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*He iwi kē koutou, he iwi kē matou, engari  
i tenei wa, tatou, tatou e*

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**You are different, we are different, but we  
are able to work together**

Family Partnership as a Model for Cultural  
Responsiveness in a Well Child Context

A thesis presented in partial fulfilment of the requirements for the degree  
of  
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**Zoë Kristen Tipa**

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## ABSTRACT

In 2006 the Royal New Zealand Plunket Society embraced a model of communication and practice titled Family Partnership. The Family Partnership model and training is designed to develop the communication skills of professionals working with families in order to acknowledge and enhance the capabilities of parents. It is acknowledged that the degree to which a service is culturally safe is defined by the individual receiving the service. Nurse leaders, educators and peers are consistently required to make judgements as to the extent to which the nurse being observed is culturally safe, without obtaining client feedback. This research examined whether the Family Partnership model could be considered a model for cultural responsiveness with the dual benefit of providing a platform to more accurately assess the cultural competence of Plunket nurse practice.

An evaluation design and methodology was used to determine the relationship between Family Partnership training for Plunket nurses in relation to Māori health outcomes. There were two phases in the data collection process. In phase one an online survey was completed by a group of Plunket nurses who had completed Family Partnership training along with a group that had not completed Family Partnership training. Phase two included ten observations and interviews with Plunket nurses and Plunket clients who identified as Māori. A combination of evaluation tables to determine merit and thematic analysis were used for the analysis of the mixed methods data.

The results were presented in three sections relating to Plunket nurse practice, client experience and the impact on Plunket as an organisation. All Plunket nurses who participated in the research believed that Family Partnership had a positive impact on their clinical practice. The extent to which their practice had changed was difficult to determine, however the need for ongoing updates in Family Partnership was strongly indicated. Māori Plunket clients were generally satisfied with the Plunket service and their responses aligned with the concepts outlined in Family Partnership communication theory. The relationship between the findings and the principles of the Treaty of Waitangi were highlighted. This research has indicated that cultural responsiveness can be defined as the way in which a service identifies and attempts to meet the needs of the individual. It has discussed the complexity around what constitutes a health outcome for Māori clients and ultimately how cultural competence may be better assessed in practice.

## ACKNOWLEDGEMENTS

This research has taken me on a journey, both personally and professionally and has inspired me to think about the ways in which cultural responsiveness is generated and demonstrated across all aspects of life. This thesis provides my account of this journey and is a testament to the generosity and humility of the people who took part.

Firstly I would like to thank the Plunket clients (whānau) who volunteered their time and feedback. Thank you for your openness and willingness to share your experiences with me. Thank you also to the Plunket nurses who volunteered to participate. You all demonstrated a determination towards improving health outcomes for Māori by looking at ways to improve the service provided to Māori whānau.

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Thank you to my supervisor, Dr Stephen Neville, for your honesty and commitment to seeing me complete this thesis. I want to acknowledge Dr Denise Wilson for her inspirational assistance in the early stages of developing my research topic. To Florence Trout and Sandra Innes from Plunket- thank you so much for your ideas, enthusiasm and confidence in me. To Helen Topia, you are a great friend and amazing nurse who will always challenge me to push the boundaries, thank you for your continued support and friendship. To my previous colleagues at Te Ha and current colleagues at Plunket, thank you for your interest and support and for the motivational conversations just when I needed them. Thank you to Marg Bigsby who proof read my research near the final stage. Also thank you to Brenda Ing, you are my friend, family and colleague all in one, thanks for the help with my formatting!

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## CHAPTER 1 – INTRODUCTION

Irihapeti Ramsden is widely acknowledged as the pioneer of cultural safety in healthcare both within Aotearoa New Zealand and Internationally (Ellison-Loschmann, 2003). In her Doctoral thesis titled “Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu” Ramsden stated that “in the future it must be the patient who makes the final statement about the quality of care which they receive. Creating ways in which this commentary may happen is the next step in the Cultural Safety journey” (2002, p 181). It is this ‘next step’ in the journey of cultural safety that has proven elusive over the past ten years. Having completed some training and facilitation of a communication programme called Family Partnership within my role as a Clinical Educator for Plunket, I began to think about the close relationship between cultural safety and communication. I therefore decided to focus this research upon how Plunket nurses work alongside Māori clients using the Family Partnership model of communication.

The whakatauki that forms the title of this thesis: “He iwi kē koutou, he iwi kē matou, engari i tenei wa, tatou, tatou e, you are different, we are different, but together we can work together” was chosen due to its close connection with Irihapeti Ramsden’s (2003) description of “cultural safety” as being defined by the recipient of the care. It also reflects the understanding of the concepts of cultural safety and cultural responsiveness throughout the thesis in terms of nurses working alongside clients to identify, acknowledge and respect cultural difference.

This chapter gives some insight as to my interest in cultural safety and communication with Māori clients. It also outlines the background information to this research topic in terms of identifying and defining key concepts that were central to understanding the position of the research within a national context. This chapter will then outline the research question and related aims and finally, provide an overview of the chapters presented throughout the body of the thesis.

## KO WAI AU? WHO AM I?

Te Kohurau te mauka

Arai te Uru te tai

Arai te Uru te waka

Poutaiki te pa nehe ra

Oraumoa te awa

Moeraki te kaika

Kai Tahu me Kahungunu oku iwi

Ko Zoe Tipa ahau

When I began my nursing training in 1999, I knew I wanted to work in the community setting. After working in gerontology for six years in multiple roles, I made the decision to move to Dargaville and begin life as a Whānau Ora nurse. Within my first three months in the role, an experienced Māori nurse was seconded to the organisation to provide guidance and structure for the new staff. I was hovering around her, asking her what she was doing and why, and she offered to take me out with her for the day to help me understand what was involved in Whānau Ora nursing.

We drove for miles until we reached a small farmhouse deep in the south of the Kaipara. When we arrived, I leapt out of the car and went to grab my medical case from the boot (which had my blood pressure cuff, dressings, blood sugar meter, and a broad selection of equipment inside). My colleague turned around and asked “what do you think you are going to do with that?” To which I replied “blood pressure and dressings?” “And what do you think the client is going to focus on when you come walking in with your case?” she retorted.

I remember that moment vividly and I am so grateful to have been challenged around my communication and having been provided an opportunity to examine the impact that a task oriented nursing culture could potentially have on the engagement with clients. I had never met the client before and I was unconsciously planning not to take the time to listen to what was “on top” for her. This conversation marked the beginning of my thinking around nurses identifying their own cultural responsiveness in working with Māori.

I began working for the Royal New Zealand Plunket Society in 2007. I was fortunate to be able to complete Family Partnership level 1 course and facilitator training shortly after employment. This training as well as the challenge of appraising well child nurse competence in cultural safety saw me revisit my thinking around the parallels of communication and being responsive to the culture of clients.

## BACKGROUND TO RESEARCH

In order to understand the direction the research was to take, I needed to firstly describe the constitution of Māori families in New Zealand as well as define the concepts of cultural safety, Family Partnership, Well Child services and Plunket nursing within a New Zealand context. This section provides an introduction to these concepts as both a platform from which to base the literature review and as a background to the research topic.

### *MĀORI FAMILIES IN NEW ZEALAND*

People who identify as Māori ethnicity make up 15.4 percent of the population in New Zealand (Statistics New Zealand, 2012). Ninety percent of Māori in New Zealand live in a household with family and of these, 42.9 percent live in households with a couple and children, 26.5 percent with a single adult and children and 11.5 percent in multi-family households (Te Puni Kokiri, 2011). Cram (2012) suggests that the number of Māori children in single parent households could be reflective of a disproportionate allocation of child rearing responsibility to Māori women who may not necessarily have reliable or extensive family support networks. Ritchie (2007) discusses the young age at which many Māori start to have children and the number of children within Māori families being significantly higher as a major differences in comparison with non-Māori. She describes an intrinsic child rearing philosophy within many Māori families as the wider whānau and community taking responsibility and 'ownership' of the children and the impact that urbanisation has had on this practice due to families moving away from communal marae environments and lifestyles.

### *WELL CHILD SERVICES*

The Well Child Framework (2010) developed by the Ministry of Health, gives context to the free Well Child Service designed to support families with children under 5 years of age across New Zealand. The Well Child National Schedule (2010) outlines the timeframes for which health and developmental assessments (core contacts) are to be completed. Well Child and Tamariki Ora providers are contracted to the Ministry of Health directly, or via District Health

Boards and/or Primary Health Organisations. The framework also provides a timeframe for the transition between the Lead Maternity Carer (LMC) and the Well Child Provider (WCP) at 2-4 weeks of age. Well Child Care in New Zealand is a 'Universal Service' and provides government funded core contacts, however health needs assessment and deprivation levels can influence the provision of additional and supplementary contacts.

To offer a Well Child/Tamariki Ora service, registered nurses are required to complete (or be working towards) a Post Graduate Certificate in Primary Health Care. This year long programme specifically covers the theory and skills involved in Well Child assessments and population health. This educational programme is delivered by the Plunket Education Team, and is available for registered nurses within Plunket and other providers with Well Child/Tamariki Ora contracts. A level 4 National Certificate in Tamariki Ora/Well Child is offered for Community Health workers employed in the area of Well Child health. The Health worker training covers elements within the health care worker scope of practice and evidence-based health promotion and education messages for families.

There are seven core contacts provided for clients enrolled in Well Child services at key developmental stages and these are completed by the Well Child/Tamariki Ora nurse. There are also a number of additional contacts which can be provided as part of a care plan negotiated with the client and are delivered by either Community Health Workers or registered nurses. The eighth core contact for 4 year olds is the B4School check which can be completed by registered nurses who have completed the B4School training.

#### *ROYAL NEW ZEALAND PLUNKET SOCIETY*

The New Zealand Plunket Society was founded by Sir (Frederick) Truby King in 1907 who had a background in medicine and plant and animal husbandry. Sir Truby King became renowned for applying his knowledge in looking after animals, to saving babies lives. The Plunket Society was regarded as instrumental in reducing infant mortality rates at the time (Sullivan, 2007). Historically, Māori did not receive Plunket services due to many Māori living in rural areas and Plunket mainly servicing urban communities (Davidson, 1984). Māori instead received nursing services from public health nurses who were more mobile on horseback (Bryder, 1998). Māori health outcomes and services targeting Māori health specifically became priorities for the Plunket Society in the early 1990s which saw the introduction of the Māori health worker role to the clinical team called the "Plunket Kaiawhina" (Royal NZ Plunket Society, 2012).

Today, Plunket is a non-government organisation that provides well child services to 92% of children and their families nationwide (Royal New Zealand Plunket Society, 2011). Plunket offers families the clinical Well Child service which is funded by the Ministry of Health as well as volunteer-led and funded “value added services” such as coffee groups, parenting classes and car seat rental schemes. Plunket also has key sponsorship relationships with the Bank of New Zealand, Huggies, Watties and Colgate.

The Plunket Board provides governance for the organisation, with the Chief Executive Officer (CEO) responsible for the implementation of the key performance indicators identified by the Board. New Zealand is divided into 18 areas of Plunket services with the majority of Plunket areas aligning with District Health Board geographical boundaries. In 2012 there was governance restructure which saw the establishment of Area Boards to allow for greater community involvement and responsiveness.

Each Plunket area has an Area Manager who reports to the General Manager of Service Delivery and in turn to the CEO. Clinical Leaders report to the Area Managers and are the direct line managers of Plunket Nurses, Community Karitane and Plunket Kaiawhina. The number of Clinical Leaders and clinical staff per area are based upon the geocoded deprivation level of populations and the predicted number of babies born in the region (Royal New Zealand Plunket Society, 2011).

Clinical Educators are in the position to assess the competence of nurses against the Plunket nurse Standards of Practice up to three times throughout the nurse’s enrolment in the Post Graduate Certificate in Primary Health Care Specialty Nursing (Well Child / Tamariki Ora). Clinical Leaders assess competence during the annual appraisal process once the post graduate certificate programme has been completed. The Standards of Practice for a Level 2 Plunket nurse have a domain titled “Culturally safe practice”. The description of the domain requires Plunket nurses to provide a service that clients deem as culturally safe. It is this assessment of the cultural competence of Plunket nurses that has proven difficult to verify in accordance with definition of “culturally safe practice” and has led to questions regarding its inclusion in the assessment process. This is due to the practice of a health professional assessing the impact that another health professional has on the experience of the client receiving the service without consultation or input from the client.

As a Clinical Educator working for Plunket, the notion of assessing nurses’ cultural competence is fraught with complexities around ensuring quality clinical practice, reading client cues and identifying and acknowledging limitations surrounding the assessment. The current emphasis

upon nursing Professional Development Recognition Programmes (PDRP) in accordance with Nursing Council of New Zealand competencies has highlighted a need to assess and provide tangible evidence of nurses' cultural competence. According to the Nursing Council of New Zealand (2005), nurses are required to examine their own belief system and cultural values and identify the ways in which these may impact on client care.

Nurses must also acknowledge and respect the cultural differences of clients and integrate these into plans of care. Within my role I have observed many registered nurses struggling to articulate the way in which they provide care that is culturally competent due to the subjective nature of cultural safety. Often this has led to the provision of tangible, generic examples of perceived cultural competence such as 'taking shoes off at the door' or 'asking permission to touch baby's head'. While it is important to consider cultural or ethnically specific practices that may be appropriate for clients, it is the recognition that the 'culturally safe' aspect of these examples lies in the identification of whether these practices are appropriate for an individual client, and this is what is often lost within nurses' own written reflections of their cultural competence in practice.

#### *CULTURAL SAFETY*

Since the late 1980s, Irihapeti Ramsden's work has been the foundation of cultural safety in nursing and midwifery within New Zealand. Irihapeti Ramsden challenged nurses to transition their thinking from 'transcultural nursing' in which the dominant culture provided the benchmark from which others were compared, to 'cultural safety' in which the difference is owned by the individual practitioner (National Aboriginal Health Organisation, 2006). This meant that the power imbalance between professional and patient was beginning to be addressed in terms of clients being given the opportunity to identify what was important and meaningful for them in accessing and receiving a service. In 1990, a report was commissioned by the schools of nursing across New Zealand to examine cultural safety in nursing education. Following this report, the principles of the Treaty of Waitangi were incorporated into organisations' mission statements and nursing philosophies. This led to a requirement that 20 percent of the state examination to become registered nurses was to focus on cultural safety, and student nurses were required to demonstrate their clinical practice was culturally safe (Ramsden & Spoonley, 1994).

As a result of these changes, in 1992 the Nursing Council introduced a set of guidelines for the content of cultural safety to be incorporated into the undergraduate nursing curriculum. These guidelines encouraged the self-reflection of nurses and midwives to promote an awareness of

their own cultural realities and the impact these may have when working with others (Ramsden & Spoonley, 1994). Widespread debate followed in the media, with an editorial describing cultural safety in practice as the “self-righteous aura of the politically correct” (as cited in Ramsden & Spoonley 1994, p 167). Cultural safety had emerged as a term that had created debate both within New Zealand and internationally. Woods (2010) discusses international perspectives that contest the value of having a particular ‘aboriginal’ group define cultural safety. He believes that these views have emerged due to the challenge cultural safety has provided in terms of questioning more established theories such as ‘transcultural nursing’. Fran Richardson’s (2010) doctoral thesis on cultural safety determined that the concept is no different than ‘caring philosophies’ provided by a range of international nursing academics. She suggests that the contexts in which nurses are to provide culturally safe care are not always fully explored.

Aotearoa has seen the integration of cultural safety into nursing competencies, with on-going ‘cultural competence’ assessed with reference to the Health Practitioners Competence Assurance Act 2003. Wilson (2008) acknowledges that a fundamental weakness exists in the clinical assessment of nurses as ‘culturally safe’ practitioners, and more specifically, the evaluation of a nurse’s practice from the client’s perspective. She discusses the tension between the assessment of culturally safe practice and the potential harm posed to clients when nurses do not receive feedback - particularly if clients are concerned that negative feedback may adversely affect the future service.

#### *FAMILY PARTNERSHIP MODEL*

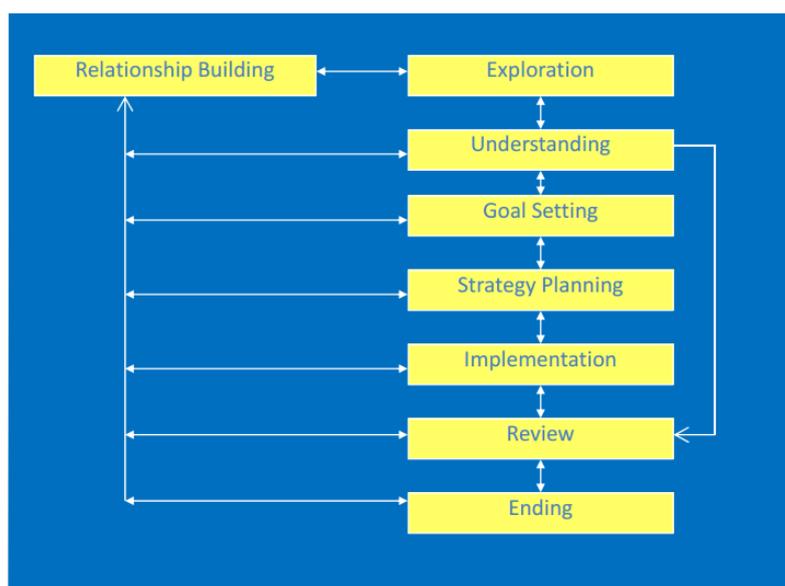
Plunket as an organisation is committed to a model of care titled “Family Partnership” which is a programme centred on what was originally called a “Parent Advisor Model for health workers”. The Family Partnership model was developed by Hilton Davis, Crispin Day and Christine Bidmead (2002) in the United Kingdom (UK) and it has been embraced by a variety of services in countries throughout the world. The Family Partnership Model (FPM) training is a ten session programme which covers the theory, skills and techniques inherent in developing relationships, communicating and working with others. The FPM training is provided by two trained facilitators who role model the partnership process over the course of the ten sessions.

There are three levels of training in the Family Partnership programme. Level one training is the basic course in which participants learn the theory relating to the Family Partnership model. Level two training involves participants learning to facilitate the programme and requires a deeper understanding of the model and the learning process. Level three training

involves “training the trainer” and this is provided by the developers of the programme from the UK. The ten training sessions for level one are each three and a half to four hours in duration. Each session comprises of a Socratic discussion or guided demonstration with a group of up to 12 participants focussing upon key elements of the Family Partnership model. The sessions incorporate a number of “skills practices” in smaller groups of three in which participants take the roles of “Listener/Helper”, “Helpee (person with the issue or problem)” and “Observer/Timekeeper”. Each participant has the opportunity to feedback on the process at the conclusion of each skills practice rotation from the perspective of the role they played in the process. The final component of each training session involves a “home task” following each session which incorporates reading chapters from the FPM manual and completing an exercise to reinforce the learning.

Family Partnership training is currently offered to Plunket care delivery staff on recommendation from individual managers, with the majority of Plunket management and nurses influencing practice having completed the level one training. The view that the helping process is one of a series of interrelated tasks - relationship building, exploration of problems, understanding the context, goal setting, planning, implementing, reviewing and ending, is central to the Family Partnership framework (Braun, Davis & Mansfield, 2006). The content of the FPM training is centred on individual participant growth and understanding of the helping process and the context in which professionals work alongside clients towards positive outcomes.

This process of helping is encapsulated in the following diagram:



**Figure 1.** Davis, H., & Day, C. (2010). *The helping process*. Retrieved from <http://www.cpcs.org.uk/uploads/downloads/family%20partnership%20model/CPCS%20FPM%20Current%20Framework%20Presentation.pdf>. Reprinted with permission.

The process outlined in Figure 1 demonstrates the steps that the “Helper” and the “Parent” can work through to identify an issue and work towards a resolution, while at the same time build upon their relationship and inform future partnerships. Davis et al (2002) describe the tendency for health professionals to remain in the “exploration” phase of the helping process which often does not result in a clear understanding of what the issue actually is. In accurately identifying the issue(s), interventions are more likely to be responsive and lead towards positive outcomes. The “end” stage does not necessarily signify the end of the partnership, rather the end of the specific issue that was being worked through. Davis et al (2002) believe however that the end of the partnership does need to be discussed from an early stage to ensure both parties are aware of the boundaries and expectations of the relationship.

Davis and Meltzer (2007) describe the way in which community services have been traditionally delivered, with an emphasis on the ‘expert’ model of practice. The concept that clients are referred to one or a number of specialists on a particular subject and in turn, that clients have the expectation for the ‘expert’ to solve their problem, is a common phenomenon in primary health care. It is the lack of successful outcomes using the expert model that the framework for working in partnership with families has emerged. Davis and Meltzer (2007) describe the importance for professionals to develop skills around acknowledging and working alongside the individual in order to counteract feelings of distrust or reluctance to seek help, as well as promote the ability for the health professional to meet the needs of all of the family involved in the situation.

#### *RESEARCH QUESTION*

It is at the level of the individual receiving a well child service and the acknowledgement of the differing experiences for the other family members involved, that the Family Partnership model can be examined in relation to cultural responsiveness. The development of this research topic has evolved out of curiosity around the skills required for registered nurses working in the well child specialty to demonstrate practice in a culturally responsive manner. Having already observed the success of the Family Partnership model within a variety of settings with participants from many different ethnic and cultural backgrounds, it has become apparent that this model for communication could potentially cross cultural and ethnic boundaries and enhance the Well Child service provided for tamariki Māori across Aotearoa. I therefore decided upon the following research question:

**Is Family Partnership a model for cultural responsiveness within a Well Child context?**

In order to provide greater clarity and direction to the research question, and more clearly illustrate the connection between Family Partnership and cultural responsiveness to be evaluated, I identified the following three aims for the research:

- 1) To examine how Plunket nurses implement Family Partnership principles and methods in practice.
- 2) To establish the quality of the Family Partnership model in working with Māori whānau in a Well Child context.
- 3) To determine the way in which cultural responsiveness is demonstrated in Well Child clinical practice.

The research question and aims provided the foundation to the logic model and second level evaluation questions which structured the data collection, analysis and presentation of results.

## REVIEW OF CHAPTERS

The following section provides an overview of the chapters presented in the thesis.

- Chapter 1** Introduces my interest in the topic of cultural responsiveness within a Well Child context. It provides a definition of key background concepts central to the formation of the research question. It outlines the research question and aims to be examined throughout the thesis. This chapter also provides a summary of each of the chapters presented in the thesis.
- Chapter 2** Provides information relating to the search strategy used to identify literature relating to Family Partnership, cultural responsiveness and Māori health. It provides a comprehensive review of the literature related to health inequities, Māori health statistics, cultural safety and responsiveness, and partnership communication models from a national and international perspective.
- Chapter 3** Describes the research methodology and methods used in this research. It defines evaluation research and describes the evaluation approach, form and design. This chapter presents the logic model developed to represent the pathway for a culturally responsive well child service. It lists the key assumptions underpinning the logic model and provides an assessment of the stakeholders' perspectives and roles in the research. This chapter re-presents the research question and aims and outlines the high level and second level evaluation questions forming the basis for data collection and analysis. It lists

the inclusion and exclusion criteria for participation and the recruitment strategies. This chapter describes the data collection methods utilised and the ethical considerations guiding the research process. It discusses the reliability and validity factors inherent in the research and the processes used for data analysis.

**Chapter 4** Presents the results relating to the first high level evaluation question on the effect of Family Partnership training on Plunket nurse practice. Qualitative and quantitative data is presented relating to the value of the Family Partnership model in interacting with Māori clients, the usefulness of the Family Partnership model in assessing the wellbeing of Māori whānau and the extent to which Plunket nurse confidence increases in working with Māori whānau following Family Partnership training. The data on the effect of Family Partnership training on nursing practice is then evaluated against a rubric rating scale to determine merit.

**Chapter 5** Presents the results relating to the second high level evaluation question on meeting the needs of Māori clients. Qualitative data is examined on the extent to which individual needs of Māori clients are being identified by Plunket nurses and the appropriateness of the Plunket nursing service for Māori clients. Finally qualitative data is presented on the degree to which the Plunket nursing service acknowledges and enhances whānau capabilities. The data on the extent to which the individual needs of Māori are being met is then evaluated against a rubric rating scale to determine merit.

**Chapter 6** Presents the results of the final high level evaluation question on the value of Family Partnership training to Plunket. It provides the qualitative data on the impact that cultural safety and responsiveness has on Māori health outcomes. The results of qualitative and quantitative data provide results on the usefulness of Family Partnership training in creating a culturally safe and responsive Plunket workforce. Finally the data on the value of Family Partnership training to Plunket is evaluated against a rubric rating scale to determine merit.

**Chapter 7** Re-presents the research question and aims. It provides a discussion of the major themes emerging from the research under the umbrella of the principles of the Treaty of Waitangi. It examines the limitations of the study

and provides six recommendations for Plunket as an organisation relating to Family Partnership and cultural responsiveness.

## SUMMARY

This chapter has highlighted that the future of cultural safety lies in the interaction between the nurse and the client. Nursing standards of practice outline cultural competency as a requirement for all New Zealand registered nurses, however there is an issue as to how this is assessed and demonstrated or even taught. Davis, Day and Bidmead (2002) have developed a model for communication and partnership which may provide some insight into the gap between theory and practice. This thesis examines the relationship between the skill development in completing the Family Partnership programme and the practice of culturally responsive care and examines whether Family Partnership could be considered a model for cultural responsiveness.

The next chapter will further examine national and international literature related to communication, cultural responsiveness and Māori health outcomes. The relationship between partnership, communication and cultural responsiveness will be discussed in the literature review, and particular consideration will be given to models of partnership utilised within a New Zealand context.

## CHAPTER 2 - LITERATURE REVIEW

### INTRODUCTION

Literature reviews are completed to identify what is already known about a topic and to determine the most significant theoretical issues that may influence the interpretation and analysis of results (Patton, 2002). This chapter reviews the literature around health inequities and cultural responsiveness, communication and partnership. It begins with outlining the search strategy including a list of terms used to identify supporting literature. It then provides a discussion on the literature relating to Māori families and Māori health outcome measures in New Zealand. The literature review highlights a significant gap in research on models to guide culturally safe and responsive nursing practice in New Zealand and a lack of evidence-based tools to assess cultural competence. The literature selected provides context to the research and provided a sound theoretical basis for evaluative merit determination. This literature review will establish the critical role of health professionals in their interactions and influence with Māori and ultimately over many Māori health outcomes.

### LITERATURE REVIEW

#### *SEARCH STRATEGY*

The literature review included a search of databases including CINAHL, Proquest, PubMed, Web of Science, Google Scholar and EBSCO host, to identify literature around cultural responsiveness and Family Partnership communication. Journals no older than five years were prioritised and other literature (theses, books and government publications) were no older than ten years - with the exception of seminal works on cultural safety and partnership.

The literature surrounding the concept of 'cultural responsiveness' was extremely limited. The search was widened to encompass 'cultural competence', 'cultural appropriateness', 'cultural safety' and 'indigenous health'. Other key terms utilised were 'culture and communication', 'nursing and communication', 'nursing and culture', 'Māori and partnership' 'partnership and communication' and 'cultural models and health'. International literature was sought using search terms such as 'health visitor and communication' and 'communication and families'.

Articles were also sourced in relation to the Family Partnership model, and the application to practice - of which there were very few publications. The literature reviewed around the Family Partnership model was theory-based and related to amendments and additions to the

model itself. In addition to online journal article sourcing, texts were reviewed in relation to Māori health, cultural safety and Family Partnership and partnership in nursing.

Following the literature search, the information selected to include in the review was categorised under headings related to the research question and aims. It was apparent that there was no New Zealand or international literature that clearly linked communication to cultural responsiveness, however many of the Māori partnership models had theoretical underpinnings aligning with communication literature.

#### *MĀORI HEALTH INEQUITIES AND CULTURAL RESPONSIVENESS*

The Ministry of Social Development and Statistics New Zealand identified 11 risk factors from the New Zealand General Social Survey which collected social and economic data from 8,000 New Zealanders aged 15 years and over (Statistics New Zealand, 2012). The Green Paper for Vulnerable Children (2011) indicated that the risk factors have a cumulative affect in so far as the higher the number of risk factors, the higher the risk of poor outcomes for children. Statistics New Zealand (2012) report that people who identify as Māori constitute 15.4 percent of the New Zealand population. In the General Social Survey (2012) Māori were represented in 43 percent of the high risk households in which there were 5 or more risk factors.

Tipene-Leach (cited in NZ Child and Youth Epidemiology Service, 2012) challenges the health system to actively manage and improve the poor health status of Māori children in New Zealand. He describes the current approach to address high rates of Māori Sudden Death of an Infant (SUDI) as innovative and responsive. It is widely acknowledged that SUDI risk factors include sleeping babies in locations that are not designed for babies, bed-sharing, smoke exposure and putting babies to sleep in positions other than on their backs (Whakawhetu, 2011). Tipene-Leach also quoted rates as high as 21 percent of Māori mothers who both smoke ante-natally and bed share with their babies. He commends the original approach of the Nukutere Weavers Collective in Gisborne, who in 2006 developed a bassinet-like structure woven from flax to provide a 'safer sleep surface' to be distributed to babies at high risk of SUDI. The "Wahakura" and subsequent "Pepi-pods", along with health promotion information have been widely accepted by whānau and projects have been implemented by two District Health Boards throughout the country.

Cunningham in a contribution to a Families Commission (2011) submission describes cultural responsiveness from a political perspective as the ability of programmes to respond to situations in a way that affirms the culture of clients. He discusses that in order for

programmes to be able to respond effectively to Māori needs, Māori need to be involved at every level. He compares the differences between culturally appropriate and culturally responsive programmes and believes that a fundamental element of cultural responsiveness is the incorporation of Māori concepts, values and world views throughout the design, development and implementation of programmes. Cultural responsiveness has been the basis for Kaupapa Māori programme delivery and cultural appropriateness has traditionally been seen as the adoption of a Westernised programme in working with Māori communities.

Tobias and Searle (2006) researched the geographic variances in relation to life-expectancy for Māori and asked whether geography explains the ethnic inequalities in health. The results were inconclusive due to a number of limitations in the research including the use of life - expectancy as the only indicator as well as the size of the geographic boundaries. They suggest that geography may play a significant role if the study analysed populations at a neighbourhood rather than a district level. They recommend that governmental policy focus upon factors directly related to ethnicity to reduce ethnic disparity - rather than allocating funding based on geographic variations and health care (Tobias & Searle, 2006). They believe this would support the notion of self-determination and facilitate increased participation of Māori communities in health and social services.

However this increased focus upon ethnicity could potentially negate the differences between people, resulting in services that are not necessarily responsive and appropriate for the population. Tobias and Yeh (2007) add in a later study, that while health services should be population targeted, the factors that shape the way populations access existing health services must not be ignored and therefore services need to be modified accordingly. It is this modification of health service delivery that causes debate in terms of effectiveness, and there is very little research surrounding how this looks in practice.

The New Zealand primary health reforms introduced in 2001 saw a move towards population health management and increased access to primary health services for vulnerable populations (Hefford, Crampton & Foley, 2004). A significant outcome of the reforms was the establishment of PHOs (Primary Health Organisations) and the increased government subsidies for medical fees and pharmacy prescriptions. Hefford et al. (2004) argue that while research suggests that removing the cost barrier results in increased service use, this may not equate to an improvement in the level of inequality for vulnerable populations. They propose that a reason for this is the under-representation of low-income, vulnerable populations at PHO

governance level - resulting in minimal buy-in from these groups towards PHO initiatives, which were originally implemented to improve the health of primarily high needs populations.

Hefford et al. (2004) describe Māori participation and representation as a crucial element in improving the health for vulnerable populations. Increasing access to services is only one way to facilitate this process. In order for communities and services to be culturally responsive and reduce inequities, active participation is required from Māori communities and the question lies in whether this should be facilitated by the organisation providing the service or by Māori themselves.

Neuwelt et al. (2009) believe that in order to reduce health inequities, a population health approach with emphasis on population health outcomes is required. They define population health as an approach that “delivers both high quality and individual care and places an emphasis on equity, community participation, and determinants of health” (p. 99). It is seen as broader than public health, with emphasis placed upon clinical activities as well as activities that address socio-ecological factors of health. It is accepted that an important feature of a population health approach is having ‘genuine community participation’ including working with communities to determine their own strategies for improving health outcomes. This is in contrast to the viewpoint of Hefford et al. (2004) who looked at ways to include Māori in existing strategies rather than have Māori develop their own. It is widely agreed that Māori participation must be fostered in health services and initiatives (Hefford et al.; Neuwelt et al.). However, services, policy and research are often unclear as to how this is achieved in a meaningful and respectful way.

Durie (2003) discusses one aspect of participation for Māori from a socio-ecological perspective in terms of having an under-representation in secondary schools and tertiary institutions, high levels of unemployment with associated financial difficulty, and in later years, high rates of marital hardship and further financial stressors. He believes that Māori participation and relationships have been mostly considered within the context of the Treaty of Waitangi - that is, the relationship between Māori and the Crown, rather than from the perspective of indigenous rights - the relationship between Māori and the Māori world. Interestingly, Durie (2003) states that studies have shown that Māori participation rates in the Māori world are no better than within the Treaty of Waitangi context, with an estimated 20 percent of Māori unable to identify any tribal origins, therefore demonstrating minimal linkages to the Māori world.

O'Brien, Boddy and Hardy (2007) believe that the process of care delivery and health outcomes should be assessed equally, when assessing how effective nursing care is with indigenous populations. They suggest that outcomes in health do not necessarily equate to a positive experience or justify the processes used. Clinical indicators are offered as a way to measure and/or assess the underlying factors accounting for the variances in health outcomes and link back to the standards of practice.

O'Brien et al. (2007) describe the insight obtained when utilising a tool to assess the quality of service delivery to examine the variances in patient outcomes. They state, "it also appears that nurses aim to provide care with clinical priorities, but not with a particular focus for meeting any predetermined professional benchmark in the delivery of that care" (p. 672). They believe that the result of not aiming to meet a predetermined benchmark is the practice of reactive rather than responsive nursing care with inconsistency in meeting any specific cultural competencies. It is clear however that the implementation of measuring the quality of care delivery must ultimately align with the observation of increased positive health outcomes. A challenge is in defining the desired outcomes in order to facilitate the steps towards their achievement.

#### *CULTURAL SAFETY*

Ramsden (1996) discusses the transition from 'cultural smorgasbord' type nursing whereby checklists of tasks / considerations were completed based on a client's ethnicity through to culturally safe practice, in which the nurse walks alongside the client in order to achieve a common goal. The importance of acknowledging diversity in order to identify the goals which are significant for the client, rather than imposing cultural or ethnic stereotypes and subsequent interventions is central to this transition. The New Zealand Nursing Council guidelines for cultural safety, Treaty of Waitangi and Māori health (2005) define culture as a diverse concept including but not limited to social, religious and gender influences, which are considered in addition to ethnicity. The guidelines implore nurses to examine the impact their own cultural influences have upon their practice and recognise actions that could potentially compromise the partnership.

Ramsden discusses the future of cultural safety in chapter ten of her thesis published in 2002. She cites concerns regarding the attempts to de-politicise the term 'cultural safety' by changing the name, therefore modifying fundamental aspects of cultural safety and losing the integrity of the concept. Ramsden (2002) highlighted the issues inherent in accepting a nurse's own feedback or exemplar around a case as evidence of culturally safe practice, rather than

client evaluations. The result is the shifting of focus from an analytical perspective to a descriptive one, which occurs as the lens is shifted from the nurse's practice, back towards the client.

Ramsden (2002) describes the future of cultural safety as precarious due to a lack of training and recruitment of teachers and forums in which to discuss new ideas. Another reason is the continual shift towards clients being analysed as different from nurses, rather than nurses being different from clients. "To turn attention back onto the emic nurse, and away from the etic and exotic patient requires a consistent and major shift in ideology" (Ramsden, 2002, p. 176). It is evident in the literature that there is no particular structure in which to assess cultural competence. It could be argued that cultural responsiveness is the **implementation** of the principles and theory of cultural safety, to ensure competence and consistency across professionals and organisations. The evaluation of the Family Partnership model in relation to cultural responsiveness can potentially gauge the degree to which cultural safety principles are implemented across Plunket, and provide a platform for further discussion and research.

Wilson and Baker (2012) discuss the tension that many Māori nurses working in mental health face in bridging the 'two worlds' of being a Māori nurse and working within a biomedical mainstream mental health system. They discuss the expectations placed on Māori nurses by Māori clients in terms of the provision of culturally appropriate care, as well as the expectations of non-Māori colleagues in terms of meeting the cultural needs of their patients. These tensions have led to the development of 'different' ways of practice for some Māori nurses working in mental health. One theme that emerged in Wilson and Baker's research (2012) was around the resilience that Māori nurses needed to have when working across two differing paradigms and the impact that this may have on Māori staff retention. They suggest that cultural supervision and targeted professional development may provide opportunities to reduce the levels of stress associated with the joining of two differing worldviews. Increasing the confidence of non-Māori nursing staff in working alongside Māori clients may also support the retention of Māori nurses working within Māori communities.

#### *PARTNERSHIP MODELS*

Fundamental to the notion of partnership and cultural responsiveness with Māori is that it is widely acknowledged that there is no standardised Māori worldview (Durie, 1997; Herbert, 2002; Ramsden 2002). This sits well with the Family Partnership framework for communication in terms of identifying what is of most importance to the client - rather than making assumptions based on ethnicity. Herbert (2002) describes one of six protocols relevant to

understanding biculturalism, as recognising the diversity that exists within Māori individuals, whānau and communities. He acknowledges that there may be commonalities within Māori culture, however suggests that organisations need to emphasise and value the diversity that exists in order to establish a bi-cultural focus to extend beyond cultural awareness and sensitivity. This emphasis on diversity has now been included in the New Zealand Psychological Society Code of Ethics which recommends that all staff have an understanding of the Treaty of Waitangi and the subsequent implications for practice (Herbert, 2002).

Walker (2004) completed a kaupapa Māori research project which analysed partnership models from a Māori social-service provider perspective. He identified two modes for interacting in partnership with kaupapa Māori social service organisations. The first model is underpinned by tikanga Māori and is informed by the kaupapa of whānau and kanohi ki te kanohi (face to face) encounters. Tikanga provides the overarching guidance for interactions and joins the past, present and future. Karakia, acknowledgement of elders, and the pōwhiri process all sit within the tikanga framework. Walker describes the kaupapa of whānau as the direction that comes from the wider group - therefore acknowledging that the issues for an individual are embedded in a wider group. Kanohi ki te kanohi is the ability to voice concerns in a larger group whereby all are given the opportunity to be involved. The second mode Walker has identified is individualised and state based. He proposes a relationship between kaupapa Māori organisations, the State and Mana Whenua (Iwi or Hapu), to ensure that the organisations can be supported to meet and not lose sight of the needs of the people (Mana Whenua) in the area. Walker's research suggests that in order to be responsive to the needs of the individual, issues need to be explored within the context of the wider whānau, particularly at an organisational level.

Another study which examined the establishment of Māori health promotion programmes revealed that the historical context must be considered in order to avoid fuelling a sense of powerlessness amongst Māori (Voyle & Simmons, 1999). The concept of forming partnerships between professionals and Māori communities based on trust was considered central to empowering the community. Other key strategies that emerged from this research involved the inclusion of all members of the community, the appropriate people and skills are employed and accepted by the community, and the majority of time is spent with the people, rather than separated in an office to ensure the partnerships are operable and sustainable. Voyle and Simmons (1999) are clear that for any partnerships with Māori communities to be successful, devolution of power must take place to provide a platform from which to begin. Durie (1997) agrees with these sentiments and adds that one Iwi must not speak on behalf of another and

that the concept of valuing the historical context includes identifying the appropriate people in areas who are the tangata whenua.

Braun, Davis and Mansfield (2006) believe that traditionally, there has been a lack of conceptual models guiding the helping process and working in partnership with children and their families. Central to understanding Family Partnership as a model for communication is the content of the Family Partnership education programme, as the education programme is the living demonstration of the theory. Braun et al. (2006) consider that the helping process is a series of interrelated tasks with the parent-helper relationship at the forefront. Central to their model is the evidence-based notion that the most effective relationships are partnerships. Partnership in this context is defined as, "...active involvement; shared decision making; complementary expertise; agreement of aims and processes; mutual trust and respect; openness and honesty; clear communication and negotiation" (Braun et al. 2006, p. 1). Braun et al. (2006) suggest that while the term 'partnership' is utilised in health policy and services, the meaning is not often examined or defined, and it is therefore unclear whether the 'partnership' has been successful from both perspectives.

The Family Partnership model in its simplest form is shown in Figure 2:

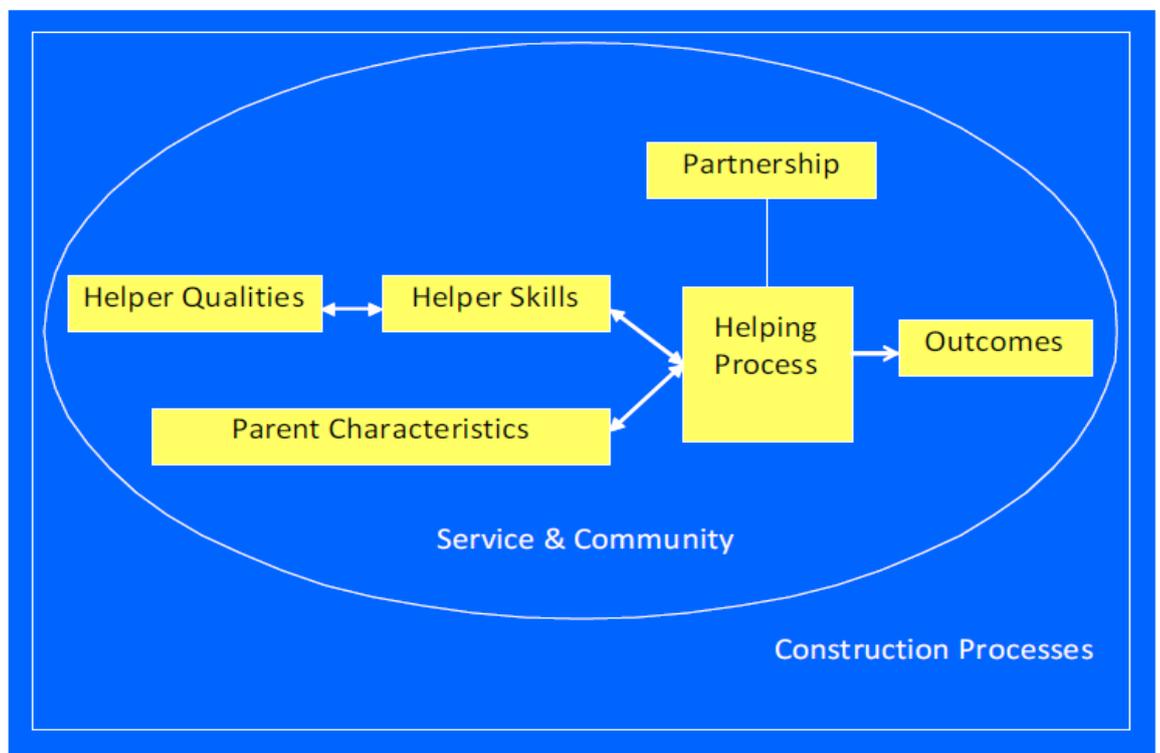


Figure 2. Davis, H., & Day, C. (2007). *Current Family Partnership model*. Retrieved from <http://www.cpcs.org.uk/uploads/downloads/family%20partnership%20model/Current%20FPM%20Framework.pdf>. Reprinted with permission.

Every component of the model has dedicated time and analysis during the Family Partnership training programme and the focus is upon growth for the participants - the degree of growth being individual to each participant (Day & Davis, 2009). Participants do not undergo any assessment of competence during the course which could be seen as a limitation of the programme; however the intent is on personal growth, which may only be defined by the individual, similar to the experience of cultural safety. The demonstration of the Family Partnership model is applied to the facilitation of the course and can also be applied to relationships and interactions between co-workers, managers and staff, and educators and students. It is clear however that the degree of growth is directly related to the openness and commitment made by the individual on the programme, which may limit any shift experienced by participants who believe they communicate optimally already.

Wilson and Huntington (2009) explored the use of the Family Partnership model within a New Zealand context. They highlight a key potential benefit of the programme as interagency collaboration, which is enhanced when all agencies use the similar language generated by the programme. They suggest that the refinement of supervision skills within the programme aligns closely with cultural safety, in allowing practitioners to reflect and challenge their thoughts, feelings and actions in a safe environment. Wilson and Huntington (2009) state that they would like to see further research regarding the appropriateness of the family partnership model for people working with Māori whānau.

Taurima and Cash (1999) have developed a “hongi model” or eyeball to eyeball model to illustrate the relationship between Māori and non-Māori in the process of bicultural inquiry. They discuss the model and its applicability, specifically to research methods involving Māori. Anecdotally, it has been expressed that the hongi process is fundamental to all types of relationships with Māori. Central to the hongi model is the belief that a systems approach (mātauranga for Māori) can bridge the communication gap between Māori and non-Māori in allowing for equal input of world views. This is essentially an acknowledgement of similarities and differences, and the establishment of a common place for interactions to occur.

The hongi model aligns closely with aspects of the Family Partnership model. Taurima and Cash (1999) describe the ‘reality’ of individuals involved in the process as the platform for interactions that occur. Davis et al. (2002) would call these realities ‘constructs’ in relation to the Family Partnership model. They describe constructs as the blueprint of our world in our heads that may be conscious or unconscious which are developed by our experiences and the

meaning we place upon our experiences. Davis et al. (2002) believe that people behave differently because of their constructs and are therefore different from each other because of them. Another similarity between the models is the discussion around partnership and power sharing. Taurima and Cash (1999) believe that one party must surrender their perceived power in order to establish a common ground from which to build the relationship. Davis et al. (2002) describe one of the ingredients of partnership as power sharing, with a focus (in a helping relationship) as redressing the balance skewed by the use of an expert model of health care delivery. They believe the people requiring the service are the senior partners in any interaction and that there should be an attempt to reach a consensus wherever possible.

Christensen (1998) has been a leading theorist in nursing partnership - particularly within the New Zealand context. She describes the partnership process as consisting of three interrelated elements including "passage", "mutual work" and "context". She discusses 'passage' as the life changes or experiences that happen which change the circumstances for a person. Christensen believes that all concurrent passages have an impact upon each other and the concept of resilience and having a history of dealing with previous similar experiences is examined as impacting on the way in which current situations are dealt with and approached. The next stage in the process is mutual work which describes the work required by the patient and the nurse for the patient to progress through their experience. Christensen believes that the patient has a role in participating in nursing care; however the wisdom remains with the nurse in promoting nursing outcomes that relate to assisting patients to achieve optimal health.

Davis et al. (2002) believes the exploration facilitated by the helper throughout all stages of the partnership should allow for the 'patient' to identify goals for themselves which therefore direct the strategies or interventions. They suggest there is a risk that in leading the process of determining outcomes, nurses may default into the expert model of practice in terms of identifying outcomes that may not sit with client priorities. In terms of cultural responsiveness, there is the possibility that the patient's beliefs and constructs may not be valued if they do not align with the nurse's outcomes, which ultimately may have a negative impact upon the partnership. The client in a Well Child context may not believe there is an issue, therefore the skill of the nurse in identifying the issue and expressing any concerns in a way that does not devalue the experience of the client is essential in working in partnership towards positive health outcomes.

The final stage in Christensen's partnership process is context. One of the three aspects to context is 'episodic continuity' in which she describes the episodes of care as the building

blocks to the experience and therefore the relationship. The second aspect is 'anonymous intimacy' which describes the nature of the nursing role and the experience of the patient being shared amongst a number of nursing staff - rather than one nurse taking ownership. The third concept is 'mutual benevolence' which describes the altruistic nature of the profession and the general goodwill between nurses and patients.

#### *COMMUNICATION AND PARTNERSHIP*

Davis and Meltzer (2007) discuss the misguided assumption of many health professionals that 'helping' someone equates to doing something for them. They expand on this to examine the 'drive for solutions' that exists when working with people. They believe that while searching and offering solutions, 'helpers' often neglect the needs of the person with the problem. This is a view that is shared in this anonymous quote, "suffering is not a question that demands an answer; It is not a problem that demands a solution; It is a mystery that demands a presence" (as cited in Davis & Meltzer, 2007, p. 2).

By understanding the process of helping, Davis and Meltzer (2007) believe that 'helpers' will be better situated to meet the needs of the entire family involved in the issue, as understanding how people function and relate to each other is fundamental to the outcomes of interventions. They propose that a model for working in partnership is a way to counteract the sometimes inappropriate interventions imposed on families using an 'expert model' of communication, and are clear that whether or not solutions exist, helpers must begin to value the support generated by relationships.

Durie (2003) suggests that supporting services to communicate in a way that identifies and acknowledges the relationships that individual Māori have with the Māori world, may assist in identifying appropriate outcomes. He believes that the answer to working in partnership with Māori lies in ensuring that client worldviews are endorsed by workplaces as well as service provision. He also believes that by increasing services that are aware of differing realities and increasing the value placed upon indigenous concepts and rights, individual and collective gains will be enhanced. Cultural responsiveness sits here in terms of taking an organisation-wide approach in communicating with clients in a skilful manner which values diversity without ethnic bias or assumptions. It is clear that the identification of outcomes is reliant upon a clear process of communication whereby a degree of mutuality is attained.

## SUMMARY

The literature on cultural responsiveness, Family Partnership, partnership models and Māori health is very limited. This literature review has identified the disparities in Māori health and the challenges in designing health services that not only meet the needs of Māori, but provide impact and momentum in addressing the disparities. There is limited literature on whether modifications made to services in response to service identified Māori health needs have had any effect on ultimate health gains. It is acknowledged that these gains are difficult to measure at an individual level, with indicators generally attached to geographic locations and populations as a way to assess progress.

Cultural safety as a concept has become an integral part of the undergraduate nursing curriculum with a focus on reducing the power-imbalance between health professionals and consumers. It is currently the assessment of the nurse's ability to provide culturally safe care that is challenging the definition of cultural safety itself. The Family Partnership model gives an example of generic communication concepts that impact on 'helping' partnerships which may provide a framework to assess cultural competence - or the application of cultural safety. The Hongi model illustrating bi-cultural enquiry, aligns closely with the Family Partnership model specifically in relation to 'constructs' and 'realities' and the impact that these have on the platform for relationships. The importance of moving from an "expert" model of care to a strengths-based, realistic model of practice has been highlighted which would allow the outcome to be defined by the individual receiving the service and gives the interventions a meaningful context.

The next chapter will examine the research design and methodology and the research methods utilised in evaluating whether Family Partnership could be considered a model for cultural responsiveness when working with Māori.

## CHAPTER 3 - RESEARCH METHODOLOGY & METHODS

### INTRODUCTION

The purpose of this research was to examine whether the Family Partnership communication model could be a model for culturally responsive nursing practice within a Well Child health context. The intent of the project was to evaluate the extent to which Plunket nurses implement the Family Partnership model in working with Māori and whether this could be considered cultural responsiveness. In order to further examine the relationship between Family Partnership, cultural responsiveness and working with Māori, I decided to use evaluation methodology. The Hawaii and Pacific Evaluation Association (2010) define evaluation as “the systematic investigation of the worth or merit of an object, which is often undertaken for the purpose of improvement or to guide decision making” (p 1). This research has taken the form of an outcome evaluation with a theory-driven approach using a mixed methodology design for systematic data collection and analysis.

This chapter will discuss the research methodology, evaluation approach and evaluation form. It will also identify the key stakeholders and examine the methods, inclusion and exclusion criteria and the recruitment strategies employed to engage participants. This chapter presents the logic model which provides a platform from which data collection and analysis tools were developed. It highlights the key assumptions underpinning the logic model in examining the relationship between the outcomes. This chapter provides a stakeholder assessment and presents the research and evaluation questions and aims. The ethical considerations are outlined, the reliability and validity of the research are discussed and the data analysis theory and process is described.

### DESIGN AND METHODOLOGY

Evaluation research is defined by Patton (2002) as “...any effort to judge or enhance human effectiveness through systematic data based inquiry” (p 10). Patton (2002) describes evaluation as the human process of questioning the accomplishments and effectiveness of engagement as well as systems involving people. He believes that evaluation research takes place when questions are examined systematically and empirically using data collection processes and analysis. Scriven (2001) describes evaluation as a discipline belonging to a unique group of trans-disciplines with the purpose of determining a wide range of effects and value of a proposed subject or phenomenon. Weiss (1997) adds that a major aim of evaluation

research is to provide representation of the perspectives of all of the stakeholders identified in a particular programme.

This section will describe outcome evaluation as the selected form, theory driven evaluation as the approach and mixed-methods as the design. It will then present the logic model and key assumptions inherent in the relationship between outcomes.

#### *EVALUATION FORM: OUTCOME EVALUATION*

Patton (2002) describes outcome evaluation as a form of evaluation which embraces and acknowledges the diversity of outcomes for individuals. This diversity can be influenced by past experiences, unique needs, and different life conditions. Outcome evaluation aligns with the Family Partnership model around our differing constructs which influence our interpretations and experiences of words, people and events (Davis, Day & Bidmead, 2002). Patton is clear regarding the link between outcome evaluation and qualitative methodology, “the more a programme moves beyond training in standard basic competencies, the more qualitative case studies will be needed to capture the range of outcomes attained” (p 158). The complexity of outcome evaluation lies in the researcher’s ability to prioritise outcomes while remaining faithful to the information gathered.

Outcome evaluation captures individual movement throughout a process or programme. The World Health Organisation (2000) describes outcome evaluation as looking at whether positive changes in health have occurred as a result of the interventions applied. It is more complex than other forms of evaluation as there is an emphasis upon linking the interventions to the outcomes. There is also an expectation to provide evidence that there was an absence of other factors that had an impact on the outcomes observed. Davidson (2005) describes these factors as the intended and unintended effects of a programme and extends this analysis further to include both short and long term effects, depending upon the data that is obtained.

I have chosen to use the outcome evaluation form for this research, due to the complexities of outcomes for individuals, both as participants in the Family Partnership training programme and as clients of the clinical service. Davidson (2005) discusses the use of outcome evaluation as a form that usually exclusively focuses on outcomes rather than process. This was a significant factor in choosing an evaluation form due to the limitations on budget and time with this research project.

## *EVALUATION APPROACH: THEORY-DRIVEN EVALUATION*

This evaluation research used theory-driven evaluation as the overall approach. Many evaluation experts are critical of programme and outcome-based evaluation approaches due to the “black box” phenomenon. This term refers to the assumption that the outcomes are achieved as a direct result of the input, with little consideration around why or how they happened (Stame, 2004). The result is an evaluation that provides minimal information as to “how” a programme can be improved or “why” it worked at all. The theory-driven approach is thought to address the gaps between inputs and outcomes by examining the theory around factors that influence the results, therefore addressing the “black box” phenomenon.

In order to understand theory-driven evaluation, it is important to understand the fundamental concept of ‘programme theory’. Davidson (2005) defines programme theory as a description around how a programme achieves the desired outcomes and is often portrayed visually by a ‘logic model’, which will be described later in the chapter. Chen (2005) believes that programme theory provides a platform for mixed methods to work collaboratively by de-emphasising their differences and incompatibilities and instead focusing upon the evaluation of outcomes. In this research, the programme theory is that the education around communication for registered nurses will have a positive impact on the way in which clinical services are delivered to Māori clients and therefore, a positive influence over whānau wellbeing and health outcomes.

Coryn, Noakes, Westine and Schroter (2011) completed a systematic review of theory driven evaluation practice and discovered that the origins of the approach can be traced back as early as Tyler in the 1930s, who formulated and tested programme theory (Donaldson, 2007, as cited in Coryn et al., 2011). They report that it was not until 1990 when Chen published his seminal book, *Theory-Driven Evaluations*, that this approach became more widely accepted and utilised in the evaluation community. Chen (1990) describes six types of theory-driven evaluations which demonstrates the flexibility in choosing to either evaluate the whole, or part of a programme theory. The six theory-driven evaluation types were divided into two categories, “Normative Theory” which provides an outline of expected outcomes based on experiences and “Causative Theory” which looks at the scientific results of the implementation of a programme (Chen, 1990). The distinction between the six theory-driven evaluation types increased the popularity of the method, as it had previously been considered a lengthy and sometimes onerous process to evaluate the whole of a programme theory. In this research the

Family Partnership training itself was not evaluated due to the size of the project, and therefore the evaluation took a normative approach based on outcome theory.

Rogers (2000) describes the process of theory-driven evaluation as the development of a model on how an input or programme achieves proposed outcomes which then leads to the completion of an evaluation directed by the model. It is clear that theory-driven evaluation informs the relationship that already exists between the cause and effect, rather than looking at whether a relationship exists at all. Davidson (2005) states that programme theory requires an understanding of how all components or outcomes relate to each other. Chen (1990) believes that without sound grounding in theory, programme evaluation can become a “cook book” method in completing research which disregards the needs, the context or the impact on the people involved.

#### *EVALUATION DESIGN: MIXED-METHODS*

This evaluation research followed a mixed-methods design, using both qualitative and quantitative methods and data to triangulate emerging themes. While mixed-methods evaluation has not been historically regarded as an optimal foundation for research design, Moon and Moon (2004) believe that it allows for the explanation and expansion of an observed pattern. Johnson and Onwuegbuzie (2004) add that a mixed-methods design gives the researcher scope to answer a variety of questions in relation to a particular topic, as the researcher is not limited to only one approach. Quantitative and qualitative traditionalists view mixed methodology as being based upon incompatible premises and techniques, and argue that mixing methods is less valid due to this conflict (Guba, 1990). Patton (2002) would argue that multiple sources in mixed methodology are critical to an effective evaluation of a programme, as a single source does not necessarily provide a comprehensive perspective.

When deciding upon an evaluation research design, Patton (2002) believes that the importance of gathering the most valuable and useful information outweighs the importance of methodological purity. Teddlie and Yu (2007) believe that triangulation combines both the arguments and the evidence with the two goals of union and unity, whereas Jick (1979) argues that the process of mixed-methods triangulation adds to the richness of a phenomenon, rather than to only the single purpose of cross-validating findings. Patton (2002) discusses triangulation from an evaluation viewpoint in which it is seen as an on-going process testing for consistency, in contrast to utilising a number of different processes with an aim of obtaining the same result. He states that when an inconsistency in the data is highlighted, an

opening is created for further investigation and therefore the inconsistencies are potentially more valuable to the researcher in terms of the informing the scope of further data collection.

### *LOGIC MODEL*

Logic models are pictorial representations of cause-effect processes that signify underlying theories of how to progress from 'inputs' through to 'outcomes' (Davidson, 2005). The logic model is the centre point for the evaluation, as it provides the framework for both the methods used and the analysis in observing the assumptions that exist between outcomes. Logic models give a starting point from which to examine the proposed relationships between outcomes, and a platform from which to analyse the potential perspectives of stakeholders and participants. McCawley (n.d.) believes the purpose of a logic model is to provide a description of a programme and identify ways in which to measure performance. Davidson (2005) adds that it is important to identify and analyse the assumptions present in logic models in order to address and observe the underlying need.

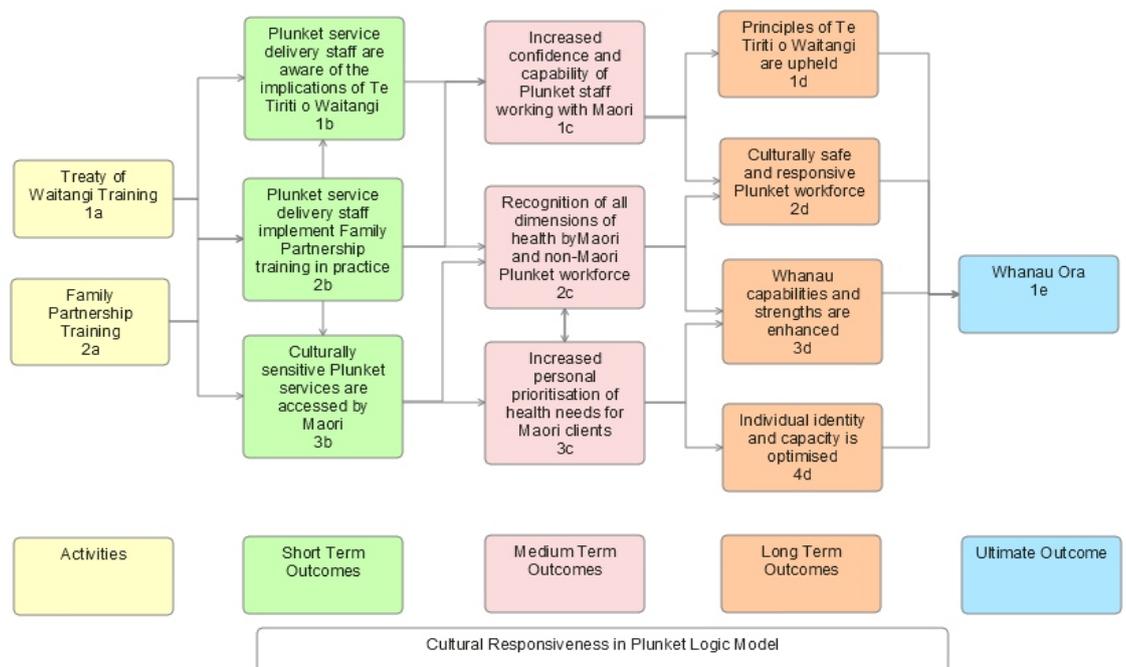
When examining assumptions within the logic model, the issue around 'causation' and evaluation is discussed in depth in the literature (Patton, 2002 & Davidson, 2005). Even though observations can be made around the relationship between an experience or event and an outcome, proving that this relationship exists can be difficult. The issue with causation is that as a theory emerges, more variables appear with theories of their own. Davidson (2005) suggests that most researchers discussing causation have disclaimers relating to how certain they are around the evidence, however this depends upon the nature of the research and whether there are any organisational requirements of evidence for decision making, such as funding or strategic decision-making implications. McCawley (2003) adds that logic models can also be used to plan programmes as well as evaluate existing programmes. It is becoming widely accepted that evaluation plans and logic models are useful to develop prior to commencing a programme in order to make adjustments as needed, rather than waiting until the end as in traditional evaluation.

As mentioned previously, logic models used in evaluation must have a theory of change underpinning the logic. The programme theory behind the logic model for this research is that Family Partnership training develops skills in cultural responsiveness for Plunket nurses, and provides a platform from which to assess cultural competence. This theory is supported by Davis, Day and Bidmead's (2002) description of the "Parent Advisor" model which sits at the centre of the Family Partnership training programme. They state that,

The Parent Advisor model was developed to enable all potential helpers... to work together with others to enable a complete system of care. The intention is to enable them to understand the processes and skills of helping, so that they can use their own technical expertise more effectively, by taking into account the interpersonal processes, yet also deal with the psychological and social issues that are invariably present when people have a problem (p. 10).

This notion of a complete or holistic system of care and the skills of helping when working with Māori specifically, are reaffirmed in Wilson’s study around culturally appropriate health services for Māori (2008). Māori women who were interviewed stated that health services often took a problem-based approach towards addressing their needs and interventions which were not always appropriate or realistic. The theory of change in this evaluation is the suggestion that Family Partnership could assist Well Child nurses to further develop communication skills to work alongside Māori in identifying priorities and responsive interventions.

Figure [4] illustrates the logic model designed for this research that demonstrates the pathway for a culturally responsive well child service and the ultimate outcome of “Whānau Ora”.



**Figure 3: Cultural Responsiveness in Plunket Logic Model**

The model is read from left to right. It begins with the “Activities” of Treaty of Waitangi Training and Family Partnership training rather than the usual “Inputs and Resources” to shift the focus of the research away from evaluating the individual programmes and facilitation, and onto the programme content and application (for both Treaty of Waitangi training and Family Partnership) in practice with Māori clients. It was important to allow this focus to shift in order to link the communication directly to service delivery.

As stated previously, it is acknowledged that there is a significant gap in the research by not starting with an evaluation of the training itself. Due to the size of the project, a decision was made not to evaluate the training, rather the outcomes of the training on communication with Māori. This may be an area for future consideration as the quality of the training will have a direct impact on the application to practice. However a key measurement for the quality of Family Partnership training would be around the growth of the individual participant rather than the extent to which the skills are demonstrated in practice, given the way the programme is designed and role modelled.

The arrows illustrate the relationships between the outcomes or activities. The model was developed from right to left with the focus upon Māori Plunket clients, Plunket as an organisation, cultural responsiveness and the Family Partnership model. Millar, Simeone and Carnevale (2001) discuss the freeing of outcomes by inverting the order in which the model is developed, as this lessens the restriction around developing outcomes from only existing activities. It also means that the research is targeting the relationships between outcomes which could potentially challenge the assumptions of those creating the model.

When developing the logic model, the earlier discussion around the “black box” phenomenon needed to be considered also. While freeing the thinking around outcome placement, there was a risk of making grand assumptions that ‘a’ is directly related to ‘b’ (Stame, 2004). Each outcome has a relationship and dependency on another as well as with the environment in which it sits, and each outcome has the potential to be researched and evaluated extensively on its own. The logic model was developed early in the research process in order to provide a framework from which to develop the evaluation questions and inform the tools designed for data collection.

The assumptions of the model need to be acknowledged as they contribute to the many variables that exist when developing a logic model, in terms of illustrating an idealistic progression of outcomes. McCawley (2003) acknowledges the difficulty in using a “linear model to simulate a multi-dimensional process” (p. 2). The intention is for the model to be

used as a simple communication tool which may be pulled apart and analysed and the context examined around each of the outcomes. The key assumptions of the model and the relationship between outcomes are listed in Table 3.1.

**Table 3.1 Key Assumptions Underpinning the Logic Model**

Activity / Outcome	Key Assumptions	Related Outcomes
Treaty of Waitangi Training (1a)	<ul style="list-style-type: none"> <li>The training is of a high standard</li> <li>Staff are aware of the connection between the principles of the Treaty of Waitangi and the skills of Family Partnership</li> <li>Staff have the ability and self-awareness to communicate in a culturally sensitive manner</li> </ul>	<ul style="list-style-type: none"> <li>Plunket service delivery staff are aware of the implications of Te Tiriti o Waitangi (1b)</li> <li>Plunket staff demonstrate the principles of Te Tiriti o Waitangi by utilising a Family Partnership style and philosophy in communication (2b)</li> <li>Staff are culturally sensitive to the needs of Māori clients (3b)</li> </ul>
Family Partnership Training (2a)	<ul style="list-style-type: none"> <li>The communication skills attained in the Family Partnership training are demonstrated in culturally sensitive responses to clients</li> <li>The Family Partnership training assists staff to have a greater understanding of the principles of Te Tiriti o Waitangi</li> <li>Staff have the ability to transfer the skills learnt in Family Partnership training into practice</li> </ul>	<ul style="list-style-type: none"> <li>Culturally sensitive services are available and accessed by Māori clients (3b)</li> <li>Plunket staff use Family Partnership communication in practice (2b)</li> <li>Plunket staff have an awareness of the implications of the Treaty of Waitangi (1b)</li> </ul>
Plunket service delivery staff are aware of the implications of Te Tiriti o Waitangi (1b)	<ul style="list-style-type: none"> <li>The knowledge surrounding the Treaty of Waitangi translates into a sensitivity regarding Māori and Māori worldviews</li> </ul>	<ul style="list-style-type: none"> <li>Increased confidence and capability of staff working with Māori (1c)</li> <li>Recognition of all dimensions of health by both Māori and non-Māori workforce (2c)</li> </ul>
Plunket service delivery staff put Family Partnership model into practice (2b)	<ul style="list-style-type: none"> <li>That participants on the Family Partnership course apply the content to practice and gain insight into their communication styles</li> <li>The insight gained in the Family Partnership course translates into confidence in asking questions and exploring the different realities of others</li> </ul>	<ul style="list-style-type: none"> <li>Increased confidence and capability of Plunket staff working with Māori (1c)</li> <li>Recognition of all dimensions of health by both Māori and non-Māori workforce (2c)</li> </ul>
Culturally sensitive services are accessed by	<ul style="list-style-type: none"> <li>The insight gained in the Family Partnership course translates into staff confidence in asking questions and</li> </ul>	<ul style="list-style-type: none"> <li>Recognition of all dimensions of health by both Māori and non-Māori workforce (2c)</li> </ul>

Māori (3b)	<ul style="list-style-type: none"> <li>exploring the different realities of others</li> <li>Staff engage in a way that acknowledges and supports the clients' existing skills and knowledge</li> </ul>	<ul style="list-style-type: none"> <li>Increased personal prioritization of health needs (3c)</li> </ul>
Increased confidence and capability of staff working with Māori (1c)	<ul style="list-style-type: none"> <li>Staff are confident that their practice demonstrates partnership, participation, protection and equality with Māori clients</li> <li>Staff and clients, in partnership, identify strategies and processes that would benefit Māori clients</li> </ul>	<ul style="list-style-type: none"> <li>Principles of Te Tiriti o Waitangi are upheld (1d)</li> <li>Culturally safe and responsive workforce (2d)</li> </ul>
Recognition of all dimensions of health by both Māori and non- Māori workforce (2c)	<ul style="list-style-type: none"> <li>Staff and clients identify risk and protective factors in partnership that are meaningful to the client and whānau</li> <li>Documentation represents the holistic interactions with clients</li> </ul>	<ul style="list-style-type: none"> <li>Culturally safe and responsive workforce (2d)</li> <li>Whānau capabilities and strengths are enhanced (3d)</li> </ul>
Increased personal prioritisation of health needs (3c)	<ul style="list-style-type: none"> <li>Clients are motivated to prioritise their own health needs</li> <li>Staff work in partnership with clients to enhance and respect personal prioritisation of health needs</li> </ul>	<ul style="list-style-type: none"> <li>Whānau capabilities and strengths are enhanced (3d)</li> <li>Individual identity and capacity is optimised (4d)</li> </ul>
Principles of Te Tiriti o Waitangi are upheld (1d)	<ul style="list-style-type: none"> <li>Plunket as an organisation demonstrates a true commitment to partnership, participation and protection</li> </ul>	<ul style="list-style-type: none"> <li>Whānau ora (1e)</li> </ul>
Culturally safe and responsive Plunket workforce (2d)	<ul style="list-style-type: none"> <li>Plunket takes an organisational approach towards cultural safety and initiatives to improve health in Māori communities</li> </ul>	<ul style="list-style-type: none"> <li>Whānau ora (1e)</li> </ul>
Whānau capabilities and strengths are enhanced (3d)	<ul style="list-style-type: none"> <li>Whānau access their right to self-determination and promote and support the health of all members</li> </ul>	<ul style="list-style-type: none"> <li>Whānau ora (1e)</li> </ul>
Individual identity and capacity is optimized (4d)	<ul style="list-style-type: none"> <li>Clients and staff are aware of the impact they have as individuals on others</li> <li>Clients and staff are continually motivated to change / challenge aspects of themselves</li> </ul>	<ul style="list-style-type: none"> <li>Whānau ora (1e)</li> </ul>

## STAKEHOLDERS

### STAKEHOLDER ASSESSMENT

A key component in planning evaluation is the identification of stakeholders and potential perspectives they may have in relation to the research process and any findings. There is some debate around the role and the potential role of stakeholders in theory-driven evaluation research. Hansen and Verdung (2010) discuss an important feature in the role of the evaluator as working alongside stakeholders to develop a common understanding of how a programme attempts to address an issue. They concede that this level of understanding may be difficult to attain with complex programmes, however believe there would be few situations in evaluation research in which stakeholders with competing perspectives would be kept apart. Although stakeholders may not share the same views across aspects of a particular programme, this could be touched upon in the discussion or addressed separately, depending upon the impact on the overall evaluation.

The stakeholders in this research ranged from service recipients, to nurses directly involved in service delivery, to management teams and developers of the model. Table 3.2 outlines the groups of stakeholders and their interests as well as their role in the research. It also indicates how I planned to engage with the stakeholders both during and following the completion of the research.

**Table 3.2 Persons Involved in Family Partnership and Cultural Responsiveness Research and Findings**

Stakeholder Categories	Interests / Perspectives	Role in the Research	How to Engage
Family Partnership Facilitators (internal and external to Plunket)	Advocates for Family Partnership training. Keen to see research outcomes that support the programme. Facilitators of Family Partnership courses throughout the country.	Advocates for participation in the research. Some participated in testing the online survey prior to distribution.	Discussion and presentation at regional Family Partnership meetings.
National Family Partnership Leader	Advocates for Family Partnership Training. National coordination of Family Partnership courses.	Distribution of phase 1 email to Clinical Leaders inviting Plunket Nurses to complete the online survey for phase 1 of the	Meetings, telephone, email.

	Keen to see research outcomes that support the programme.	research.  Distribution of the letter sent to eligible participants to participate in phase 2 of the research.	
Clinical Leaders	Daily management of clinical Plunket staff and overseers of day to day clinical practice.  Increased staff competence and knowledge relating to communication can support the team to build inter and intra related reliability.	Select and distribute email information to two interested Plunket Nurses within their teams for phase 1.  Provided agreement for their interested staff member to participate in phase 2 of the research.	Meetings, telephone, email, communication via National FP Leader.  Presentation of results once published.
Plunket Nurses	May or may not be aware of the Family Partnership programme.  Keen to ensure clients receive a service that optimises health outcomes.  An interest in the findings of the research.	Participants in both phase 1 and phase 2 of the research.  Identification of a Māori whānau who might like to participate in the research.	Telephone, text, email, face to face.  Presentation of results once published. Results of research published on website.
Māori clients	May or may not be aware of the Family Partnership programme.  May or may not be satisfied or see value in the Plunket service.  An interest in the findings of the research.  Commitment to the health and wellbeing of Māori whānau.	Participants in phase 2 of the research.	Face to face, email, text, post.  Results of research published on website.  Overview of research to be developed and sent to interested participants.
Plunket Clinical Leadership, Management and Senior Management Teams	A commitment to improving Māori health outcomes.  A commitment to Family Partnership training implementation.  An interest in the findings of the research.	Provision of overarching support for the research.	Email, meetings, discussions.  Presentation of results once completed.
Family Partnership Developers	An interest in the findings of the research.	Consent provided to utilise their model in research.	Email. Copy of completed research to be sent to the organisation.

## RESEARCH QUESTION:

The overarching research question and aims were the starting point for the entire project. The term “cultural responsiveness” has not been widely used in nursing literature. As discussed in the literature review, it was proposed that cultural responsiveness could be considered the **implementation** of the theory of cultural safety in terms of how it may be assessed by an individual observing or receiving the service. The research question which evolved was:

### **Is Family Partnership a model for cultural responsiveness in a Well Child context?**

#### *AIMS*

Three aims were developed from the research question to give direction to the project and link the components being evaluated:

- 1) To examine how Plunket nurses implement Family Partnership principles and methods in practice.
- 2) To establish the quality of the Family Partnership model in working with Māori whānau in a Well Child context.
- 3) To determine the way in which cultural responsiveness is demonstrated in Well Child clinical practice.

#### *EVALUATION QUESTIONS*

The purpose of the evaluation was to examine whether the outward demonstration of the skills and qualities developed in Family Partnership training could enhance service cultural responsiveness towards Māori clients enrolled in Plunket services. This research focussed upon the way in which partnerships are developed between Plunket staff and Māori clients, and the subsequent impact upon health outcomes for Māori.

The evaluation questions were divided into three key areas and developed using the logic model as the foundation. Davidson (2005) discusses the importance of identifying the key “big picture” questions that are central to the evaluation, in order to inform the methods used for data collection. The questions were further divided into high level and outcome specific (second level) questions in order to allow for deeper analysis across Family Partnership and cultural responsiveness. The evaluation questions and categories are as follows:

**Category 1: Personal/Professional** experiences of the Plunket nurse, the interaction with Māori clients and the use of the Family Partnership model in practice.

**High level question:**

**1. What effect does the Family Partnership training have on nursing practice?**

**Second level questions:**

- 1.1. What is the value of the Family Partnership model in terms of interacting with Māori clients?
- 1.2. How useful is the Family Partnership model in assessing the wellbeing of Māori whānau?
- 1.3. To what extent do Plunket nurses feel more confident, following the training, in being able to work alongside Māori whānau?

**Category 2: Māori clients'** experiences of service delivery and satisfaction with the quality of service delivered and communication style of their Plunket nurse.

**High level question:**

**2. To what extent do Plunket nurses meet the needs of Māori clients?**

**Second level questions:**

- 2.1. To what extent are the individual needs of Māori being identified by Plunket nurses?
- 2.2. How useful and appropriate is the Plunket nursing service for Māori clients?
- 2.3. To what degree does the Plunket nursing service acknowledge and enhance whānau capabilities?

**Category 3: Organisational** benefits of the Family Partnership programme and achievement of positive health outcomes for Māori clients.

**High level question:**

**3. What is the value of Family Partnership training to Plunket?**

**Second level questions:**

- 3.1. What impact does cultural safety and responsiveness have on Māori health outcomes?
- 3.2. How useful is Family Partnership training in creating a culturally safe and responsive Plunket workforce?

These evaluation questions formed the basis for the data analysis and were mapped back through to the logic model which is illustrated by the tables in Appendix I.

## RESEARCH METHODS

This research used a mixed-methods approach to data collection in order to triangulate the results against the evaluation questions drawn from the logic model. The project was approved by both Massey University Human Ethics and Plunket Ethics Committees. Initially both qualitative and quantitative data collection methods were combined and the Plunket Ethics Committee provided feedback around the process being unclear due to the volume and variety of data being collated, so subsequently two phases for data collection were developed.

Phase 1 was the online questionnaire and Phase 2 was the observation and interview component. Due to the size and purpose of the research, it was important to consider the number of participants in both phases. It was decided that Plunket Nurses who had not completed Family Partnership training would not be observed or interviewed in Phase 2. Initially I was concerned that there would be no 'control' group for the interview component to provide data for comparison. However, as the major focus was on the elements of Family Partnership theory demonstrated in practice rather than the comparison between the two groups, the data was obtained comprehensively with the one group.

### *PARTICIPANTS*

#### **Phase 1**

There was a questionnaire designed for a portion of Plunket nursing staff that had completed the Family Partnership training and those who were yet to complete the training. At the beginning of data collection there were 94 Plunket nurses nationwide who had completed the training and a further 13 who had completed the training and no longer worked for Plunket. A total of 210 Plunket staff including Community Karitane, Plunket Kaiawhina, Plunket Management, Paid Volunteers, Clinical Advisors and Educators had also completed the training. The inclusion/exclusion criteria for the questionnaire component (Phase 1 of data collection) is illustrated in Table 3.3.

**Table 3.3 Inclusion/Exclusion Criteria for Phase 1**

Inclusion for Questionnaire Distribution	Exclusion for Questionnaire Distribution
<ul style="list-style-type: none"> <li>• Plunket nurses - no limit on how long they had been working for Plunket</li> <li>• 25 Plunket nurses who had completed Family Partnership training</li> <li>• 25 Plunket nurses who had not completed Family Partnership training</li> <li>• Participants who were willing to participate in the interview and observation component of research</li> </ul>	<ul style="list-style-type: none"> <li>• Plunket Community Karitane, Kaiawhina, Management, Clinical Educators and Advisors</li> <li>• Plunket nurses who had completed a higher level of Family Partnership training (i.e. above level 1)</li> <li>• Nurses and other health professionals who are not employed by Plunket</li> <li>• Participants currently undertaking Family Partnership training</li> </ul>

**Phase 2**

The second aspect in the selection of participants (Phase 2) revolved around the willingness of nurses and clients to participate in interviews as well as the observation of the interaction between the Plunket nurse and a client who identified as Māori. The inclusion/exclusion criteria for the interviews and observation of practice are outlined in Table 3.4.

**Table 3.4 Inclusion/Exclusion Criteria for Phase 2**

Inclusion for interview and observation	Exclusion for interview and observation
<ul style="list-style-type: none"> <li>• Plunket nurses who had completed Family Partnership training Level 1</li> <li>• Plunket nurses who had prior approval from their Clinical Leaders and Area Managers</li> <li>• Plunket nurses who were willing to participate in the research</li> <li>• Pairs of Plunket nurses and Māori clients who had consented to participate</li> <li>• 10 Plunket nurses who met the above criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Plunket nurses who were unable to gain consent from a Māori client</li> <li>• Plunket nurses who had completed a higher level of Family Partnership training</li> <li>• Plunket nurses and/or clients who did not consent to the use of the data collated</li> <li>• Plunket nurses who were undergoing a process of performance improvement or a complaints procedure</li> <li>• Participants who were undertaking Family Partnership training at the time</li> </ul>

## *RECRUITMENT STRATEGIES*

### **Questionnaire (Phase 1)**

The questionnaire was based online to reduce cost and time for both the researcher and participants. Griffis, Goldsby and Cooper (2003) describe the advantages of using online technology as minimising cost and creating a more efficient means of obtaining and analysing data. Conversely, Simsek and Veiga (2001) argue that researchers choosing to utilise online questionnaires need to consider the audience appropriateness of this mode and also the purpose of what is to be achieved, before completely disregarding the use of paper questionnaires. Mail (paper-based) questionnaires are considered useful in obtaining a response from a wide spectrum of the population being sampled (Zutshi, Parris & Creed, 2007). Another benefit of mail survey questionnaires in research is that this method may allow generalisation to the wider population - depending on sampling techniques. However Zutshi, Parris and Creed (2007) add that online questionnaires can be useful when researching targeted populations with guaranteed access to the Internet.

An information email was sent out to all Plunket Clinical Leaders nationwide [refer Appendix III] explaining the research and purpose. The email gave the Clinical Leaders and prospective participants an opportunity to contact the National Family Partnership Leader with any questions they had regarding the research. The Clinical Leaders were asked if they could match the numbers of Plunket nurses who had completed the Family Partnership training with those that were yet to complete the training and supply the pre-survey email information [Appendix III] to all prospective participants. The link to the website containing the survey and log-on details was included in the email to all Clinical Leaders on the list with the expectation that the Plunket nurses identified would complete the survey over the course of a week.

### **Interviews and Observation (Phase 2)**

Recruiting participants for the interviews and observation study was slightly more complex in terms of the time taken to gain Plunket nurse interest, Clinical Leader buy-in and client interest. Participants had to be willing to participate in the research and the interview/observation process. An email was sent to all Clinical Leaders asking them to approach staff that had completed Family Partnership training and give them the information sheet for Plunket nurses and Plunket clients [refer Appendices IV and V]. The Plunket nurses then contacted a client who identified as Māori who they were working with, to gauge their interest and give them the information sheet. The Plunket nurses then contacted me directly

to arrange a date and time for a visit. All Plunket nurses who volunteered to participate in the interview and observation component of the research were of Pakeha and European ethnic backgrounds.

## DATA COLLECTION

### *PHASE 1: QUESTIONNAIRE*

Akbayrak (2000) describes a questionnaire as a list of questions requiring answers and believes that the complexity in developing a usable questionnaire for data collection lies in the design. Foddy (1994) outlines three considerations when designing a questionnaire for data collection. The first consideration is topic definition. Without an adequate understanding of the topic, the questions may stray from the original intent. The second is knowledge around the applicability of the questions to the respondents. If the questions have no bearing to the role or knowledge of the respondent, the answers provided could potentially sway the data or participants may 'skip' questions altogether. The third consideration is the perspective required for responding to the question. This involves providing clarity around the angle from which you are requesting participants to respond.

Taylor-Powell and Hermann (2000) reiterate the importance of defining survey content and topics prior to development in order to reduce the amount of unnecessary data obtained in the process. They suggest setting boundaries around topics in order to promote the most useful questions. The questionnaire developed for this research was divided into 7 categories; demographics, communication, decision making, service delivery, qualities and skills, confidence, and the Treaty of Waitangi and cultural safety. In dividing the questions into categories, participants were provided with the perspective from which to answer the questions, and I gained the data that specifically related to the evaluation questions I had developed.

The questionnaire in this research was designed to collect both quantitative in terms of multi-choice and rating scale data as well as qualitative data, relating to the free-text written responses. Due to the relatively small number of participants in the interview component of the research, I chose to add qualitative questions into the survey in order to obtain more of an understanding around the responses from the group of participants who had not yet completed Family Partnership training. De Leeuw (1992) provided a comparison between the self-administrated qualitative questionnaires and interview modes of data collection. The results showed that self-administrated questionnaires were more useful in obtaining data

around sensitive questions, which supported my decision to incorporate opportunities for Plunket nurses to openly reflect upon their practice.

The questionnaire was developed on the Survey Monkey website and in order to protect anonymity, the link to the questionnaire was embedded on a free website (fpthesis.yolasite.com) which was developed solely for the purpose of obtaining and presenting the data. Prior to sending invitations to participate in the survey, the questionnaire was 'piloted' by members of the Family Partnership facilitators stakeholder group. Feedback was provided relating to the initial order of questions and the usability of access. After the changes to the survey and website were implemented, the survey [refer Appendix XIV] went 'live' for participants to access.

As discussed previously, information regarding participation in the online questionnaire was sent to all Clinical Leaders in New Zealand with Plunket nurses in their teams who had completed Family Partnership training. The log-on information was then passed on to a Plunket nurse in each team who had completed Family Partnership training and one who had not. Some participants reported issues with logging on to the website, however the majority of issues were related to incorrect log-on input. Any issues were brought to my attention by the National Family Partnership Leader who was assisting me with the recruitment process and I provided suggestions for solutions via her in return. All log-on details were the same for each participant and the website provided a generic platform to provide the participant information sheet and access to the questionnaire.

While Plunket nurses did not have individual computer access at work, their Clinical Leaders and administration staff across the country had computers and online access. Most nurses could access the survey from home, while two participants chose to print off the survey and return it by post. The website and survey went 'live' in April 2011 and as a result of the promotion of the project over the course of 6 months, 46 participants out of 50 responded which equated to a 92% response rate.

#### *PHASE 2: CLINICAL OBSERVATIONS AND INTERVIEWS*

The second phase of data collection was the clinical observation and interview process. This was more difficult to organise participants for, as both the Plunket nurses and the clients needed to consent to be observed and interviewed. Kawulich (2005) describes these as 'ethnographic' methods of data collection which have been traditionally seen as methods of observing people from an 'outsider's' perspective. Kawulich also discusses the benefits of

observation methods in assisting to determine non-verbal expressions, interactions and how much time is taken on specific activities. DeWault and DeWault (2002) add that participant observations can increase the validity of the research when used alongside other methods of data collection due to the increased richness of the data obtained.

For this research, the observations were completed using the 'Interpersonal Communication Skills Rating Scale' [refer Appendix VI] which rated the Plunket nurses on the demonstration of Family Partnership qualities and skills observed. Observations were based on 13 qualities and skills of communication identified in the Family Partnership programme and participants were rated on a Likert scale between 1 (minimal evidence demonstrated) and 5 (considerable evidence demonstrated). The observations were completed at the time of the clinical assessment so they were not informed by the interview content and therefore provided data to triangulate ideas.

The purpose of interviewing is to enter in to and capture a participant's perspective (Patton, 2002). For the purpose of this research, I developed an interview guide which listed the questions to be explored during the course of the interview. Patton (2002) discusses the benefits of utilising an interview guide in terms of allowing the interviewer to be free to develop a conversation around a particular response or subject. He adds that a guide can assist in streamlining the discussion in identifying topics to be explored that align with the research goals. I developed the interview guide using the logic model as the foundation for topics to be covered and this assisted in collating information that supported the aims of the research. The interview guide consisted of seven questions [refer Appendix VII], however more questions were asked as needed in order to clarify and acknowledge responses.

Ironically, my interviewing technique improved when I 'let go' of the structure of the interview guide and actively demonstrated the qualities and skills I was seeking to observe in the Plunket nurses. I began to expand upon ideas and identify key constructs that were coming through from the participant's responses. My opening question for all participants was "tell me about how the visit went today?" Patton (2002) describes the sequencing of interview questions as a process that may assist with the flow of the interview. He believes that by commencing an interview with a question that requires minimal recall with a focus upon current activities, respondents are encouraged to provide descriptive responses. He suggests that probing questions can then be used to obtain more information to aid understanding.

I was open to being relatively flexible in the order in which the interviews were completed following the observation of the Plunket nurse and client, however on all ten occasions the

process followed the same structure. The Plunket nurses contacted me directly regarding their participation in the research, and we arranged a mutually agreeable time for the observation which had been negotiated with the client. On the day of the observation, I connected with the Plunket nurse at her clinic or office and followed her to the client's home. A negotiated time and location was agreed upon to complete the interview with the Plunket nurse later in the day. I discovered that many participants had not read through their information sheets so I ensured that this information was covered prior to the commencement of the observations.

Following the completion of the nurse's clinical assessment and my observation, the Plunket nurse would conclude the visit and leave the house and I would ask the Māori client whether it was ok to commence the interview process. The interviews with clients varied in length in order to fit in with babies' needs and routines. The high definition audio recorder was a target for toddlers and I occasionally needed to camouflage it under cushions, which had a slight impact on the quality of the sound. Participants were given the opportunity to turn the recorder off at any stage during the interview, however this option was not utilised in any of the interviews. Patton (2002) encourages the use of tape recorders in qualitative data collection not only to improve the accuracy of the data obtained, but to allow the interviewer to listen and be present in the conversation.

The interviews with the Plunket nurses generally took place in a private space within their clinics or offices. These interviews were mostly lengthier due to the interest in the topic and communication being seen as a fundamental component of their roles. Some nurse participants asked me for specific feedback on their practice, knowing my background as a Clinical Educator. I reminded them that this was not the intention or purpose of the research and that they needed to obtain this feedback through another avenue. These situations reminded me of the importance in recapping the details and expectations as well as my role outlined in the information sheets. Over a period of ten months, I observed and interviewed 10 Plunket nurses and 10 Māori whānau to obtain the data to inform the evaluation.

## ETHICS

Ethics approval was obtained from the Royal New Zealand Plunket Society Ethics Committee [refer Appendix VIII] as well as Massey University Human Ethics Committee [refer Appendix IX]. Virtanen and Laitinen (2004) describe the intention of professional ethics as the application of guiding principles, norms or mores to practice. Professional ethics therefore

guided the research process in terms of emphasising the “way” in which the research was completed.

Participants were given the opportunity to review their transcripts and decline to have their data used in the research. Participants were given the opportunity to start and stop the interview process at any stage. Audio data has been securely destroyed following transcription and checking for accuracy. All Plunket staff and clients involved in this research completed consent forms (refer Appendices XII and XIII) after reading the information sheets and asking any questions they had regarding the research (refer Appendices IV and V). All participants were able to contact myself or the National Family Partnership Leader for further clarification or information regarding any aspect of the research.

In order to maintain anonymity in phase 1, the survey responses were collated and analysed by the online survey software. While Clinical Leaders were aware that specific Plunket Nurses participated in the survey, the responses were anonymous and the analysis did not incorporate any identifiable information. I was unaware of participants’ identity in completing the online survey, as Plunket nurses were invited to participate by the National Family Partnership Leader. The information page on the website used to access the questionnaire gave participants the option to ‘click here to enter survey’ once they had read the information sheet.

In Phase 2, Plunket nurses who had read the information sheet and discussed the research with a client contacted me directly. I arranged to meet them either at the clinic or at the client’s home. The interviews were conducted at a mutually agreed upon location for both the Plunket nurse and the client. The data collated in the observation phase had any identifying features removed such as names, geographical locations and any other information that could potentially identify the participants. Pseudonyms were used to link the pairs of participants with observation notes in order to triangulate the data. The consent forms were kept in a separate location from the data.

Key stakeholders were consulted and kept informed throughout the research process. The information gained throughout the research will be used to enhance, inform and respond to the needs of Māori accessing Plunket services. Participants were not coerced in any way to participate in the research and were able to decline the invitation without consequence or discrimination. Information and data remained confidential, and transcriptions were not attributed to any particular staff member, area or client within Plunket.

Survey data were collated by surveymonkey.com which ensured complete anonymity. As mentioned previously, anonymity was enhanced by the utilisation of a website from which to take the survey. The raw data from interviews and observations was stored in a locked filing cabinet at my home during the data collection and analysis process. At the completion of the research, written data will be stored securely in the School of Nursing at Massey University Albany Campus and will be destroyed after 5 years. Transcripts were coded into common codes directly related to the data triangulation in order to provide structure for data collection and maintain anonymity.

#### *RELIABILITY AND VALIDITY*

Validity in research examines whether the results of the research can be attributed to the methods used to collate the data (Chen, 2010; Chen & Rossi, 1987). Validity can be further defined into both internal and external validity. Internal validity is thought to be the minimum requirement for any research and looks at the structure and steps of the research method and whether these have been followed through to obtain the results. External validity identifies any external factors that may have influenced the results, or conversely, identifies other environments in which the results may be applicable (Chen, 2010; Chen and Rossi, 1987). The discussion around validity in theory-driven evaluation relates back to the 'black box' phenomenon discussed previously, in which activities are directly attributed to outcomes regardless of the context.

To increase the internal validity in this research, the questionnaire was piloted by colleagues prior to the distribution of log-on details. Participants for phase 1 were ultimately selected by their Clinical Leaders, and this provided a cross-section of responses from throughout the country. Opening the participation criteria to all people working with Māori whānau regardless of organisation would have increased the external validity of the research. Davidson and Tolich (1999) believe that validity in qualitative research is often easier to obtain due to the accuracy of the accounts of participants. This is a benefit of the process undertaken in phase 2 of the research. The issue around the black box approach to causation has been addressed in utilising a theory-driven evaluation approach. This is evident in the evaluation questions in terms of asking how Family Partnership works with Māori and the data analysis section examining why this may be.

Golafshani (2003) describes reliability in research as the consistency in the methods utilised in order to achieve consistent results. Central to this definition is the notion of replicability and repeatability of observations and results. This research has potential to be replicated in a

variety of contexts both within and external to Plunket, however differences occurring as a result of the stability of qualitative data due to variances between people need to be considered. This research focuses upon the individual experiences of participants as both recipients and providers of the Well Child service, however, the responses would be expected to reflect the views of a greater proportion of nurses and clients they represent.

Reliability was enhanced by the number of participants that took part in this research. Responses from 46 Plunket nurses for phase 1 and the triangulation of ten sets of data for phase 2 provided a cross-section of nationwide data and results that would be repeatable in a similar project. The second level research questions also enhanced reliability by ensuring there was a 'drilling down' into the high level questions, therefore the methods for obtaining data could be mapped back to achieve similar results if the process was followed again. Triangulation of the data against each of the second level evaluation questions improved the reliability of the results due to the cross-referencing nature of triangulation and the reduction of the likelihood of errors linked to the use of one particular method (Patton, 2002).

## DATA ANALYSIS

This section explores the two methods used for data analysis. In order to inform which data set would be used to evaluate which high level evaluation question, a table was developed which mapped the second level questions to the logic model outcomes [Appendix II] and the method for data collection. Thematic analysis (Braun & Clarke, 2006) was used to analyse the qualitative data within the transcribed interviews and the open-ended survey responses. Tables outlining the process in determining merit (Davidson, 2005) mapping the second level evaluation questions to the survey questions [Appendix X] were used to analyse the quantitative data. The average of observation scores was used throughout the data analysis to further triangulate ideas as they emerged.

### *THEMATIC ANALYSIS*

The process of thematic analysis was used to analyse and provide structure to the qualitative data obtained in the interviews and in the free text questionnaire responses. Braun and Clarke (2006) describe thematic analysis as a method for loosely organising data into patterns for analysis. They discuss the use of thematic analysis as a way of interpreting specific components of the research topic. Although thematic analysis is a process that is widely used in qualitative research, Braun and Clarke (2006) believe that there is a lack of clarity around both the

definition and the way in which it is conducted. They also propose that many other forms of qualitative analysis are in fact thematic analysis under different titles.

Central to the process of thematic analysis is the notion of 'themes' and from where they 'emerge'. Braun and Clarke (2006) describe a common misconception is believing that themes actually reside and emerge from within the data, when the thought processes and experience of the researcher actually determine which themes are derived from the data. This has implications for the reliability of the research in terms of whether a different researcher given the same set of data would identify the same results. However this has been somewhat mitigated with the triangulation process within this research providing differing perspectives to each of the high level evaluation questions.

Braun and Clarke (2006) developed a series of six steps in conducting a thematic analysis. The first step involves becoming familiar with the data. Braun and Clarke (2006) discuss the process of transcription as important in informing early analysis and familiarisation with the data. My involvement in the interview process and transcribing the interviews ensured that I was familiar with the types of data that were being collected. The second step is generating initial codes for identifying themes. Braun and Clarke (2006) suggest that there are no strict rules to follow when completing a thematic analysis as long as the intent is to analyse repeated patterns of meaning within the data. The qualitative data was collated and coded against the headings and then distributed amongst the second level evaluation questions. It was clear that there was some overlap between the relevance of the data across the questions and judgements were made as to the 'fit' of the data in representing Plunket nurses, Māori clients or Plunket as an organisation. In coding the data, concepts and descriptors were used that linked back to the qualities and skills embedded within Family Partnership theory and the data was then loosely categorised under headings implying a similar theme.

Braun and Clarke's third step involves searching for themes. Braun and Clarke (2006) define a theme as a "patterned response" within the data that captures an idea important to the research topic. They are clear that the number or frequency of which an idea occurs does not have bearing upon the importance or relevance of a theme and that the researcher's judgement is used to decide which aspects of data could be considered a theme. The qualitative data was worked through systematically and sub-themes were identified and organised under the broader themes which were then organised against the wider data set.

The fourth step is reviewing the themes. The themes were reviewed using the theory embedded within the Family Partnership programme in order to examine the relationship

between the data collated and the existing Family Partnership theory. Braun and Clarke (2006) describe this process as sometimes being referred to as “thematic discourse analysis” as the theory provides an overarching summary of the underlying meaning within the data. This involved re-reading all of the data obtained with the lens of the themes that had been identified. During this phase I identified further sub-themes that had been overlooked in my previous analysis. When I was confident that I had captured the all of the themes I could identify in the data and they were organised against the three high level evaluation questions, I returned to the literature to define and expand upon the themes and the applicability to my research aims.

The fifth and sixth steps involve defining and naming the themes and producing the report. The themes identified in this research were then presented within the context of the principles of the Treaty of Waitangi to demonstrate the link between the concepts identified and the historical agreement between Māori and the Crown. The themes were looked at both in terms of their relationship to the research questions as well as their relationships with each other. I made a conscious decision not to provide headings for the themes in the writing up of the results in order to allow freedom in expressing the relationships between each other and bring all of the findings together in the final discussion.

#### *PROCESS FOR DETERMINING MERIT*

Davidson (2005) describes evaluation as the process of measuring the value or worth of an evaluand. In order to measure the data against an evaluand, it is important to firstly determine what constitutes poor, adequate, good, very good and excellent performances and secondly use the evidence to make evaluative conclusions. Davidson (2005) suggests that it would not be ideal to assess the performance against an evaluand using a single measure and with a mixed-method approach to data collection, data sets in evaluation are usually very complex.

In this research, the data sets were extremely varied and the programme was being evaluated against its cultural merit in working alongside Māori clients. This complicated the process in terms of triangulating the data against all of the outcomes presented on the logic model. Because of this complexity and the length of the research, I decided to evaluate the three high level evaluation questions that had been developed using the logic model at the beginning of the research. The relationships between the evaluation questions and the logic model outcomes as well as the method for data collection are illustrated in Appendix II.

Part of the process of determining merit in evaluation research is the identification of what represents success. It needs to be acknowledged that different evaluators with differing perspectives and priorities will have different measures on what constitutes success. However, the merit criteria developed for this research derived from the logic model that provided the foundation for the research and the use of the same logic would reduce the variation in perspectives.

To determine the merit of the data and performance ratings, I had to firstly describe the ideal observations that would support a high level of congruence in the relationship between the evaluation questions and the data. These definitions are outlined in the ‘success definition’ tables [refer Appendix XI]. Following the identification of what would constitute success; I developed a rubric rating scale to provide a mechanism to assess the performance against the evaluation questions. The rubric scales provide examples of which evidence would constitute which rank, from “Very High” through to “Very Low” in response to the evaluation questions.

The quantitative survey data was analysed separately from the interview, observation and open-ended survey response data. In order to provide structure to the survey data, I developed tables that mapped the survey questions through to the second level evaluation questions and identified themes in the qualitative responses that were also linked to the second level evaluation questions [refer Appendix X]. The quantitative results for the average of the survey questions were graded as follows:

<b>0 – 1</b>	<b>Very low</b>
<b>1 – 2</b>	<b>Low</b>
<b>2 – 3</b>	<b>Moderate</b>
<b>3 – 4</b>	<b>High</b>
<b>4 – 5</b>	<b>Very High</b>

The quantitative data table generated a working grade according to the performance against the rubric and this result was able to be changed based on the triangulation of the qualitative interviews, observation scores and open-ended survey responses.

The final grade for each of the high level evaluation questions are highlighted on each of the rubric rating scales alongside the definitions of the grades. The final discussion chapter provided presents and explores the themes in a more concise format and aligns them with the principles underpinning the Treaty of Waitangi. Due to the volume of the data collected and analysed, it was important to provide structure to support the ‘drilling down’ on the results against the overarching research question.

## SUMMARY

Evaluation is widely acknowledged as a way to make judgements, and determine the value and effects of specific phenomena (Patton, 2002; Scriven, 2001; and Weiss 1997). This research took the form of outcome evaluation which examines the degree of positive change following a specific intervention. This form of evaluation guided the research away from examining the process of Family Partnership training and onto the effect upon Plunket nurses, Māori clients and Plunket as an organisation. The approach used in this research was 'theory-driven evaluation'. Central to a theory driven approach is the use of logic models which are pictorial representations of how a programme achieves proposed outcomes. Theory-driven evaluations have a 'theory of change' underpinning the process and in this research, the theory of change is that Family Partnership training develops Plunket nurse skills in cultural responsiveness in working with Māori clients.

This chapter has provided an account of the design, methodology and methods used in the data collection and analysis in this research. The recruitment strategies and processes undertaken for collecting the data in both phases of the research were described. The ethical principles underpinning the research were outlined and there was a relatively high level of confidence that similar results could be attained should the research be repeated under similar conditions. The reliability of the research was enhanced by the triangulation of the data as well as the size of the participant group.

The final section in this chapter examined the method and processes used for data analysis. Qualitative data was analysed using the process of thematic analysis which involved a process of identifying and analysing themes and relating them back to each other as well as the research question. Quantitative data was presented and analysed in table formats and given working grades against rubric rating scales which were developed to determine merit for each of the high level evaluation questions.

The following three chapters will present the findings in relation to the three high level evaluation questions. Chapter 4 specifically will discuss the results from a Plunket nurse practice perspective in relation to the effect of Family Partnership training on nursing practice.

## CHAPTER 4 - THE EFFECT OF FAMILY PARTNERSHIP TRAINING ON PLUNKET NURSE PRACTICE

This chapter presents the data collected around the effect of Family Partnership training on nursing practice. The foundation for the data analysis in this research was the use of the three high level evaluation questions. The high level evaluation questions were developed and designed to incorporate the outcomes illustrated on the 'Cultural Responsiveness in Plunket logic model [Figure 3 and Appendix I].

The question, "what is the effect of Family Partnership training on nursing practice?" was designed to examine the personal and professional experiences of the Plunket nurse in working with Māori. This included both nursing interactions with Māori clients as well as whether the use of Family Partnership qualities, skills and processes, support Plunket nurses with tools to engage and respond to the needs of Māori.

This chapter will examine and triangulate the data against the second level evaluation questions and provide the basis for the evaluative conclusions and recommendations related to the effect of Family Partnership on Plunket nurse practice which will be outlined in the final chapter.

### 1.1) WHAT IS THE VALUE OF THE FAMILY PARTNERSHIP MODEL IN TERMS OF INTERACTING WITH MĀORI CLIENTS?

The purpose of the Family Partnership model and the foundation course is to equip people working with families with transferable communication skills to assist them in helping others (Davis, Day, Bidmead, Ellis & MacGrath, 2009). This second level evaluation question is examining the degree to which the Family Partnership model is useful in working alongside Māori whānau. This is from both a Plunket nurse and a client perspective in terms of the data obtained for this research.

#### *SURVEY DATA*

The questionnaire data illustrated a relatively high level of self-assessed ability in communication by Plunket nurses. This level of communication was slightly higher for nurses who had completed the Family Partnership training [Refer Figure 4]. This could be reflective of the promotion and use of a communication model from which to base and align practice. Davis, Day, Bidmead, Ellis and MacGrath (2009) discuss the transition that some highly skilled

practitioners have made in terms of increasing the confidence in their own knowledge around communication and being able to apply this knowledge to practice.

**Figure 4 Plunket nurses' perception of their communication ability**

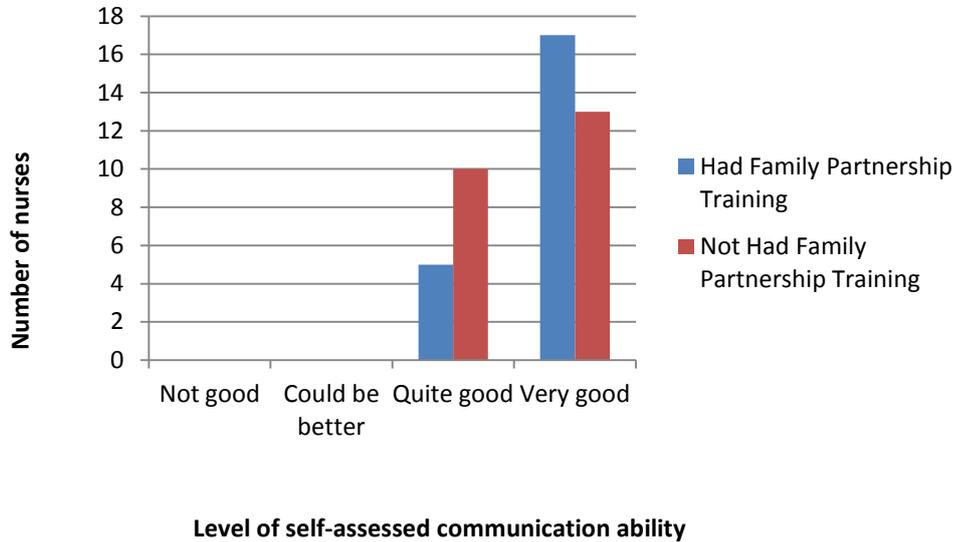
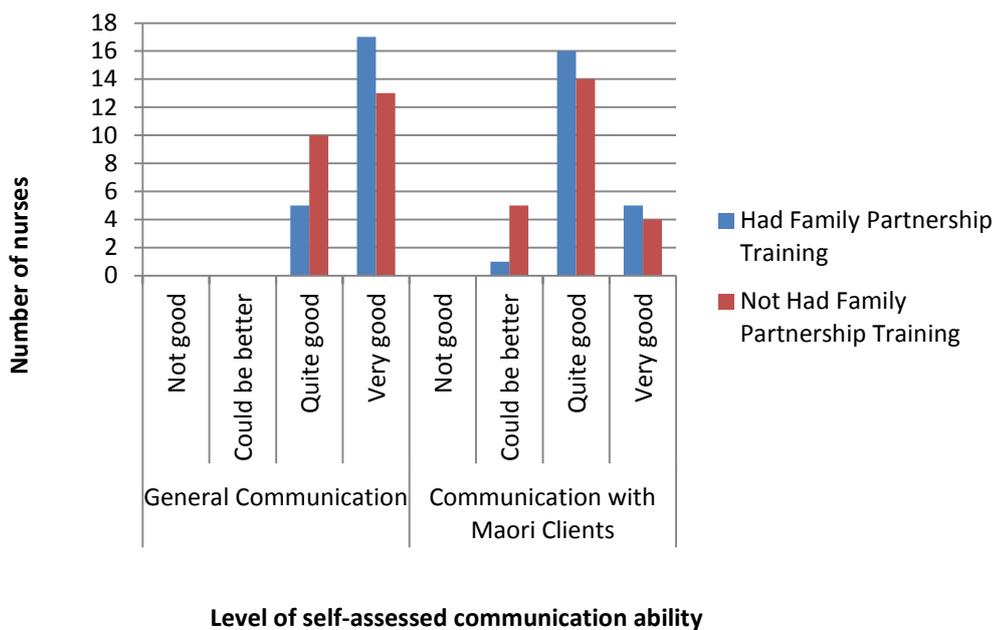


Figure 5 provides a comparison between Plunket nurse perception of their communication ability generally and their communication with Māori clients.

**Figure 5 Plunket nurses' perception of their communication ability generally and with Māori clients**



The Plunket nurses' self-ranking of their communication and engagement with Māori clients was lower than their general ranking of their own communication abilities. This was true for

both Plunket nurses who had, as well as those who had not completed Family Partnership training. This lower self assessment in communication and engagement with Māori may be a reflection of a perceived lack of knowledge around Te Ao Māori (the Māori world) when engaging with Māori clients. Durie (2003) discussed the importance of identifying the relationships Māori have with the Māori world in relation to channelling energy into appropriate outcomes. In examining the questionnaire data, it appears that while Family Partnership increases Plunket nurses' perceptions of their communication ability, there remains a significant difference in all Plunket nurse participants' perceived ability to engage and interact with Māori clients.

Figure 6 provides a comparison between the perceptions of the importance of Family Partnership qualities in working with Māori by both groups of Plunket nurse participants. The nurses ranked their importance of each of the qualities from "not important" to "essential".

**Figure 6 Plunket nurse ranking of the importance of Family Partnership qualities in working with Māori**



In examining the two groups, the majority of Plunket nurses perceived the Family Partnership qualities as 'essential' in working alongside Māori clients. It is unclear as to whether some of the responses from the participants who had not yet completed Family Partnership training,

reflected their level of understanding of the terms and how these may be demonstrated in their practice. Of interest was the relatively low prioritisation of the 'technical knowledge' quality across both groups, which could potentially relate to the technically specific knowledge of 'Te Ao Māori' and the nurses' lower perception of their communication ability with Māori clients. This may also be representative of an increased level of awareness of the importance of engagement with clients for Plunket nurses who had completed Family Partnership training.

Questionnaire respondents who had not completed Family Partnership training indicated that having knowledge of Māori cultural values and practices is important in engaging with Māori, whereas nurses that had completed Family Partnership training indicated that they would be led by the client as to whether they would like culturally specific interventions. Wilson (2008) describes this acknowledgement and provision of a culturally appropriate service as critical to informing service interventions and suggests that tailoring the approach to meet the needs of Māori may ostensibly lead to different intervention pathways.

#### *OBSERVATION AND INTERVIEW DATA*

"I know she respects me and I respect her. I just know, there's no question. And I'm sure she knows it too." (Plunket nurse F)

A recurring theme in the application of the Family Partnership qualities and skills to practice in working with Māori from the Plunket nurses interviewed was the demonstration of respect. This correlated with the questionnaire data from both groups, with the quality of 'respect' rating as having the highest importance in working alongside Māori. Davis, Day and Bidmead (2002) describe the quality of respect as aligning closely to Carl Rogers' (1959) concept of "unconditional positive regard". Davis et al. discuss the quality of respect as encompassing behaviours such as courtesy, showing an interest and dedicating attention to the person you are helping during the time allocated.

This notion of being 'interested' in people appeared to align closely with the Plunket nurse view of 'building a relationship'. The relationship between the Plunket nurse and the client from a Plunket nurse perspective was complex in terms of the influences and variables that could impact on the relationship. A common fear for Plunket nurses was the potential damage to the relationship when challenging parenting practises with Māori clients. This included the fear of damaging the relationships that exist between whānau members in discussing or promoting interventions that may not align with advice from whānau.

“It’s all very well for us to be in there 20 minutes every couple of months, but they’re dealing with family that’s working with them all the time, and supporting - and they want that support and you don’t want to upset that relationship, it’s quite tricky.” (Plunket nurse G)

Davis et al. discuss the importance of being genuine, constructive and balanced with communication in working alongside parents and valuing what is said even if it does not align with personal or professional beliefs and knowledge. This is the crucial difference between demonstrating respect by electing ‘not to say’ anything and respecting the relationship in terms of the ability of the partners in the relationship to value and accept the feedback without negative consequences.

Wilson (2008) discusses the ability of service providers in developing and engaging in positive relationships with Māori women as having a strong correlation to the level of access and use of services. The importance of indirect communication with extended family and an awareness of body language came through as an important factor in the demonstration of respect by Plunket nurses. One participant described how she felt respected when she has contact with the Plunket nurse as opposed to other health services she had previous experiences with.

“It’s just like when she greets you and stuff like that. Then they greet the kids. It makes you feel good about having that person in your house.”  
(Client E)

Davis et al. describe the importance of acknowledging any children present during a visit and addressing them directly demonstrates respect for them and enhances the relationship with the parents. They also discuss the process of orientating to each other and settling down in the physical environment. One whānau described their dissatisfaction with the number of questions asked by the Plunket nurse prior to establishing any rapport with them.

“You’ve got to build up that rapport first ... if I’m selling you something, I understand that I can’t just come up to you and ask you for \$20,000 in the first two minutes of meeting you. I have to sit down with you and understand you and get to know who you are.” (Client I)

Other participants felt that they had a ‘good’ relationship with their Plunket nurse and they could discuss anything as required, as the relationship had been established. One participant discussed how impressed she was with the way the Plunket nurse got down onto the floor and joined in the conversation with the family at the first visit. Davis et al. describe this as being

responsive to parent's cues in terms of recognising how the parent wants to lead the interaction.

The average score of my observations of the Plunket nurses demonstrating positive and open body language was 3.6 out of 5. Most Plunket nurses were quick to pick up upon client cues and were guided by the clients as to where to sit and the level of eye contact to maintain. The quality of respect was assessed against all of the qualities and skills observed, however featured significantly in having a 'non-threatening' approach with an average score of 3.9 (out of 5) and appropriate confidence and assertiveness which scored 3.1 out of 5. There appeared to be some reluctance from Plunket nurses to discuss cultural issues or respectfully challenge any parenting practices that did not align with evidence based knowledge. This reluctance appeared to stem from a fear of inadvertently disrespecting or offending Māori clients, which is reflected in the following Plunket nurse's comment,

"I think sometimes we're a bit wary when we shouldn't be and if we just treat everybody with the same amount of respect... Hopefully you build up that relationship where you know what your client wants from you."

(Plunket nurse A)

While Family Partnership theory appears to provide tools in which to respectfully challenge and work alongside whānau towards positive health outcomes, the trust in the process and in the relationships established with Māori needs to be higher for this to consistently take place.

## 1.2) HOW USEFUL IS THE FAMILY PARTNERSHIP MODEL IN ASSESSING THE WELLBEING OF MĀORI WHĀNAU?

At the core of the Family Partnership model is the facilitation of the 'helping process.' Davis et al. (2002) outline the helping process as a series of eight interrelated steps that can assist a 'helper' to work alongside a client to navigate through an issue. They acknowledge that in practice, the helping process may stop at a particular stage, depending on the outcomes and requirements identified by the client. All stages in the helping process provide feedback into the relationship between the nurse ('helper') and the client. The 'end' stage relates to any possible ending, whether the relationship finishes, the issue is resolved, or a decision is made not to continue the process. At whatever stage the end point occurs, it is important to discuss the ending of the relationship in order to provide both partners with information to support subsequent relationships (Davis et al., 2002).

## QUESTIONNAIRE DATA

A key component of working in partnership with clients is the engagement and involvement of clients throughout the helping process. This involves careful exploration on behalf of the nurse to come to an understanding around what the issue is from the client's perspective while resisting the temptation to 'jump in' with solutions which may or may not be appropriate (Davis et al., 2002). The questionnaire data showed that most participants believe that they involve Māori clients in decisions relating to their care, most of the time. Participants who had completed Family Partnership training rated themselves slightly higher than those who hadn't completed Family Partnership training, as they did with ranking how well their service meets the needs of Māori whānau.

Interestingly, the overall ranking for how well Plunket nurses believe their service meets the needs of Māori was relatively low in comparison to their perception of the client's level of involvement in decision making. It was not clear from the open-ended responses why this would be, other than gaining a sense that Plunket nurses are trying to understand whether they make a positive difference to the lives of Māori clients. The difficulty in receiving feedback within the role of a Plunket nurse needs to be acknowledged. In comparison to nursing in a hospital or illness focussed context in which the results of the interventions can be identified more immediately, Plunket nurses grapple with subtle change and interventions that may or may not lead to long-term outcomes.

Cawley and McNamara (2011) completed research in West Ireland around the empowerment and advocacy role of Public health nurses. They discovered that the 'curative' nature of the nursing role saw the health promotion and empowerment aspects become less of a priority in client interactions. They describe the curative approach as closely aligning with an 'expert' model of practice and challenge support frameworks surrounding nurses to foster environments that support the relinquishment of a disease-oriented model. This transition to working in primary health care is evident with many newly employed nurses to Plunket in their interpretation of what constitutes a positive intervention.

A critical stage of the helping process is the review or evaluation of what has been implemented, and includes discussion around what has been successful or not so successful from the parent's perspective (Davis et al., 2002). There were no comments around reviewing the outcomes of helping process from either group of participants completing the questionnaire. This may suggest that evaluating outcomes may not be happening as part of working alongside Māori whānau in practice, or reviewing and evaluating outcomes is not

necessarily identified by Plunket nurses as a way to obtain feedback in the use of the helping process.

#### *OBSERVATION AND INTERVIEW DATA*

All Plunket nurses who participated in the observation component of the research were positive about the impact that Family Partnership training has had on their practice. For most, the relationship with the client remained central to their level of engagement with Māori whānau. Davis et al. (2002) describe the relationship as the foundation of the helping process, as without a mutually effective relationship, communication will break down and little will be achieved. Understanding that a positive relationship is pivotal to a partnership with Māori clients was a common theme amongst the Plunket nurses.

“We are not going to be effective just by telling everybody what to do, that they actually have to find out themselves. But hopefully with our help and input. Really having a good relationship with people. If you don’t have a good relationship, it’s not going to be a happening thing.” (Plunket nurse A)

The notion of resisting the urge to provide solutions for clients was another consistent theme across the Plunket nurse participants. This incorporated the skill of active listening and the demonstration of the quality of humility, which I rated the Plunket nurses on average at 3.5 and 3.6 out of 5 respectively. Davis et al. (2002) describe humility as the demonstration of equality within the partnership. This is around the ‘helper’ not assuming they have all of the solutions or that the client has inferior qualities and skills that they bring to the relationship. This may have been identified as a key learning from the Family Partnership training by the Plunket nurses, as rushing in to providing solutions is a practice that is often challenged throughout the training.

Solutions and strategies are closely entwined and are only effective if the issues and goals have been accurately identified. Davis et al. (2002) discuss the importance of the parent and helper working together in sharing their ideas in order to identify appropriate strategies. This acknowledges the parent’s expertise and investment in the process as well as relieves the helper of unnecessary pressure in having to develop solutions that may well sit outside their area of expertise. The appropriateness of strategies was identified by the Māori clients in this research as an important factor in determining whether they implemented the strategies or

not. One participant felt that the Plunket nurse did not identify strategies that she considered were appropriate for her situation, particularly relating to the inclusion of whānau.

“...it’s hard to explain but she needs to look at us as a family. She’s basing it just on me. There’s a lot of us in this house and I suppose she only sees me, but we’re just family oriented. I don’t mind stuff being directed at just me, but it needs to be taken into account that there’s a family that runs the house too...” (Client Y)

Some clients described how they often acknowledged the information and suggestions being given by the Plunket nurses, but were more likely to listen to someone that they believed knew their individual situation on a more personal level. This would suggest that the assessment and exploration around what the issues were by the Plunket nurse had not correctly or fully identified the issue or perhaps that solutions were being offered without adequate input from the clients. Wilson (2008) discusses the close relationship between inappropriate solutions being identified and the practitioner having a “problem based, bio-medical focus”. She discusses one of the issues around this approach in working with Māori as the lack of acknowledgement of the socio-cultural dimensions that can impact on health. In not fully recognising social factors that may influence the strategies negotiated with clients, Wilson describes how this can lead to a culture of ‘victim blaming’ when client outcomes are not achieved.

Throughout the observations there was evidence that the majority of Plunket nurses tried to identify the appropriateness of interventions and the impact that socio-economic factors may be having on their clients. This was expressed in one Plunket nurse’s statement,

“...understanding that some clients don’t have transport or maybe have other issues happening in their family and understanding that sometimes the appointments aren’t kept ... but you’ve got to keep going back until you see them, because often they’re the ones that really need it. There might be so much more happening in that family that we don’t know.”  
(Plunket nurse C)

The observations did elicit a gap in the evaluation stage of the helping process in terms of Plunket nurses identifying what worked or what could have been approached differently. This type of meaningful dialogue between the health practitioner and Māori women has been determined as an essential element in practitioners demonstrating a genuine commitment

towards improving health outcomes (Wilson, 2008). There was a sense amongst the Plunket nurses interviewed that they were uncertain around how to obtain feedback from Māori clients, and often relied on organisational or national statistical data relating to Māori health to inform their practice.

“I think of Māori families I’m working with now and I have worked with over the years and it’s hard to know if we’re making a difference as Plunket nurses.” (Plunket nurse H)

Davis et al. (2002) discuss the value of evaluation in terms of “shedding light” upon some of the reasons that strategies did not go according to plan or the extent to which they achieved the intended outcomes. Evaluation is also helpful in determining the point in the helping process at which the strategies became unsuccessful and allows for the redevelopment of plans. Davis et al. discuss another important aspect of evaluation as the celebration of success and the role of the helper in redirecting the credit to the parent to enhance self-efficacy and empowerment. This has implications for Plunket as an organisation in terms of ensuring that support structures are in place to provide the same level of recognition and celebration for the Plunket nurses in their work alongside Māori clients. Cawley and McNamara (2011) discovered that there was need for public health nurses to be supported to understand the concept of empowerment from an organisational perspective in order for them to be able to integrate empowerment strategies into their practice with clients.

### 1.3) TO WHAT EXTENT DO PLUNKET NURSES FEEL MORE CONFIDENT FOLLOWING THE TRAINING IN BEING ABLE TO WORK ALONGSIDE MĀORI WHĀNAU?

In 2002, Ramsden described the future of cultural safety as precarious due to the few forums established to address training issues and develop new ideas. While cultural safety was developed from an indigenous perspective, the intent was to encompass all aspects of culture that makes people unique. The qualities and skills required in identifying what makes individuals unique and also challenge thought processes that may be hindering positive progress, are outlined in the Family Partnership model. One element of the model which is central to individual perspectives is the concept of constructs.

Davis et al. (2002) describe people as “scientists” in terms of the way each individual develops theories in order to predict and anticipate what will happen. These theories form a model of the world which is called a construct system. This system is a dynamic and complex web of interwoven experiences and meanings which are unique to us all and inform our responses to

stimulus both consciously and sub-consciously. To ascertain Plunket nurse confidence in working alongside Māori, it needs to be acknowledged that every Plunket nurse's construct around their ability and confidence would have differed based on their own previous experiences, feedback and interpretation.

#### *QUESTIONNAIRE DATA*

The survey data illustrated a low level of confidence from both groups of Plunket nurses in working alongside Māori whānau, hapu and iwi. There was a slightly higher level of confidence from Plunket nurses who had completed Family Partnership training as opposed to those who hadn't [refer Appendix X] with an average score of 2.14 vs 1.86 out of 5. This would suggest that although Plunket nurses are not overly confident in working across Māori social structures, they may be equipped with more communication resources from which to draw from following Family Partnership training.

The theme of obtaining minimal feedback from Māori clients appeared to have an impact upon the confidence level of Plunket nurses. This feedback was expressed more specifically in the questionnaire data as the content of the interactions rather than the way in which the information is delivered. This may relate to the Plunket nurse's own knowledge and experience working with Māori communities.

"I enjoy working with Māori clients but find it more challenging as they are harder to keep engaged especially as the child gets older and don't always see a benefit in the service. More ways of giving value to Māori clients would be great or knowing what Māori clients see as valuable within the Plunket service." (Had FP training, Respondent G)

Davis et al. (2002) discuss the quality of 'personal integrity' as another fundamental characteristic of the helper. Personal integrity relates to strength of the helper in not being drawn into an emotionally vulnerable position in which the ability to remain objective becomes clouded. Davis et al. (2002) describe the importance of the helper to leave their own issues and insecurities outside of the situation as parents are less likely to trust someone who is vulnerable. This has implications when asking for feedback from clients, as requesting feedback has the potential to shift the Plunket nurse into an emotionally 'needy' mind set and minimise the chance of positive change for the client.

## *OBSERVATION AND INTERVIEW DATA*

“I guess if they’re keeping appointments then that’s feedback.” (Plunket nurse C)

The relationship between feedback and confidence extended to the observations and interviews with the Plunket nurses. For many Plunket nurses interviewed, the only source of feedback is whether the client is home at the next visit. Although the Plunket nurse knowledge around how to obtain feedback was evident in the interviews, it was not routinely observed throughout the observations. It appeared that there was some merit in obtaining feedback by the number of people at home for their appointments. One client discussed how they were thinking about ‘not being home’ following their first meeting with their Plunket nurse, but elected to keep the appointment and establish some boundaries.

“..the next time she came, we were sort of like let’s go, but no, we had to make the decision to make sure that baby’s doing alright. So I was like ok then we’ll stay, but we’ve just got something to go to in an hour. Then I had to point out that these are the days that I’m happy for you to come around here, but I’m not happy to have you around here for hours.”

(Client I)

This client felt they were able to move forward with the relationship and that setting boundaries was beneficial and adhered to, however it does raise a concern as to how changes to practice occur if constructs are not challenged by feedback due to it not being offered. This correlates to the setting up of the relationship and the purpose of the interactions and the roles of the people involved. Davis et al. (2002) describe one of the ingredients of a partnership as ‘open communication’. This refers to the clear communication of the helper in setting up the psychological ‘environment’ in which the discussions take place with the client. Davis et al. make a point of the importance of the client feeling that they can express any negative or contradictory feedback about the helper, so that meaningful discussions can take place and the two parties are not talking at cross-purposes.

Another concept that was highlighted by many Plunket nurse participants that corresponded directly with confidence was ‘challenging’.

“... trying to give some information that wouldn’t upset, so we can do it more gently perhaps and come back but, yes I would find Māori clients, I

think more challenging and taking a lot more time, and probably I find it a lot more difficult to confront issues.” (Plunket nurse H)

The helping process refers to the process of enabling people to change the way they act or their constructs around a particular issue. The way this change occurs in a helping partnership is through the skill of enabling change in unhelpful constructs (Davis et al., 2002). The notion of ‘challenging’ on the surface appears to contradict the fundamental principles of cultural safety in terms of the responsibility of the nurse in reducing the power differential within nurse-client relationships. However, if nurses have the humility to accept that they do not hold the power or the solutions to clients’ problems and if they challenge from within the partnership and for the parent’s benefit then respectful challenging can add to the relationship rather than detract from it.

Ramsden (2002) described her struggle as a nursing lecturer in 1994 in which most of her class boycotted her lectures due to them feeling challenged by the information she was sharing relating to Māori health and the Treaty of Waitangi. When she reoriented her approach to include nursing practice examples, a level of commonality was attained and the students began to return to her classes. The common ground and purpose served to cement the partnership she had with her students and the mutual challenging allowed for both parties to re-evaluate their constructs and shift their perspectives.

Many of the Plunket nurses interviewed and observed were very cautious around challenging Māori clients for fear of the impact that their challenges may have on their continued relationships. Clarity around the roles, responsibilities and perspectives of both Plunket nurses and clients were observed as important factors in supporting Plunket nurse confidence in challenging constructs and facilitating positive change.

#### *MERIT DETERMINATION*

The mapping of the second level evaluation questions to the logic model outcomes and the data collection methods is presented in Appendix II. Where questionnaire data was to be included as part of the analysis, the survey questions were mapped to the second level evaluation questions [refer Appendix X]. The average scores from the respondents were presented in the tables alongside the themes from the open-ended responses from survey participants. The grades used to evaluate the second level evaluation questions were taken from the rubric rating scales, which were developed using the success definition tables [Appendix XI]. The second level questions were given a working grade which was then adjusted

by the analysed interview and observation data. Key themes were then elicited to be discussed further in the final discussion chapter.

The process of triangulating the data for the first high level question is illustrated in Table 4.1:

**Table 4.1 The effect of Family Partnership training on nursing practice – data triangulation table**

Second level evaluation question	Survey Response Working Grade	Interview and Observation Adjusted Grade	Final Grade and Key Themes for Discussion
1.1) What is the value of the Family Partnership model in terms of interacting with Māori clients?	Moderate / High	Moderate	<b>Moderate</b> <ul style="list-style-type: none"> <li>• Client-led</li> <li>• Respect</li> <li>• Relationships</li> <li>• Evaluation/client feedback</li> </ul>
1.2) How useful is the Family Partnership model in assessing the wellbeing of Māori whānau?	Moderate	Moderate	
1.3) To what extent do Plunket nurses feel more confident in being able to work alongside Māori whānau?	Moderate	Moderate	

Based on the Plunket nurse questionnaires, observations, interviews and client interviews analysed in relation to the practice of Family Partnership and the effect on nursing practice with Māori, the data would mostly sit in the **'moderate'** category on the rubric rating scale [Table 4.2].

**Table 4.2 The effect of Family Partnership training on nursing practice - rubric rating scale**

<b>Very High</b>	All Plunket nurses who have completed Family Partnership training demonstrate a high level of Family Partnership communication, qualities, skills and processes in working alongside Māori. All Plunket nurses trained in Family Partnership are confident in working alongside Māori whānau, hapu and Iwi and consistently demonstrate acknowledgement, recognition and respect around cultural differences. All Plunket nurses work in partnership with Māori whānau and Māori receiving the Plunket service have a strong sense that the service meets their needs.
<b>High</b>	Most Plunket nurses who have completed Family Partnership training demonstrate a high level of Family Partnership communication, qualities, skills and processes in working alongside Māori. Most Plunket nurses trained in Family Partnership are confident in working alongside Māori whānau, hapu and Iwi and consistently demonstrate acknowledgement, recognition and respect around cultural differences. Most Plunket nurses work in partnership with Māori whānau and most Māori clients receiving the Plunket service have a strong sense that the service meets their needs.
<b>Moderate</b>	Some Plunket nurses who have completed Family Partnership training demonstrate a high level of Family Partnership communication, qualities, skills and processes in working alongside Māori. Some Plunket nurses trained in Family Partnership are confident in working alongside Māori whānau, hapu and Iwi and consistently demonstrate acknowledgement, recognition and respect around cultural differences. Some Plunket nurses work in partnership with Māori whānau and some Māori clients receiving the Plunket service have a strong sense that the service meets their needs.
<b>Low</b>	Few Plunket nurses who have completed Family Partnership training demonstrate a high level of Family Partnership communication, qualities, skills and processes in working alongside Māori. Few Plunket nurses trained in Family Partnership are confident in working alongside Māori whānau, hapu and Iwi and consistently demonstrate acknowledgement, recognition and respect around cultural differences. Few Plunket nurses work in partnership with Māori whānau and few Māori clients receiving the Plunket service have a strong sense that the service meets their needs.
<b>Very low</b>	Plunket nurses who have completed Family Partnership training demonstrate no Family Partnership communication, qualities, skills and processes in working alongside Māori. Plunket nurses trained in Family Partnership are not confident in working alongside Māori whānau, hapu and Iwi and do not consistently demonstrate acknowledgement, recognition and respect around cultural differences. Plunket nurses do not work in partnership with Māori whānau and Māori receiving the Plunket service do not have a sense that the service meets their needs.

While there is a definite increase in the awareness of the Family Partnership skills and qualities conducive to quality interactions with Māori clients, there appears to be some disconnect in the application to practice. The observation data and the client interviews provided information to suggest that in some cases the perceptions of the partnership approach of the Plunket nurses are not necessarily mirrored by the recipients of the service. However when asked to identify what would be conducive to a more helpful and positive experience, clients identified skills and qualities that were embedded within the Family Partnership model.

## SUMMARY

This chapter has presented the data around the effect of Family Partnership Training on Plunket nurse practice. The level of confidence of Plunket nurses working with Māori whānau is relatively low across both Plunket nurses who have and those who haven't completed Family Partnership training. Use of the Family Partnership model and the helping process has been highlighted as a way in which to increase Plunket nurse confidence and competence in working across cultural differences. Creating opportunities to understand constructs is central to achieving this. Another mechanism for increasing Plunket nurse confidence is to determine ways in which to evaluate progress towards the negotiated outcomes and obtain constructive and supportive feedback from clients and the organisation.

This chapter has presented the process of triangulation of the questionnaire, interview and observation data and presented the final evaluation grade on the rubric rating scale. The next chapter will provide the results on the experience of Māori clients receiving the Plunket Well Child service in response to the second high level evaluation question.

## CHAPTER 5 – MEETING THE NEEDS OF MĀORI

This chapter examines the second high level evaluation question around the experiences and needs of Māori clients in receiving the Well Child service, “do Plunket nurses meet the needs of Māori clients?” This question was developed from the logic model [Figure 3 and Appendix I] with the purpose of identifying the perceptions of consumers and triangulating the data with the perceptions of the Plunket nurses. A driver for this question is the statement from Irihapeti Ramsden quoted in the introduction to this thesis, “in the future it must be the patient who makes the final statement about the quality of care which they receive. Creating ways in which this commentary may happen is the next step in the Cultural Safety journey” (Ramsden, 2002, p 181).

As identified in the previous chapter, Plunket nurses are searching for feedback in their work with Māori clients and the majority of feedback is obtained by whether or not the client is home and engaging in the next visit. This chapter provides examples of opportunities to obtain different types of feedback as well as ascertain other ways in which feedback may be obtained and examined against the Family Partnership model.

### 2.1) TO WHAT EXTENT ARE THE INDIVIDUAL NEEDS OF MĀORI BEING IDENTIFIED BY PLUNKET NURSES?

Cunningham, Stevenson and Tassell (2005) completed research around the characteristics of Māori whānau in Aotearoa. They comment that Māori live in a range of social, cultural and economic contexts, however the concept of whānau remains consistent to a Māori worldview. They comment that over time, the definition of whānau has been extended into two categories. Firstly the traditional interpretation of whānau as whakapapa or descent-based and secondly, a kaupapa or activity-based whānau which encompasses new activities and new ways of life. They developed the following “framework for describing Māori diversity” which outlines four diverse categories of Māori in New Zealand.

- **Conservative**

These are Māori who are likely to be older and have close links with the marae. They have an innate understanding and competence of Te Reo, and tikanga and are often involved in traditional Māori protocols and events.

- **Integrated**

Integrated Māori live in a more mainstream environment and have little or no association with marae or Iwi-based activities. They are less likely to have knowledge around Te Reo although often express a willingness to learn.

- **Pluralistic**

Pluralistic Māori can walk in both worlds. They have strong iwi and marae connections and feel comfortable in Westernised employment and educational settings as well as being immersed in traditional Māori tikanga and te reo.

- **Isolated**

Isolated Māori are less likely to interact with the Māori world or the mainstream society and have little or no positive whānau support.

The notion that ‘all Māori are not the same’ is not new. Irihapeti Ramsden (1996) developed the registered nurse clinical competency of ‘cultural safety’ based on this very fact. She discusses the importance of the removal of ‘ethnic stereotypes’ in being able to appropriately respond to the individual needs of Māori and indeed all people. It is for this reason that one of the second level evaluations questions examines the extent to which individual needs of Māori are being identified by Plunket nurses.

*OBSERVATION AND INTERVIEW DATA*

“She acknowledges the fact that we’re Māori so that’s pretty cool and the fact that when she asks us what books we wanted, what language - she actually done it for us.” (Client Z)

The acknowledgement and interest regarding Māori culture and identity appeared to be an important quality for a Plunket nurse to demonstrate. Showing a genuine interest in the clients as individuals and acknowledging that they may have different perspectives and priorities from the nurses’ own was highlighted as important to the majority of Māori clients. Central to the concept of acknowledging culture was the recognition of whānau and the identification of the culture within whānau in terms of the support systems in place for clients.

“...acknowledging his Mum there, she was like “oh hi, how are you?” That was really good. Because our family is really family oriented, including everyone else was really good.” (Client Y)

One Māori client felt that all clients were treated the same by Plunket nurses regardless of their ethnicity or culture. She felt it would improve the service if there was more acknowledgement around individual cultural identity.

“I think everyone should be treated equally but at the same time, they should acknowledge everyone’s culture.... I think it would be good in a way because you can relate better. Everyone has different backgrounds and stuff.” (Client Y)

This would align with the framework developed by Cunningham et al. (2005) relating to Māori diversity. While the Plunket nurse may have thought she had acknowledged the client as Māori, she perhaps had not identified the ways in which this may impact on all of the discussions and interventions discussed following the initial visit when the demographics are obtained. Overall the qualitative data was conclusive that the clients wanted to be acknowledged as ‘being Māori’ in so far as being individuals in what ‘being Māori’ means for them. One client described the tension between the acknowledgement of cultural identity and the risk of being labelled as fitting a specific set of characteristics.

“I think that’s what a lot of Māori are complaining about is that they’re being classed as Māori which is strange because they’re also wanting to be known as Māori. It’s terrible. We want to be proud as being Māori but we don’t want to be categorised as Māori either.” (Client I)

This potentially feeds into the uncertainty the Plunket nurses have when working with Māori clients. Davis et al. (2002) describe one of the foundations of an effective partnership as open communication. This is to reduce confusion and misunderstandings and needs to be led by the helper. If an environment is established that clients feel they are able to freely express their uncertainties and confusion, then theoretically, cultural nuances and personal beliefs and the impact on interventions can be fully appreciated.

The quality of genuineness is discussed by Davis et al. (2002) as a complex set of characteristics that relates to the notion of congruence. “Genuineness involves honesty and sincerity, and implies valuing the truth, not deliberately misleading others, and reliability” (Davis et al. 2002, p.60). They go on to describe the aspects of spontaneity and consistency as two important concepts involved in ‘being genuine’. Spontaneity refers to how freely the helper responds to the discussion rather than hiding behind a role or task, and consistency refers to the helper not

presenting two or more entirely different pictures of themselves to the clients - which can cause confusion and distrust.

Every Plunket nurse participant observed in phase 2 articulated a strong sense of interest and commitment to engage with Māori. The concept of spontaneity was identified as something that was important for some Māori clients as it closely aligned with their ability to direct and engage with the content of the assessment.

“It’s predictable, I know what’s going to happen once she gets here, and I know it’s only going to last ten minutes or whatever it is.” (Client S)

When asked what impact this style of practice had on meeting her needs, the client responded that although she felt the topics were covered superficially, she did feel that she was able to ask questions and gain more in-depth information if she needed to. This suggested that the client had established a sense of trust in the Plunket nurse in terms of obtaining information as needed. However it does highlight an issue around the Plunket nurse facilitating client engagement and interest throughout all clinical assessments.

The skill of timing when questions were asked appeared to have an impact on the experiences of Māori clients receiving the service. One client described how the Plunket nurse completed the physical assessment on her baby and then asked her what she would like to talk about. The client had found it difficult to listen to the discussion while trying to remember the questions to ask the Plunket nurse. While others felt that they could interrupt and direct the visit or ask questions at any stage if they needed to,

“She asks me “do you have any concerns?” She actually always asks every time I see her, do you have any questions for me, do you have any concerns for baby?” (Client R)

In allowing the clients to lead the discussion, the nurses are able to identify what the needs are for individual clients. This is a conscious skill adopted by many of the Plunket nurses following the level 1 Family Partnership training. One Plunket nurse described how she thought she could be better at tailoring the discussion to meet the needs of the individual by identifying whether the client would like their whānau included in discussions.

“Certainly if I knew that there is more awareness of their own cultural practices and beliefs and whether they would like family and things around. I probably could be much better at finding that out. Maybe asking if they

want the family to be included more in the talking and information sharing - that type of thing.” (Plunket nurse B)

In trying to understand the situation from the client’s perspective, this nurse demonstrated the quality of humility in reflecting upon and potentially making changes to her own practice. This quality not only promotes an environment conducive to sharing ideas, but also allows for needs that may otherwise not have been identified to be revisited. Davis, Day and Bidmead (2002) describe humility as the helper not having an inflated sense of their abilities or importance in relation to how they portray themselves to clients.

A Māori whakatauki (proverb) that highlights the value placed on whakaiti (humility) in Māori society states “kahore te kumara e korero mo tana reka, the kumara does not speak of its own sweetness”. Humility appeared to be a virtue that was appreciated by clients and influenced their engagement in the relationship with the Plunket nurse. One client described the positive impact that the Plunket nurse’s adaptability had on her ability to share information, which appeared to refer to the demonstration of humility.

“She definitely adapts with me, which I think makes it easier because then we’re always on the same page rather than being at different levels. She asks me questions and you can tell that she’s listening because she’ll come back and she’ll repeat it without having to write it down. She keeps things in mind. Then you know that she’s actually keeping track instead of saying something to you that could be about somebody else or whatever.” (Client T)

In maintaining eye contact and actively listening to the client, the Plunket nurse appeared to be genuinely interested in what was happening for the client at that time. The impact of the non-verbal body language on the client was that they felt they were the most important person in the interaction which attempted to redress the potential power imbalance in the nurse-client interaction.

## 2.2) HOW USEFUL AND APPROPRIATE IS THE PLUNKET NURSING SERVICE FOR MĀORI CLIENTS?

As discussed in the introduction to this research, Plunket provides a service to 92% of all new babies born in New Zealand. Of these babies, 22% identify as Māori. This is a significantly large proportion of the Māori population that Plunket as an organisation has contact with. Wilson (2008) describes the fundamental need for Māori women’s cultural identity and practices to be

acknowledged and integrated into health service provision and is clear that these needs vary from person to person. Other than informal surveys, there has been no recent research completed around how appropriate the Plunket nursing service is specifically for Māori clients.

Ball (2010) discusses anecdotal and research evidence that Māori are more likely to access and engage with services run by Māori. A reason given for this is the compartmentalisation of health needs by many non-Māori service providers and the failure to include whānau considerations in planning interventions. Services are considered appropriate to Māori if they are responsive to what is important in their (the client's) world in terms of what wellness/hauora means.

#### *INTERVIEW DATA*

The relationship with the Plunket nurse had a major influence over whether the clients felt the service was appropriate and met their needs. Being able to relate to, and engage, with the Plunket nurse appeared to put clients at ease and make them feel that they could discuss any concerns. A contributing factor in this was the provision of Plunket services in the home and the impact that being in the client's environment has on the appropriateness of the service for Māori.

“They're more like a friend than a Plunket Nurse. We sort of try to make them feel comfortable and that makes us feel comfortable. Because they come into our home and they must feel weird, so we want us all to feel comfortable.” (Client Q)

Many of the Māori clients commented that although they were conscious of trying to make the Plunket nurses feel at ease in their environment, they preferred the assessments taking place at home. In most cases this was due to the logistics of getting to a clinic with a number of small children or that transport to a clinic was an issue. Davis et al. (2002) discuss their preference for home visiting in working alongside clients wherever possible. They suggest that parents that are in their own environment are potentially less anxious as they have more control over the situation. There is also less need for adaptation to a new environment for both the parents and the children.

Having the Plunket nurse provide home visits was particularly beneficial for one client interviewed who had a child that was extremely fearful of clinic environments. She commented that her child was much more settled in the home environment.

“...it’s comfortable for the people that they are going to see, the family. I mean it’s comfortable for the kids because if you take them to a clinic, they’re going to be so unsettled and so grumpy. Makes you more relaxed when it’s in your own whare and the kids are comfortable with it.” (Client U)

Another feature of the Plunket nursing service that the client participants stressed as being important was the Plunket nurses being able to provide them with information that they were previously unaware of. Davis, Day, Bidmead, Ellis and MacGrath (2009) describe this knowledge as technical expertise. Professional and technical knowledge refers to the specialist information nurses and service providers bring to the situation in working alongside families. They propose that relationships are not formed without a purpose and often the skills and knowledge that the clients bring to the relationship, complement those of the helper and allow for working in partnership.

Clinical skills of observation and assessment were highlighted by participants as a critical component in ensuring the service meets the needs of the client. In one instance a Plunket nurse had immediately picked up upon a hereditary medical condition when assessing the baby. The client reported that this expertise and action served to enhance their relationship with the nurse. Another client mentioned the experience of the Plunket nurse being a major factor in meeting her needs as a client.

“She knows how other people are and if I ask her a question she’ll know it from different perspectives. Saying like, other studies have shown this and all of that, just knowing from experience.” (Client T)

A common theme that emerged from clients was the importance of the Plunket nurse being able to relate to them and their whānau. For some clients, this aligned closely with having technical expertise in terms of cultural knowledge. The access to health workers from a similar cultural background provided a more engaging platform for some clients to address issues. One client felt that the Plunket Kaiawhina (Healthworker) was more able to connect with her reality than her Plunket nurse.

“I found that the Māori lady was more, she knew our struggles, she didn’t know us personally but she knew of our struggles. It was her that asked about if we needed anything, how’s the car seats and ... said that she knew how we have struggled and she was willing to help.” (Client U)

Davis et al. (2009) discuss empathy as an essential element in helping others. They define empathy as the ability (or attempt) to examine situations from the viewpoint of the client. The effect on the client is an increased belief that the helper is genuinely interested in their view and they engage more readily in the exploration process. In demonstrating empathy, the helper gains a more accurate understanding of the issue, and therefore a higher likelihood of successful interventions and outcomes. The Plunket Kaiawhina in the previous example was more able to demonstrate empathy for the client than the Plunket nurse. This may have been due to a commonality of experiences or it may have been due to a number of other factors such as time, listening skills or a prior relationship with the family. Regardless of the reason, the client felt that the Plunket Kaiawhina knew where she was coming from and could best meet her needs. Other clients felt that the Plunket nurse was the appropriate person to meet their needs. The points of comparison were different for all of the clients interviewed as some had previous experience with Plunket or other Well Child providers, some with Community Karitane or Kaiawhina and for some, this was their first experience with a Well Child service.

For many participants, it was extremely important that they didn't feel judged by the Plunket nurse in order for them to feel the service was appropriate and develop trust in it. One client provided an example around how she connected with her Plunket nurse when she was faced with a decision to start formula feeding.

"I didn't even know what I was doing ...breastfeeding and bottle feeding in New Zealand is such an issue, I just felt judged everywhere. Probably people weren't even judging me, but I was judging myself. And so when (Plunket Nurse) came along, because she didn't judge me and it was an issue right at that point... it was a fresh issue and she came in like a professional telling me that it was alright and that my baby's going to be fine and everything. Yeah I think I had a lot more respect for her and trusted her more." (Client V)

Davis et al. (2009) align the quality of being non-judgemental with respect and describe the process of 'suspending' generalised judgements as a way of the helper valuing what is said even if they disagree. Without demonstrating respect or being non-judgemental, any attempt to follow the helping process will be unsuccessful. Another client described the respect shown in their home by the Plunket nurse as a key factor in not being judged and suggested that there is a fear within some Māori whānau around what they might experience when they encounter a service.

“There’s a lot of Māori families out there who are scared ... because to them they think they’ll get judged about how they live and stuff like that. And Plunket come to the home. You can feel it when they first get here, that they treat you with respect.” (Client U)

### 2.3) TO WHAT DEGREE DOES THE PLUNKET NURSING SERVICE ACKNOWLEDGE AND ENHANCE WHĀNAU CAPABILITIES?

Davis et al. (2009) describe one of the characteristics of an effective partnership as the recognition of complementary roles and expertise. The acknowledgement of these roles is essential in addressing the power differential inherent in a nurse-client partnership. The fundamental premise that underpins this characteristic is that the parent is more knowledgeable than the nurse in relation to their experience of their own issues and development of potential outcomes. In relationships in which there is institutional power, the onus is on the nurse to ensure the client does not feel that they have to hide their cultural differences or perspectives (Ramsden, 2002).

#### *QUESTIONNAIRE DATA*

“Find out what is working for them and what they are hoping for with their outcome. Involve the extended family. I am respectful and ask permission from the client when appropriate careful not to rush client. Allow the time needed for planning care.” (No FP training, Respondent D)

The first survey question in evaluating this section discussed whether Plunket nurses felt they make decisions based around client’s needs. The questionnaire data indicated that Plunket nurses who had not completed Family Partnership training felt that they make decisions based on client’s needs slightly more often than Plunket nurses who had completed Family Partnership training, at 3.52 vs 3.27 respectively. As the Family Partnership process by nature is client-led, this inverse result was initially surprising. It may suggest however, that as a result of Family Partnership training, Plunket nurses are more aware of the need to be led by the client and are therefore more aware when this is not happening, as a result of other compounding factors.

Open ended questionnaire responses suggested that the majority of Plunket nurses identify that involving the whānau in all aspects of care is a significant enabler in acknowledging and supporting whānau capabilities. This would align with the plethora of literature around whānau inclusion in health services being associated with long term resilience and positive

health outcomes (Durie, 2004; Hicks, 2008; Maloney-Moni, 2006; Ministry of Health, 2008). The way and the extent to which whānau are included in care needs to be identified by the client with the opportunities facilitated by the nurse. This is expressed in the following response from a survey participant,

“Working as a Plunket nurse with Māori clients I am aware that if whānau are present, and with client consent, they should be fully involved in the visit and relaying information, health promotion etc, should be shared with all the whānau if that's appropriate for that family.” (Had FP training, Respondent B)

#### *INTERVIEW DATA*

The appropriateness of interventions appeared to have an impact upon the client's perception of how the Plunket nurse acknowledges their abilities and knowledge. When interventions were suggested that did not fit with the client's beliefs, the information was either disregarded or agreed upon and then ignored when the assessment was over. One client described her reluctance to implement some of the suggestions discussed by the Plunket nurse. When asked what it would take for her to make a change, she described the need for proof that her current parenting practice was harming her baby in some way. She said that while she would disregard the advice from the Plunket nurse if she didn't believe in it, she would take the information into consideration in terms of being more aware of the risks.

Whereas other clients were keen to take onboard any information and suggestions from the Plunket nurse, as the nurse was seen as having expertise in looking after babies.

“When I was breastfeeding and I would get quite full fast and I would just express it and tip it out. And she (Plunket nurse) suggested to put it in the freezer and I took it (breastfeeding) for granted because some families find it really difficult. And I did save it, so then I was able to go night fishing and my partner was able to feed baby. Well, I didn't know that before. Just took it for granted I think ... usually we take all their advice on board in a positive way.” (Client Q)

Davis et al. (2009) discuss the client's perception of the problem as a key influence over all aspects of the helping process. Forcing an issue that is not perceived as being a problem for the client makes positive outcomes more difficult to attain and places increased pressure on the relationship. Davis et al. (2009) describe the effect that client perceptions of health

professionals may have on the relationship and in particular, on their openness to accept information and/or follow what is suggested. This was evident in the responses from some participants when they described the way they make decisions regarding their children.

“The kids go to their Grandparents and they have more of an understanding than what (Plunket nurse) would. So I would listen and hear what she has to say but at the end of the day, it’s coming back to me and how I feel about it. But if my mum and all that said something, well then I’ll probably do it straight away.” (Client U)

The notion of ‘telling’ people what to do regarding a problem sits in contrast to the Family Partnership model in which the goal is often to enable a change in ideas (Davis et al., 2009). A significant step in attempting to change ideas is the helper ensuring that they gain permission to challenge aspects of thinking. Within Plunket, the explanation of the service, roles and expectations often occurs at the first meeting. Davis et al. (2002) dedicate an entire chapter to the first meeting as they believe it is a critical point in the relationship at which the platform is laid for further work to be negotiated and completed.

Many of the Plunket nurses interviewed indicated that a major part of their role is around supporting clients to identify and develop their own support structures in order to promote and enhance positive health outcomes. Positive relationships are considered to be a protective health determinant and are seen to both prevent issues from developing as well as provide support in response to problems (Davis, et al. (2009). The thinking around identifying whānau strengths in relation to care planning is depicted in the following statement,

“I guess not thinking that you need to solve or provide everything. That they have their own strengths and often they have their own networks and families that they can draw support from. Not always, and then you ask and you can explore a bit.” (Plunket nurse B)

#### *MERIT DETERMINATION*

The mapping of the second level evaluation questions to the logic model outcomes and the data collection methods is presented in Appendix II. Table 5.1 illustrates the process of triangulation of the data collated against the second high level evaluation question.

**Table 5.1 To what extent do Plunket nurses meet the needs of Māori clients – data triangulation table**

Second level evaluation question	Survey Response Working Grade	Interview and Observation Adjusted Grade	Final Grade and Key Themes for Discussion
2.1) To what extent are the individual needs of Māori being identified by Plunket nurses?	N/A	Moderate / High	<b>High</b> <ul style="list-style-type: none"> <li>• <b>Acknowledgement</b></li> <li>• <b>Engagement</b></li> <li>• <b>Technical Expertise</b></li> <li>• <b>Non-judgemental</b></li> </ul>
2.2) How useful and appropriate is the Plunket nursing service for Māori clients?	N/A	High	
2.3) To what degree does the Plunket nursing service acknowledge and enhance whānau capabilities?	Moderate / High	High	

The analysis of the data relating to Māori client experiences of the Plunket nursing service generated a rating of “**high**” in the rubric rating scale [Table 5.2]. The majority of clients interviewed were positive around the Plunket nurses meeting their needs relating to Well Child. The literature clearly identifies the differences that exist amongst Māori that need to be considered when working alongside clients. The removal of ‘ethnic stereotypes’ in favour of a genuine professional curiosity and responsiveness appears to increase the positive perception of the Plunket service by Māori clients. If Plunket nurses are encouraged to treat Māori in a specific manner without acknowledging the differences that exist as individuals, they run the risk of appearing to provide a “one size fits all Māori” service that does not meet the diversity of needs.

**Table 5.2 To what extent do Plunket nurses meet the needs of Māori clients – rubric rating scale**

<p><b>Very High</b></p>	<p>All Māori clients are positive around the Plunket service meeting their needs. All Māori clients feel respected by the Plunket nurse and believe that their perspectives are valued in all interactions. All clients feel that they are able to direct the way an assessment is completed and that the service is culturally safe. All clients can articulate the value in the Plunket service contributing to positive health outcomes for their family and feel that they are acknowledged as having individuals’ needs within a whānau context. All Plunket nurses believe their communication qualities and skills facilitate positive client experiences.</p>
<p><b>High</b></p>	<p>Most Māori clients are positive around the Plunket service meeting their needs. Most Māori clients feel respected by the Plunket nurse and believe that their perspectives are valued in interactions. Most clients feel that they are able to direct the way an assessment is completed and that the service is culturally safe. Most clients can articulate the value in the Plunket service contributing to positive health outcomes for their family and feel that they are acknowledged as having individuals’ needs within a whānau context. The majority of Plunket nurses believe their communication qualities and skills facilitate positive client experiences.</p>
<p><b>Moderate</b></p>	<p>Some Māori clients are positive around the Plunket service meeting their needs. Some Māori clients feel respected by the Plunket nurse and believe that their perspectives are valued in interactions. Some clients feel that they are able to direct the way an assessment is completed and that the service is culturally safe. Some clients can articulate the value in the Plunket service contributing to positive health outcomes for their family and feel that they are acknowledged as having individuals’ needs within a whānau context. Some Plunket nurses believe their communication qualities and skills facilitate positive client experiences.</p>
<p><b>Low</b></p>	<p>Few Māori clients are positive around the Plunket service meeting their needs. Few Māori clients feel respected by the Plunket nurse and believe that their perspectives are valued in interactions. Few clients feel that they are able to direct the way an assessment is completed and that the service is culturally safe. Few clients can articulate the value in the Plunket service contributing to positive health outcomes for their family and feel that they are acknowledged as having individuals’ needs within a whānau context. Few Plunket nurses believe their communication qualities and skills facilitate positive client experiences.</p>
<p><b>Very low</b></p>	<p>Māori clients are not positive that the Plunket service meeting their needs. Māori clients feel disrespected by Plunket nurses and believe that their perspectives are not valued in interactions. No clients feel that they are able to direct the way an assessment is completed or that the service is culturally safe. No clients can articulate the value in the Plunket service in contributing to positive health outcomes for their family and feel that they are not acknowledged as having individuals’ needs within a whānau context. No Plunket nurses believe their communication qualities and skills facilitate positive client experiences.</p>

## SUMMARY

This chapter has presented the collated research data to evaluate the extent to which Plunket nurses meet the needs of Māori clients. The genuineness of Plunket nurses was observed in most cases by their ability to adapt and be spontaneous in their response to clients. The majority of clients felt that they were given the opportunity to lead the way an assessment was completed and that their needs were accurately identified at the time. The value of humility was described by the clients as important in them feeling able to share information without intimidation.

Being able to relate to the Plunket nurse was a significant factor in assessing the appropriateness of the service from the client's perspective and the majority of clients felt they could easily relate to the Plunket nurse allocated to them. Many clients felt that the Plunket nurse coming to visit them at home supported them to have access to and feel comfortable with the Plunket service. The level of technical expertise and information provided by the Plunket nurses also supported clients to feel that the service was meeting their needs. The definition of technical expertise appeared to also incorporate cultural knowledge and connectedness for some clients who identified that this could be provided by the Plunket Kaiawhina.

The majority of clients felt that the Plunket nurse treated them respect throughout their contacts with them and accessing a service that was non-judgemental was important to many. Most clients also indicated that the Plunket nurse connected with their whānau as part of the assessment process. It was clear that interventions, strategies and outcomes needed to be considered appropriate for them to be implemented and maintained by clients.

Based on the analysis of the evaluation data on the extent to which Plunket nurses meet the needs of Māori clients, the grading on the rubric scale was "high". How appropriate Family Partnership is within Plunket as an organisation will be examined in the next chapter in relation to the third high level evaluation question.

## CHAPTER 6 - THE VALUE OF FAMILY PARTNERSHIP TRAINING TO PLUNKET

Feldstein and Glasgow (2008) developed a model for the integration of research findings into practice after identifying a gap in the translation of the implementation of theory-based health programmes to increased client outcomes. They believed that for an organisation to be successful in embedding a programme into practice, the programme needs to align with fundamental organisational philosophies. The Family Partnership programme aim of enabling professionals to utilise their expertise more efficiently and effectively sits well within Plunket's organisational aim to work together for the "best start for every child". The key aspect of integration as identified by Feldstein and Glasgow (2008) in their model is the development of ways to evaluate organisational implementation.

Davis et al. (2009) discuss the importance of the Family Partnership model remaining relevant to organisations in order for it to continue to be put into practice effectively by staff. They describe a key advantage of the model as the wide applicability across a variety of settings. Another benefit is the adaptability of the model and its ability to adjust to contexts, timeframes and environments as required.

The previous results chapters have examined the value of Family Partnership to Plunket nurses and Plunket clients. This chapter will look at the value of Family Partnership to Plunket as an organisation, with a specific focus upon Māori population health outcomes. The final chapter will bring of the themes together and organise them under the principles of the Treaty of Waitangi.

### 3.1) WHAT IMPACT DOES CULTURAL SAFETY AND RESPONSIVENESS HAVE ON MĀORI HEALTH OUTCOMES?

Māori as a population are undeniably a vulnerable group in accessing and receiving health services in New Zealand. The Ministry of Health state that Māori have "on average the poorest health status of any ethnic group in New Zealand" (2012, para. 1). The vision of "whānau ora" outlined by the Māori Health Strategy, He Korowai Oranga (Ministry of Health, 2002) refers to Māori families being supported to enjoy maximum levels of health and wellbeing. In 2006, the Ministry of Health developed an action plan called "Whakatataka Tuarua" which was designed to implement strategies to support the vision. A key aim of the action plan was to enhance "the effectiveness of mainstream services in delivering and positively contributing towards improving Māori health outcomes" (Ministry of Health, 2006, p. 2).

In March 2012, Plunket presented a submission to the Māori Affairs select committee to support an inquiry into the determinants of wellbeing for Māori children. The submission posed a question around whether social determinants of health needed to be given increased priority when looking to improve health outcomes for tamariki Māori. The submission detailed the extent to which Māori have consistently chosen to enrol with Plunket services and outlined the fact that Māori who do not enrol with Plunket are either enrolling with a Tamariki Ora provider or receiving no well child service at all. Plunket highlighted the need for the Government to identify ways to ensure that all tamariki Māori are enrolled with child health services as a way to be supported to realise their full potential (Royal New Zealand Plunket Society, 2012).

#### *QUESTIONNAIRE DATA*

The qualitative questionnaire responses relating to Māori health outcomes focussed upon engagement and minimising barriers to access. As outlined in previous chapters, the Plunket nurses are aware that if they do not engage and form a relationship with the client, they are unlikely to find the client at home for the next visit and they are therefore contributing to inequities in health outcomes. The adaptability required in supporting engagement is highlighted in the following questionnaire participant's comment;

“Attempting to work out ways to deliver messages, interact and supply the service we do in a way that is cohesive within any one persons cultural existence is a really important factor in engaging with clients” (Had FP training, Respondent R)

The survey question around how well the Plunket service meets the needs of Māori clients was another indicator relating to the impact of the service on Māori health outcomes from the Plunket nurses' perspective. Plunket nurses who had completed Family Partnership training rated their service slightly higher than Plunket nurses who hadn't completed the training however both scores were positioned at low to moderate. This rating related to how well nurses believe their service meets the needs of Māori and how well they deliver on the principles of the Treaty of Waitangi. The issue around confidence and feedback was discussed previously as a potential reason for these scores, although another reason may be around the organisational statistical data and the translation to individual Plunket nurse practice.

The Well Child Tier 2 service specifications (Ministry of Health, 2003) clearly state that for Māori children, the effectiveness of Well Child and Tamariki ora providers will be measured by

a reduction in Māori health inequalities. These include “the 13 priority Population Health Objectives, as well as the Māori health gain objectives, in particular, targeting services to impact on asthma, diabetes, injury prevention, smoking, hearing, mental health, oral health, immunisation and violence prevention” (Ministry of Health, 2002, p. 3-4). Plunket nurses report on a number of additional indicators relating to the health and wellbeing of families and this data is generally looked at in terms of the trends in populations or caseloads rather than outcomes for individuals.

This compartmentalisation of measurable indicators may serve to provide a picture of ethnic trends compared with the general population of New Zealand however it does not measure or evaluate individual progress, nor consider health determinants from a broad socio-ecological perspective. For example, if a Māori client states that they have just lost their job and have taken up smoking, success might be measured by the Plunket nurse in terms of coming to an agreement that the client does not smoke around the baby and promotion of safe sleeping messages. There would also most likely be a discussion around forward planning in relation to employment, and an assessment of potential risk and development of mitigation strategies related to the reduction in income (e.g. a referral to budgeting services). As far as nationally reported upon statistics are concerned, this Māori client will be flagged as a smoker which would count towards an increase in Māori health disparity and a decrease in effectiveness of the Plunket service according to the categories outlined in the Tier 2 specifications (Ministry of Health, 2003).

The “He Ara Hou: The Pathway Forward - Every Child Counts” report (Henare, Puckey, Nicholson, 2011) challenges that the current measures of Māori wellbeing do not reflect Māori values and capabilities. Plunket nurses are exposed to data on Māori health outcomes on a regular basis and the interpretation of statistical data relating to outcomes for Māori may be a factor in the uncertainty from Plunket nurses as to whether the service makes a difference. It may also be causing a tension around the Plunket nurses’ ability to allow the service to be led by the client, if what is measured as success does not align with client priorities. This tension is reflected in a statement from one of the questionnaire respondents.

“The expectation of management and MOH to “meet the contract” in terms of numbers and achieving/delivering a certain number of health promotion topics at one particular visit is an unreasonable and unacceptable model to use when providing well child care for Māori Whānau.” (No FP training, Respondent H)

Conversely, the questionnaire participants who had completed Family Partnership training were on the whole, more likely to weave the priority health education messages into the contacts with clients and could potentially see ways in which they could balance both requirements.

“I appreciate the way Plunket has, in my experience and impression, been proactive in ensuring Māori clients/whānau/culture is given very high priority in the service ... there is a constant awareness of our responsibilities and the organisation supports us to do our very best to deliver our service appropriately to tangata whenua.” (Had FP training, Respondent M)

It is clear that a holistic view of health outcomes needs to be considered when attempting to measure the impact that cultural safety and responsiveness has on creating a difference for Māori.

#### *INTERVIEW DATA*

The ability to accurately assess health literacy was closely related to providing individualised care for many of the Plunket nurses interviewed. Clients with a higher level of health literacy could clearly and relatively quickly articulate their needs and questions, whereas clients with a lower level of health literacy required prompting and more time taken to explore and assess issues. Many of the Plunket nurses interviewed described their need to spend more time with clients who they assessed as having a lower level of health literacy in order to obtain the information they needed for assessments.

“If she asks more complex questions, she’s probably getting a more complex answer from me, whereas a mother with a low level of education, may not even ask that question. With the lower health literacy, I’m trying to ask the questions and fathom out where the thinking is at.” (Plunket nurse D)

The effect of being able to accurately assess health needs, priorities and compounding factors and respond accordingly was seen as a critical factor by the Plunket nurses in improving the health outcomes identified by the client. The motivation for creating a difference sits within the Plunket organisational philosophy of “the best start for every child”. It is widely accepted that children who grow up in an environment of hardship will, more often than not, lack the resources required to make a positive change for themselves in adulthood (Henare, Puckey & Nicholson, 2011). Davis et al. (2009) state that “much of what enables people to cope with life

generally and deal with specific problems, stems from their self-esteem and self-efficacy and all professionals are in a very powerful position to enhance these considerably, or, alternatively, undermine them” (p. 28). Plunket nurses at times feel that they walk a fine line in terms of addressing issues relating to parenting practice and undermining the confidence and capability of the clients.

“The parents make the decisions... we can jump up and down and say this is by far the safest and these awful things can happen if you continue to do this, but I’m not going to go in there each night and tuck the baby into bed, they’ve got to be responsible to make the decision. They need to trust us so that so that they know that we are coming from a place that we’re working for them. It’s not just coming down on them, it’s saying “you love your baby and you want to keep it safe.” (Plunket nurse G)

This Plunket nurse felt that by developing a trusting relationship with the client, the client was more likely to engage with the information the nurse was providing in relation to keeping the baby safe.

The challenge facing Plunket nurses is around the receipt of feedback that they have made a positive difference to health outcomes. As health outcomes are often measured by a reduction in the incidence of morbidity and/or mortality, it can be difficult to define whether self-reported health outcomes align with the actual health status (Gunasekara, Carter & Blakely, 2012). However in the case of the Plunket nurse, it is exceedingly difficult to measure the impact of their discussion with the client in preventing or minimising risk factors to their wellbeing, when the outcomes are only measured in one manner. Increasing the emphasis on client identified outcomes may be a way to capture the effect of the Plunket service in a more authentic way.

Davis et al. (2009) describe one of the most interesting concepts of the Family Partnership course is that no matter how many times it is delivered, it will always be different due to the complexity of people and variety of perspectives. To attempt to measure the outcomes of the course without asking the participants directly would therefore be inconceivable and considered inaccurate. This mirrors the need of Plunket nurses to respect and acknowledge the uniqueness of the client’s perspective in obtaining feedback.

### 3.2) HOW USEFUL IS FAMILY PARTNERSHIP TRAINING IN CREATING A CULTURALLY SAFE AND RESPONSIVE PLUNKET WORKFORCE?

“Cultural Safety is about the nurse rather than the patient. That is, the enactment of Cultural Safety is about the nurse while, for the consumer, Cultural Safety is a mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use” (Ramsden, 2002, p.6).

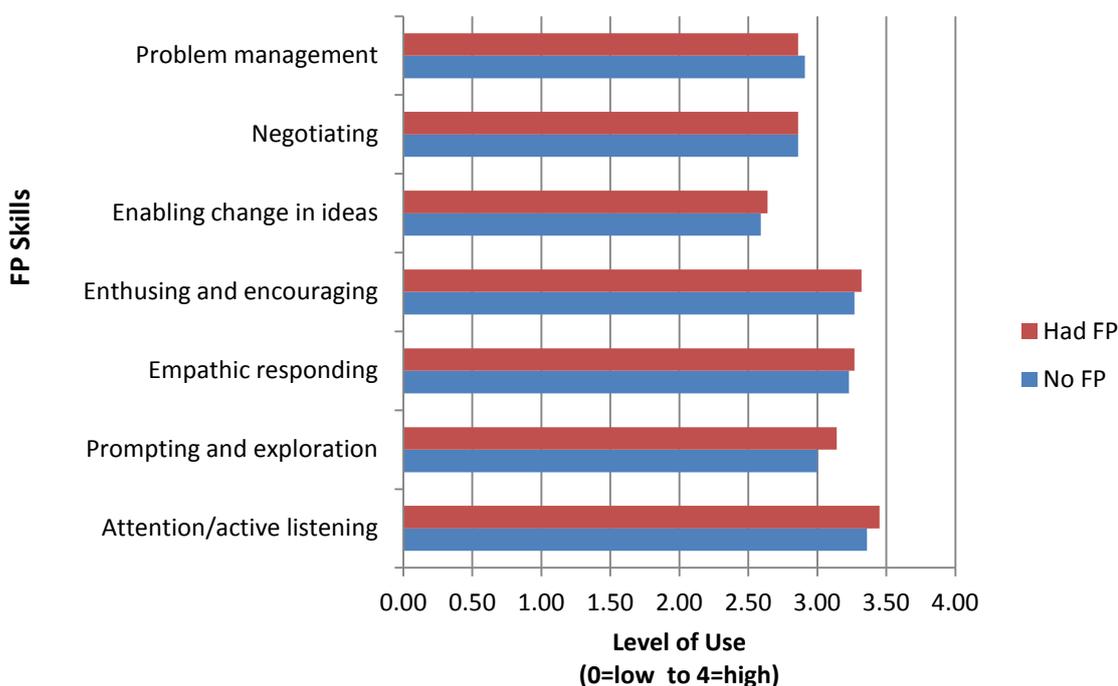
The Plunket workforce has the opportunity to work alongside over 65 percent of all Māori new born babies born every year (Royal New Zealand Plunket Society, 2012). If this level of engagement is to be maintained or improved upon, the service needs to ensure that the workforce is safe and responsive to the needs of Māori. The Nursing Council of New Zealand (2011) has supported the integration of cultural safety as a standard registered nurse competency. Across all healthcare contexts, registered nurses are required to provide evidence of self-reflection regarding the impact they have upon others, utilise a holistic approach in assessing patients and be flexible and adaptable to patient needs that may differ from their own.

#### *QUESTIONNAIRE DATA*

As outlined in the earlier chapters, Family Partnership qualities and skills were seen as a way that Plunket nurses may be able to demonstrate the principles of cultural safety in being responsive to client needs. The questionnaire data showing the differences between Plunket nurses who had completed Family partnership training and those who had not, is presented in the following graph [Figure 7]. It illustrates how nurses rate themselves in utilising Family Partnership skills in working alongside Māori clients. A score of 0 equates to a low self-perception, while a score of 4 rates as high.

Figure 7 shows a slightly higher level of self-perception of the use of most of the Family Partnership skills for Plunket nurses who had completed Family Partnership training. Interestingly the Plunket nurses who had completed Family Partnership training rated themselves lower in the skill of problem-management. This lower self-perception in problem management may be related to an increased awareness of the skills involved and the complexity of working alongside clients in managing issues following the Family Partnership training. It may also be related to an increase in humility following the training and in particular, awareness that the helper does not hold all of the solutions to clients' problems.

**Figure 7 Self-perception of use of Family Partnership skills (both groups)**



There were numerous comments in the qualitative questionnaire data around the perceived need for more Māori Plunket nurses within the organisation. This would align with the literature identifying cultural responsiveness as a kaupapa Māori approach as opposed to cultural appropriateness which is measured by Māori accessing mainstream services (Families Commission, 2011). The following comment from a Plunket nurse who has completed Family Partnership training touches upon the tension between the provision of contractual requirements and meeting the needs of Māori clients she works with.

“I am often asked if they can have a Māori Plunket nurse. Unfortunately there are none in my area so I let them know I work in partnership with a Kaiawhina and if they want we can co-visit. I don't think doing a TOW workshop gives me the skills to work with Māori clients, maybe working with a group of Māori mums and asking what they want from Plunket would be a better way to go and reflect the contract to their needs as well.” (Had FP training, Respondent J)

Accessing the cultural knowledge, expertise and time of the Plunket Kaiawhina when working alongside Māori was indicated by some of the questionnaire respondents as important in

ensuring the Plunket service meets the needs of Māori clients. Mauri Ora Associates (2011) describe Māori Health Workers as “insiders” with strong advocacy skills and strong linkages to the Māori communities in which they work. One Plunket nurse surveyed described the role of the Plunket Kaiawhina as being essential in enabling changes in ideas around specific parenting practices.

“The role of the Kaiawhina plays a huge part in working with partnership with Māori families. Utilisation of this role is vital for involvement to change parenting practice and gain better health.” (Had FP training, Respondent J)

The notion of advocacy within the role of the Plunket Kaiawhina can be examined from a variety of perspectives. Kaiawhina are expected to advocate on behalf of the child, i.e. follow organisational protocols if parenting practice is not conducive to the well-being of the child. They are also expected to advocate on the behalf of parents who may be having difficulty accessing appropriate or required services. Finally there is the expectation from their communities that they advocate on behalf of Māori accessing the service and provide feedback around what is appropriate and what could be working better. Working alongside Māori clients to identify potential strategies and facilitate access to services and people that will be the most helpful from the client’s perspective is the role of the Plunket nurse and this is supported by the community and cultural knowledge of the Plunket Kaiawhina.

#### *INTERVIEW DATA*

The majority of Māori clients interviewed did not have a preference over the ethnicity of their Plunket nurse. While the clients did not specify a preference over the ethnicity of their Plunket nurse, many did indicate that they would like to see more Māori Plunket nurses in the community.

“It’d be cool, not that it really matters to me, but it would be cool to see them around. I mean, Māoris understand Māoris eh, it’s sort of underlying .... I dunno you’d probably get a bit more laughs.” (Client Y)

The desire to see more Māori Plunket nurses indicates that the Plunket nurses are held, for the most part, in high regard by Māori clients. The client’s comments were made not from a deficit standpoint, but from a position of wanting to see their own people reflected in the Plunket workforce. One client interviewed said that she would be happy with someone that knows the language and the culture, but they did not necessarily have to be Māori. This aligns with Moeke-Maxwell’s (2007) findings regarding three key ways the non-Māori workforce can

better meet the needs of Māori. The first consideration is the recruitment, retention and development of Māori staff within the health workforce. The second recommendation is to ensure that non-Māori staff recognise the contribution that Māori staff are making within the service. Moeke-Maxwell describes the third way as the development of bi-cultural training to increase the cultural competence of non-Māori staff.

Humility came through as an important quality and the reason that some clients felt they would connect better with a Māori Plunket nurse. Having the ability to 'let go' of the structure and be led by what the client wanted to discuss appeared to contribute to the demonstration of humility in practice.

"I think a Māori Plunket nurse's views would be a lot different and more relaxed and less structured" (Client F).

Part of this sits within the power differential inherent in providing a service that is funded and measured upon outcomes that do not directly translate to the care of the individual. Disregarding the contractual obligations would have significant implications upon the sustainability and accountability of the service, whereas ignoring the needs of the individual and providing information that fulfils a specific agenda, potentially increases the power imbalance between the nurse and the client. Davis et al. (2009) discuss the importance of determining which aspects of power are relevant to a particular interaction. They stress that the onus is on the helper to ensure that the client is aware that the power lies with them in terms of decision making and maintenance of the relationship.

The desensitisation of some Plunket nurses working in pockets of high need communities appeared to have an impact on the responsiveness of the nursing service. There is increasing evidence that nurses, teachers, general practitioners and other professionals working in areas of high need, poverty and neglect, can become desensitised to the impact of these realities on families (Gardner, 2008). An example of one type of desensitisation was expressed by one of the clients interviewed.

"The only thing is, is that maybe before she comes, just to text and say she's on her way, because sometimes I'll be in the shower and then she'll come and I don't know if she's been or not. Or like I wait all day and they don't come at all which has happened to me with some services, not Plunket." (Client J)

In working in a community with high needs, it is not uncommon for Plunket nurses to have a high 'not at home' rate or 'appointments not kept'. The concept of desensitisation relating to the value placed upon appointments may lead to a casual approach to the timing around the delivery of the service, with potentially detrimental consequences around the perception of the provider in some communities. This casual approach to negotiation of appointments included the concept of 'cold calling'. Plunket nurses working in high need areas were observed to be more likely to attempt to access families by knocking on the door without an appointment rather than visit at a mutually negotiated time.

As illustrated in the previous quote by Client J, professionals who work in the community appear to represent all community-based organisations and negative experiences can have long-lasting impacts on individuals. Being responsive to the needs of the individual can have a positive impact upon the organisation as a whole and contribute to increased trust levels between clients and nurses.

Davis et al. (2009) describe the Family Partnership training as "inadequate" without the consideration of factors that allow for the maintenance and further development of the skills of the helper. Many of the Plunket nurses interviewed highlighted the length of time that had passed since they completed Family Partnership training. While every one of them saw the benefits that the training had on their communication awareness and skills, they were concerned that they had forgotten key components and wanted some form of retraining.

"I think at the start I was putting everything into practice but there again, I need some revision on that. At some moments, I think, oh, I did that well and other times I don't ... I think we do need more updates and more education around Family Partnership 'cause it's so important." (Plunket nurse B)

#### *MERIT DETERMINATION*

Table 6.1 illustrates the process of triangulation of the data collated against the third high level evaluation question relating to the value of Family Partnership training to Plunket as an organisation. It is clear that in order to determine the value of Family Partnership training to Plunket in regards to Māori health outcomes, what a health outcome looks like for Māori must be defined.

**Table 6.1 The value of Family Partnership training to Plunket – data triangulation table**

Second level evaluation question	Survey Response Working Grade	Interview and Observation Adjusted Grade	Final Grade and Key Themes for Discussion
3.1) What impact does cultural safety and responsiveness have on Māori health outcomes?	N/A	Moderate / High	<b>High</b> <ul style="list-style-type: none"> <li>• <b>Positive health outcomes</b></li> <li>• <b>Role-modelling</b></li> <li>• <b>Desensitisation</b></li> <li>• <b>Ongoing-learning</b></li> </ul>
3.2 How useful is Family Partnership training in creating a culturally safe and responsive Plunket workforce?	Moderate / High	High	

This chapter has examined various measures to determine ‘Māori health’, however for the purpose of this evaluation, health outcomes were defined by the recipients of the service - the Māori clients. The majority of the data collated and analysed sat in the “**high**” category on the rubric scale Table 6.2.

**Table 6.2 The value of Family Partnership training to Plunket - rubric rating scale**

<b>Very High</b>	All Plunket nurses trained in Family Partnership contribute to the reduction of inequities in Māori health outcomes and can identify whether the service they are providing is appropriate and acceptable to Māori clients. All Plunket nurses trained in Family Partnership develop strategies within their practice to enhance Māori wellbeing and believe that the Plunket service meets the needs of Māori. All Māori clients can describe positive outcomes for their whānau as a result of the Plunket service and all Plunket nurses are positive regarding the impact that Family Partnership has on their practice and the wider organisation.
<b>High</b>	Most Plunket nurses trained in Family Partnership contribute to the reduction of inequities in Māori health outcomes and can identify whether the service they are providing is appropriate and acceptable to Māori clients. Most Plunket nurses trained in Family Partnership develop strategies within their practice to enhance Māori wellbeing and believe that the Plunket service meets the needs of Māori. Most Māori clients can describe positive outcomes for their whānau as a result of the Plunket service and most Plunket nurses are positive regarding the impact that Family Partnership has on their practice and the wider organisation.
<b>Moderate</b>	Some Plunket nurses trained in Family Partnership contribute to the reduction of inequities in Māori health outcomes and can identify whether the service they are providing is appropriate and acceptable to Māori clients. Some Plunket nurses trained in Family Partnership develop strategies within their practice to enhance Māori wellbeing and believe that the Plunket service meets the needs of Māori. Some Māori clients can describe positive outcomes for their whānau as a result of the Plunket service and some Plunket nurses are positive regarding the impact that Family Partnership has on their practice and the wider organisation.
<b>Low</b>	Few Plunket nurses trained in Family Partnership contribute to the reduction of inequities in Māori health outcomes and can identify whether the service they are providing is appropriate and acceptable to Māori clients. Few Plunket nurses trained in Family Partnership develop strategies within their practice to enhance Māori wellbeing and believe that the Plunket service meets the needs of Māori. Few Māori clients can describe positive outcomes for their whānau as a result of the Plunket service and few Plunket nurses are positive regarding the impact that Family Partnership has on their practice and the wider organisation.
<b>Very low</b>	Plunket nurses trained in Family Partnership do not contribute to the reduction of inequities in Māori health outcomes and cannot identify whether the service they are providing is appropriate and acceptable to Māori clients. No Plunket nurses trained in Family Partnership develop strategies within their practice to enhance Māori wellbeing and believe that the Plunket service does not meet the needs of Māori. No Māori clients can describe positive outcomes for their whānau as a result of the Plunket service and no Plunket nurses are positive regarding the impact that Family Partnership has on their practice and the wider organisation.

There was some evidence to suggest that Plunket nurses who had completed Family Partnership training had an increased focus upon engagement, in terms of making meaningful connections with Māori clients. There was also evidence of an increase in the perception of how well the Plunket service meets the needs of Māori clients from the nurses who had completed Family Partnership training. Obtaining accurate assessment data and taking the time to assess the levels of health literacy were seen as important factors for Plunket nurses in working alongside Māori and planning care.

Most Plunket nurses felt that the Plunket service meets the needs of Māori however some nurses wanted to be able to offer the service of a Māori Plunket nurse or a Plunket Kaiawhina who were not available as a resource within their teams. From the clients' perspective, most indicated they would like to see more Māori Plunket nurses in terms of increasing the number of Māori role models in the community, rather than necessarily thinking the service would be more appropriate. Some clients however felt the Plunket service would be more relaxed with a Māori Plunket nurse.

All Plunket nurses were positive regarding the impact that Family Partnership training has had on their practice. The desensitisation of some Plunket nurses working in areas of high need was highlighted by the adoption of a casual approach to appointment time-keeping. A client's individual response to their negative impressions of any community service has potential implications for all professionals providing a service in the community. Therefore the effect of Family Partnership training in terms of the value to a community based service such as Plunket is high.

## SUMMARY

This chapter has presented the data relating to the value of Family Partnership training to Plunket as an organisation. The importance of receiving feedback around successful strategies or the positive impact that the Plunket nurse has had with families is described, however determining ways in which to measure and report upon this feedback has been highlighted as challenge. Plunket nurses who had completed Family Partnership training generally had a higher self-perception around the use of Family Partnership communication skills in their practice with Māori clients. The role of the Plunket Kaiawhina has been identified as pivotal in being able to provide options for culturally specific care within the organisation. The majority of Māori clients who participated in the research were positive in relation to achieving self-identified outcomes as a result of the Plunket service.

The next chapter will provide further discussion around the results of this research in relation to the principles of the Treaty of Waitangi and outline the evaluative conclusions as well as the recommendations that have evolved out of this research to enhance client and service delivery outcomes.

## CHAPTER 7- DISCUSSION

This chapter will re-introduce the research question and aims. It will then use the headings of each of the three principles of the Treaty of Waitangi to provide a discussion around the themes identified against each of the high level evaluation questions. The limitations of this research will then be explored and finally, the recommendations and concluding statement will provide some direction for the future of Family Partnership and cultural responsiveness within Plunket.

In 1988 the Royal Commission on Social Policy developed a set of principles that were designed to increase the applicability of the Treaty of Waitangi to national health and social strategies, policies and practice (Ministry of Justice, 2006). The principles of 'Partnership', 'Participation' and 'Protection' were derived from both versions of the Treaty of Waitangi with the intention to enhance the understanding around how the Treaty may be applied to practice (Kingi, 2007).

It is appropriate that this historic agreement between Māori and Pakeha is accessed to provide structure to the findings of this research as Plunket is predominantly seen as an agent of the Crown working within Māori communities to support the best outcomes for tamariki Māori. The focus of this chapter is to further discuss the themes that have emerged throughout the three previous chapters as a result of the thematic analysis.

### RESEARCH QUESTION AND AIMS

The research question that was developed at the beginning of the research was:

#### **Is Family Partnership a model for cultural responsiveness in a Well Child context?**

In order to fully explore this question, I decided to design and complete an evaluation using a logic model to pictorially represent the pathway from Family Partnership and Treaty of Waitangi training to the ultimate outcome of "Whānau Ora". Three aims for the research were then developed which were based on the research question and logic model.

The first aim examined how Plunket nurses implement Family Partnership principles and methods in practice. This was examined in relation to working alongside Māori whānau and aligned with the organisational aims of improving Māori health outcomes and engagement. The research findings highlighted a high level of integration and understanding of Family Partnership concepts in Plunket nurse practice. The Family Partnership training appeared to challenge Plunket nurses to critically reflect upon aspects of their communication and examine

the correlation between communication and positive outcomes for Māori clients. All of the Plunket nurses who participated in the research could identify Family Partnership concepts that they had become more conscious of utilising in their practice, however many felt that they needed to refresh their knowledge after the initial training to continue to embed the theory in practice.

The second aim was to establish the quality of the Family Partnership model in working with Māori whānau in a Well Child context. This built upon the first aim in terms of Plunket nurses observing how effective the use of the concepts inherent in the Family Partnership model are in working with Māori whānau. There was strong evidence to suggest that Plunket nurses saw the quality of respect as a critical factor in enhancing the relationships they have with Māori clients. There was a fear expressed by some Plunket nurses around compromising the relationship with Māori clients by challenging specific aspects of their parenting practice. The effect of this fear was Plunket nurses electing not to say anything in order to demonstrate respect towards clients and support the relationship. An important consideration from the clients' perspective relating to respect is that interventions are appropriate and realistic and that the Plunket nurse takes the time to find out how proposed interventions might work.

The third aim was to determine the way in which cultural responsiveness is demonstrated in Well Child clinical practice. In a similar manner to cultural safety, cultural responsiveness was evaluated from the client's perspective of the service and the way in which it meets their needs. Building a relationship and engaging with clients as individuals with individual needs were important factors for Māori clients accessing the Plunket service. Clients did not want a service that felt "the same" for everyone and it was clear that the use of active listening and allowing the client to lead the discussions were ways in which Plunket nurses could tailor the service to reflect the needs of individuals and their whānau.

The following three sections will examine the main findings that emerged from each of the high level evaluation questions in relation to the three principles of the Treaty of Waitangi, partnership, protection and participation.

## PARTNERSHIP

The Nursing Council of New Zealand defines the Treaty of Waitangi principle of 'Partnership' as "nurses working together with Māori with the mutual aim of improving health outcomes for Māori" (2011, p. 5). The first high level evaluation question in this research examined the effect of Family Partnership training on Plunket nursing practice with Māori clients.

Underpinning both Family Partnership training and Plunket nurse practice with Māori is the concept of equal partnership.

#### *REDUCING THE POWER DIFFERENTIAL THROUGH CLIENT-LED INTERACTIONS*

To work in partnership with clients, the nurse-client power differential needs to be addressed by allowing the client to lead the conversation and prioritise topics to be covered. It is clear that Family Partnership training has had a significant impact upon Plunket nurses' awareness around encouraging the client to lead the discussions, however some challenges lie in balancing contractual requirements with client-led priorities within limited timeframes. This aligns with Christensen's (1998) model of partnership in which the nurse takes a leadership role in using knowledge to identify outcomes that will benefit the client. Increased practice and conscious use of the Family Partnership helping process may allow for a more seamless integration of the priorities of both participants in the partnership. However, it needs to be acknowledged that competing pressure on nursing time is seen to impact on the ability of nurses to support clients to identify their own needs. Davis et al. (2009) suggest that the personal and professional development of communication skills needs continual attention for improvements to be observed.

#### *THE DEMONSTRATION OF RESPECT THROUGH HUMILITY*

Having 'unconditional positive regard' (Davis et al. 2009) for clients was identified by the Plunket nurses as an important enabling factor in working in partnership with Māori. Building a relationship with clients in which both parties were consciously aware of the respect for each other was seen by Plunket nurses to influence the engagement of Māori clients in the Plunket service. Inclusion of the whānau and acknowledgement of the children was identified as a way that clients identified the Plunket nurse was demonstrating respect. Being humble in terms of listening to and acknowledging the client's perspective was also seen as a way that the Plunket nurse could demonstrate respect. Davis et al. (2009) are clear that without respect, any partnership is likely to be unsuccessful as respect is seen as a fundamental premise from which relationships are developed. Buchanan and Malcolm (2010) suggest that respect is entwined with the health professional acknowledging the understanding of the whānau in client-professional interactions.

#### *BUILDING RELATIONSHIPS AND SETTING BOUNDARIES*

Identifying the purpose, aims and potential outcomes of relationships between the Plunket nurses and Māori clients had an impact upon the ability to generate positive change towards

improving health outcomes. Paralinguistic communication skills were identified as having a significant impact upon the formation of positive relationships with Māori clients. Activities as simple as sitting down on the floor with the children had a positive influence over the relationship established with Māori clients. Some Plunket nurses identified the tenuousness of some of their relationships with Māori clients as a rationale for not challenging non-evidence based parenting practice or lifestyle choices. The trust that Plunket nurses had in the depth of the relationship and ability to challenge parenting practice varied at times due to a 'fear' of appearing to disrespect parent or whānau decisions relating to their baby. Durie (2003) suggests that the relationships Māori have with the Māori world have a strong influence over the approach Māori clients take in building relationships with mainstream providers. When the relationship between the Plunket nurse and Māori client was based on honesty and openness, both parties are more likely to gain increased satisfaction from the encounters.

#### *GAINING CLIENT FEEDBACK*

The ability to obtain feedback relating to the experience of Māori clients receiving the Plunket service appeared to correlate with the level of Plunket nurse confidence in working alongside Māori. Most Plunket nurses indicated that they were unsure if the service they were providing was meeting the needs of Māori clients and there was little evidence to suggest that the evaluation stage of the helping process (Davis et al. 2009) was being utilised to obtain this feedback. Central to being able to evaluate the effectiveness of the strategies implemented is the activity of receiving feedback around the strategies proposed. It is clear that if the strategies are inappropriate they are unlikely to be implemented and the resulting impact on the relationship is often negative. Plunket nurses are potentially missing opportunities to celebrate successes with clients if evaluation and feedback are not planned and prioritised within the partnership at every contact with Māori families.

#### **PARTICIPATION**

The second principle of the Treaty of Waitangi involves the participation of Māori and the right to Māori self-determination over health and wellbeing (Nursing Council of New Zealand, 2011). The second high level evaluation question in this project analysed the extent to which Plunket nurses were meeting the needs of Māori clients. The close relationship between meeting client needs and participating in the direction of interventions is the rationale for considering the data relating to the second evaluation question under the umbrella of the participation principle.

### *ACKNOWLEDGEMENT OF CULTURE*

The majority of Māori Plunket clients want to be acknowledged as being Māori. The extent to which this acknowledgment extends to culturally specific interventions or conversations needs to be led by the client. All clients in this research expressed a desire for the Plunket nurse to show an interest around who they are and what they specifically see as their cultural identity. It is clear that this acknowledgement needs to extend past the first meeting or enrolment in the service. Many Māori clients indicated that they wanted the Plunket nurse to explore the impact that their specific cultural practices, influences and beliefs may have upon proposed interventions. Cunningham et al. (2005) outline the extent of Māori diversity in New Zealand society which reflects the individuality expressed by Māori participants in this research.

### *FOSTERING ENGAGEMENT BY ADAPTING TO NEEDS*

Having the ability to engage with the Plunket nurse from the client's perspective was an important factor in feeling that they were able to participate in the service. Clients were aware of trying to make the Plunket nurse feel comfortable within their homes and having the service provided at home was a significant step in achieving this. The ability of the Plunket nurse to adapt to the different needs of Māori clients - whether it was through the use of humour, home visiting, or remembering and recapping information that was significant to the family in some way were identified by the clients as ways to support engagement. The inclusion and engagement of whānau in assessments and strategy development was identified as a way to support Māori parents in implementing interventions. Wilson (2008) clearly outlined the desire of Māori women to be viewed by health professionals as people rather than problems when accessing health services. This research has highlighted ways in which Plunket nurses can foster engagement with Māori whānau in acknowledging feelings of vulnerability – from nurse and client perspectives.

### *IMPARTING TIMELY AND ACCURATE KNOWLEDGE*

The knowledge of the Plunket nurse and the ability to provide timely and appropriate information was stressed by the clients as important in assisting them to make decisions relating to their children. Technical knowledge was described by the clients in terms of the provision of health education information as well as clinical assessment observations. The inclusion of cultural expertise from a Plunket Kaiawhina was also seen as an important facet of the service by some Māori clients that supported their engagement with the Plunket service. Davis and Meltzer (2007) describe expertise as not limited to the helper, but as complementary with the parent's own knowledge and expertise of their child. They describe

this as most effective when the expertise differs between parties, as this allows both partners to learn from the interaction.

#### *ACKNOWLEDGEMENT OF DIFFERENCE*

Clients needed to feel that they were not judged by the Plunket nurse in order for them to develop a sense of trust in her and the service. Many clients expressed a generalised sense of fear in encountering health and social services related to thinking they may be judged negatively due to their culture and way of life. It is clear, both in the literature and in analysing the comments from clients, that attempts to follow the helping process will be unsuccessful without a platform of suspended judgements and respect for difference (Davis et al., 2009). Durie (2003) discusses the importance of re-orientating health services to ensure that Māori client worldviews are supported in health environments. Therefore in order for clients to feel that they are not being judged, health services need to reflect upon the difference they bring to the reality for clients rather than vice versa.

#### PROTECTION

The Nursing Council of New Zealand (2011) outlines the third principle of the Treaty of Waitangi as protection. Protection is defined as the nursing workforce recognising that “health is a taonga” and therefore acting to “protect” it. The final evaluation question in this research discussed the value of Family Partnership training to Plunket. As Family Partnership was identified as a model to be responsive to the needs of Māori, the organisational commitment to improving and enhancing the health of Māori is encapsulated under the principle of protection.

#### *INDIVIDUALISED MEASUREMENT OF HEALTH OUTCOMES*

The measurement of health outcomes and indicators of Māori health gains do not always reflect client progress towards decision making nor do they capture the prevention of risk factors or events at an individual level. The result is the provision of national and organisational data around Māori health outcomes that are not ‘being met’. This feedback may contribute to the uncertainty many Plunket nurses face in relation to whether their service is making a difference for Māori clients. A holistic view of health outcomes can potentially align more directly with the needs identified by clients. Neuwalt et al. (2009) discussed the importance of community participation in determining appropriate strategies to improve collective health outcomes whereas O’Brien et al. (2007) highlighted the experience of the individual as paramount in assessing health gains. Walker’s (2004) research suggested that

issues for Maori need to be examined within the context of the wider whānau group. This research has raised questions as to whether the “kaupapa of whānau” - the wider group making decisions for all, is being ‘lost in translation’ in terms of the use of ethnic statistics in making judgements relating to service effectiveness.

#### *THE SIGNIFICANCE OF ROLE MODELS*

Cunningham (2011) discussed the importance of health services being able to respond to clients in a way that affirms Māori culture. While the majority of clients were impartial around the ethnicity of their Plunket nurse, many indicated that Māori Plunket nurses would act as positive role models in the community. Plunket nurses generally felt that they would like to see more Māori staff within Plunket as a resource and support for them in their role. Access to working alongside a Plunket Kaiawhina was generally seen as a way to create opportunities for the service to ‘look different’ for Māori clients as appropriate and indicated by them.

#### *DESENSITISATION AND THE IMPACT ON ENGAGEMENT*

In working within a population in which the majority of clients are assessed as having high long term needs, there is a risk of desensitisation to what is observed as well as a potential de-valuing of the Plunket service. Chambers and Ryder (2009) describe desensitisation as a coping mechanism for nurses working in stressful environments. They suggest that prolonged episodes of desensitisation can lead to nurses losing their empathy and sensitivity towards clients. Plunket nurses may be inadvertently contributing to the de-valuing of their service by taking a more laid back approach to keeping appointment times or not providing the depth of information and health education that is anticipated by the parents. This can be exacerbated by the client’s knowledge of other community services as negative experiences can often influence client constructs around all community services. A degree of desensitisation was also highlighted in terms of the negotiation around appointment times with clients, specifically in relation to the practice of ‘cold calling’. Plunket nurses specifically working in high needs communities need to be consciously creating opportunities to ensure that negotiation takes place so that a mutual partnership is facilitated.

#### *ONGOING LEARNING TO SUPPORT APPLICATION TO PRACTICE*

Working in a Family Partnership model requires conscious consideration and practice. The majority of Plunket nurses felt that although they had completed the initial training, they would benefit from ongoing updates or re-training in the application of Family Partnership to practice to support the application of a Family Partnership approach. Davis et al. (2009)

suggest that development of interpersonal communication skills could be considered as “never complete” and therefore opportunities for re-training and continual application need to be prioritised.

## LIMITATIONS

There were a number of limitations in this research which need to be acknowledged. Firstly the participant eligibility criteria for the online survey and subsequent analysis differentiated Plunket nurses who had completed and those who had not yet completed Family Partnership training. Even though one group had not completed the official level 1 training, they may have still had exposure to the concepts and principles of Family Partnership throughout their general professional development sessions. Therefore the Plunket nurses who had not completed Family Partnership training should not theoretically be considered a ‘control’ group with no understanding at all of the Family Partnership approach.

The understanding around the terminology used in Family Partnership, which in itself is not Family Partnership owned, but is explored in depth via Family Partnership training is an issue for all participants in this research. The participants who were interviewed later in the research were asked more questions to clarify and drill down upon their understanding of these concepts rather than having their meaning superficially accepted as the same as my own. This occurred as my learning increased around the interviewing and data collection process. The questionnaire design limited the ability to clarify my understanding of their meanings and therefore the concepts mentioned were interpreted in relation to the Family Partnership literature.

The use of the Likert scales in averaging the scores of the results for the questionnaire and observation data resulted in the majority of the scores sitting close to the median. Increasing the range of numbers on the rating scale may have increased the variety of responses, although the purpose of the questionnaire was to provide a platform from which to analyse the qualitative data obtained in the interviews and triangulate perspectives. Jaimeson (2004) describes the debate that surrounds the appropriate use of Likert scales and suggests that without a median assessment point, many responses to surveys return with polarised data sets. Upon reflection I would design more qualitative questions for the questionnaire to expand upon the responses further.

Another limitation that needs to be acknowledged is the recruitment of participants for the interviews and observational component of data collection. Firstly it could be argued that the

group of Plunket nurses who indicated their interest to participate in this research would be more likely to demonstrate a specific set of qualities and skills and therefore would not necessarily represent a cross-section of Plunket nurses working with Māori clients. Secondly the clients that agreed to participate already had a relationship with the Plunket nurses and as a result of this relationship were more likely to be a group that were engaged with the Plunket service rather than clients who did not feel the service was appropriate to them.

There were a number of qualities and skills specifically related to the setting up of the relationship in the 'first visit' that were unable to be observed due to the eligibility criteria set for the client participants. The Plunket nurse was required to have an existing relationship with the client and therefore presumably the setting up of the relationship had already taken place. This critical element of relationship building and goal setting would be extremely beneficial to observe if the research was to be repeated.

The decision not to evaluate the Family Partnership training was important in order to control the size of the research. It became clear throughout the analysis however that the quality of the Family Partnership training would have a direct impact on how the approach is applied to Plunket nurse practice. Evaluation around the training of Plunket nurses in Family Partnership would dovetail into the findings of this research. There were limitations in selecting to evaluate only the high level evaluation questions as some of the detail inherent in evaluating both the Family Partnership programme and the individual outcomes outlined in the logic model would have made the research more robust.

The process of evaluating Family Partnership as a model for cultural responsiveness within Plunket was relatively complex as it was difficult not to default into evaluating the extent to which Plunket was culturally competent. The use of frameworks and evaluation questions assisted to keep the focus upon the relationship between Family Partnership and cultural responsiveness and the variety of perspectives allowed for a range of data to be collated in response to the questions.

As indicated in the introduction to this thesis, the measurement of "cultural safety" from the client's perspective has not been specifically conceptualised in nursing literature. Evaluating the extent to which the Plunket nursing service is culturally responsive has proven difficult and has defaulted to measures that exist within a nursing culture. The results therefore reflect minimal interpretation of kaupapa Māori philosophy in relation to Family Partnership and cultural responsiveness.

## IMPLICATIONS / RECOMMENDATIONS

As a result of this research, six significant recommendations have been identified for Plunket as an organisation relating to the use of the Family Partnership model in working with Māori whānau and communities.

### *RECOMMENDATIONS:*

Family Partnership training is essential in working alongside Māori in order to support Māori health outcomes and service engagement within a Well Child context. Therefore;

- Plunket needs to support and promote Family Partnership training across all levels of the organisation in order to implement the principles of the Treaty of Waitangi.
- Family Partnership training needs to be completed within the first 6 months of orientation for Plunket staff in order to provide a platform from which to develop a culturally responsive service.
- Plunket staff in positions of assessing and developing cultural competence need to be confident in recognising and utilising Family Partnership principles in observing communication with clients.
- The principles of Family Partnership need to be reinforced within Plunket through ongoing formalised opportunities to refresh and review content and the application to practice.
- Plunket needs to regularly review the process in place for Māori clients to evaluate and provide feedback regarding the service, including engagement and the appropriateness of interventions, with the results disseminated to frontline staff.
- Plunket needs to identify further ways in which to create an environment whereby Māori clients are encouraged to provide ongoing feedback and feel comfortable in doing so.

The recommendations from this research reflect the importance of the sustainability of Family Partnership within Plunket in the future and the ways Family Partnership can support the practical application of the principles of the Treaty of Waitangi. Overall this research has provided a platform to base further research into the way in which a mainstream service can attempt to meet the needs of individual Māori and how the feedback around these needs may be obtained.

## CONCLUDING STATEMENT

Family Partnership is a training programme that is designed to support professionals working alongside families to communicate more effectively to enhance client outcomes. Cultural responsiveness within Plunket has been defined in this study as the application of the principles of cultural safety in working alongside Māori clients. This research provided an evaluation of whether Family Partnership is a model for cultural responsiveness in a Well Child context.

The Family Partnership process allows for the identification of health outcomes that are meaningful for individuals and families. The accurate identification of health outcomes is essential in providing a Well Child service that is responsive to individual needs and resources. In order for responsiveness to occur, both Plunket nurses and clients need to receive honest feedback relating to the interactions and subsequent plans put in place as part of service delivery.

This research has comprehensively highlighted the importance of communication in determining the appropriateness of a service and has provided a strong indication that Family Partnership could indeed be considered a model for cultural responsiveness in working with Māori whānau. The Plunket nurses observed were all extremely committed to working alongside Māori clients in an enabling way and this commitment was reflected in their desire for feedback in order to make changes to their practice as necessary. It was clear that Māori clients were, on the whole, looking for a service that was responsive and reflective of their needs and that Family Partnership provided the Plunket nurses with some structure around the skills required to facilitate this process.

It has been a humbling experience to observe the Plunket nurses and their passion in working alongside Māori clients and a privilege to meet the parents and whānau shaping the lives and thinking of future Māori generations. It is clear that when faced with issues, parents and whānau have the answers that are most suitable for themselves, within themselves. The onus is on Plunket nurses in the use of their qualities and skills to work together with Māori clients and facilitate partnerships in which wellness gains are optimised and interventions support the ultimate outcome of “Whānau Ora”.

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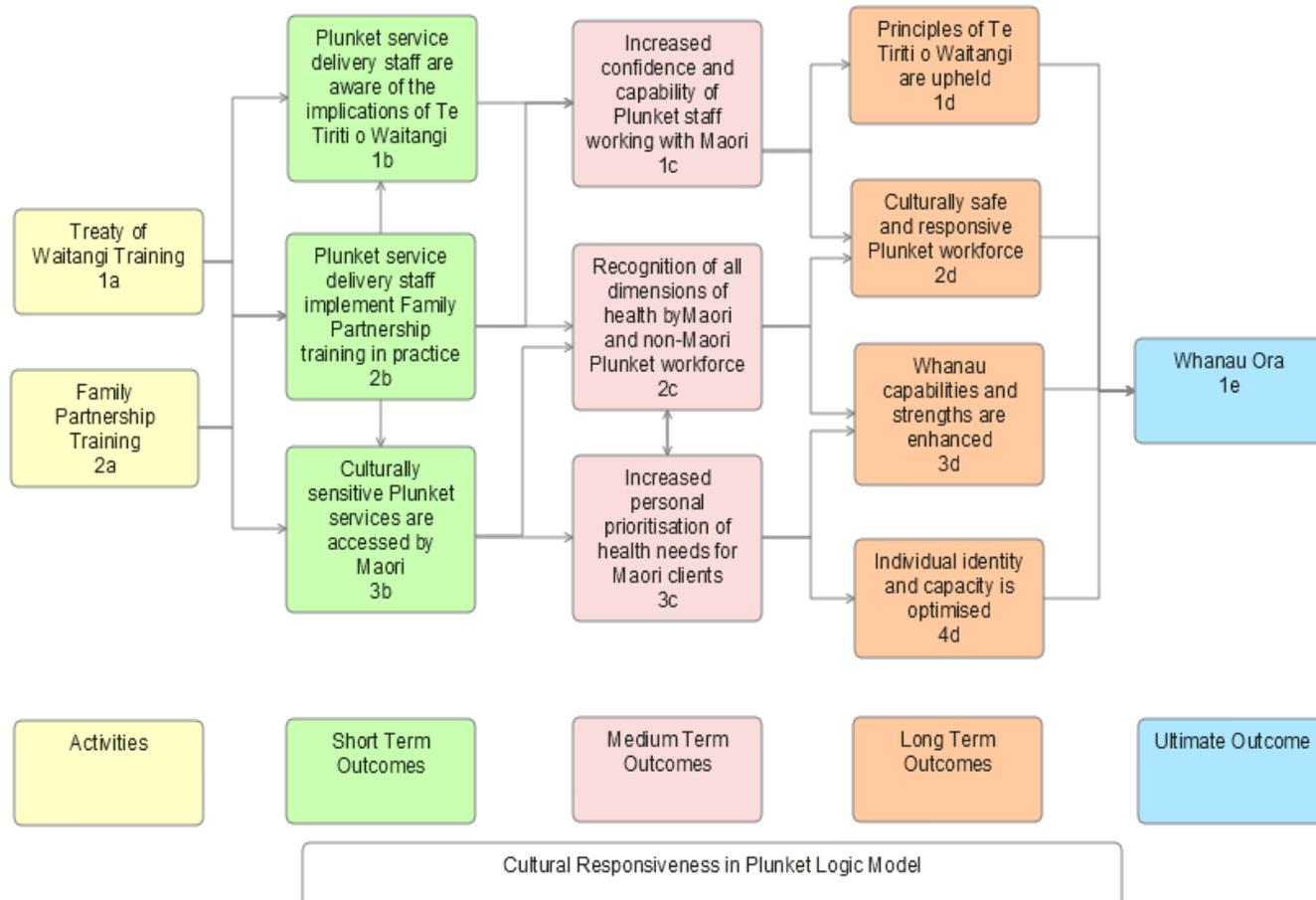
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APPENDIX I - Cultural Responsiveness in Plunket Logic Model



**APPENDIX II - Key Evaluation Questions Mapped to Logic Model Outcomes and Methods for Evaluation**

**High Level Evaluation Question 1: What effect does the Family Partnership training have on nursing practice?**

1. Evaluation Questions:	Logic Model Outcomes:	Methods:
1.1) What is the value of the Family Partnership model in terms of interacting with Māori clients?	(3b) Culturally sensitive Plunket services are accessed by Māori  (3c) Increased personal prioritisation of health needs for Māori clients	Questionnaire  Observations  Plunket Nurse Interviews  Client Interviews
1.2) How useful is the Family Partnership model in assessing the wellbeing of Māori whānau?	(2b) Plunket service delivery implement Family Partnership training in practice  (1c) Increased confidence and capability of Plunket staff working with Māori  (2c) Recognition of all dimensions of health by Māori and non- Māori workforce	Questionnaire  Observations  Plunket Nurse Interviews  Client Interviews
1.3) To what extent do Plunket nurses feel more confident following the training in being able to work alongside Māori whānau?	(1c) Increased confidence and capability of Plunket staff working with Māori  (2b) Plunket service delivery implement Family Partnership training in practice	Questionnaire  Plunket Nurse Interviews

<b>High Level Evaluation Question 2: To what extent does Plunket meet the needs of Māori clients?</b>		
<b>2. Evaluation Questions:</b>	<b>Logic Model Outcomes:</b>	<b>Methods:</b>
2.1) To what extent are the individual needs of Māori being identified by Plunket nurses?	<p>(2b) Plunket service delivery staff implement Family Partnership training in practice</p> <p>(3c) Increased personal prioritisation of health needs for Māori clients</p> <p>(2d) Culturally safe and responsive Plunket workforce</p> <p>(4d) Individual identity and capacity is optimised</p>	<p>Questionnaire</p> <p>Plunket Nurse Interviews</p> <p>Client Interviews</p>
2.2) How useful and appropriate is the Plunket nursing service for Māori clients?	<p>(3b) Culturally sensitive Plunket services are accessed by Māori</p> <p>(2c) Recognition of all dimensions of health by Māori and non- Māori Plunket workforce</p> <p>(2d) Culturally safe and responsive Plunket workforce</p>	<p>Client Interviews</p>
2.3) To what degree does the Plunket nursing service acknowledge and enhance whānau capabilities?	<p>(2c) Recognition of all dimensions of health by Māori and non- Māori workforce</p> <p>(1d) Principles of Te Tiriti o Waitangi are upheld</p> <p>(3d) Whānau capabilities and strengths are enhanced</p>	<p>Questionnaire</p> <p>Client Interviews</p> <p>Plunket Nurse Interviews</p>

**High Level Evaluation Question: What is the value of Family Partnership training to Plunket?**

3. Evaluation Questions:	Logic Model Outcomes:	Methods:
<p>3.1) What impact does cultural safety and responsiveness have on Māori health outcomes?</p>	<p>(3c) Increased personal prioritisation of health needs for Māori clients</p> <p>(2c) Recognition of all dimensions of health by Māori and non- Māori Plunket workforce</p> <p>(3d) Whānau capabilities and strengths are enhanced</p> <p>(4d) Individual identity and capacity is optimised</p>	<p>Plunket Nurse Interviews</p> <p>Client Interviews</p>
<p>3.2) How useful is Family Partnership training in creating a culturally safe and responsive workforce?</p>	<p>(1b) Plunket service delivery staff are aware of the implications of the Te Tiriti o Waitangi</p> <p>(2b) Plunket service delivery staff implement Family Partnership model in practice</p> <p>(1c) Increased confidence and capability of Plunket staff working with Māori</p> <p>(2c) Recognition of all dimensions of health by Māori and non- Māori Plunket workforce</p>	<p>Questionnaire</p> <p>Observations</p> <p>Plunket Nurse Interviews</p> <p>Client Interviews</p>

**APPENDIX III – Information email for Phase 1 sent to Clinical Leaders and Plunket nurses**

Tena koutou katoa, Greetings all

This email is being sent out on behalf of Zoe Tipa from Marg Bigsby, National Family Partnership Coordinator. Marg Bigsby has access to the names and areas of Plunket Nurses who have completed Family Partnership Level 1 training.

I am currently undertaking research through Massey University on the Family Partnership Programme in relation to Cultural Responsiveness in the Well Child setting. I need to recruit a sample of Plunket Nurses as part of the data collection process.

The first part of the research has a survey which can be completed online. It will take about 10 minutes to complete. I would appreciate your assistance in inviting two Plunket Nurses in your team to consider participating by completing the survey. If they are interested, access to your work computer or their own home internet would be necessary.

Please invite one Plunket Nurse who has completed the Family Partnership Level 1 training and one Plunket Nurse who has not completed the Family Partnership Training to participate in the online survey.

Please do not complete the survey yourself. You are welcome to read the information sheet on the survey website once you log in however please **do not** click on the "[click here to take survey](#)" button, as it will count you as a participant.

For participating Plunket Nurses who do agree to be in the survey, please ask them to complete the survey questions once only.

If the Plunket Nurses decide not to participate, it would be helpful if you email Marg Bigsby, to avoid any further contact regarding this research.

**Login details are as follows:**

- 1) Please copy and paste this link into your browser window  
<http://www.fpthesis.yolasite.com>
- 2) You will see a screen which says this is a "password protected page".
- 3) Enter the following login: **fpmāorisurvey**

**Password: teknulp007**

Now you should see the information sheet regarding the survey. If the Plunket Nurse scrolls down to the bottom of the page there is a link to click on which says: "[click here to take survey](#)"

Once the survey is completed, the Plunket Nurse will be redirected back to the information page. If the second Nurse is ready to take the survey, they can click on "[click here to take survey](#)" and it will start the survey format again. The Plunket Nurses are welcome to take a copy of these instructions and complete the survey at home

Once finished click on close the window and it will log out of the website automatically.

Thank you very much for considering this request. I appreciate your help in this research and will be in contact again regarding the second phase for data collection.

Please respond to Marg Bigsby if you have any further questions regarding this research.

Kind regards,

Zoe Tipa

**Clinical Leader Counties-Manukau Area**

**Student researcher- Massey University**

AN EVALUATION OF FAMILY PARTNERSHIP AND CULTURAL RESPONSIVENESS IN THE WELL CHILD CONTEXT

*INFORMATION SHEET- for Plunket Nurses*

**Kia ora, Greetings**

My name is Zoe Tipa and I am completing some research for a Master of Philosophy (Massey University). My research is dependent upon the participation of Plunket Nurses and Plunket clients. This research has been approved by Plunket ethics committee. My focus is on the impact that the Family Partnership Course may have on Plunket Nurse cultural responsiveness when working with Māori families, whānau and communities.

I have a particular commitment towards improving Māori health outcomes and I am interested in how this may be achieved in the specialty of Well Child Nursing.

The aim of this research is to identify the ways in which Plunket Nurses communicate with Māori families, whānau and communities and whether this could be considered culturally responsive nursing practice.

**Project Description**

Ramsden (2008) stated that “in the future it must be the patient who makes the final statement about the quality of care which they receive. Creating ways in which this commentary may happen is the next step in the Cultural Safety journey” (p 181). Developed within the UK context, Family Partnership is a communication training programme for health and social service professionals, and has been jointly implemented by both Plunket and the Ministry of Social Development.

There will be two phases to the data collection in this research. The first phase includes an online survey of 25 Plunket Nurses who have completed Family Partnership training and 25 Plunket Nurses who have not had Family Partnership training. The second phase of the research consists of the student researcher (myself) observing 10 clinical assessments between Plunket Nurses who have completed Level 1 Family Partnership training and Māori Plunket clients. Following each observation, there would be separate interviews of both the client and the Plunket Nurse.

I would like to invite you to participate in the **second phase** of this research, which involves me observing you work with one client who identifies as Māori and interviewing you both following the visit. There will be no disadvantage to you if you choose not to participate and you would have the opportunity to withdraw your participation and any information already collated at any stage up until one week after the interview.

## **Participant Identification and Recruitment for Phase 2**

Prospective participants have been identified from our records of all Plunket Nurses who have completed Family Partnership Level 1 training. These letters have been posted out by the National Family Partnership Coordinator (Marg Bigsby) who is the only person that can access these records.

If you decide to participate, I would ask that you contact a Plunket client who identifies as Māori who would also be willing to participate in the research and ask if they would be willing for me to contact them further. I have enclosed an information sheet for clients with this letter.

If you are currently under a performance review / management process, you will not be eligible to participate in the research. If you are currently under my direct management in my role as a Clinical Leader, you will also not be eligible to participate.

Throughout the clinical observation, all information shared between the client and yourself would remain confidential to the people present during the assessment. As I am a Plunket employee and this research involves Plunket staff and clients, in the unlikely event that I observed any serious misconduct, I have a professional obligation to discuss this with you at the earliest opportunity and then we may need to proceed to involve your Clinical Leader.

Both you and the client would receive \$30 Prezzie cards as a token of appreciation for participating in the research.

## **Project Procedures for Phase 2**

Following the verbal consent of a Māori Plunket client, the observation study would involve negotiating a mutually agreeable time for the visit to occur. Throughout the visit I would be taking notes regarding the communication style that you use in relation to the family partnership model.

Following the visit I would arrange to meet you at a location agreeable / chosen by you to complete the interview. The interview would take approximately 15-20 minutes and would be audio recorded and transcribed by the research assistant (Brenda Ing) who has signed a confidentiality agreement.

At the completion of my interview with you, I would return to the client's home and complete an interview with the client regarding the communication style and techniques used throughout the assessment. None of the information obtained in the interview would be shared with the client and none of the information obtained from the client would be shared with you at any stage of the research.

## **Data Management for Phase 2**

All data will be coded to protect anonymity and kept separate from consent forms or any other identifiable documentation. Only myself, my Supervisor (Dr Stephen Neville) and my research assistant (Brenda Ing) will have access to the data prior to it being analysed. Audio data will be transcribed within 1 week with all copies deleted from the recording device immediately after

transcription. You would have the opportunity to review the data on the transcript prior to it being analysed and sign a release agreement. All data will be stored securely at Massey University at the College of Humanities and Social Sciences Albany Campus. All of the data collated will be kept in a locked filing cabinet at an offsite location for 5 years following the completion of the research before being securely destroyed. Should you withdraw from the study up until 7 days following the interview, any information / data regarding you and / or transcripts will be securely destroyed and will not be used in the analysis or write up of the research.

If you would like a copy of the findings of this research once completed, please email me at [fpthesis@gmail.com](mailto:fpthesis@gmail.com). A summary of the results will be available on the website <http://www.fpthesis.yolasite.com> from December 2011.

### **Participant's Rights**

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

- decline to answer any particular question;
- withdraw from the study up until 7 days after the interview;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

Any clients that you may assist in recruiting in this project will have the same rights as outlined above.

### **Project Contacts**

Student Researcher: Zoe Tipa  
Email: [fpthesis@gmail.com](mailto:fpthesis@gmail.com)  
Mobile: 0212462176  
DDI: 092625970  
PO Box: PO Box 76533, Manukau City 2241

Research Supervisor: Dr Stephen Neville  
Email: [S.J.Neville@massey.ac.nz](mailto:S.J.Neville@massey.ac.nz)  
Phone: 094140800 extn: 9065

Please feel free to contact either myself or Stephen if you have any questions regarding this research project. Thank you for your time in considering this invitation. If you wish to participate in this observation study, please contact me directly by 30<sup>th</sup> November 2010.

Yours sincerely,

Zoe Tipa

**Student Researcher**

**Massey University**

Email: [fpthesis@gmail.com](mailto:fpthesis@gmail.com)

#### COMMITTEE APPROVAL STATEMENT

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/080. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 9570, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz). This project has also been reviewed and approved by the Plunket Ethics Committee.

## APPENDIX V – Information sheet for Māori clients phase 2

### AN EVALUATION OF FAMILY PARTNERSHIP AND CULTURAL RESPONSIVENESS IN THE WELL CHILD CONTEXT

#### *INFORMATION SHEET- for Plunket Clients*

Te Kohurau te mauka  
Arai te Uru te tai  
Arai te Uru te waka  
Poutaiki te pa nehe ra  
Oraumoa te awa  
Moeraki te kaika  
Kai Tahu me Kahungunu oku iwi  
Ko Zoe Tipa ahau

Tena koe, greetings,

My name is Zoe Tipa and I am a student at Massey University, completing a Master of Philosophy. My research is dependent upon the participation of Plunket Nurses and Plunket clients. This research has been approved by both the Plunket and the Massey University ethics committees.

I am dedicated towards improving Māori health outcomes and looking at how this can be achieved in well child health. The aim of this research is to identify the ways in which Plunket Nurses communicate with Māori families, whānau and communities and look at whether this could be considered culturally responsive nursing practice.

#### **Project Description**

This study is looking at whether a model for communication called Family Partnership is helpful for Plunket Nurses working with Māori whānau. There will be two phases to collecting the information for the research. The first phase involves an online survey of Plunket Nurses. The second phase involves my observations of 10 Plunket Nurses in practice working with Māori families in the community.

I would like to invite you to participate in the second phase of the research which would involve me observing the Plunket Nurse working with you and your whānau at one Plunket visit. Following the visit, there would be separate interviews of both yourself and the Plunket Nurse.

There will be no disadvantage to you or your family if you choose not to participate and you would have the opportunity to withdraw any information already collated at any stage up until one week after the interview.

## **Participant Identification and Recruitment for Phase 2**

The Plunket Nurse will have contacted you to see if you are interested in participating in this research. You would have been asked because you have identified as of Māori descent on the Plunket records. If you let the Plunket Nurse know that you are interested, the Plunket Nurse will give me your name and contact details so we can arrange a time for the visit and interview. If you are not interested, I will not be given any of your details.

There will be 10 Plunket Nurses and 10 Plunket families involved in this research. If you decide to participate, both you and the Plunket Nurse will receive \$30 Prezzie cards in appreciation of your time and assistance with this project.

## **Project Procedures for Phase 2**

If you are willing to participate in this study, the Plunket Nurse will contact me with your contact details. I would then contact you via phone to arrange a suitable time for the visit to occur. Throughout the visit I would be taking notes regarding the communication style that the Plunket Nurse uses with you. I would not be taking any notes regarding you or your child's personal health or social information.

Following the visit, I would arrange to meet you at a location and time chosen by you to complete the interview. The interview should take approximately 15-20 minutes and would be audio recorded by me and transcribed by the research assistant (Brenda Ing) who has signed a confidentiality agreement. None of the information provided to me by you would be shared with the Plunket Nurse involved at any stage during or after the research.

## **Data Management for Phase 2**

All data will be coded to protect anonymity and kept separate from consent forms or any other identifiable documentation. Only myself, my supervisor (Dr Stephen Neville) and my research assistant (Brenda Ing) will have access to the data prior to it being analysed. Audio data will be transcribed within 1 week of the interview with all copies being deleted from the recording device immediately after transcription.

You would have the opportunity to review the data on the transcript prior to it being analysed and sign a release agreement. All data will be stored securely at Massey University at the College of Humanities and Social Sciences Albany Campus. All of the data collated will be kept in a locked filing cabinet at an offsite location for 5 years following the completion of the research before being securely destroyed. Should you withdraw from the study up until 7 days following the interview, any information / data regarding you and / or transcripts will be securely destroyed and will not be used in the analysis or write up of the research.

If you would like a copy of the findings of this research once completed, please email me at [fpthesis@gmail.com](mailto:fpthesis@gmail.com). A summary of the results will be available on the website <http://www.fpthesis.yolasite.com> from March 2011.

### **Participant's Rights**

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

- decline to answer any particular question;
- withdraw from the study up until 7 days after the interview;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded;
- ask for the recorder to be turned off at any time during the interview.

### **Project Contacts**

Student Researcher: Zoe Tipa  
Email: [fpthesis@gmail.com](mailto:fpthesis@gmail.com)  
Mobile: 0212462176  
DDI: 092625970  
PO Box: PO Box 76533, Manukau City 2241

Research Supervisor: Dr Stephen Neville  
Email: [S.J.Neville@massey.ac.nz](mailto:S.J.Neville@massey.ac.nz)  
Phone: 094140800 extn: 9065

Please feel free to contact either myself or Stephen if you have any questions regarding this research project. Thank you for your time in considering this invitation to participate.

Naku noa na,

Zoe Tipa

**Student Researcher**

**Massey University**

Email: [fpthesis@gmail.com](mailto:fpthesis@gmail.com)

### **COMMITTEE APPROVAL STATEMENT**

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This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application 10/080. If you have any concerns about the conduct of this research, please contact Dr Ralph Bathurst, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 9570, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz). This project has also been reviewed and approved by the Plunket Ethics Committee.

**BROMLEY CHILDREN PROJECT**

**INTERPERSONAL AND COMMUNICATION SKILLS  
RATING SCALE**

Excellent interpersonal and communication skills are essential for this job. The points made in the interview may not alone reflect these qualities. After each interview, members of the interview panel are asked to complete a rating scale for their observations of these essential qualities for each candidate.

Please circle one number for each item.

Candidate's Name: <input style="width: 350px; height: 30px;" type="text"/>					
	Very little evidence				Considerable evidence
Warmth	1	2	3	4	5
Listening skills	1	2	3	4	5
Humility	1	2	3	4	5
Appropriate confidence	1	2	3	4	5
Positive, open body language	1	2	3	4	5
Eye contact	1	2	3	4	5
Assertiveness	1	2	3	4	5
Enthusiasm	1	2	3	4	5
Genuineness	1	2	3	4	5
Non-judgemental	1	2	3	4	5
Non-threatening	1	2	3	4	5
Sense of humour	1	2	3	4	5
Appropriate sensitivity	1	2	3	4	5

## **APPENDIX VII – Semi-Structured Interview Questions**

### **Client Semi-structured Interview Questions**

How do you feel the visit went today?

Can you tell about your experience with Plunket as a whole?

What do you think are the most important things for a Plunket Nurse to offer your family?

Do you think Plunket meets your needs culturally?

How do you think (Plunket Nurse) works in partnership with you?

Are you given the chance to direct the way a visit is going?

Is there anything else you wanted to add?

### **Plunket nurse Semi-structured Interview Questions**

Any comments about the assessment today?

Do you think you approach Māori clients and whānau differently to other clients?

What aspects of family partnership do you find useful in your practice?

What do you think Plunket Nurses need to do to work more effectively with Māori clients and communities?

What do partnership, protection, participation and equality mean for you in practice?

What are the key messages you took from Family Partnership training?

Any other comments you would like to add about today?

Dear Zoe,

**An Evaluation of the Family Partnership Programme in Relation to Cultural Responsiveness in a Well Child Setting**

Thank you for your response to the points put to you in my letter of 13 July, and also for the revised information sheets. I am happy to say that you have attempted to address the points raised with you. I acknowledge that some of the statistical issues cannot be readily addressed, but you have shown that you are aware of the issues and that you will take these into account in your write up.

In view of your responses, you have final approval to proceed with the study from the Plunket Ethics Committee.

Yours sincerely

Gareth Jones

On 20/09/2010, at 3:49 PM, Zoe Tipa wrote:

Tena koe Gareth

Please find my attached response to the Plunket ethics committee letter dated 13<sup>th</sup> July 2010.

Kind regards

Zoe

**Zoe Tipa**

**Clinical Leader**

*Counties-Manukau Plunket*

**Mobile:** 0212462176

**DDI: (09)** 2625970

**PO Box** 76533 Manukau

Ms Zoe Tipa

13 July 2010

Dear Ms Tipa

**An Evaluation of the Family Partnership Programme in Relation to Cultural Responsiveness in a Well Child Setting**

On behalf of the Plunket Ethics Committee I wish to acknowledge your response to the points made in my letter of 6 March, and the revised proposal you have now submitted. You have adequately addressed the previous points raised by the Committee. The issues raised below touch on the design of your study and are put forward as a means of assisting you in the study. In the light of your positive responses and taking into account the remaining design issues, the Committee is giving provisional approval to your proposal.

The design issues that you should consider are as follows:

1. It is not clear to the members of the Committee how potential participants for the survey will be selected in an effort to minimize bias in the type of respondents. Had you thought of using a random sampling process?
2. If formal statistical analysis is carried out to determine differences between the groups, the small sample size will make it difficult to detect differences. The lack of statistical power in the sample survey may be inevitable in a project of this size, but it should be acknowledged. A related point is to ask whether, in terms of the small number of participants, you can use the tool as intended. (If you would like any additional information on these statistical points please let me know)
3. The application gives people time to withdraw their data, but it is not clear if – once someone has withdrawn – any other aspects of the data related to them can be used.

Once you have responded to these queries I shall be pleased to give you final approval to proceed. Please feel free to contact me directly on <gareth.jones@otago.ac.nz>

Yours sincerely



D Gareth Jones  
Chair, Plunket Ethics Committee



Ms Zoe Tipa

6 October 2010

Dear Ms Tipa

**An Evaluation of the Family Partnership Programme in Relation to Cultural Responsiveness in a Well Child Setting**

Thank you for the documents sent to support your ethics application and we are pleased to give you final approval to proceed.

Please feel free to contact me directly on <gareth.jones@otago.ac.nz>

Yours sincerely



D Gareth Jones  
Chair, Plunket Ethics Committee



**APPENDIX IX – Massey Human Ethics Committee Approval**

Dear Zoë

Thank you for your protocol which was received and considered by the Massey University Human Ethics Committee: Northern at its meeting held on 25 November 2010. The Committee was pleased to be able to meet with you and your supervisor, and we commend you on the quality of your application.

Your project is approved, and a formal letter of approval will follow.

There are some items for your attention, as discussed:

- Information Sheet for Observation Study (Appendix C1):
  - We suggest that you mention your expertise, and your role in Plunket in the first paragraph of this document.
  - Participants' Rights (page 3): We recommend that you extend the right to withdraw to seven days after participants have reviewed the transcript.
- Information Sheet for Plunket Clients (Appendix C2):
  - We suggest that you simplify this document.
- Question 38: We suggest that you need to acknowledge possible risks with regard to your findings should they be negative in any way, and with regard to your reputation as a manager, or to Plunket.

Please email your responses so that they can be retained on your file.

Yours sincerely

Dr Ralph Bathurst, Chair

Massey University Human Ethics Committee: Northern

**Merle Turner**

**Secretary/Administrator**

**Massey University Human Ethics Committee Northern**

**P O Box 102 904 NSMC AUCKLAND**

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**Room 2.25, Study Centre, Massey University at Albany  
Gate 1 State Highway 17 Albany AUCKLAND**

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**T (09) 414 0800, extn 9539**

**F (09) 414 0814, internal 9414**

**email [M.L.Turner@massey.ac.nz](mailto:M.L.Turner@massey.ac.nz)**

**<http://humanethics.massey.ac.nz/>**

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**APPENDIX X – Survey Responses Mapped to Second Level Evaluation Questions**

1.1) What is the value of the Family Partnership model in terms of interacting with Māori clients?	Survey Questions Mapped to Evaluation Questions	FP Training Scale 1 (low)-5 (high) Average rating	No FP Training Scale 1 (low)-5 (high) Average rating	Working Grade
	How would you rate your communication (verbal, non-verbal and written)?	3.77	3.57	Moderate / High
How well do you communicate with Māori clients?	3.18	2.96		
How easily do you make contact / engage with Māori Plunket clients?	3.14	2.91		
<b>Open- ended Questions Survey Themes</b>	Use of active listening Use of open ended questions Engagement of wider whānau as identified by client Use of client-led discussions Use of humour Individualised care planning process to identify and work towards goals	Knowledge of cultural values and practices Listening Sharing of self Being respectful Being inclusive Being positive and using praise		

1.2) How useful is the Family Partnership model in assessing the wellbeing of Māori whānau?	Survey Questions Mapped to Evaluation Questions	FP Training Scale 1 (low)-5 (high) Average rating	No FP Training Scale 1 (low)-5 (high) Average rating	Working Grade
	How well do you think you involve Māori parents / caregivers and / or whānau in decisions relating to their child?	3.36	3.26	Moderate
	How well do you think your service / practice meets the needs of Māori Plunket clients?	2.71	2.61	
Open- ended Questions Survey Themes	Negotiating preferences around contacts e.g. time, place, person  Being led by the client as to what they would like to cover  Being clear in explaining the process of the assessment and why	Gain an understanding around expectations from the service  Checking in as to the 'fit' of proposed strategies  Identifying priorities for families		

1.3) To what extent do Plunket nurses feel more confident following the training in being able to work alongside Māori whānau	Survey Questions Mapped to Evaluation Questions	FP Training Scale 1 (low)-5 (high) Average rating	No FP Training Scale 1 (low)-5 (high) Average rating	Working Grade
	How easily do you make contact / engage with Māori Plunket clients?	3.14	2.91	Moderate
	How well do you think your service / practice meets the needs of Māori Plunket clients?	2.82	2.61	
	How confident are you in working with and alongside whānau, hapu, iwi?	2.14	1.86	
	Open-ended Questions Survey Themes	Polite enquiry Difficulty in gaining feedback to inform practice	Acknowledging parent's expertise Asking for feedback- not knowing the extent of engagement	

2.3) To what degree does the Plunket nursing service acknowledge and enhance whānau capabilities?	Survey Questions Mapped to Evaluation Questions	FP Training Scale 1 (low)-5 (high) Average rating	No FP Training Scale 1 (low)-5 (high) Average rating	Working Grade
	How often do you make decisions based on the client's needs (when working with Māori specifically)?	3.27	3.52	Moderate / High
	How well do you think your service/practice meets the needs of Māori Plunket clients?	2.82	2.61	
	How well do you think you involve Māori parents / caregivers and / or whānau in decisions relating to their child?	3.36	3.26	
	Open-ended Questions Survey Themes	Being non-judgmental Adaptation and flexibility Involvement of whānau in all aspects of care Empowerment	Involvement of whānau in all aspects of care Positivity and encouragement Acknowledging individuality	

3.2) How useful if Family Partnership training in creating a culturally safe and responsive Plunket workforce?	Survey Questions Mapped to Evaluation Questions	FP Training Scale 1 (low)-5 (high) Average rating	No FP Training Scale 1 (low)-5 (high) Average rating	Working Grade
	How well do you think your service / practice meets the needs of Māori clients?	2.82	2.61	Moderate / High
	How well do you deliver on the Treaty of Waitangi principle of equity?	3.14	3.09	
	Open-ended Questions Survey Themes	Working in partnership Being flexible Knowledge of self Whakawhānaungatanga Tailoring the service to individual needs	Adaptability Being flexible Showing respect Accepting and acknowledging difference Knowledge around cultural 'norms'	

**APPENDIX XI – SUCCESS DEFINITION TABLES**

**Personal / Professional experiences of the Plunket nurse, the interaction with Māori clients and the use of the Family Partnership model in practice**

<b>High Level Question 1</b>	<b>Evaluation criteria</b>	<b>Key sources of data</b>
<p>What effect does the Family Partnership training have on nursing practice?</p>	<ul style="list-style-type: none"> <li>• All Plunket nurses who have completed Family Partnership Training identify Family Partnership communication, qualities, skills and processes as essential components in working alongside Māori.</li> <li>• All Plunket nurses trained in Family Partnership demonstrate a high level of helper qualities and skills.</li> <li>• All Plunket nurses trained in Family Partnership are confident in working alongside Māori whānau, hapu and Iwi.</li> <li>• All Plunket nurses consistently demonstrate acknowledgement, recognition and respect around cultural differences.</li> <li>• All Plunket nurses work in partnership with Māori whānau resulting in optimal engagement by Māori with the Plunket service.</li> <li>• All clients receiving a service from Plunket nurses who have completed Family Partnership training are positive regarding the service and believe that the service meets their needs.</li> </ul>	<p>Questionnaire responses from FP and non- FP groups</p> <p>Plunket nurse interviews</p> <p>Client interviews</p> <p>Observations</p>

<b>Māori clients' experiences of service delivery and satisfaction with the quality of service delivered and communication style of their Plunket nurse</b>		
<b>High Level Question 2</b>	<b>Evaluation criteria</b>	<b>Key sources of data</b>
To what extent do Plunket nurses meet the needs of Māori clients?	<ul style="list-style-type: none"> <li>• All clients are positive around the Plunket service meeting their needs</li> <li>• All clients feel respected and that their perspectives are valued when receiving the Plunket service</li> <li>• All clients feel that they are able to direct the way in which an assessment is completed</li> <li>• All clients can articulate the value in the Plunket service in contributing to positive health outcomes for their family</li> <li>• All clients believe that the Plunket service is culturally safe</li> <li>• All clients feel that they are acknowledged as having individuals needs within a whānau context</li> <li>• All Plunket nurses believe their communication qualities and skills facilitate positive client experiences</li> </ul>	<p>Client interviews</p> <p>Questionnaire responses from FP and non- FP groups</p> <p>Plunket nurse interviews</p> <p>Observations</p>

<b>Organisational benefits of the Family Partnership programme and achievement of positive health outcomes for Māori clients</b>		
<b>High Level Question 3</b>	<b>Evaluation criteria</b>	<b>Key sources of data</b>
What is the value of Family Partnership training to Plunket?	<ul style="list-style-type: none"> <li>• All Plunket nurses trained in Family Partnership contribute to the reduction of inequities in Māori health outcomes</li> <li>• All Plunket nurses trained in Family Partnership identify whether the service they are providing is appropriate and acceptable to Māori</li> <li>• All Plunket nurses trained in Family Partnership develop strategies within their practice to enhance Māori wellbeing</li> <li>• All Plunket nurses trained in Family Partnership believe that the Plunket service meets the needs of Māori</li> <li>• All Māori clients can describe positive outcomes for their whānau as a result of the Plunket service</li> <li>• All Plunket nurses are positive regarding the impact that Family Partnership has on their practice and the organisation</li> </ul>	<p>Client interviews</p> <p>Questionnaire responses from FP and non- FP groups</p> <p>Plunket nurse interviews</p>

**APPENDIX XII – Consent Form Plunket Nurse Interview and Observation**

**Family Partnership as a Model for Cultural responsiveness in a Well Child Context**

**PARTICIPANT CONSENT FORM – Plunket nurses**

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

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

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

I wish /do not wish to have data placed in an official archive

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

**Signature:** ..... **Date:** .....

**Full Name - printed** .....

**APPENDIX XIII – Consent Form Plunket Client Interview and Observation**

**Family Partnership as a Model for Cultural responsiveness in a Well Child Context**

**PARTICIPANT CONSENT FORM – Plunket nurses**

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

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

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

I wish /do not wish to have data placed in an official archive

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

**Signature:** ..... **Date:** .....

**Full Name - printed** .....

**1.**

**1. Have you completed Level 1 Family Partnership Training?**

- Yes  
 No

**2. Have you completed Treaty of Waitangi Training?**

- Yes  
 No

**3. How long have you worked for Plunket?**

- < 1 year  
 1-2 years  
 3-5 years  
 6-10 years  
 11 years +

**2.**

**1. Communication**

	Not good	Could be better	Quite good	Very good
How would you rate your communication (verbal, non-verbal and written)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**2. Communication**

	Not well	Could be better	Quite well	Very well
How well do you communicate with Maori Plunket clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**3.**

**1. Decision Making**

	Not well	Could be better	Quite well	Very well
How well do you think you involve Maori parents / caregivers and / or whanau in decisions relating to their child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 2. Decision Making

	Rarely	Sometimes	Often	Always
How often do you make clinical decisions based mostly upon the client's needs and preferences (when working with Maori specifically)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 4.

### 1. Service

	Not easily	Could be better	Quite easily	Very easily
How easily do you make contact / engage with Maori Plunket clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### 2. Service

	Not well	Could be better	Quite well	Very well
How well do you think your service / practice meets the needs of Maori Plunket clients?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 5.

### 1. Can you describe some strategies you use to communicate effectively with Maori Plunket clients / whanau?

## 6. Qualities

**1. How important do you believe the following qualities are when working with Maori clients and whanau?**

**(please select one answer for each quality)**

	Not Important	Quite Important	Very Important	Essential
Humility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quiet Enthusiasm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Technical Knowledge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interpersonal and Emotional Attunement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal Integrity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**7. Skills**

**1. How would you rate yourself in the following communication skills with Maori Plunket clients / whanau?**

	Not good	OK	Good	Excellent
Attention/active listening	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prompting and exploration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empathic responding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enthusiasing and encouraging	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Enabling change in Ideas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Negotiating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**2. How confident are you in:**

	Not very confident	Moderately confident	Very confident
Working with Maori clients / whanau	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Participating in Maori health community initiatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Responding to the needs of Maori whanau and communities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**8. Treaty of Waitangi**

**1. In your opinion, how well do you (in your role as a Plunket Nurse) deliver on the principles of:**

	Not well	Moderately well	Above average	Very well
Partnership	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Protection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Participation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Equality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 9. Cultural Safety

**1. Can you describe briefly what 'cultural safety and responsiveness' means for your practice as a Plunket Nurse?**

## 10.

**1. Have you got any other comments to add regarding working with Maori clients / whanau in your role as a Plunket nurse?**

**APPENDIX XV – Observation Data**

<b>Communication Qualities</b>	<b>Mean Score out of 5</b>
Warmth	3.5
Listening skills	3.5
Humility	3.6
Appropriate confidence	3.4
Positive, open body language	3.6
Eye contact	3.9
Assertiveness	3.1
Enthusiasm	3.5
Genuineness	3.5
Non-judgemental	3.6
Non-threatening	3.9
Sense of humour	2.6
Appropriate sensitivity	3.8