

The following recommendations are made for MCH nursing education.

**Development of a National Universal Education program**
• Development of a minimum standard for the education programs for MCH nurses across Australia by representatives from peak professional bodies.

• National Promotion of a Universal service across all jurisdictions.

**Actively promote a cohesive model of professional development for MCH nurses**

• Develop interdisciplinary professional development opportunities.

**Recommendations for Research**

The following recommendations are made for MCH nursing research.

Where the above recommendations for practice and education are implemented it is recommended that research evaluate the outcomes on MCH nursing practices and education. Ongoing research is necessary to assess the effectiveness of the change process and to inform future MCH practice outcomes.

Research issues recommended for further study includes:

• Undertake a systematic and comprehensive review for the requirement of the midwifery qualification for maternal and child health care in the community - as a required qualification to practice in MCH across all jurisdictions.

• Undertake a comprehensive evaluation of all the jurisdictions practice - to inform the development of benchmarks to recognise minimum national standards of practice.

• Undertake a comprehensive evaluation of all the jurisdictions services - to inform the development of benchmarks to recognise minimum national standards of practice.
• Undertake a comprehensive evaluation of professional development - and what is required to fulfil the practitioners and the employer's role in mandated continuing professional development for practice registration.

• Undertake a comprehensive evaluation of scope of practice – to identify barriers and enablers of the Bachelor of Midwifery qualification and the appropriateness of being allowed as an entry point to the MCH nursing post graduate program.

• Create a research culture for MCH- Increase jurisdictional collaboration through a positive research culture to inform practice by publishing significant cross jurisdictional findings in practice.

Challenges in the future

There is a strong possibility that a full integration of services between the jurisdictions may not be achievable in the short term. Long term solution may, however, be possible if evidenced based frameworks for practice are developed and validated to support primary health care services to families in the continuum of care in the early years. Furthermore, the decisions regarding the disparity of qualifications and educational requirements cannot be made by policy makers alone. For such an integration of professionals to proceed, there requires strong collaborative commitment between not only the governing bodies and peak professional groups, but also the grassroots workforce needs to be involved, included and to feel valued as part of the change process. In addition there needs to be a concerted commitment from governing bodies to adequately resource and independently fund the national framework to facilitate a collaborative transition to a National Universal Maternal and Child Health platform.

The most important and challenging effect of all will be to change the mindset of practitioners to further develop their own body of knowledge and professional outlook. For this to occur, a significant change in the professionals’ perceptions and vision of the service for the future is required. With this mind shift comes greater responsibility of professionalism, where once certain tasks have been considered a nursing task may now be attended by personnel with less training.
Similarly, many types of care previously provided by medical practitioners can be effectively provided by advanced practice registered nurses such as MCH nurses. This continuum of care will no doubt shift the importance of primary health nursing. The implications of this type of change for MCH nursing will be considerable as a quantum shift of such a magnitude is not yet fully understood or comprehended by governing bodies and practitioners themselves either. MCH nurses could, therefore, undertake more reflective research into their own practice by asking the women what they want from the service.

**Conclusion**

This thesis explored the perceived impact of the change to a National Registration and service provision on the Maternal, Child and Family Health (MCH) nurses in Victoria. The period of time just prior to and after the implementation of the National Registration saw the emergence of an unsettled period of time for the MCH nurses which in fact remains unresolved at present. A number of the MCH nurses were questioning their value and worth, with some going as far to question their employability as MCH nurses. Much of this was due to the loss of the notation of being qualified MCH nurses on their registration and the pending possibility of having the midwifery qualification removed as a requirement to practice as a MCH nurse in Victoria. Primary health care offered by the MCH nurse is considered essential health care, which is universally accessible to all individuals and families in the community. The MCH nurse is most often the first level of contact many families have with a support agency in the community following discharge from hospital after giving birth. It is well recognised in the literature that children and families require good access to appropriate services and that the services are well positioned in the community.

This thesis contends that further research is required to thoroughly examine how the national service compilation would be accomplished. It is further advised that there is a need to investigate thoroughly and have a national collaborative discussion on the future direction then decide the direction the service should proceed. While retaining and preserving the current Victorian MCH service is commendable the service needs to change with the times to be more reflective and
responsive to clients’ needs especially the vulnerable and the disadvantaged. In saying this, the Victorian service should be considered as a benchmark for the National service to be based upon. In doing so, this would enable increased flexibility for the National Services to work with vulnerable and disadvantaged families through the provision of proportionate support and an increased level of service frequency, intensity and interventions.

Most significantly this study has contributed to the literature with new knowledge as to what is known about the Victorian MCH nurses and their knowledge, attitudes and beliefs regarding the national changes. This was revealed by the participants in their interviews and will contribute to the growing knowledge base of underpinning factors from the impact of the decision to move to a national platform for all health professionals. A number of the insights from this study confirm what is already known as existing knowledge. These have been identified in this chapter and include issues such as communication pathways, collaboration between jurisdictions, disparity of qualifications and education pathways. Other insights revealed by this study have built on or have extended existing knowledge regarding the national changes. The researcher believed this was due to the rich description revealed by the participants in their interviews which gave voice to the passion and dedication of the MCH nurses of Victoria. Becoming a Mother for the first time and having a baby is one of the biggest life changing decisions a mother can make.

Being a MCH nurse in the universal service is a highly valued position by the MCH workforce in Victoria. This thesis has explored and illuminated the perceived impact of the national changes to registration and service provision as voiced by the MCH nurses who participated in this study. This study has in addition, given the Victorian MCH nurses a voice in regards to the national changes where otherwise they believed they would not have had one. While this research study has been concluded and offered for critique and comment by the academic community, from a qualitative explorative descriptive perspective the investigation of the phenomenon of the perceived impact of change on the Victorian MCH nurses cannot be completed. This is because change is constant and new reviews are always being instigated. Nonetheless, the findings presented here contribute a rich insights and awareness of this phenomenon. The challenge remains for MCH nurses to reflect on theses and to use the insights revealed here to value their worth as a specialty nursing and educational service to the community.
Taking the “Midwife” out of credentials enables you to take the “Maternal” out of the service and the “Mother” out of a child’s world... without a Mother... a child cannot survive... Anon
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Volunteers Needed

For a study looking at the Knowledge, Attitudes and Beliefs of Key Stakeholders and Victorian Maternal & Child Health Nurses to The National Framework and National Registration.

The purpose of this study is to investigate the knowledge attitudes and beliefs of Key stakeholders and Victorian Maternal & Child Health Nurses of the impending changes with the introduction of the National Framework and National Registration.

Volunteers need to be:

✓ A Victorian Division 1 nurse with midwifery endorsement and the additional qualification of Maternal & Child Health.
✓ Stakeholder with specific involvement in implementation of National changes.
✓ Working as Maternal & Child Health Nurse.
✓ Minimum 12 months experience.
✓ Willing to participate in an individual interview.

Interviews will be audio taped, lasting approximately 45 minutes and will occur at a time and place agreed to with the researcher.

For further information or expressions of interest please contact:

Rayleen Breach at RMIT University on 9925 7417
Email: Rayleen.breach@student.rmit.edu.au

Dr. Linda Jones at RMIT University on 9925 7417
Email: linda.jones@rmit.edu.au
**Appendix: B**

**School of Health Sciences**
PO Box 71  
Bundoora VIC 3083  
Australia  
Tel: +61 3 9925 7376  
Fax: +61 3 9467 5286

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**Project:** The perceived impact of the National Changes to Registration and Service Provision on the Victorian Maternal Child and Family Health Nurses: *A Qualitative approach.*

**Participation Number:**  
Demographic details

**Personal Information**

Please provide your details below:

1. **What are your current qualifications?** *(please tick all that apply)*
   - Registered Nurse  
   - Registered Midwife  
   - Grad. Dip. Community Health  
   - Grad. Dip. Maternal and Child Health  
   - Master of Maternal and Child Health/Public Health  
   - Lactation consultant  
   - Nurse Immuniser  
   - Other *(Please specify)*  

2. **Which of the above qualifications do you use in your practise?** *(please tick all that apply)*
   - Registered Nurse  
   - Registered Midwife  
   - Grad. Dip. Community Health  
   - Grad. Dip. Maternal and Child Health  
   - Master of Maternal and Child Health/Public Health  
   - Lactation consultant
3. **How long have you been a practising MCH Nurse?**

<table>
<thead>
<tr>
<th>Duration</th>
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<tbody>
<tr>
<td>≤ 1 years</td>
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<tr>
<td>2-5 years</td>
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<tr>
<td>6-10 years</td>
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<tr>
<td>11-15 years</td>
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<tr>
<td>16-20 years</td>
<td></td>
<td></td>
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<tr>
<td>≥ 20 years</td>
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</tbody>
</table>

4. **How old are you?**

<table>
<thead>
<tr>
<th>Age Range</th>
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</thead>
<tbody>
<tr>
<td>25 - 35 years</td>
<td></td>
<td></td>
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<tr>
<td>36 - 45 years</td>
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<td>46 - 55 years</td>
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<tr>
<td>56 - 65 years</td>
<td></td>
<td></td>
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<tr>
<td>≥ 66 years</td>
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</tbody>
</table>

5. **Where is the bulk of your practice? (please tick all that apply)**

- Universal   
- Enhanced Maternal and Child Health   
- Outreach   
- Home Visiting   
- Team Leader   
- Clinical Education   
- Other (Please specify)...........................................................................................................

6. **Are you aware of the National Changes?**

- Yes/No  
  
  Please specify...........................................................................................................

7. **Have you attended any professional Development regarding the National changes?**
Yes/No Please specify........................................................................................................
Project working title:

The perceived impact of the National Changes to Registration and Service Provision on the Victorian Maternal Child and Family Health Nurses: A Qualitative approach.

Investigators: Rayleen Breach - rayleen.breath@student.rmit.edu.au  
Dr Linda Jones - linda.jones@rmit.edu.au

My name is Rayleen Breach (Maternal and Child Health Nurse). I am conducting a study as part of the requirement for my Doctor of Philosophy in the School of Health Sciences, RMIT University Bundoora. This information sheet describes the project in straightforward language, or ‘plain English’. Please read this information sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators for clarification.

Who is involved in this research project? Why is it being conducted?

This research is part of the requirement for a Doctor of Philosophy thesis. Approval by the RMIT Human Ethics Advisory Committee and DEECD Ethics committee has been granted for this study.

You are invited as a Key Stake Holder or Maternal and Child Health Nurses working in or as a significant persons to the Universal service to participate in this study. The projects aim is to explore the; Knowledge, Attitudes and Beliefs of Key Victorian stakeholders and Maternal and Child Health Nurses in regards to the National changes to registration and proposed service provision.
Why have you been approached?

The number of Maternal and Child Health Nurses required for this study will be 20 to 25 purposively sampled on years of experience, (i.e. less than 5 years, between 6-14 years and over 15 years), (or until no new additional information can be gained with further interviews).

The number of Key stakeholders required for this study will be 10 to 15 recruited for interview MCH Co-ordinators network, DEECD and the Municipal Association of Victoria (or until no new additional information can be gained with further interviews).

If I agree to participate, what will I be required to do?

Semi structured interviews will be conducted in order to discover key stake holder's knowledge of the National changes as well as the potential impact of these changes on the Maternal and Child Health Nurses in Victoria.

The Maternal and Child Health Nurse component of the study will be conducted by way of semi structured interviews to discover the Maternal and Child Health Nurses current knowledge, attitudes and beliefs in relation to the National changes to registration and proposed service provision.

What are the risks or disadvantages associated with participation?

There is a low level of risk associated with participating. If you are unduly concerned about any of your responses to the interview questions or find your participation in the project distressing, please contact Dr Linda Jones to discuss your concerns at a time suitable to yourself. Dr Jones will discuss these concerns confidentially and suggest appropriate follow-up, as required.

What are the benefits associated with participation?

Your participation in this study will benefit yourself and colleagues while ensuring the knowledge gained regarding the transition to the national changes on the Victorian Maternal and Child Health Nurses is explored and made available to the respective management implementing the national changes. By exploring the knowledge, attitudes and beliefs of Key
stakeholders along with Victorian Maternal and Child Health Nurses, it is envisaged the transition and organizational change processes required across jurisdictions will be more effective as a consequence.

This contemporary research has the potential to inform the development of future policy in the early year's domain.

What will happen to the information I provide?

Once the research has been conducted and findings analyzed you will have access to the information gathered via a written report. During the study all research documentation will be securely stored at the researcher's property in a locked cabinet. On completion of the study all data will be stored at RMIT for a period of 5 years upon completion of the project before being destroyed. Any information that you provide can be disclosed only if; you provide the researchers with written permission.

Results from this research will be published and presented at conferences. A copy of the final reporting will be made available to RMIT and DEECD for their records. The study will generate useful information and insight into the knowledge and transition experiences of the Victorian Maternal and Child Health Nurses to a National body. If you wish to receive a copy of the results from the study please contact Rayleen Breach by phone on 9925 7417, or email rayleen.breach@student.rmit.edu.com.au or address Rayleen Breach, School of Health Sciences. PO Box 71, Bundoora Victoria. 3083 Australia.

If you agree to an interview a consent form is required to be signed for the use of data from the study. All information relating to you will be kept strictly confidential and only accessible to me and my supervisors.

What are my rights as a participant?

- The right to withdraw from participation at any time without prejudice.
- The right to request that audio recording be terminated at any stage during the interview.
- The right to confidentiality - the documentation from your interview will be de-identified by coding given to each participant. Codes will be securely stored at RMIT Bundoora as per the Human Research Ethics Committee guidelines.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any ti
**What other issues should I be aware of before deciding whether to participate?**

Your participation is voluntary with no incentives being offered. There are no disadvantages, penalties or adverse consequences for not wanting to participate or for withdrawing from the study.

**Whom should I contact if I have any questions?**

Any questions regarding this project may be directed to the investigators.

Rayleen Breach - rayleen.breach@student.rmit.edu.au  Principal Investigator. Phone: 99257417
Dr Linda Jones - linda.jones@rmit.edu.au  Senior Supervisor RMIT. Phone: 99257417

Name: ___________________________  Date: ___________________________
(Signature of Principal Investigator)

Name: ___________________________  Date: ___________________________
(Signature of senior supervisor)

Name: ___________________________  Date: ___________________________
(Signature of second supervisor)

Further enquiries and/or complaints concerning your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001.
Telephone number: (03) 9925 1745
Details of the complaints procedure are available from the above address.
Research working title:

The perceived impact of the National Changes to Registration and Service Provision on the Victorian Maternal Child and Family Health Nurses: A Qualitative approach.

Participation Number: ☐

Interview Questions for Key Stake Holders

National Registration

1. What is your understanding of National Registration?
   
   (Prompt to describe National Registration)

2. What impact do you think National Registration will have on the M&CH service in Victoria?

3. What impact do you think National registration will have on Employment opportunities?
   
   (Prompt to describe impact on employment opportunities).

4. Do you believe National registration will change how the Victorian Maternal and Child Health will practice?
   
   Yes/No – Why

5. Has your organisation put in place any review processes for interstate applications to work in your local area?
   
   Yes/No – What

6. Is there anything else you would like to add in regards to National registration?
**Proposed National Framework**

7. What is your understanding of the proposed National Framework for the Universal Child and Family Health Services?

   *(Prompt to describe National Framework)*

8. Do you think the proposed National Framework will influence your current position?
   - Yes/No – Why
   - How

9. Do you believe there has been wide enough consultation with the stakeholders on the proposed National Framework?
   - Yes/No – Why

10. Do you believe the Victoria model should be adopted in principle for the National Universal service?
    - Yes/No – Why

11. What do you believe are the most important aspects of a National Framework?
    *(Request up to five suggestions in level of important to them)*.

12. Has your organisation put in place any review processes for implementation of a new framework?
    - Yes/No – What

13. Is there anything else you would like to add in regards to the proposed National Framework?

**Qualifications**

14. What do you understand in regards to ‘Recency of practice’?
    *(Prompt to describe recency of practice)*

   **Statement:** ‘Recency of Practice’
   This means that a practitioner has maintained an adequate connection with, recent practice in, the profession since qualifying or obtaining registration.
   Nurses and Midwives must demonstrate that they have practiced in their profession within the past five years for a period equivalent to a minimum of three months full time (these hours can be accumulated over five years); or successfully completed a program or assessment approved by the Board; or successfully completed supervised practice approved by the Board.

15. Do you believe the current nursing and midwifery qualifications to practise in Victoria as a M&CH service should be maintained?
Yes/No – Why

17. How important do you believe it is to keep midwifery as a requirement for M&CH postgraduate qualification?
   Yes/No – Why (Prompt to describe how and why this is important)

18. Do you believe the current qualifications to practise as M&CH in Victoria should be adopted by all the other states?
   Yes/No – Why?

19. What do you see as a future pathway for the Maternal and Child Health Nurse in Victoria?
   (Prompt to describe possible future pathway direction)

20. Would you be prepared to support the MCH nurse in the additional postgraduate studies required for the Nurse Practitioner role?
   Yes/No – Why

21. How familiar are you with the qualifications required in the other states to practise as Child and Family Health / Maternal and Child Health workers compared to qualifications in Victoria?
   (Prompt to indicate knowledge of required qualifications in other states)

   Statement: Child and Family Health Nurses qualified in other states may not have the same level of qualification as the Victorian Maternal and Child Health Nurses.

22. How do you suggest you could have been better prepared for the transition to the National Registration? (If applicable)

23. Is there anything else you would like to add in regards to qualifications?

Service provision

24. How familiar are you with the services provided by the other states compared to services provided in Victoria?
   (If No – what recommendations would you make to facilitate consultation?)

25. Do you believe the proposed National Framework will influence your current position as a key stakeholder?
   Yes/No - Why & How (Prompt to describe influence on current position)
26. If a position became available interstate would you apply?
   Yes/No – Why

27. Do you believe Maternal and Child Health service should be in the Education or Health portfolio?
   Yes/No – Why

28. Is there anything else you would like to add in regards to service provision?

   **Professional Development**

29. Do you see difficulties with MCHN’s completing their Professional Development required hours in your organisation?
   Yes/No – Why

30. How will your organisation assist with this requirement?
    
    *(Prompt to describe assistance)*

31. Is there anything else you would like to add in regards to professional development?
    
    *(Prompt to give examples)*

   **Organisational Change**

32. Do you feel comfortable with change?
   Yes/No – Why

33. What do you perceive the advantages of change?
    
    *(Prompt to give examples)*

34. What do you perceive the disadvantages of change?
    
    *(Prompt to give examples)*

35. What do you perceive as the most important aspect of implementing organisational change in your organisation?
    
    *(Prompt to give up to five examples in order of importance)*

36. Is there anything else you would like to add in regards to organisational change?
Research working title:

The perceived impact of the National Changes to Registration and Service Provision on the Victorian Maternal Child and Family Health Nurses: A Qualitative approach.

Interview Questions for Maternal and Child Health Nurses.

Participation Number: 

National Registration

1. Can you tell me what your understanding of National Registration is?
   
   *(Prompt to describe National Registration)*

2. What impact do you think National registration will have on the M&CH nurses in Victoria?
   
   *(Prompt to describe belief of impact from changes on).*

3. What impact do you think National registration will have on Employment opportunities?
   
   *(Prompt to describe impact on employment opportunities).*

4. Do you believe National registration will change how you practice?
   
   Yes/No – Why

5. Is there anything else you would like to add in regards to National registration?

Proposed National Framework

6. What is your understanding of the proposed National framework for the Universal Child and Family Health Services?
   
   *(Prompt to describe National Framework)*

7. What do you believe are the most important aspects of a National Framework?
(Request up to five suggestions in level of important).

8. Has your organisation put in place any review processes for implementation of a new framework?
   Yes/No – What

9. Do you believe the proposed National Framework will influence your current position as a practising M&CHN in the Universal service? (Prompt to describe belief of changes)
   Yes/No – Why

10. How do you suggest you could have been better supported for the transition to the proposed National Framework?
    (if applicable prompt to describe support efforts required).)

11. Has your organisation put in place any review processes for implementation of a new framework?
    Yes/No – What

12. Do you believe the Victoria model should be adopted in principle for the National Universal service?
    Yes/No – Why

13. Is there anything else you would like to add in regards to the proposed National Framework?

Qualifications

14. What do you understand in regards to ‘Recency of practice’?
    (Prompt to describe recency of practice)

   **Statement:** ‘Recency of Practice’
   This means that a practitioner has maintained an adequate connection with, recent practice in, the profession since qualifying or obtaining registration. Nurses and Midwives must demonstrate that they have practiced in their profession within the past five years for a period equivalent to a minimum of three months full time (these hours can be accumulated over five years); or successfully completed a program or assessment approved by the Board; or successfully completed supervised practice approved by the Board.

15. How important is it to you to keep midwifery as a requirement for the M&CH postgraduate qualification? (Prompt to describe how and why this is important)
    Yes/No – Why
16. Do you believe the current qualifications to practise as M&CH in Victoria should be adopted by all the other states?
   Yes/No – Why?

17. What do you see as a future pathway for Maternal and Child Health nurses in Victoria?
   Yes/No - Why

18. Would you be prepared to undertake the additional education required for the Nurse Practitioner role?
   Yes/No – Why

19. How familiar are you with the qualifications required in the other states to practise as Child and Family Health / Maternal and Child Health workers compared to qualifications in Victoria? (Prompt to indicate knowledge of required qualifications in other states)

   **Statement:** Child and Family Health Nurses qualified in other states may not have the same level of qualification as the Victorian Maternal and Child Health Nurses.

20. Should interstate qualified Child and Family Health nurses be given the same employment opportunities as qualified Maternal & Child Health Nurses in Victoria?
   Yes/No – Why?

21. Do you believe the current qualifications to practise as M&CH in Victoria should be adopted by all the other states?
   Yes/No – Why?

22. How do you suggest you could have been better prepared for the transition to the National Registration? (If applicable)

23. Is there anything else you would like to add in regards to qualifications?

**Service provision**

24. How familiar are you with the services provided by the other states compared to services provided in Victoria?
   Yes/No (If Not – what recommendations would you make to facilitate consultation?)

25. If a position became available interstate would you apply?
   Yes/No – Why
26. Do you believe Maternal and Child Health service should be in the Education or Health portfolio?
   
   Yes/No – Why

27. Is there anything else you would like to add in regards to service provision?

Professional Development

28. Do you see difficulties with completing your Professional Development required hours?
   
   Yes/No – Why

29. What has your organisation put in place to ensure Professional Development hours are completed?
   
   Yes/No – Why (Prompt to give examples)

30. Is there anything else you would like to add in regards to professional development?
   
   (Prompt to give examples)

Organisational Change

31. Do you feel comfortable with change?
   
   Yes/No – Why

32. What do you perceive the advantages of change?
   
   (Prompt to give examples)

33. What do you perceive the disadvantages of change?
   
   (Prompt to give examples)

34. What do you perceive as the most important aspect of implementing organisational change.
   
   (Prompt to give examples)

35. Is there anything else you would like to add in regards to organisational change?
Prescribed Consent Form for Persons Participating In Research Projects Involving Interviews, Questionnaires or Disclosure of Personal Information

Portfolio
School of
Name of participant:
Project Title:

Health Science, Nursing and Midwifery

The perceived impact of the National Changes to Registration and Service Provision on the Victorian Maternal Child and Family Health Nurses: A Qualitative approach.

Name(s) of investigators:

Principal Investigator
Rayleen Breach
rayleen.breach@student.rmit.edu.au

Senior supervisor
Dr Linda Jones
linda.jones@rmit.edu.au

1. I have received a statement explaining the interview/questionnaire involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.

3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.

4. I acknowledge that:
   (a) Having read Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to DEECD and RMIT Library as a thesis. Any information which will identify me will not be used.

Participants Consent

Participant: ___________________________ Date: ___________________________
(Signature)

Witness: ___________________________ Date: ___________________________
(Signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 2251.

Human Research Ethics Committee, June 2005
Details of the complaints procedure are available from the above address.
Dear

I am presently enrolled as a PhD student at RMIT University Bundoora undertaking research in relation to the National changes currently being implemented. I request permission to interview select M&CH nurses including the M&CH Coordinator at -------------- council. The research involves a semi structured interview of approx 45 minutes on their knowledge, attitudes and beliefs regarding implementation of National Registration and the proposed Universal Framework. Appropriate times will be arranged with the staff member so as to not impede on work requirements.

By exploring the knowledge, attitudes and beliefs of Key stakeholders along with Victorian Maternal and Child Health nurses, it is envisaged the transition and change process across jurisdictions will be more effective as a consequence. This contemporary research has the potential to inform the development of future policy in the early year’s domain.

Please indicate your approval of this permission by signing the letter where indicated below and returning it to me by e-mail at your earliest convenience. Your signing of this letter will confirm permission to contact staff in the above mentioned area of the ------------ council to participate in the research.
Thank you for your consideration.

Sincerely,

Rayleen Breach

**Principal investigator**
Qualifications: Grad.dip Nursing RMIT,
Grad.Cert. Diab.Ed, RN, RM, M&CHN
School: Health Sciences
Discipline of Nursing and Midwifery
Address: PO Box 71,
Bundoora Vic. 3083
Phone: 99257417
Email: rayleen.breach@student.rmit.edu.au

**Senior Supervisor**
Name: Dr Linda Jones
Qualifications: PhD, MNA, B Appl. Sc, Grad Dip Ed, RM,RN.
School: Health Sciences RMIT Bundoora
Discipline of Nursing and Midwifery
Phone: 99257417
Email: linda.jones@rmit.edu.au

**Permission granted for the above request:**

Sign: ____________________________________________

Date: __________________________
14th February 2011

Rayleen Breach
9 Claremont Street
Craigieburn VIC 3064

Dear Rayleen

ASEHAPP 73 – 10 BREACH What are the National influences on the changing role of Maternal and Child Health Nurses working in the Universal Child and Family Health Service in Victoria

Thank you for submitting your amended application for review.

I am pleased to inform you that the CHEAN has approved your application for a period of 2 Years to February 2013 and your research may now proceed.

The CHEAN would like to remind you that:

All data should be stored on University Network systems. These systems provide high levels of manageable security and data integrity, can provide secure remote access, are backed up on a regular basis and can provide Disaster Recover processes should a large scale incident occur. The use of portable devices such as CDs and memory sticks is valid for archiving; data transport where necessary and for some works in progress. The authoritative copy of all current data should reside on appropriate network systems; and the Principal Investigator is responsible for the retention and storage of the original data pertaining to the project for a minimum period of five years.

Annual reports are due during December for all research projects that have been approved by the College Human Ethics Advisory Network (CHEAN).

The necessary form can be found at: http://www.rmit.edu.au/governance/committees/hrec

Yours faithfully,

Diana Donohue
Chair, Science Engineering & Health
College Human Ethics Advisory Network ‘A’

Cc: CHEAN Member: Madeleine Shanahan School of Medical Science
Supervisor/s: Linda Jones School of Health Sciences
Eleanor Holroyd School of Health Sciences