WHAT ARE THE PERCEPTIONS OF NURSES WORKING IN CHILD HEALTH REGARDING THEIR ROLE IN CHILD PROTECTION?

A mixed method study

Master of Philosophy in Nursing
At Massey university New Zealand

Grace Ann Shallard
2019

Abstract

The global and national figures of child abuse and neglect are overwhelming and highlight an imminent need to focus on the well-being of tamariki[1]. Due to the long-lasting individual and societal impact of child abuse and neglect, it is a profoundly important health issue. Nurses are not only the largest group of health professionals, but they are typically at the forefront of health care and have a unique and significant ability not only to detect, but also to intervene in and prevent situations of child abuse and neglect. Despite their potential impact, they have rarely been the focus of investigation in this area, particularly in New Zealand. This thesis presents research undertaken to explore the current perceptions of nurses working in child health in regards to their role in child protection.

A mixed method study was conducted using a sequential explanatory (two-phase) design. These distinct stages comprised of a survey and subsequent, complementary interviews. The quantitative aspect of the design was conducted through a survey; there were 134 surveys included in the analysis and these data were used to inform the second phase which comprised of six complementary interviews. This qualitative aspect of the design drew on grounded theory approaches.

The main findings of this research can be divided into the following categories. *Eyes and ears*: nurses are regularly exposed to children who have experienced child abuse or neglect and are well positioned to detect abuse and neglect. *Hands*: Nurses engage in this sphere in a number of ways-including medically caring for children who have been abused or neglected, coordinating care, making referrals, and practically supporting in a wide variety of ways. *Head*: Despite most nurses having received training in this area, only half of nurses describe feeling confident to identify child maltreatment. Furthermore, although there are discrepancies in area, there is little standardisation of how nurses engage with this sphere. There are a number of both supports and barriers; the main barriers being lack of certainty and limited confidence in social services. *Heart*: Nurses experience deep and profound emotions when engaging in this sphere, which not only effects nurses personally, but also affects decision making and quality of care. *Gut*: Nurses rely on gut feelings to make decisions, an important and advanced way of knowing. Finally, it was clear, that nurses deeply care for the children they work with and the wellbeing of children is at the centre of all they do.

[1] *Children* in Māori

Acknowledgements

I would like to begin by acknowledging that without the support of friends, family, colleagues and university staff this research would not have been possible.

I would firstly like to thank my supervisor, Dr. Karen Hoare, Associate Professor and Postgraduate Director of Massey University. You have allowed me freedom in this learning process, while pointing me in the right direction when I needed it. You have been an encouragement, advocate and inspiration for me - not just in the academic world, but in the wider world of child health nursing. I am sincerely grateful and am honoured to be working with you.

To all of you who have showed interest, listened, encouraged, advised and encouraged, I thank you. To Dr. Nilo Atefi, thank you for all the help with statistics; you are such a delight. To Allie Fyfe, Dr. Carmen Basu, Linda Chalmers, Alice Lindsay, Bevan Erueti, Joanna Peterson, Sarah Little and Megan Bonisch - thank you for sharing your knowledge and time.

Particular thanks to all the participants – I am extremely grateful. It was a privilege to hear your stories and your passion for the wellbeing of children is evident and inspiring.

My Mosaic / Crave / KIND / Morningcidery / Morningside family. You guys are the best. I'm lucky to have such a great whanau. To Crave for all the coffees, to the couch crew for all the well needed distractions, and to little T for being my constant companion and reminding me how great it is to be a child, thank you.

To my parents, for your endless support in this arena and in every other I am eternally grateful. For your example, encouragement, proofreading skills, and kindness, thank you.

To my unwavering habibi, BFF and biggest support, Timothy Shallard. You are my favourite. Thanks for loving and encouraging me always.

Last, but not least - to the tamariki of New Zealand, you are the epitome of hope and you deserve all the safety and love in the world. I hope that we can live up to our potential as nurses, as individuals, and as a nation to ensure this.

Table of Contents

Chapter One

Introduction

'Children are our taonga[2] and, as such, should be loved and cared for in ways that support them to reach their greatest potential.' (Office of the Minister for Child Poverty Reduction & Office of the Minister for Children, 2018, p. 2).

Child abuse and neglect is a health and social issue affecting many people globally and in Aotearoa, New Zealand. New Zealand's rates of child abuse and neglect are some of the highest in the world, and, although affecting every demographic in society, persistently and disproportionately negatively impact those from a lower socio-economic background, and Māori and Pasifika children. Child abuse and neglect have long-lasting, wide-ranging health and well-being impacts which are likely to influence an individual throughout their life. The New Zealand Government ratified the United Nations Convention on the Rights of the Child (UNCRC) just over 25 years ago - establishing its commitment to fulfil the rights of all children and to ensure that children in New Zealand are not only healthy but are thriving. This study contributes to the ever-growing body of literature on child abuse and neglect by providing insight into the current nursing practices of those working in child health settings. It is aligned to the government and Ministry of Health priorities of improving child wellbeing (Ministry of Health, 2018), reducing the harm that family violence causes (Little & Logie, 2018), and reducing the number of assaults on children (Ministry of Social Development, 2014).

This chapter outlines the background of my interest in the topic, explore the scale of the problem in New Zealand, and summarise the effects of abuse and neglect. It will also delineate New Zealand's commitment to addressing these issues, associated legislation, and the current nursing role in this sphere. It will finish with some definitions and an outline of each chapter.

My Background

It is important that the reader understand who I am in order to understand the lens through which I view the world, and, in particular, this topic. For the first few years of my nursing career I worked in an emergency department, where I was exposed to issues of child

[2] A *treasure* or *something highly prized* in Māori

protection; later when I worked as a paediatric public health nurse working in low decile schools my interest in this area peaked. I was often confronted with issues of child protection and realised the enormity of the problem. It appeared to me that a large cohort of children and families were left unsupported- with needs too great for the threshold of one organisation yet too low for another. Services were siloed, with significant overlap between health, social, and education spheres, and no clear delineation as to who fulfils which roles. I found that as a nurse, I was in a unique and profoundly privileged position to gain insight into the lives of tamariki and whānau. This led me to ponder the role of nurses within this sphere- what are we currently doing, and how could we be better equipped to be more effective?

In doing research like this it is easy to dehumanise and view children and families as measurable and treatable damage. I am aware of this and want to do my utmost to steer away from this. I recognise that I come from a western view, often conceptually flawed when it comes to dealing with other cultures, and this can detract from addressing the deeper causes of child abuse.

The basic premises on which I based this research are:

- As New Zealanders, we care about the welfare of our children.
- Whānau and parents care for their children.
- There exists intrinsic racism within our overarching systems and structures, and I acknowledge the western world view through which I (and others) tend to approach this issue.
- Children are valuable, intelligent, and have a right to be heard.
- New Zealand is a small country with a correspondingly small amount of bureaucracy. Although we have a long way to go, change is possible within a relatively short space of time.
- The vast majority of children in New Zealand do not suffer from maltreatment, and live happy, fulfilled lives. I think this is important to remember.

My ideal is that this be a courageous research project, with the potential not only to benefit me and my knowledge, but to be part of a movement in New Zealand aiming to provide a future nation in which all children can achieve their full potential. I have sought to conduct this research in a way which avoids further damage or marginalisation in an already highly vulnerable group.

Child Abuse and Neglect in Aotearoa, New Zealand

Though it is very difficult to determine the prevalence of child neglect and abuse accurately (Taylor & Bradbury-Jones, 2015), a study conducted by Rouland And Vaithianathan (2018) found that 9.7% of New Zealand children had suffered substantiated neglect or abuse (emotional, physical and/or sexual), and that 23.5% had been the subject of at least one report to child protection services by the age of 17. There were 694 hospitalisations for injuries arising from maltreatment from 2012-2016, and 108 children (age 0-14 years) died from injuries arising from maltreatment within the 5 year period from 2010-2014 (Duncanson et al., 2017). According to Duncanson et al., (2017, p. 52) hospitalised cases are only the 'tip of the iceberg', and data on hospitalisation rates alone grossly underestimate the prevalence of child abuse and neglect in the community. To put this into perspective, the accumulated prevalence of substantiated maltreatment is at least comparable to the prevalence of obesity, and the cumulative incidence of child protection notifications is 1.4 times higher than the incidence of medicated asthma (Rouland & Vaithianathan, 2018).

The latest Innocenti Report Card 14 by UNICEF (2017) reported NZ as having the 7th highest rate of child homicides at 0.78 child homicides per 100,000 in 2010; five times the rate of Sweden (Duncanson et al., 2017). In this same report, New Zealand ranked 38th out of 41 EU/OECD countries for overall child health and well-being, and in the bottom three to 'ensure healthy lives and promote wellbeing for all at all ages' (p. 20). The concluding observations of the United Nations Committee on the Rights of the Child (2016) noted serious concerns in a number of areas, in particular the area of violence- family violence, abuse and neglect. Not only does this have immeasurable health, social and emotional cost, the financial cost of child abuse for the country has been estimated at $2 billion annually (Dalley, 2018).

There are significant limitations when it comes to measuring the prevalence of child maltreatment. Within hospital data, there are limitations such as undercounting injuries and potential reporting bias: children perceived to be at risk are more likely to be included in the statistics for child maltreatment (Duncanson et al., 2017). Findings are also dependent on substantiation practices specific to New Zealand, which may lead to further bias in comparing data (Fanslow & Kelly, 2016; Rouland & Vaithianathan, 2018).

Child abuse and neglect occur across economic, social and ethnic groups (Saltmarsh & Wilson, 2017). However, there is a clear social and ethnic disparity. Child maltreatment is more likely to affect children growing up in poverty. According to UNICEF (2017), 19.8% of children in New Zealand live in relative income poverty. The NZDep13 estimates the relative

socioeconomic deprivation of an area. It combines census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and communications. Children living in the highest NZDep2013 scores were eight times more likely to be hospitalised due to assault, neglect or maltreatment than their counterparts living in areas with the lowest scores (Duncanson et al., 2017). There is also a clear disparity by ethnicity - with Māori and Pacific children overrepresented in statistics of child abuse and neglect. The NZ Family Violence Death Review Committee (2014) reported that Māori and Pacific children were 5.5 times and 4.8 times (respectively) more likely than other children in New Zealand to be victims of child abuse homicide. Hospitalisations due to assault, neglect or maltreatment were over twice the rates of other children (Duncanson et al., 2017). Despite making up only 28% of the child population, 60% of children in care in 2015 are Māori (Expert Panel- Modernising Child Youth and Family, 2015). It is important to note that within traditional Māori society, violence within the whānau was not the norm nor tolerated (Pihama et al., 2003 in (Ministry of Health, 2016a). This over-representation may be due to higher levels of deprivation, bias in the system (both unconscious and conscious), and a lack of culturally appropriate models (Expert Panel- Modernising Child Youth and Family, 2015; Ministry of Health, 2016a). Furthermore, it is important to note that changes to New Zealand society since colonisation significantly impacted whānau relationships, distancing Māori whānau from support and fragmenting Māori values (Ministry of Health, 2016a). This research will not take a victim-blaming or cultural-deficit approach, but instead will view wider society as the contributor to Māori and Pacific health disparities. It is also important to note that the knowledge of this disparity does not add diagnostic utility when providing care, as prevalence of violence is high across all demographics (Fanslow & Kelly, 2016).

It is also important to recognise the frequent co-occurrence of intimate partner violence with situations of child abuse; between 20-60% of families experiencing one of these experience the other (Fanslow & Kelly, 2016). Of note, women in New Zealand experienced the highest rate of intimate partner violence in the years 2000-2010 of any women in the OECD countries (Wilson, Smith, Tolmie, & de Haan, 2015). These issues should not be addressed in isolation as they are entangled forms of family violence (Family Violence Death Review Committee, 2016).

Given these statistics, and the performance of the current system as measured by outcomes, it is unsurprising that child maltreatment is an intensely political issue, raising challenging questions around how New Zealand's systems are resourced and organised.

Long term sequelae of child abuse and neglect

Child abuse and neglect have long lasting individual and societal effects. The knowledge of both acute and long-term health consequences of adverse childhood events – particularly violence and trauma - continues to increase (Fanslow & Kelly, 2016). The correlation between adverse childhood events and poorer health and quality of life throughout the lifespan is unequivocal. Converging evidence from both epidemiology and neurobiology suggests that these experiences cause enduring brain dysfunction (Anda et al., 2006), the effects of which are far-reaching. These effects are cumulative, and for some, start prior to birth (Family Violence Death Review Committee, 2016). There is a strong correlation with not only acute injuries, but also mental health, sexual health, the risk of chronic disease (see table 1) (Fanslow & Kelly, 2016) and cognitive, socio-emotional and behavioural development (Hildyard & Wolfe, 2002). In any given year, 5-10% of children in New Zealand are exposed to violence by one adult toward another (T. Clark et al., 2013). Exposure to observed abuse and violence leads to outcomes and symptoms which resemble those in direct victims of violence. There is particularly strong correlation with substance abuse, depression and trauma-related symptoms (Fanslow & Kelly, 2016), hence it is viewed as a form of emotional abuse (Family Violence Death Review Committee, 2016).

Table 1. Consequences of child abuse

Physical	Abdominal/thoracic injuries
	Bruises and welts
	Burns and scalds
	Disability
	Fractures
	Head injuries
	Lacerations and abrasions
	Ocular damage
	Other neurodevelopmental problems*
Sexual and reproductive	Reproductive health problems
	Sexual dysfunction
	Sexually transmitted diseases, including HIV/AIDS
	Unwanted pregnancy
Psychological and behavioural	Alcohol and drug abuse
	Cognitive impairment
	Delinquent, violent and other risk-taking behaviour
	Depression and anxiety
	Developmental delays
	Eating and sleep disorders
	Feelings of shame and guilt

	Hyperactivity
	Poor relationships
	Poor school performance
	Poor self-esteem
	Post-traumatic stress disorder
	Psychosomatic disorders
	Suicidal behaviour and self-harm
Other longer-term health consequences	Cancer
	Chronic lung disease
	Fibromyalgia
	Irritable bowel syndrome
	Ischaemic heart disease
	Liver disease
Other consequences	Reduced educational attainment and annual earnings**

Source: (Ministry of Health, 2016a)

Current literature is unequivocal in its conclusion that abuse and neglect have severe, deleterious short- and long-term effects in every area of a child and young person's development, health and well-being. The implied public health burden given the statistics and prevalence as outlined above is immense; as such, child abuse and neglect is a profoundly important health issue. Despite the health system carrying this enormous long-term cost, adverse childhood events have thus far been largely in the sphere of the social services, with the health system contributing very little specific resource into interventions.

Legislation

The United Nations Convention on the Rights of the Child (UNCROC) (United Nations, 1989) was conceived at the UN Summit for Children in 1989 and is the most widely ratified international human rights treaty in history (UNICEF, 2018b). The purpose of the document was to guarantee a range of rights which apply to all children aged 0-18, regardless of gender, ethnicity or religion, and to determine the responsibilities of governments to ensure those rights were met. These rights are based on what children need in order to survive, participate, grow, and reach their potential (UNICEF, 2018a). The four fundamental principles include non-discrimination (article 2), the best interest of the child (article 3), ensuring the child's survival and development (article 6) and participation (article 12) (The UN Convention on the Rights of the Child Monitoring Group, 2017). New Zealand ratified the United Nations Convention on the Rights of the child in 1993; in doing so the government of New Zealand

agreed to respect, fulfil, promote and protect the rights of children in New Zealand (The UN Convention on the Rights of the Child Monitoring Group, 2017).

Not only are the areas of child maltreatment and neglect addressed by all the fundamental principles of UNCROC, the treaty specifically recognises that children have the right to grow and develop in an environment free from abuse and neglect. According to the Fifth Periodic Report by the New Zealand Government on the UNCROC, 'the elimination of all forms of violence against children is a priority for New Zealand…' (Ministry of Social Development, 2015, p. 29). New Zealand is also unique in its commitment to Te Tirito o Waitangi, which underpins the delivery of all health services to Māori. Te Tiriti o Waitaingi (The Treaty of Waitangi), signed in 1840 between Māori and the Crown, outlines the Crown's obligation to safeguard the rights and interests of Māori (Wilson, 2013), and consequently outlines New Zealand's commitment to ensure that all children have equal rights and opportunities.

Action for Children and Youth Aotearoa (2017) note that although there has been a 'discernible shift in the government's attitude towards children's rights to participate in decision making' (p. 3), there is a significant group of children whose experience growing up in New Zealand is 'shocking'. During New Zealand's last Universal Periodic Review (a quinquennial report for member countries of the United Nations), key children's rights issues where New Zealand is not upholding their commitment to the UNCROC were raised - namely child poverty, discrimination against Māori and Pacific children, and the widespread effect of child abuse and domestic violence (Action for Children and Youth Aotearoa, 2017). It is not only in New Zealand's best interests to investigate this topic, it is New Zealand's duty to honour its commitment to do so.

There has been a resurgence of national focus on child wellbeing with the recent change in government, and the current government is demonstrating significant political commitment to promotion and improvement of child well-being. It has explicitly stated that it is focused on 'making the changes needed to help New Zealand become the best place in the world to be a child' (Ardern, 2018).

Efforts so far which have demonstrated a country-wide commitment to this goal include a number of high-level cross-department government collaboration groups and a number of cross-agency groups (Fanslow & Kelly, 2016). The first Child and Youth Wellbeing Strategy, aims to set the direction for how to improve the wellbeing of children and young people in New Zealand. This Strategy aims to improve the wellbeing of all children. It is explicitly stated that children's wellbeing encompasses safety, that children not only are safe but also feel safe.

There has been other significant legalisation in the past decade. In 2014 the Vulnerable Children's Act, along with the supporting Children's Action Plan (Ministry of Social Development, 2012), made broad changes to protect 'vulnerable' children. The heads of six government departments were made accountable for both protecting and improving the lives of 'vulnerable' children in a focus on working together. This also required organisations working with children to implement child protection policies and systems for reporting, with new obligations for screening and vetting processes for every person in central and local government children's workforce. The Children's Action plan and the White Paper for Vulnerable children also highlighted the need for legislation around mandatory training in recognising the signs of child abuse. Of note, unlike many comparable countries, New Zealand does not have mandatory reporting, an area sparking much debate as to whether the risks of this outweigh the benefits (Donald, 2012; Goodyear-Smith, 2012).

Nursing within Child Care and Protection

In 2016, the World Health Organisation identified nurses as having a vital role in the prevention of child abuse (World Health Organisation, 2016). They are in frequent contact with children and families, are often the first to identify when a family is under stress, and are able to pick up worrying patterns of behaviour (for example multiple visits to hospitals) (El-Radhi, 2015). They are the largest group of health professionals, have professional accountability, and provide a universal service; hence they are well positioned to detect child abuse and to support children and families (Wilson, Gonzalez-Guarda, & Campbell, 2017). Of the 37 children who were killed as a result of maltreatment and neglect between 2009-2012, only 46% of them were known to Child Youth and Family services (Family Violence Death Review Committee, 2014); it is likely that a much higher percentage would have been in contact with the health services at some point (Wilson et al., 2017). It has also been noted that there is a higher prevalence of violent victimisation within those accessing health care compared with the overall population (Koziol-McLain, Gardiner, Batty, Ramika, & Fyfe, 2004). Nurses' actions can contribute to optimising the safety of a child and possibly to reducing the detrimental health effects of unsafe environments (Wilson et al., 2017).

Both in New Zealand and internationally, reports published in this area have a strong focus on the role of the social worker to the exclusion of other professionals (Hanafin, 2013). Little is known, particularly in New Zealand, about how nurses experience their role in child protection and the challenges within this. It is only recently that a few reviews have been carried out internationally to investigate nurses' roles and experiences in keeping children

safe, as well as what nurses do to achieve this (L Lines, Grant, & Hutton, 2018; L. Lines, Hutton, & Grant, 2016).

One integrative review of studies exploring nurses' roles and experiences in keeping children safe (L. Lines et al., 2016) found that nurses perceived in themselves a lack of confidence and knowledge to effectively respond to child abuse and neglect; that they rely on other professionals to guide them in their response; and that there was a lack of confidence in and dissatisfaction with child protection services. It also highlighted the tensions nurses perceive between their roles in caring and surveillance. Although this research about nurses' involvement in child protection is helpful, it has not been replicated in New Zealand. There are significant limits of transferability due to different legislation and context.

Given the possible impact of nurses in reducing rates of child abuse and neglect in Aotearoa, this area deserves investigation. According to Wilson, et al., (2017, p. 2098), '…the important role nurses […] have in identifying those affected by abuse and violence occurring in families cannot be under-estimated. […] It is time to reconsider the approaches nurses can take in this area of health care'. The role of the nursing profession must be clearly articulated and developed in line with best practice to ensure children are protected and given every opportunity to thrive.

Definitions

As there are no universally agreed definitions, the following terms used in this study are defined.

According to the Oranga Tamariki Act (1989, p. 25), child abuse 'means the harming (whether physically, emotionally, or sexually), ill-treatment, abuse, neglect or deprivation of any child or young person.'

Physical abuse is any act or acts which result in a physical injury to a child or young person. This may involve hitting, burning, shaking, drowning or any deliberate use of physical force which results in (or increases the likelihood of) harm (Ministry of Health, 2016a; National Institute for Health and Care Excellence, 2009).

Emotional abuse is the persistent emotional maltreatment of a child or young person; it includes any act or omission which results in impaired psychological, social, intellectual, and/or emotional functioning and development (Ministry of Health, 2016a; National Institute for Health and Care Excellence, 2009).

Sexual abuse involves either enticing or forcing a child or young person to take part in sexual activities (irrespective of whether they are aware of what is happening). This includes both physical contact and non-contact activities (such as involving children watching sexual activities or encouraging children to behave sexually) (Ministry of Health, 2016a; National Institute for Health and Care Excellence, 2009).

Neglect is the persistent failure to meet the child or young person's basic physical or psychological needs that is likely to result in the serious impairment of their health or development. This may or may not be deliberate. For example, failure to provide adequate food or shelter for a child, or failure to ensure access to appropriate medical care (Ministry of Health, 2016a; National Institute for Health and Care Excellence, 2009).

A child is a 'person under the age of 14 years' ("Oranga Tamariki Act 1989," 1989, p. 25) and a young person is 'of or over the age of 14 years but under the age of 18 years' ("Oranga Tamariki Act 1989," 1989, p. 29), however (and despite the distinct differences between these age groups) this study will refer to a child as a person under 18 years old for the sake of simplicity and as this consistent with the UNCRC's definition of a child (United Nations, 1989).

Research Question and Study Aim

Aim

To explore paediatric nurses' perceptions of their roles and responsibilities in child maltreatment

Objectives

The following areas were explored to uncover this:

1. What actions nurses currently take when caring for children who have been maltreated
2. What paediatric nurses perceive to be their role within child protection
3. What are the supports and barriers for nurses to report child maltreatment

This research aims to provide a baseline understanding of current practice within paediatric nurses in the area of child protection. It serves as baseline data for further study on the role of nurses in protecting children, with the ultimate aim of delineating a more defined role for paediatric nurses in child protection and setting a standard for this nationally.

Chapter overviews

Chapter One has introduced my personal interest and reason for doing this research. Some aspects of the background to this research were also introduced.

Chapter Two reviews and critiques the literature around the emotions which nurses experience when dealing with child abuse and neglect.

Chapter Three outlines the underlying methodology and research design.

The results of the study are presented in Chapter Four.

The conclusion of this thesis is outlined in Chapter Six. It presents the key areas of research and presents recommendations for practice and further research.

Chapter 2

A review of the literature

'Our affective dispositions define our sense of reality and value.' (Furtak, 2018, p. 159)

Introduction

A literature review serves several purposes- not only does is inform the reader of other similar studies, but it also serves to put a new study in the context of a larger, ongoing dialogue (DePoy & Gitlin, 2016). I had planned a review of all the literature examining nursing roles in child protection; however, after starting to delve into this literature I came across a recent integrative review which looked at nurses' roles and experiences in keeping children safe (L. Lines et al., 2016). I quickly realised however, that despite the increase in literature around the nursing role in this area, it continues to focus on the practicalities as opposed to the emotional response and support needs of those involved (Rowse, 2009b). On further exploration, and in discussion with my supervisor, I recognised how crucial it is that the emotional nature of this work be taken into consideration in order to provide an effective and sustainable service. Therefore, I amended the focus to a review of nurses' emotional responses to child abuse and neglect within their work places.

Child abuse and neglect is a highly emotive topic, as mistreating children deeply offends contemporary moral and ethical code. Caring for children who have been abused can have long lasting effects on individuals, influencing their personal lives as well as their professional ones (Rowse, 2009b). One study found that from a list of stressful critical incidents, sexual abuse, death and nonaccidental injury of a child ranked one, two and four respectively (O'Connor & Jeavons, 2003). Instead of presenting a wider overview of all the literature referring to the nursing role in child maltreatment, this literature review explores the literature in relation to the emotions nurses experience when interacting with children who have been abused and/or neglected.

There is much controversy as to what constitutes emotion. This chapter does not have the scope to enter into the intricacies of the debate of cognitive and bodily aspects of emotion, but will rely on Furtak (2018, p. 3) definition of emotion: 'experiences through which we can apprehend important truths about ourselves and about the world'. From a physiological point of view, emotions are associated with somatic nervous system activity, and electrical and chemical changes in the brain. Emotions are also 'mental states directed toward the world…

whether we conceive of them as appraisals, evaluative judgments, perceptual feelings, or experiences with intentional content which are best described in some other terms' (Furtak, 2018, p. 5). Paul Ekman, noted psychologist and researcher best known for his work in studying emotion, proposed a list of basic emotions ("Award for Distinguished Scientific Contributions: Paul Ekman," 1992; Ekman, 1992). He lists the basic emotions as fear, anger, sadness, disgust, happiness, surprise and contempt (Price, 2010).

Aim of the review

To identify nurses' emotions and emotional responses in response to child abuse and neglect within their work places.

Design

An integrative review was conducted using some elements of Whittemore and Knafl (2005) framework. Elements of this method were chosen as they allow for the combination of diverse methodologies - both experimental and non-experimental. Integrative reviews are the broadest type of research review method, allowing for a more comprehensive understanding of a specific phenomenon. Bias is reduced and accuracy increased by using systematic and explicit methods (Whittemore & Knafl, 2005).

Search Methods

Databases Pubmed, CINAHL, Scopus, Cochrane, UpToDate were searched between June-August 2018. As recommended (Whittemore & Knafl, 2005), a number of approaches to searching literature were undertaken in order to be more comprehensive. These included appraisal of the references of the included studies. Search terms were as follows: 'nurs* (nurse, nursing, nurses)', 'child abuse', 'child neglect', 'child maltreatment', 'safeguarding'. The search was restricted to studies published within the past 10 years (2008-2018) and written in English (see Table 2.)

Search outcome

Titles and abstracts of articles resulting from the initial search were screened for relevance according to the inclusion/exclusion criteria (see table 2). Once this was completed, I read the full text in order to confirm eligibility. Scanning of reference lists identified a number of

additional studies. The eligibility of those papers which were deemed to fit these criteria were discussed with my supervisor. Overall, 45 studies were found to have met the inclusion criteria and are included in this review.

Table 2. Inclusion and exclusion criteria

Criteria focus	Inclusion	Exclusion	Comments
Document type	Peer-reviewed articles with full text available		Relevance, credibility and accessibility
Research methods	Primary research	None	
Time	2008-current	Before 2008	Up-to-date
Professional group	Includes (though not necessarily exclusively) registered nurses who specifically work with children- including nurse practitioners and nurse specialists	Research solely focused on health visitors, or nurses whose primary aim was caring for adults	Specialty nurses with a different defined role (we don't have health visitors in a NZ context)
Intervention terms	Child protection, safeguarding, child abuse, child neglect, child maltreatment, domestic violence, children and families, nurses, nurse, nursing		
Topic	Addressed the role of nurses in child protection		
Language	English	Studies written in a language other than English	Ability to understand, with and no guarantee of accurate translation

Table 3. Flow diagram of study selection (according to the PRISMA Statement) (Page & Moher, 2017).

Potentially relevant articles identified (n = 2,789)
Limiting search (n = 134)
Remaining after reading abstract/ duplicates removed (n = 36)
Studies included from hand searching (n = 8)
Total studies included in the review (n = 45)

Table 4. Summary of included studies

Study	Aim	Method and sample	Major findings- comment on emotions
Aragão, Ferriani, Vendruscollo, Souza, and Gomes (2013) Brazil	To analyse how cases of violence against adolescents and children are approached by primary care nurses	Qualitative; semi-structured interviews with nurses in Family Health teams (n=8)	Helpless; fear; indecisive
Ben Natan, Faour, Naamhah, Grinberg, and Klein-Kremer (2012) Israel	To examine whether the theory of planned behaviour succeeds in predicting nursing and medical staff reporting of suspected child abuse	Quantitative; Descriptive, correlational, cross-sectional survey of nursing and medical staff in a hospital and community centre (n=185, 143 nurses)	-
Ben Yehuda, Attar-Schwartz, Ziv, Jedwab, and Benbenishty (2010) Israel	To study Israeli health professionals' experiences with identification and reporting of suspected cases of child abuse and neglect, and their perceived training needs related to this	Quantitative; anonymous structured questionnaire, (n= 95, nurses n=28)	-
Borimnejad and Fomani (2015) Iran	To explore Iranian nurses' experiences of and barriers to reporting child abuse	Qualitative; semi-structured interviews with nurses who had cared for abused children (n=16)	Uncertainty; guilt; outrage; apprehensive; fear
Browne, Doane, Reimer, MacLeod, and McLellan (2010) Canada	To report on how public health nurses use relational approaches in their work with 'high priority' families.	Qualitative; Interviews and focus groups with public health nurses (n= 32), home visitors (n=3), caregivers (n=20)	-
Chen, Huang, Lu, and Feng (2015) Taiwan	To examine aspects of competency in child abuse among community nurses	Quantitative; Cross-sectional study, structured questionnaire (n=588)	-
Dahlbo, Jakobsson, and Lundqvist (2017) Sweden	To describe child healthcare nurses' experiences when encountering families in which child maltreatment was identified or suspected	Qualitative; Individual open interviews, qualitative (n=8)	Gut feeling; uncertainty; concerned; stressed
D Davidov, Nadorff, Jack, and Coben (2012b);	To examine nurse home visitors' perspectives of, attitudes towards, awareness and intentions to report children's exposure to intimate partner violence in the context of the home visitation setting	Quantitative; Web-based questionnaire, cross-sectional study (n=532)	Uncertainty

D Davidov, Nadorff, Jack, and Coben (2012a); D Davidov and Jack (2014) USA			
D Davidov, Jack, Frost, and Coben (2012) USA	To highlight participants' perceptions about mandatory reporting of IPV and reporting of children's exposure to IPV.	Qualitative; A secondary analysis of qualitative data phase from above study was undertaken. Semi-structured interviews (n=43)	-
Eisbach and Driessnack (2010) USA	To explore the process of mandated reporting of child maltreatment by paediatric nurses	Qualitative; grounded theory, interviews with school nurses and paediatric nurse practitioners (n=23)	Uncertainty; comfortable; hesitant; fear; frustration; secure; concerned
Feng, Fetzer, Chen, Yeh, and Huang (2010) Taiwan	To explore the perspectives and experiences of professionals working with other disciplines when reporting child abuse	Qualitative; grounded theory, interviews (n=21, nurses: n=5)	Fear; heavy, slippery, not easy [burden]; safe; concerned
Finn (2011) USA	To describe forensic nurses' perceptions of receiving disclosures of child abuse	Qualitative; interviews, narrative analysis, purposeful sampling strategy of nurses in ED, clinics, schools, and forensic settings (n=30)	-
Flemington and Fraser (2016) Australia	To examine the intensity and duration of maternal involvement in a nurse home visiting programme to prevent child maltreatment	Quantitative; A retrospective, longitudinal design (n=40)	-
Francis et al. (2012) Australia	To explore how mandated professionals in rural Australia identify children at risk and their subsequent decisions	Qualitative; Interviews, exploratory descriptive study, grounded theory (n=17, nurses: n=7)	Guilt; unsupported; disappointed; fear; remorseful; uncertain; stressed
Hackett (2013) Scotland	To explore school nurses' perceptions of their role in child protection and to identify training needs	Qualitative; semi-structured interviews with school nurses, purposive sampling (n=6)	Confusion
Herendeen, Blevins, Anson, and Smith (2014) USA	To examine the experience of paediatric nurse practitioners in the identification and management of child abuse, determine the frequency of their reporting, and describe the effects, attitudes, and confidence in reporting child abuse	Quantitative; Online survey of paediatric nurse practitioners (n= 604)	Confidence

Ho and Gross (2015) USA	To examine paediatric nurses' views on acceptable versus unacceptable discipline behaviours	Quantitative; Q methodology, quantitative, hospital-based paediatric nurses (n=48)	Confidence
Hornor et al. (2017) USA	To describe paediatric nurse practitioner practice behaviour related to screening and providing anticipatory guidance for child maltreatment and its psychosocial risk factors	Quantitative; survey, paediatric nurse practitioners (n=243)	Lack of comfort
Hornor and Herendeen (2014) USA	To describe the practice characteristics of advanced practice nurses who care for maltreated children	Quantitative; a descriptive design, survey (n=136)	-
Jordan, MacKay, and Woods (2017) USA	To examine the effectiveness of an educational intervention program for school nurses regarding children at risk of maltreatment, and discover issues surrounding this	Mixed methodology; Education intervention, focus groups (n=174)	Fear
Kent, Dowling, and Byrne (2011) Ireland	To explore the views of public health nurses regarding their role with pre-school children	Qualitative; interviews with public health nurses (n=10)	Confusion; unease; uncomfortable; frustrated; enthusiastic
Koetting, Fitzpatrick, Lewin, and Kilanowski (2012) USA	To describe the knowledge level of nurse practitioners regarding symptoms of child sexual abuse in children with cognitive disabilities	Quantitative; questionnaire of family and paediatric NPs (n=43)	-
Kraft and Eriksson (2015) Sweden	To explore how school nurses detect child abuse and initiate support measures	Qualitative; grounded theory approach, focus group interviews (n=23)	Intuition; concerned; fear; frustration; discomfort; despair; anger; guilt; distraught; discomfort; uncertain
Engh Kraft, Rahm, and Eriksson (2017) Sweden	To explore the ability of school nurses to detect and support sexually abused children	Qualitative; Secondary analysis of above study, grounded theory approach, focus group interviews (n=23)	Ambivalent; uncertainty; vulnerable; uneasy; concerned; gut feeling; powerless; alone; shame
Land and Barclay (2008) Australia	To explore nurses' perceptions of their role in protection children and to identify any barriers to implementing this role	Qualitative; semi-structured, open ended questions, qualitative, purposive sampling (n=10)	Felt constrained; frustration; uneasy; unhappy; fear; apprehensive; vulnerable; concerned

Lavigne, Portwood, Warren-Findlow, and Brunner Huber (2017) USA	To explore the perceptions of child maltreatment among inpatient paediatric nurses	Quantitative; online cross-sectional survey (n=80)	Fear; lack of confidence; confident
E. Louwers et al. (2012) The Netherlands	To investigate whether introducing screening and training of emergency department nurses increases the detection rate of child abuse.	Quantitative; Intervention cohort study, quantitative (n= 104,028 children visiting emergency departments)	-
Louwers, Korfage, Affourtit, De Koning, and Moll (2012) The Netherlands	To identify facilitators of, and barriers to, screening for child abuse in emergency departments	Qualitative; semi-structured interviews (n=27, nurses n=6)	-
Matthews et al. (2008) Fraser, Mathews, Walsh, Chen, and Dunne (2010) Australia	To examine the relationship between nurse characteristics, training, knowledge of legislative reporting duty and attitudinal factors on the reporting by nurses of different types of child abuse and neglect	Quantitative; cross sectional survey (n=930)	Fear; lacking faith; uncertainty
Maul et al. (2018) Pakistan	To explore the challenges that health care professionals face when managing cases of abuse, to explore cultural beliefs and how these shape practice and to identify training needs	Qualitative; phenomenological design, in-depth interviews (n=15, some nurses but unsure how many of the 15)	Confusion; fear; anxiety; disgust; confidence
Moreira, Vasconcelos, Marques, and Vieira (2013) Brazil	To analyse training and knowledge of professionals in the Family Health Team on reporting the mistreatment of children and adolescents	Quantitative; Cross-sectional questionnaire, (n=51, nurses= 26)	-
Murphy-Oikonen, Brownlee, Montelpare, and Gerlach (2010) Canada	To explore the experience of NICU nurses in caring for infants with neonatal abstinence syndrome	Qualitative, open-ended questions using computer-assisted personal interviews (n=14)	Frustration; burnout; dissatisfaction; internal conflict; sad; taxing emotionally; empathy; worried; disheartened; stressed; upsetting; anxiety; disappointed; angry
Pabis, Wronska, Slusarska, and Cuber (2011)	To evaluate paediatric nurses' assessment and diagnostic skills and interventions used for child maltreatment	Quantitative; descriptive, cross-sectional questionnaire (n= 160)	-

Poland			
Pakiş, Demir, Altun, and Yildirim (2015) Turkey	To evaluate the knowledge, awareness and actual professional experience of health professionals regarding child abuse and neglect	Quantitative; Descriptive study, anonymous, structured questionnaire (n=471, n= 333 nurses)	-
Raman, Holdgate, and Torrens (2012) Australia	To examine and compare child protection knowledge, confidence and practice of frontline clinicians	Quantitative; survey of nurses and doctors working in General Practices and Emergency Departments (n=113, nurses= 35)	-
Reijnders, Giannakopoulos, and de Bruin (2008) The Netherlands	To investigate whether emergency room physicians and nurses, forensic physicians, and interns are competent in describing, recognising and determining the possible cause of abuse related injuries	Quantitative; surveys of ED physicians and nurses, forensic physicians and interns (n=364, nurses n=84)	-
Rolim, Moreira, Gondim, Paz, and Vieira (2014) Brazil	To analyse the factors associated with the underreporting on the part of nurses within primary health care of abuse against children and adolescents	Quantitative; Cross-sectional study of nurses working within primary health care (n=616)	
Rowse (2009a) Rowse (2009b) England	To explore the views and feelings of nurses (and midwives) who had been involved in child protection cases; to discover their support needs and suggests developments in training and support	Qualitative; individual semi-structured interviews, an interpretive phenomenological approach, (n= 15, n=13 nurses)	Anxious; uncertain; gut feeling; hideous; horrific; horrible; shock; distress; stressful; frustrated; angry; sad; scary; tragic; traumatic; anxious; intimidated; self-confident; lack of confidence; self-doubt; unprepared; vulnerable; isolated; victimized; betrayed; abandoned; empathetic
Saltmarsh and Wilson (2017) New Zealand	To explore the processes neonatal intensive care nurses used in their child protection role with preterm infants	Qualitative; Glaserian grounded theory, semi-structured interviews with neonatal intensive care nurses purposive sampling (n=10)	Helpless; intuition; frustration; angry; sad; fear; valuable; ambivalent
Sathiadas, Arunath, and Karunya (2018)	To assess knowledge and attitudes towards and previous experiences of child protection	Quantitative; descriptive analytical study, self-administered questionnaire (n= 246, nurses: n=59)	Confident; uncertainty; fear; anxiety; satisfaction; traumatic
Schols, de Ruiter, and Öry (2013) The Netherlands	To investigate frontline workers' child abuse detection and reporting behaviours	Qualitative; focus group interviews (n= 37, 11 public health nurses)	Gut feeling; dissatisfied; fear

Skarsaune and Bondas (2015) Norway	To describe nurse's experiences when they had suspected child abuse in their encounters with children and their families In various health care contexts	Qualitative; individual interviews, descriptive exploratory (n=8)	Doubt; fear; uncertainty; anxiety; gut feeling; insecurity; powerful; frustrated; abandoned;
Thamlikitkul, Yunibhand, and Chaiyawat (2009) Thailand	To explore and understand the nursing practice processes of psychiatric nurses for school-aged sexually abused children admitted to psychiatric wards	Qualitative; Grounded theory, in-depth interviews (n=12)	'Severe symptoms'; 'negative moods'; anger
Tingberg, Bredlöv, and Ygge (2008) Sweden	To identify nurses' experiences in the clinical care of children experiencing abuse- in particular when the suspected perpetrator is present	Qualitative; interviews of nurses who cared for abused children and their parents (n=11).	Hateful; empathy; discomfort; fear; deceived; unhappy; uncertainty; compassionate; disgust
Visscher and van Stel (2017) The Netherlands	To explore practice variation amongst child healthcare professionals in prevention of child maltreatment	Mixed methodology; qualitative- interviews (n=11, nurses n=3), quantitative – survey (n=1104, nurses n=772)	Fear

Data abstraction and synthesis

The studies meeting the inclusion criteria were read in detail, in particular focusing on any emotions mentioned. These documented emotions were highlighted and coded using QSR International's NVivo 12 qualitative data analysis software. The constructed themes relating to emotions were then discussed with my supervisor, considered and refined.

Results

45 studies satisfied the inclusion criteria. The origin of these studies covered a range of continents Australasia (n = 8), Europe (n = 13), North America (n = 14), Asia (n = 4), the Middle East (n = 3), and South America (n = 3); most of these studies were located in developed countries (n = 31). Many focused exclusively on the nursing profession (n = 27). A variety of settings were investigated including a hospital setting (n = 13), public health or community setting (n = 11), schools (n = 4), a mixture of settings (n = 8) or another/unidentified setting (n = 8).

The first four of Paul Ekman's list of basic emotions are clear themes which emerge throughout the literature around child maltreatment - fear, anger, sadness and disgust (Price, 2010). Each of these will be discussed, along with the emotion of confusion (which although not one of Paul Ekman's basic emotions, was the most common 'emotion' which arose, therefore deserves to be considered). 'Gut feeling', a phenomenon that initiates a sudden sense of anxiety and alarm, was also included in this review due to its prevalence throughout the literature searched.

Confusion

Confusion emerged as the most common theme from the literature; it was mentioned in more articles than any other emotion (Borimnejad & Fomani, 2015; Dahlbo et al., 2017; D Davidov, Nadorff, et al., 2012b; Eisbach & Driessnack, 2010; Engh Kraft et al., 2017; Francis et al., 2012; Hackett, 2013; Kent et al., 2011; Kraft & Eriksson, 2015; Land & Barclay, 2008; Lavigne et al., 2017; Matthews et al., 2008; Maul et al., 2018; Murphy-Oikonen et al., 2010; Rowse, 2009a; Saltmarsh & Wilson, 2017; Skarsaune & Bondas, 2015; Tingberg et al., 2008). It is important to note that descriptions such as feeling uncertain, ambivalent and conflicted were included under the umbrella of 'confusion'.

Nurses felt confused about their role (Hackett, 2013; Kent et al., 2011), about how to prioritise (Kent et al., 2011), how to detect child abuse and neglect (Engh Kraft et al., 2017; Land & Barclay, 2008), and, most commonly, how to deal with situations when they arose (Dahlbo et al., 2017; Engh Kraft et al., 2017; Kraft & Eriksson, 2015; Matthews et al., 2008; Rowse, 2009a; Skarsaune & Bondas, 2015; Tingberg et al., 2008). ' The nurses… were aware of their responsibility to report cases of child abuse - but felt very uncertain of how to judge the situation' (Tingberg et al., 2008, p. 2722); 'Uncertainty… haunted the nurses' (Skarsaune

& Bondas, 2015, p. 24). In the study by Maul et al. (2018, p. 53) there was confusion 'as to whether there [was] a hospital guideline'.

Having conflicting emotions were described: '…feelings of hate for the abuser while simultaneously feeling empathy for the child's family circumstances…' (Tingberg et al., 2008, p. 2720), in addition to balancing conflicting roles: 'nurses were unhappy in their conflicting roles of both policing and nursing… I'm thrown into the role of security guard, police, judge and caregiver…all rolled into one and in reality not really knowing how to react' (Tingberg et al., 2008, p. 2721). This confusion and uncertainty contributed to nurses thinking of families outside of work, and having a hard time 'switching off' (Dahlbo et al., 2017).

Fear

Fear is a major theme which arose in almost half of the articles. In particular, nurses described fear of personal recrimination when reporting a concern (Borimnejad & Fomani, 2015; Eisbach & Driessnack, 2010; Feng et al., 2010; Francis et al., 2012; Fraser et al., 2010; Jordan et al., 2017; Land & Barclay, 2008; Matthews et al., 2008; Maul et al., 2018; Saltmarsh & Wilson, 2017; Skarsaune & Bondas, 2015; Visscher & van Stel, 2017); 'I'm frightened that if they find out, I'm the one who brought it up to start with, they'll come and get me' (Saltmarsh & Wilson, 2017, p. 2250). Some studies described experiences which nurses had faced of verbal attacks and serious threats; '…the father of the child… told [Family and Children's Services] it was that nurse and I'll track her down.' (Land & Barclay, 2008, p. 23); 'Reporting child abuse in this situation is playing with fire' (Borimnejad & Fomani, 2015, p. 4). Fear of reprisals is difficult to address, as some nurses, particularly those in small communities, may genuinely be at risk (Matthews et al., 2008).

As well as personal retribution, nurses also feared consequences for the child and the family (Eisbach & Driessnack, 2010; Maul et al., 2018; Murphy-Oikonen et al., 2010; Skarsaune & Bondas, 2015); '… they feared the stress of a CPS report would stress an already-stressed family and the threat of child maltreatment would be actualized based on the nurse's action.' (Eisbach & Driessnack, 2010, p. 321).

Being wrong and/or making a mistake was also a key source of fear described in the literature, echoing the theme of confusion (Eisbach & Driessnack, 2010; Lavigne et al., 2017; Rowse, 2009b; Sathiadas et al., 2018; Skarsaune & Bondas, 2015; Visscher & van Stel, 2017). 'What if I'm wrong'… Nurses describe this as…'crying wolf, wolf' even if there are

no wolves' (Skarsaune & Bondas, 2015, p. 28). In some cases this was linked to the fear of being ridiculed and judged by colleagues and other professionals (Rowse, 2009a, 2009b). A lack of information and poor communication were also found to induce anxiety (Rowse, 2009b).

The possibility of having to appear in court (Land & Barclay, 2008; Sathiadas et al., 2018), of being linked to the case through documentation (Skarsaune & Bondas, 2015), and legal liability (Matthews et al., 2008) were also mentioned as causing fear in nurses. One article mentioned a fear of alerting parents to internal conflict and emotion, through showing emotion by gestures or body language (Tingberg et al., 2008). Another raised the fear of losing contact with the families (Schols et al., 2013). In the study conducted by Visscher and van Stel (2017) fear of being wrong, of reaction, of damaging the relationship, of suffering rebuke and of breaching medical confidence were all separated out as topics. This climate of fear for all aforementioned reasons may discourage nurses from reporting (Lavigne et al., 2017; Matthews et al., 2008; Saltmarsh & Wilson, 2017; Skarsaune & Bondas, 2015), and compromises efficacy and quality care (Rowse, 2009b; Saltmarsh & Wilson, 2017).

Although slightly separate, another theme related to fear recurring in a number of the research articles was that of vulnerability or being isolated (Engh Kraft et al., 2017; Francis et al., 2012; Rowse, 2009a, 2009b; Skarsaune & Bondas, 2015); nurses described feeling isolated, vulnerable and abandoned: 'nobody knew what I was going through' (Rowse, 2009a, p. 174). When discussing child sexual assault school nurses in particular felt professional vulnerability as they lacked support and mentoring, and they were unable to discuss with other professionals in the school (Engh Kraft et al., 2017). Some research found that the lack of support signalled to participants that there shouldn't be a problem, which led to further isolation (Rowse, 2009b).

Anger

These studies identified that nurses experienced anger when working with in the sphere of child abuse and neglect (Kraft & Eriksson, 2015; Murphy-Oikonen et al., 2010; Rowse, 2009a, 2009b; Saltmarsh & Wilson, 2017; Thamlikitkul et al., 2009; Tingberg et al., 2008); 'I was just so mad and wound up by the situation that it almost brought me to tears' (Saltmarsh & Wilson, 2017, p. 2249). Nurses felt anger toward the perpetrator, 'you feel disgust for this person. Real loathing' (Tingberg et al., 2008, p. 2721), and also toward child protection services and other professionals (Kraft & Eriksson, 2015; Rowse, 2009a, 2009b), 'when the social workers…did not progress the referral, participants felt both angry and betrayed'

(Rowse, 2009b, p. 664). The cause of anger was not always clearly outlined and was often just mentioned in a list of emotions experienced.

Frustration is closely linked to anger (often as a precursor). In the reviewed literature, frustration was the third most commonly mentioned emotion which nurses experience (Eisbach & Driessnack, 2010; Feng et al., 2010; Kent et al., 2011; Kraft & Eriksson, 2015; Land & Barclay, 2008; Murphy-Oikonen et al., 2010; Rowse, 2009a, 2009b; Saltmarsh & Wilson, 2017; Skarsaune & Bondas, 2015).

Frustrations mentioned were almost entirely focused around interactions with other professionals (mainly child protection services). In particular, frustration was caused by a lack of communication by social services (Kent et al., 2011; Land & Barclay, 2008; Rowse, 2009a) 'It's pretty much a one-way street as far as information goes. I find that really frustrating' (Land & Barclay, 2008, p. 22); and in one instance by other health services (Land & Barclay, 2008). A lack of follow up and action by social services also caused frustration (Kraft & Eriksson, 2015; Land & Barclay, 2008; Rowse, 2009b; Saltmarsh & Wilson, 2017), '[s]everal participants also raised concern that Family and Children's Services… is poorly resourced… half the time [reports] are not investigated' (Land & Barclay, 2008, p. 22). This perceived negative response and lack of action by social services, and the resulting frustration, affect the likelihood of nurses reporting concerns (Engh Kraft et al., 2017; Rowse, 2009b; Saltmarsh & Wilson, 2017).

Sadness

Words describing the emotion of sadness were interspersed throughout the literature. Nurses used the words sad (Murphy-Oikonen et al., 2010; Rowse, 2009b; Saltmarsh & Wilson, 2017), tragic (Rowse, 2009b), traumatic (Rowse, 2009b; Sathiadas et al., 2018), upsetting, disheartened, disappointed, dissatisfaction, emotionally taxing, (Murphy-Oikonen et al., 2010) despair, distraught (Kraft & Eriksson, 2015), and heavy (Feng et al., 2010). The associated emotions were so strong that Engh Kraft et al. (2017, p. 139) noted that nurses '...used terms such as having repressed, not wanting to think about, not wanting to know, and not remembering. They avoided thinking about [child sexual abuse] both unconsciously and consciously'. Eisbach and Driessnack (2010) talk about nurses being 'haunted' by the particularly complex cases and Francis et al. (2012) describe participants feeling 'let down' by their superiors, and 'disappointed' when further action wasn't taken by others. These feelings sometimes led to nurses avoiding the situation altogether, 'Not all child abuse batons

are worth carrying, some are too heavy, a psychological and emotional burden' (Feng et al., 2010, p. 1487).

Disgust

Words that nurses used to describe experiences included: hideous; horrific; horrible (Rowse, 2009b), awful (Tingberg et al., 2008); '[i]t feels almost like a physical reaction, you get nauseated and I do not think you really understand it… simply makes you stick to your stomach' (Tingberg et al., 2008, p. 2721); 'disgusting at times' (Maul et al., 2018). The presence of such strong emotions and subsequent actions inevitably affects the care of children and families (Rowse, 2009b).

Other emotions

According to Borimnejad and Fomani (2015), Francis et al. (2012) and (Kraft & Eriksson, 2015) nurses felt guilty. The main stated reason for this was the feeling of ineffectual efforts to improve the child's situation through reporting (Borimnejad & Fomani, 2015). In the study conducted by Francis et al. (2012, p. 64), nurses discussed the ramifications of living with decision they made; one nurse describing regret 'I forever wish I had taken it further'. Helplessness (Aragão et al., 2013; Land & Barclay, 2008; Saltmarsh & Wilson, 2017) and powerlessness (Engh Kraft et al., 2017) are other emotions mentioned. The more powerless one feels in a situation, the more stressful it is (Rowse, 2009b) As sexual abuse in particular is often seen as taboo, it incited feelings of shame (Engh Kraft et al., 2017).

Positive emotions

Although the emotions experienced in this area were overwhelmingly negative, there were a number of positive emotions mentioned in relation to some aspects of working within child protection. In the studies conducted by Lavigne et al. (2017), Rowse (2009b), Ho and Gross (2015), Sathiadas et al. (2018) and Hornor and Herendeen (2014) many participants felt confident in identifying and managing cases of child maltreatment. There was also sense of satisfaction described in two studies (Rowse, 2009a, 2009b; Sathiadas et al., 2018). The nurses felt positive about seeing children who had been taken into care thrive, felt that their involvement was worthwhile and learned from the experience. The feeling of being valuable also evident in the study conducted by Saltmarsh and Wilson (2017, p. 2248); '[n]eonatal nurses felt they were valuable to the baby and keeping it safe and living'. Two participants in

Francis et al. (2012) echoed this sentiment, feeling they had done the right thing. Feng et al. (2010) found that nurses felt safe within a 'hospital barricade', where they have others on whom they can depend. Nurses felt 'comforted' when there were absolute descriptors of abuse, as they felt it was less subjective (Eisbach & Driessnack, 2010).

Gut feeling

Intuition, or 'gut feeling' was mentioned numerous times throughout the literature. Although 'gut feelings' are not a specific emotion, emotion is strongly linked to and has been recognised as a key factor of intuition. Our emotional response provides us with an instantaneous sense of something (Cook, 2017).

According to Kraft and Eriksson (2015) child maltreatment is often detected through intuition. Most participants in the study conducted by (Rowse, 2009a), and all participants in the study by Skarsaune and Bondas (2015) described 'gut feelings' about the situation; 'All informants talked about a gut feeling telling them that something was not right, but without being able to put their finger on it' (Skarsaune & Bondas, 2015, p. 27). In one study neonatal nurses described being forced to rely on their intuition (Saltmarsh & Wilson, 2017).

Words used to describe this include: vibes, feelings, coming from within (Kraft & Eriksson, 2015), intuition (Saltmarsh & Wilson, 2017), and, most commonly, a gut feeling (Engh Kraft et al., 2017; Rowse, 2009a, 2009b; Saltmarsh & Wilson, 2017; Schols et al., 2013).

Due to abstract nature of intuition and difficulty to 'pin down' (Rowse, 2009a), it caused disagreement and frustration and self-doubt '[i]t's really hard when you get those feelings and intuition, and you don't know whether it's valid or not, and you keep tumbling over and over and thinking, 'Is it just me? Is it real?'' (Saltmarsh & Wilson, 2017, p. 2248), again, relating back to the previously discussed emotion of confusion. Conversely, one nurse in Engh Kraft et al. (2017, p. 138), felt 'my years of service and experience mean that I am not so scared anymore but feel that I can rely on my gut feeling'.

No mention of emotion

Though it may be possible to infer emotions, it is important to note the large number of studies satisfying the inclusion criteria which did not specifically mention emotional responses of nurses (Ben Natan, et al., 2012; Ben Yehuda et al., 2010; Browne et al., 2010; Chen et al., 2015; D Davidov & Jack, 2014; D Davidov, Jack, et al., 2012; Finn, 2011; Ho & Gross, 2015; Hornor & Herendeen, 2014; Koetting et al., 2012; Eveline Louwers et al., 2012; E. Louwers et al., 2012; Moreira et al., 2013; Pabis et al., 2011; Pakiş et al., 2015;

Raman et al., 2012; Reijnders et al., 2008; Reupert & Maybery, 2014; Rolim et al., 2014). This list highlights and confirms the extent to which emotions have been omitted from study in this area.

Discussion:

This chapter examined the emotional responses of nurses working with children who had been, or were suspected to have been, abused or neglected. The findings indicate that there is a range of emotions experienced by nurses, the most common (in order) being: confusion, fear, frustration/anger, and sadness. Other emotions included disgust, guilt, regret and helplessness. Although positive emotions were rare, it is important to notice that they were present in the literature in the forms of confidence, satisfaction, and the feeling of safety and comfort (although these were mentioned in defined circumstances within this area). As well as the breadth of mentioned emotion, the depth and long-lasting nature of the emotions felt were also recurring points in the literature. The wide range of negative emotion was exemplified in the study by Rowse (2009), where words used to describe these experiences included: "difficult, gut feeling; hideous; horrific; horrible; sad; scary; shock; tragic and traumatic" (Rowse, 2009b).

Emotions were felt at every stage of interaction - during the initial decision making, while interacting with families, and long after contact with the child and family had concluded. Because of the frequency of occurrence, many nurses will have a personal history of child abuse and neglect. This is important as introduces a different dimension of emotion and of 'being human'. Francis et al. (2012) mention that those who have been personally affected by this have a heightened awareness.

This systematic review re-emphasized the fact that studies in this area have mainly focused on the practicalities as opposed to the emotional aspects; highlighted by the fact that none of the research focused solely on the emotional responses, and much of the research which satisfied the inclusion criteria didn't even mention it.

Intuition

Intuition, or 'gut feeling' is inextricably linked to emotion, and therefore important to further examine in this context. Notably, emotions may be triggered by the unconscious interpretation of information. Emotions invoked by signs and symptoms which do not fit into a particular pattern contribute to what we know as intuition (Stolper et al., 2011).'Intuition is the process by which we come to know something without being able to explain how we

know' (Vaughn 1979 cited in (Cook, 2017, p. 432)). Also known as a gut feeling, or a sixth sense, it is a form of information-processing in a nonconscious and holistic manner (Cook, 2017). There has been an increasing amount of research done around the role of 'gut feelings' in the judgements of professionals (Cook, 2017; Mikels et al., 2011; Radin & Schlitz, 2005). Although many nurses were unsure how much to trust their intuition, some nurses, particularly experienced nurses, had learned to rely on this. This accords with research (Mikels et al., 2011) which finds that those with expertise within a given field rely more on intuitive judgements; using intuition is an advanced and effective means of making decisions.

Influence on action

In many cases, emotion directly influences action taken, whether feeling fear of parental reactions becoming a barrier to reporting (Borimnejad & Fomani, 2015) or the intense distress associated with this topic (in particular child sexual assault) resulting in failing to address concerns (Engh Kraft et al., 2017). Frustration, in particular with social services (commonly mentioned in the literature), often resulted in hesitation or failure to refer to services (Eisbach & Driessnack, 2010).

There is some evidence that when making a decision, emotion is equal or greater in importance than thought (Cadman & Brewer, 2001). Furthermore, the accumulation of emotions towards a particular event can shape attitudes, and attitudes influence ability to recognise cases of abuse and neglect, and subsequent actions. (Borimnejad & Fomani, 2015; Fraser et al., 2010). With these realisations taken into account, it is no surprise that a number of studies have shown that the ability to regulate emotion is directly related to quality care (Gómez-Díaz, Delgado-Gómez, & Gómez, 2017).

Not only is quality care affected, there is also a direct cost impact. With these emotions in mind, unsurprisingly, professionals working in this area have a higher risk of stress and burnout (Rowse, 2009b). Roles in which nurses are exposed to distressing events is shown to be linked to a high staff turnover, with some individuals even choosing to leave the profession. A high turnover leads to the increased cost of training new workers, higher workload for remaining professionals, and, ultimately a decrease in quality of services for children and families (Haight, et al., 2017).

Coping strategies

There are a number of strategies adopted by nurses in order to cope with these emotions, or 'being human', while maintaining a professional persona; strategies include avoiding situations by choosing not to see risk factors or problems, becoming ambivalent and avoiding

feedback post-discharge, or becoming overinvolved (Saltmarsh & Wilson, 2017) - none of which encourage quality care.

Nurses found supervision, discussion with colleagues (Dahlbo et al., 2017), debriefing, and counselling (Tingberg et al., 2008) were good support measures. Receiving feedback was also stated as a helpful process in dealing with the emotive side of the nursing role (Dahlbo et al., 2017).

Cultural context

Definitions of child abuse and neglect are largely determined by cultural and societal norms (Land & Barclay, 2008). Similarly, emotions and view of emotions are shaped by culture and society. The study based in Thailand done by Thamlikitkul et al. (2009) mentions emotions in a context of nurses '[controlling] themselves' and '[reminding] themselves of their professional role'; comparing emotions to a 'symptom' and a 'negative mood'. Ho and Gross (2015) suggest that nurses' views on unacceptable and acceptable discipline behaviours differ according to background and ethnicity. Additionally, a number of studies mentioned nurses who are regularly exposed to high rates of child maltreatment become desensitised 'it's a normal type thing for … parents to come in intoxicated… we say, that is culturally acceptable' (Land & Barclay, 2008, p. 22). Context also contributes in terms of size of community; nurses who are based in a smaller community, or who are highly visible, share different experiences (Francis et al., 2012; Matthews et al., 2008). The study conducted by Maul et al. (2018), overtly explores how cultural beliefs and understanding shape practice. Interviewees frequently discussed the impact of culture on the prevalence of abuse, but also on the ability to detect it. Cultural issues included the barrier of talking to the opposite gender, concern around shame or stigma that child abuse would bring to the child or family, and barriers related to financial dependence on the perpetrator. As an example, stigma around abuse in Sri Lanka is said to be 'profound' (Sathiadas et al., 2018).

As the research reviewed was international, it is important to acknowledge that different countries have their own definitions, policies and frameworks for dealing with child abuse and neglect. Therefore some comparisons are not necessarily equitable. Furthermore, despite computerised databases being effective, there are significant limitations associated with terminology; I am unsure if all the eligible studies have been found.

Emotions are rarely delineated in experience, and are often complex and nuanced. For ease of this review, emotions were artificially divided, whereas in reality they often 'seep' into one another, and one emotion may lead to another. Different emotions deemed similar by the reviewer were grouped together, for example uncertainty and confusion, while there may be

significant nuances between the two. The reviewer was careful not to surmise emotions from what was reported, but tried to rely on emotions which were directly reported in an attempt to reduce bias and assumption.

Summary

Working in the sphere of child abuse and neglect is extremely complex and multifaceted; it is unsurprising that many strong emotions are experienced. Ultimately, with the intensely challenging and emotive context of working in child protection, nurses are human; they should acknowledge their humanity and embrace the emotional reactions which accompany this. This review of the literature has given validity to intuitive, emotion-focused decision strategies. Affective experience is a distinct way of knowing and recognising - only available through emotion. It is crucial that nurses do not divorce affective feeling from intellect, and that they recognise the extent to which emotions underpin interpretation of events and subsequent actions. Understanding the role of emotion in the sphere of child abuse and neglect is crucial to informing nursing practice, and more importantly, to promoting the wellbeing of families and children.

It is important to note that due to time restraints, I needed to devise my methodology concurrently with reviewing the literature. Although some specifics were modified due to this literature review (mainly additional questions asked in the interview), the survey was already formulated prior to the realisation that little had been written on emotions.

The next chapter examines the methodology and methods used in this research.

Chapter 3

Methodology and methods

This study aimed to explore paediatric nurses' perceptions of their roles and responsibilities in child maltreatment. In order to do this, a mixed methods approach was chosen as the most appropriate way to gain data. The methodological underpinning, ethical considerations and methods used in data collection and analysis are discussed in this chapter.

Methodological Underpinning

Research is generally divided into three major traditions: experimental-type (quantitative), naturalistic inquiry (qualitative), and mixed methods. Often seen as opposing, experimental-type research and naturalistic inquires have, until recently, been the two primary views in Western culture on how to obtain knowledge (DePoy & Gitlin, 2016). The tradition of mixed methodology integrates strategies from both naturalistic and experimental-type traditions (V. Clark & Ivankova, 2016); it is the 'mediator or point of integration' (DePoy & Gitlin, 2016, p. 50). Traditionally, these two styles of research have had incompatible philosophies, and distinct advantages and disadvantages, however, researchers now realise that the '[multimethod research] fundamental strategy is to attack a research problem with an arsenal of methods that have nonoverlapping weaknesses in addition to their complementary strengths.' (DePoy & Gitlin, 2016, p. 50). Although mixed methodologies have had almost a 40-year history in some disciplines (namely anthropology and education), they have recently become not only acceptable, but popular within health research (DePoy & Gitlin, 2016).

All research has underpinning philosophical foundations with major implications for every aspect of the research- from the specific details of the design to assumptions about knowledge (ontology) and ways of knowing (epistemology) (Mills & Birks, 2014). A mixed method ontology not only includes but welcomes a number of methodological traditions and epistemologies. It recognises the premise of naturalistic inquiry that knowledge is constructed through individual experience, perception and perspective, while maintaining that accurate inquiry and measurement of data are possible and that this data can be manipulated and analysed objectively (DePoy & Gitlin, 2016). Mixed methods are rooted in values of respect and acceptance of difference, and actively engage in difference and diversity, generating understanding through the juxtaposition of these different lenses (Greene, 2005).

While all human experience is complex, the area of child care and protection is particularly so. The complexity of this issue cannot be overstated- the very complicated interplay between social, political, economic, cultural, educational and physical contexts is challenging. Mixed methodology is able to create space for engaging with the challenges of a complex context such as child protection. It allows for an understanding that comprises 'particularity and generality, contextual complexity and patterned regularity… the whole and its constituent parts…' (Greene, 2005, p. 208).

Mixed methods are used in order to have an integrated approach, involving purposeful selection and combination of designs which complement each other and contribute to a wider understanding of the issue (DePoy & Gitlin, 2016). This research is founded on the assumption that gathering diverse types of data offers a more complete understanding of the research question (John Creswell & Creswell, 2018). As there has been very limited research on New Zealand nurses in the area of child protection - only one known about, focusing on NICU nurses (Saltmarsh & Wilson, 2017) - this research aimed to be broad and provide an overview of the topic.

The quantitative aspect of the design was conducted through a survey design. A common method used in health research, survey designs are primarily used to measure characteristics of a population as well as exploring relationships between these characteristics (DePoy & Gitlin, 2016). Research using surveys has been conducted for centuries with its roots in census taking (Wolf, Joye, Smith, & Fu, 2016). Emerging in the 1930s, modern survey research used questionnaires which covered a wide range of topics and sample designs which were able to represent most populations. It was this combination of questionnaire design, data collection, and sampling that led to the establishment of modern survey research (Ornstein, 2013).

Surveys are largely based on the belief that outcomes can be measured and quantified - indicating a particular epistemology and ontology. The outcomes of the survey are expressed in numerical form and quantitative approaches are employed to explore relationships among variables (Daniel & Harland, 2018). Survey designs have a number of advantages. They can reach a large number of respondents with minimal time and expenditure, numerous variables can be measured by one instrument, and statistical analysis allows multiple uses of the data set (DePoy & Gitlin, 2016).

This study additionally drew on grounded theory approaches for the qualitative aspect of the design. Grounded theory was fist described by Anslem Strauss and Barney Glaser in 1967 in their influential work The Discovery of Grounded Theory (Glaser & Strauss, 1967; Mills &

Birks, 2014). It is one of the most formal and systematic approaches within naturalistic inquiry, and, at its most basic, aims to construct theories through a number of well-defined steps (D. Walker, 2014). This theory has continued to evolve, and there is now a range of established methodological positions (Mills & Birks, 2014). Despite revision and development of some specific stances and strategies, the main characteristics of the theory remain (Bowling & Ebrahim, 2006). According to Birks & Mills (2011, p. 8), the following methods are essential for grounded theory: 'initial coding and categorization of data, concurrent data generation or collection and analysis, writing memos, theoretical sampling, constant comparative analysis using inductive and abductive logic, theoretical sensitivity, intermediate coding, selecting a core category, theoretical saturation and theoretical integration'. Although this is not a 'grounded theory study', a number of these methods were utilised in the second phase of the research (explained in more detail below). Charmaz, Thornberg, and Keane (2018, p. 436) explain grounded theory as conducting research 'with […] participants instead of on them'; it is vital to recognise the innate reflexivity and understand the researchers' place within the research process (Birks & Mills, 2011). This recognition of reflexivity fits well within my epistemology as a beginning researcher and is particularly pertinent as I have an interest in and experience of the topic. Furthermore, grounded theory aims to generate a theory on a subject about which little is known and starts the research with a broad query in a particular area (as opposed to a hypothesis), hence this is an appropriate methodology to incorporate.

Ethics

Ethics is a crucial aspect of undertaking research (Plowright, 2011). The project was reviewed and given ethics approval by the Massey University Human Ethics Committee: Southern A (see appendix 6), by the Auckland DHB Research Review Committee (ADHB-RCC) (see appendix 7), and the Waitematā and Auckland District Health Boards Māori Research Committee (see appendix 8).

Throughout my research, I adhered to the guidelines set out in the following publications: The Massey University Code of Ethical Conduct for Research, Teaching, & Evaluations Involving Human Participants (2017), the HDC code of Health and Disability Services Consumer's Rights Regulation (Health and Disability Commissioner, 1996), HRC Research Ethics Guidelines (Health Research Council of New Zealand, 2017), and Guidelines for Researchers on Health Research involving Māori (Health Research Council of New Zealand, 2010).

It is imperative that ethical issues are carefully considered given the sensitive nature of this topic. While unlikely, there was potential for psychological discomfort, both personally and professionally, particularly during the interview stage of the research. Although I did not directly ask about the personal situations of participants, talking about this topic could bring up personal issues and cause stress. Furthermore, delving into the professional experience of participants potentially caused anxiety as they reflected on situations which may not have gone well, may been unpleasant and challenging to be involved in, or may have led to decisions later regretted. Sharing these incidents may have led to negative emotions such as sadness, confusion or guilt.

I offered participants the option of a break during any part of the interview process and gave participants the option of stopping the interview process at any point. I also offered information for Employee Assistance Programme.

Cultural Safety

In the process of ensuring Māori ethicality, I sought the guidance and advice of the Māori Associate Dean at Massey University, who was happy to act in the capacity of both a method and methodological kaupapa Māori advisor. I also sought and received the advice of the Associate Nurse Director Workforce Development & Learning Auckland DHB, who advises on cultural safety, in order to advise approach to safe and effective engagement of Māori nurses who may participate.

There are 15 Māori nurses working within Starship. I hoped to have at least 5 Māori participants in the survey and was pleased when 10 participants identified as Māori. Ethnicity data was collected in the demographic data in order to ensure that a range of voices, in particular the Māori voice, was heard. As mentioned, there was a secondary recruitment strategy for engaging Māori nurses. A separate e-mail was sent to Māori nurses inviting them to participate in the research.

When researching with Māori participants, the researcher followed Tikanga principles. I protected the mana of participants. One important concept to be considered is that of whakawhanaugatanga - the process of identifying, maintaining, or forming past, present and future relationships (S. Walker, Eketone, & Gibbs, 2006). In order to honour this concept, I took the time to establish a trusting relationship with the participants prior to the interview

I committed to he kanohi kitea. This talks to integrity and being transparent with all participants about the research. Although the survey does not involve a personal interaction, the interview process will honour the importance of meeting face to face. During this

meeting, I was open to protocols such as a karakia prior to commencing the interview, if this was how the participant wished to proceed.

As mentioned earlier, this research did not take a victim blaming or cultural-deficit approach. Not only is this disrespectful, it provides little value for Māori (Curtis, 2016).

Throughout the process, I developed relationships with the underlying principle of Manaakitanga, treating participants with respect and valuing culture and cultural norms.

Confidentiality

Any identifying information was only accessible to my supervisor, and myself. The interviews were solely transcribed by myself. The recorded information was erased once the transcripts were checked for accuracy, and information used in this thesis or any publications contains no identifying information.

The interview information has been kept securely throughout the process and my access to the information is limited to the period of the study. All consent forms were kept separately in a secured location and following the research all data will be disposed of as per the School of Health and Social Services protocol.

Language and definitions

It is crucial to mention the importance of language in this topic. Language points to underlying mindsets and beliefs, frames the way in which we understand an issue, and is ultimately a precursor to response. Language has historically rendered invisible the structural and social inequities which often advantage perpetrators over victims. Historically in New Zealand, we have had a blaming and perpetrator-enabling language around this issue, as evidenced by the Family Violence Death Review Committee reviews of practice (Wilson et al., 2015). This research attempted to use language which re-frames the issue in a way which is not victim blaming, and which is inclusive and respectful to a wide audience.

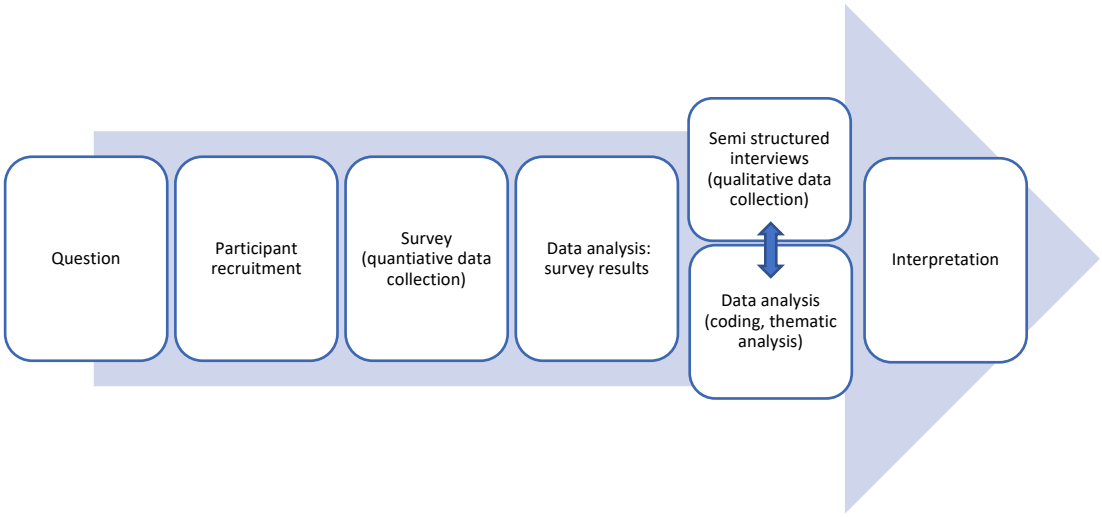
Research Design

The research was completed in two distinct stages. A survey was conducted in order to obtain baseline data about how nurses working in child health are currently engaging with some aspects of child care and protection in their current roles. These data were then analysed and used in order to inform the second phase. The second phase involved complementary interviews which were completed with the aim of gaining some depth and insight into the results of the survey. Thus, the two data forms are integrated in an explanatory sequential

(two-phase) design (John Creswell & Creswell, 2018). The overall intent of this design is to use qualitative data to explain in more detail the initial results from the survey (John Creswell, 2014).

Data Collection:

Explanatory Sequential Mixed Methods Design using a survey and grounded theory methods.



Participant recruitment and consent process

Initial recruitment involved accessing nurses who worked with children in a District Health Board (DHB) This is an example of convenience sampling as I work within this setting and already had existing contacts with the DHB (Plowright, 2011). Furthermore, this DHB includes the only dedicated paediatric hospital in the country. Nurses were eligible to participate if they currently work with children and had worked in that setting for more than 6 months. This meant that participants had enough experience to draw on to reflect on their practice. Nurses were not eligible to participate if they had a history of working with child protection agencies in order that participants were not biased by previous experiences or specialist knowledge in the area.

All paediatric nurses working within one DHB were e-mailed an invitation to be involved in this study by the nursing director. This was not only practical, as she had access to all the e-mail addresses, but also protected the privacy of the potential participants. The e-mail included a link to the survey together with a participation information sheet (see appendix 1). This contained information about the study, involvement required, participant rights, and the

contact details of the researcher and supervisor, allowing potential participants to ask questions prior to involvement.

Consent to be included in this survey was implicit in the participant opting to fill out the voluntary survey. At the end of the survey participants were asked if they would be willing to participate in an interview. Those who agreed to an interview were asked to provide their e-mail address for further contact. Participants who responded were then invited to choose a time and venue for the interview.

Stage 1 – Surveys

The survey e-mailed out was an anonymous, online, structured survey. This 10-minute survey was designed to gain an understanding of how nurses working in child health are currently engaging with some aspects of child care and protection. It was accompanied by some basic demographic information. There was a mixture of multiple choice, checkboxes and free-text questions. Therefore, there were questions with both a low degree of structure and a high degree of structure (see appendix 2).

A web survey, using the tool SurveyMonkey[3], was chosen as an effective way to gather baseline data from a large cohort within a short space of time (Balch, 2010; Tourangeau, Conrad, & Couper, 2013). Access to the internet, often a drawback of web surveys in the general population (Tourangeau et al., 2013) was not an issue, as nurses working in this DHB have work e-mail addresses which they are expected to check on a regular basis.

Questions were grouped by subject and clear instructions given. Closed questions were used where possible responses were known as they are quick to administer, are more likely to be answered, and are easily comparable by coding and analysis. (It is important to note however, that they have the potential to artificially confine the range of responses.) Free-text questions were used where possible replies are unknown, and, while they are more demanding for participants, they provide more insight and depth (Kate, Belinda, Vivienne, & John, 2003; Ornstein, 2013). The survey is a paging design (Peytchev, Couper, McCabe, & Crawford, 2006), and, as recommended, uses standard conventions throughout - for example bold font for questions (Tourangeau et al., 2013).

Nonresponse has been found to be a major problem with online surveys (Tourangeau et al., 2013), therefore some simple strategies to increase response rate were used. The announced length of 10 minutes is associated with a higher completion rate (Liu & Wronski, 2018). The

[3] www.surveymonkey.com

survey did not take longer than the time outlined in the participant information sheet; according to Survey Monkey, the average time to complete the survey was 7 minutes. The large proportion of multiple choice and checkboxes also made it more likely that a larger cohort would respond to the survey (DePoy & Gitlin, 2016).

Once the data were collected, as per the guidelines of Sue & Ritter (2012), the data were cleaned and prepared for analysis. Data were then analysed using coding and frequency distributions (using the inbuilt web-based software). Answers to open ended questions were categorized and sub-categorized - enabling a level of depth in the information gathered (Tourangeau et al., 2013).

As mentioned, there was a secondary recruitment strategy for engaging Māori nurses. A separate e-mail was sent to Māori nurses with a re-introduction of the survey and an invitation to participate in the interviews. This ensured that the Māori voice was heard, and Māori were presented.

Data analysis

Statistical analysis was conducted using SPSS Statistics ("IBM SPSS software," 2018) - a software platform which offers advance statistical analysis (Davis, 2013). The narrative data in the survey was also analysed to produce frequencies and counts (for example, the number of times a particular theme was mentioned in the surveys) (Plowright, 2011).

These results, in particular the responses to the free text questions, were then used to build on and inform the qualitative questions asked in the second phase.

Stage 2 – Interviews

Seven nurses who had initially given their e-mail addresses responded to the follow up e-mail that they were still willing to participate (one was excluded because she worked within a child protection specialty service) within the week. I then interviewed all six of those nurses using a semi-structured one-on-one interview model, at a time and in a location of their choice. Most of the participants chose the hospital environment (three in a private meeting room, one in her office, one in the hospital café and one in their own home).

Prior to the interview, participants were reminded that anything they said would remain confidential, that at any stage they could ask for the interview to be terminated, and that the interview would be audio recorded. They then signed the consent form (see appendix 5) in order to confirm that they understood their rights and to confirm informed consent (Plowright, 2011)

The questions asked (as in most qualitative research) were open-ended and general (DePoy & Gitlin, 2016), and, as mentioned, informed by the responses from the survey. The method of a semi-structured interview is characterised by its unique flexibility – sufficiently structured to address a specific research question while maintaining space for those being interviewed to offer new meanings and insight. It allows for the multi-dimensional nature of experience and creates an opening for narratives, while being supported by theory (Galletta & Cross, 2013). This ability to explore complexity is particularly pertinent in a topic as multi-faceted as this. The questions asked were open-ended to allow participants to narrate their experiences; however, the questions are also deliberately focused on the research topic (Galletta & Cross, 2013) (see appendix 4). A semi-structured interview lends itself to reciprocity between the interviewer and the interviewee, and to reflexivity in terms of dilemmas encountered while conducting the research (John Creswell & Creswell, 2018). The space and ability to do this fit well within my epistemology as a researcher.

The interviews were digitally recorded using a high-quality digital audio recorder, and subsequently transcribed. Voice recording was used in order to retain communication as accurately and precisely as possible (Silverman, 2013). I personally transcribed all the interviews and double-checked the typed data to ensure accuracy. During the transcribing process, I removed any identifying names, and numbered the transcriptions and respective interviewees numbers 1-6.

Data Analysis

Once an interview was conducted, the analysis started with the process of listening to, organising and transcribing the interview. The transcription was then formally analysed using a process of coding and thematic analysis. I identified important words (or groups of words) and labelled them. Groups of related codes were then put into categories (as per the process of grounded theory) (Birks & Mills, 2011). Data analysis and data collection happened concurrently (i.e. I was analysing interviews prior to conducting the next interview). This process differentiates grounded theory form other research models which often require data collection to occur prior to analysis. Memos were also written during this second phase of research. Memos are written records of the researcher's thinking during the research process (Birks & Mills, 2011). Not only does this inform the findings, it also maintains an audit trail and gives accountability. The subjective self can be examined in this process also (D. Walker, 2014), echoing the idea that the researcher is inextricably linked to the research. Once preliminary categories were outlined, 'theoretical sampling' was undertaken - collecting data which explain these categories further (Silverman, 2013).

Information was constantly compared, contrasted, and added to in a process termed constant comparison (Bowling & Ebrahim, 2006). This section, as in all grounded theory, is inductive in nature (theory is built from data) (Boychuk Duchscher & Morgan, 2004). I hoped to continue this process of theoretical sensitivity until 'saturation' was reached. As explained further in chapter 5, it is arguable that I did reach saturation; however, because there was such a large sample population, it is hard to be certain.

Establishing rigor

An essential part of research is establishing rigor; methodological rigor is necessary to attaining trustworthy results (Rettke, Pretto, Spichiger, Frei, & Spirig, 2018). The survey was disseminated to and pretested by 10 nurses in different departments of Starship (both within the tertiary and community setting). The pre-test was conducted in order to improve existing questions, and to detect and remedy problematic questions prior to collection of data, for example to ensure clarity and that the desired level of information could be obtained. Pretesting is effective, and inexpensive (Ornstein, 2013). It also served to validate the questionnaire. The validity of this survey was supported by establishing face validity; experts in the field of research and also in the field of child protection also reviewed the survey (Tourangeau et al., 2013).

I have discussed my research with a number of people working in the DHB Child Protection Service- Te Puaruruhau. They gave feed-back from a specialist perspective with a wealth of experience and knowledge in the area. I also had discussions with the DHB nurse director, the Starship Community clinical director, a Nurse Specialist of the DHB Violence Intervention Programme, a research nurse co-ordinator, and the Allied Health Director, Women and Chlidrens to talk about my research, applicability, and the research process.

Summary

Mixed methods is appropriate in order to gain insight, where the point is not to find a well-fitting model, but instead, to generate understanding and discernment through juxtaposing different perspectives and stances (Greene, 2005). This method was chosen as a way of combining the strengths of both quantitative and qualitative methods, and to develop a stronger understanding of what nurses are experiencing in the sphere of child protection. It not only provided, but also created space for engaging with this particularly complex sphere.

The particular type of mixed methods design used was one which was explanatory and sequential. A survey was initially conducted which then informed subsequent interviews. Using grounded theory methods, these interviews expanded upon the initial quantitative results. The following chapter presents the findings of this study using these methods.

Chapter 4

Results

In this chapter I present the findings of my research. As outlined in the previous chapter, the data were collected using an explanatory sequential mixed methods design, comprising a survey for the initial phase and interviews drawing on grounded theory methods for the subsequent phase. In total 141 surveys and 6 interviews were completed.

Phase one- Survey

I will first present the quantitative results from the survey (see appendix 2), and will then present the themes which emerged after a thematic analysis of the free text questions in the survey.

Sample

The e-mail surveys were sent out to an estimated 600 available nursing staff (from a total of 531 full time equivalents within Starship Hospital; the director was unable to provide me with an exact number of staff). 141 surveys were completed for an estimated response rate of 23.5%. Of those surveys, seven were excluded; four due to nurses having less than 6 months experience, and 3 due to working in a child protection speciality service- as per earlier outlined exclusion criteria. A total of 134 surveys remained, included in the analysis.

The survey took 7 minutes to complete on average (including those who were excluded and therefore unable to complete the questions beyond the demographic section).

Table 5 outlines the area in child health where participants worked. Of the 134 surveys, just under one fifth of the participants worked in a community setting, with the majority working in a tertiary setting (one respondent worked in both settings). Two identified as nurse specialists but did not identify their area of work. It is important to note that Starship hospital is currently undergoing a redesign process, where the previous child age-related services are being disbanded to form a locality-based service. A number of nurses who participated (n= 5) were working in a locality model (i.e. working across two or three of the original teams). This meant that only 1 nurse who works in home care was working exclusively in home-care.

Table 5. The area in child health where participants worked

Area of Child Health	(n = 134)	
Starship Community	26	19%
Children's Emergency Department (CED)	21	16%
Paediatric Intensive Care (PICU)	15	11%
Cardiac (23B)	14	10%
Orthopaedic (24A)	2	1%
Surgical (24B)	3	2%
Medical (25)	8	6.%
Neurology (26A)	8	6%
Medical specialties (26B)	9	7%
Oncology (27)	6	4%
NICU (ward 92)	10	7%
Theatre	8	6%
Other	14	10%

There was a range of seniority, from level one nurses to nurse practitioners (see table 6); and of training, from those who were hospital trained, with undergraduate degrees, to those with masters (see table 8). Just over half of the participants had worked in child health for more than 10 years (table 7), and just over three fifths had a qualification specific to child health (table 9).

Table 6. Level of nursing practice

Level of nursing practice	(n = 134)	
1	3	2%
2	38	28%
3	29	22%
4	23	17%
Senior nurse	15	11%
Nurse specialist	28	21%
Nurse practitioner	3	2%

Table 7. Length of time participants had worked in child health

Time	(n = 134)	
6 months - 2 years	24	18%
3 – 5 years	24	18%
6 – 10 years	16	12%
>10 years	70	52%

Table 8. The highest level of university (or other) qualification the participants held

University qualification	(n = 134)	
Undergraduate	31	23%
Postgraduate certificate	38	28%
Postgraduate diploma	40	30%
Masters	22	16%
Higher	0	0%
Hospital trained	5	4%

Table 9. Whether participants held a qualifications specific to child health

Qualification specific to child health?	(n = 134)	
Yes	83	62%
No	51	38%

Table 10 breaks down the ethnic groups that participants identified with. The majority (a little over 2/3) of participants identified as New Zealand European. It is important to note that although only 7.46% of the participants identified as Māori, this includes most (67%) of Māori nurses working within Starship. There is a higher percent of Māori working in the community than in tertiary (50% of Māori respondents were in the community). A wide variety of other nationalities were represented, including Indian, Chinese, Tongan, Filipino and British, indicating the ethnic diversity within Starship.

Table 10. Ethnic groups participants identified with

Ethnic group	(n = 134)	
New Zealand European	91	68%
Māori	10	7%
Samoan	1	1%
Cook Islands Māori	0	0%
Tongan	3	2%
Niuean	1	1%
Chinese	4	3%
Indian	4	3%
Other	30	22%

Family Violence

The majority of the participants (90%) had been trained in how to screen for family violence (refer to table 11). Of those who had not been trained in screening, five worked in the Paediatric Intensive Care Unit, four in operating theatres, two in the cardiac ward, one in the medical specialties ward, and two were unidentified nurse specialists.

Table 11. Whether or not participants were trained to screen for family violence

Trained	(n = 132)	
Yes	119	90%
No	13	10%

Over half reported screening ‘very rarely’ for family violence, and a total of 16% reported screening 3 or more times (table 12). In the community, 40% of respondents screen ‘very rarely’. The majority of these respondents are from the child and youth subsection of this cohort, with 57% in this group reporting that they screen very rarely in this group. Of the 8 respondents working in the well child cohort, none answered ‘rarely’, making this the work area with the highest rates of screening out of all the areas represented.

Table 12. Times per week (or per 40 hours) the participants screed for family violence

Times per week screen (or per 40 hours)	(n = 123)	
Very rarely	71	58%
1-2 times	31	25%
3-5 times	15	12%
6-10 times	2	2%
>10 times	4	3%

Therefore, there is no association between the area in which the participants work and how commonly they screen.

Training and confidence

Overall, most of the respondents (79%) had received training in how to recognise and respond to child abuse and neglect (see table 13). Of participants who did not answer yes to having received training for this, about half reported they had not received training, while the other half were unsure (see table 13). Further analysis revealed that there was no statistical relationship between work setting and whether this training was received.

Table 13. Whether participants had received training in how to recognise and respond to child abuse or neglect

Training	(n = 128)	
Yes	101	79%
No	15	12%
Unsure	12	9%

Of those who had received training, the majority of this had occurred at the DHB Family Violence Training day (see table 14) (similar for both community and tertiary settings). Department-specific training was the second most common training received (14%) - particularly in the community where 33% had received department-specific training, as opposed to only 11% in the hospital. Of those working in the hospital, thirteen% reported some other form of training (mainly from previous employment).

Table 14. Where participants had received this training

Training received	(n = 113)	
ADHB family violence training day	104	92%
MEDSAC[4] training	1	1%
Department specific training	16	14%
Child matters	6	5%
Other	15	13%

Exactly half of respondents felt confident in their ability to identify child maltreatment. Less than half (44%) of respondents answered 'sometimes'; and only 6% did not feel confident (see table 15).

Table 15. Whether participants felt confident in their ability to identify child maltreatment

Confident	(n = 128)	
Yes	64	50%
No	8	6%
Sometimes	56	44%

There was a statistically significant association between training and confidence; participants who had received training were more confident to identify child maltreatment (56.40%) compared to those who had not (26.70%), χ^2 (4) = 11.59, p = 0.021.

[4] Medical Sexual Assault Clinicians Aotearoa

Table 16. Training * Confidence Crosstabulation

			Yes	No	Sometimes	Total	X^2	P
Training	yes	Number	57	4	40	101	11.59	0.021
		%	56.40%	4.00%	39.60%	100.00%		
	no	Number	4	3	8	15		
		%	26.70%	20.00%	53.30%	100.00%		
	unsure	Number	3	1	8	12		
		%	25.00%	8.30%	66.70%	100.00%		
Total		Number	64	8	56	128		
		%	50.00%	6.30%	43.80%	100.00%		

There is also an association between the area in which participants worked and how confident they felt in identifying child maltreatment. Significantly more participants felt confident in the community (80%), than in the tertiary setting; χ^2 (8) = 15.89, p = 0.044.

Table 17. Area * Confidence Crosstabulation

			yes	No	sometimes	Total	X^2	P
Area	Community	Number	16	0	4	20	15.89	0.044
		%	80.00%	0.00%	20.00%	100.00%		
	CED	Number	7	1	12	20		
		%	35.00%	5.00%	60.00%	100.00%		
	PICU + NICU	Number	13	1	8	22		
		%	59.10%	4.50%	36.40%	100.00%		
	Wards	Number	23	3	22	48		
		%	47.90%	6.30%	45.80%	100.00%		
	Others	Number	5	3	10	18		
		%	27.80%	16.70%	55.60%	100.00%		
Total		Number	64	8	56	128		
		%	50.00%	6.30%	43.80%	100.00%		

There was no statistical significance between confidence and the level of nursing practice, the qualification specific to child health, the length of time spent in child health, or whether the participant had witnessed a case of child abuse or neglect within the previous year.

What are nurses currently doing in this sphere?

Overall, the vast majority of nurses (96%) who participated in the survey viewed recognition and referral of child protection concerns as part of their job description (table 18). The remaining small percentage answered that they were unsure whether or not it was; they worked in a variety of areas (Children's Emergency Department, Medical specialties, oncology, Day Stay Unit and Post Anaesthetic Care Unit). It is important to note that 20 respondents in the survey did not answer this question.

Table 18. Whether or not participants viewed recognition and referral of chid protection concerns as part of their job description

Part of job description	(n = 114)	
Yes	109	96%
No	0	0%
Unsure	5	4%

Almost 75% of nurses who participated had seen a case of suspected child abuse or neglect in the previous year (table 19). Of those who did not answer yes, one fifth reported they had not witnessed a case of child abuse or neglect, and less than one tenth were unsure. There was not a statistically significant difference between participants those had seen a case of suspected child abuse or neglect in the previous year in community and tertiary (80% and 73% respectively). Participants who had received training were not statistically significantly more likely to report having seen a case of suspected child abuse or neglect in the preceding year.

Table 19. Whether or not participants had seen a case of suspected child abuse or neglect in the last year

Witnessed	(n = 128)	
Yes	94	73%
No	25	20%
Unsure	9	7%

Referrals

Making referrals appeared to be a large part of how nurses engage in this sphere (see table 20 for complete referral statistics). In the tertiary setting nurses most commonly referred on to an ADHB Social worker (81%), followed by a senior colleague (43%), Oranga Tamariki (37%), Te Puaruruhau (35%), a social worker from another organisation (13%), and the police (4%). In the community setting nurses most commonly referred on to Oranga Tamariki (83%). They also referred to the ADHB SW (66.67%), Te Puaruruhau (67%), a senior colleague (39%), and a non ADHB SW (33%). The police (11%), and the GP (5%) also received referrals.

Table 20. Where concerns have been referred on to

Referrals	107	
Oranga Tamariki [5]	47	44%
ADHB social worker	85	79%
Social worker from another organisation	18	17%
Senior colleague	45	42%
Te Puaruruhau	42	39%
The police	6	6%
Other	5	5%

Reports of concern

Participants were asked if they had ever made a report of concern (ROC) / notification to Oranga Tamariki (formally known as Child Youth and Family). Responses to this varied greatly (see table 21). The nurses in the community had completed far more ROCs in total- 15% had done this once or twice; 40% 'a number of times' and 15% 'frequently' (with only 30% of nurses in the community reporting never having completed one). However, in the tertiary setting most nurses- 57% - had never made a report of concern.

[5] Formally known as Child Youth and Family

Table 21. Whether participants had made a report of concern

Report of concern	(n = 128)	
Never	69	54%
Once or twice	37	29%
A number of times	18	14%
Frequently	4	3%

The chi squared test shows that the majority of PICU or NICU (n=17, 77.3%) stated that they had never made a ROC. The community nurses (n=11, 55%) stated that they had made a ROC a number of times or frequently. There is a statistically significant association between making reports of concern and area of work, χ^2 (48) = 33.42, p = 0.00.

Table 22. Area * Report of Concern Crosstabulation

			Never	Once or twice	A number of times or frequently	X^2	P
Area	Community	Number	6	3	11	33.42	0.00
		%	30.00%	15.00%	55.00%		
	CED	Number	14	4	2		
		%	70.00%	20.00%	10.00%		
	PICU + NICU	Number	17	3	2		
		%	77.30%	13.60%	9.10%		
	Wards	Number	25	19	4		
		%	52.10%	39.60%	8.30%		
	Others	Number	7	8	3		
		%	38.90%	44.40%	16.70%		
Total		Number	69	37	22		
		%	53.90%	28.90%	17.20%		

Those who had not submitted a report of concern (ROC) gave a number of reasons as to why they had not. There were a total of 81 responses to this question. In regards to making a ROC, two nurses said explicitly, ‘it is not part of my nursing role’; ‘not my role’ (these worked in

NICU and PICU), but said they would instead refer on to a social worker to complete this. Referring on to a social worker was the most common reason as to why nurses have not done a ROC (in 17 responses). These respondents outlined that the social worker/s then 'contact Oranga Tamariki', 'facilitates'/'completes' notifications, 'funnel concerns', 'follow up family', and 'help with this matter'.

The next most common reason for not completing a ROC was that it was not necessary, this comment was mentioned 15 times. Such responses included 'not applicable to any situation', 'haven't needed to', 'not suspected', 'not identified', and 'never had a positive screen'.

Referring to a doctor was mentioned 8 times as a reason not to do a ROC. The doctor is then said to 'make the report', 'refer to a social worker', 'take over the case' or 'refer to Oranga Tamariki'. 6 participants mentioned referring to a senior nurse- including a family liaison nurse, a charge nurse, a co-ordinator, a long term care co-ordinator, a CCN, and a CNS. One participant said that she did not do these when a staff nurse, but would now do as a CNS.

Follow up/ liaison with other services

The most common action that the participants perceived as their role in follow up was the referral and communication with other services and/ or colleagues. Out of a total of 94 total responses, this was mentioned 39 times. A significant theme included not only ensuring that the referral was received, but also ensuring that the referral was acted on/ followed through – some nurses appeared to work in a 'safety net type' role; 'often I keep Oranga Tamariki focused and working on the case. They are often very slow and do not initiate anything until the child is discharged'.

Nurses acted as a liaison for the medical team, Oranga Tamariki (Social worker or duty supervisor), Te Puaruruhau, cultural workers, schools, hospital social workers and other colleagues. Other things mentioned in the area of follow-up included facilitating appropriate connections, ensuring family had support, and, in a tertiary setting, handing over to the next nurse.

Ongoing monitoring and observation was the next most common theme; answers such as maintaining child safety, following up on health needs, supporting and maintaining relationships with whānau, and care coordination.

Documentation was mentioned 12 times in response to being asked about follow up.

15 participants who answered this question stated that follow up was not their role, and 4 others were unsure. Of those who stated that it was not their role 10 worked in CED, 3 in PICU, and the others in tertiary areas.

Child Protection Alert

There were 108 responses outlining what nurses did differently if there was a child protection alert on the system. The most common response to this was to find more information, mentioned 50 times (46%). This was mainly done through the computer system (mentioned 48 times). The stated reasons for this were to find out if the concerns were current, what other agencies were involved, if a safety plan was in place, who has legal responsibility and/or access to the child, and to have a greater understanding of the situation.

The next most common response was around the idea of awareness. This included statements such as 'heightened safety concerns', 'part of overall knowledge of family' 'more vigilant' 'greater appreciation of complexity'; this theme was mentioned 39 times.

Other actions mentioned were to contact a social worker (17 times), to ensure screening (13 times), to discuss with other medical professionals/ colleagues (10 times), to complete a more focused/intentional assessment (8), to contact Oranga Tamariki or other agencies (6), to have more interaction with the family (5), to ensure legal terms are met (4) and to ensure community supports (3).

There were however, some respondents who said that they did nothing differently; 'very little, as I don't see these so often and they lack detail' and 'probably don't do anything different'. One respondent stated 'nothing, except maybe cuddle that baby a little longer, and stronger….'

Supports/ Positives

Participants were asked what enabled them to respond to suspected care and protection concerns. The emerging themes from the free text comments on the questionnaire are summarised below.

Table 23. Supports

Theme	Subtheme
Time	Time to develop a rapport; time to document; time to screen; time to talk to the families.
Physical location	A private space for discussion
Knowledge	presenting history likely for an NAI; of signs and symptoms; knowledge of processes- particularly the referral process and mandatory reporting process; yearly updates on family violence and child protection
Skill	Clinical judgement; past experience; patient observation skills
Information	Easily accessible information; information on the charts; the alert on CHiPs[6]; clear documentation; good handovers; care plans; little quick cards; the family violence folder
Systems and processes	Multiple ways to report concerns; the Ministry of Vulnerable Children notification processes; quick cards for routine enquiry
Policies	Duty of care obligation; mandatory reporting in ADHB; SSH child abuse and neglect policy
Multidisciplinary team	Presence of social workers, support from physicians, Te Puaruruhau, the Oranga Tamariki liaison (it is worth particularly highlighting that the Te Puaruruhau and the Oranga Tamariki liaison person were mentioned numerous times). Cultural support- Over 75% of participants reporting having engaged cultural services, and under 10% reported not engaging cultural services.
Personal attributes	Ability to develop rapport with family; communication skills; self-awareness; confidence; compassion

Table 24. Whether participants had engaged cultural services

Engaged cultural services	126	
Yes	97	77%
No	11	9%
Unsure	5	4%
Sometimes	13	10%

[6] Clinical handover computer system

Barriers

There were 100 responses to the question which asked about barriers, if any, which prevented participants from reporting suspected care and protection concerns. The table below divides the responses into main themes.

Table 25. Barriers

Theme	Percent of respondents mentioning theme	Subthemes	Sample of relevant data segments
No Barrier	16%		'No barriers. Strongly feel that we should be representing the needs of the child and that we should become their voice when they are not heard'.
Uncertainty	27%	Self-doubt; Concern around lack of evidence; Concern about overreaction; Not wanting to cause additional stress if incorrect; Lack of confidence; Worry about unfairly judging families.	
	11%	Uncertainty around process; unsure how to make a referral; lack of clear pathways; disagreement about who does what	'Unsure of whether it is part of my role or the social workers'.
Time	19%	Not enough time; high workload; staffing issues; short time frame in acute care	
Space	7%	Lack of privacy; no space to hold child while waiting for social worker	
Social worker support	7%	Not having a permanent social worker/ lack of out of hours social worker support (only mentioned in tertiary setting)	
Lack of education and training	6%		

Limited confidence in Oranga Tamariki	16%	High threshold for intervention; inaction; don't have understanding of how to deal with medical neglect; don't appreciate importance of health issues; lack of communication; take up time and effort to get them to do their job; poor feedback on outcome of referral; difficult to contact; under resourced	'Limited confidence in OT/CYFs- their threshold for intervention is extremely high, therefore little point in reporting as it will be NFA'ed at the call centre. And then the family have had a negative health experience of a ROC being made against them only for it not to actually result in any actions.' 'I find the ministry of children a fragmented under resourced unprofessional, under-skilled agency that definitely interferes with using them'. 'We have had some terrible experiences with (formerly) CYFS who have either dismissed our reports or acted unnecessarily heavy handed.'
Caregiver's situation	4%	Worried, distressed, uninformed parents	
Emotions	11%	Fear of response from family; fear or destroying therapeutic relationship; feeling awkward; lack of confidence	'the risk of ruining that trust with invasive questions was not one we were willing to undertake'
Systems and processes	5%	Lack of documentation, time it takes to get support when asked, the report of concern form on HCC poorly formatted, culture of it not being a nursing responsibility; school politics	'valid evidence is lost in words passed between people',

Free text

Nurses were given the option to add or comment at the end of the survey. A few of them took the opportunity to offer suggestions.

The most common recommendation made was to increase information and education. A few participants suggested more study days/ regular training/ refresher courses on family violence and child abuse (n=5). One asked for more education about recognising signs of abuse, another for teaching about documenting sensitive information.

Although the survey did not directly ask about emotional responses, some participants used the free text space as a vehicle to express frustration. A sample of these comments are listed below:

> 'Nurses need to feel more empowered to advocate for children.'
>
> 'It's really frustrating that concerns around medical neglect that can lead to long term physical and mental health consequences are not understood or dealt with adequately'
>
> 'Child protection and family violence needs to be addressed better in health care.';
>
> 'It's about time NZ stopped paying lip service to child abuse in this country and started doing something about it.'

Phase two: Interviews using grounded theory methods

A total of six nurses were interviewed. 3 were in senior nursing roles- a nurse practitioner in the Children's Emergency Department, a neuromuscular nurse specialist, and a nurse consultant. 2 nurses who work in the community were interviewed, and 1 registered nurse who works in the Medical Specialities ward.

Overall, 5 out of the 6 interviewees perceived

> '[care and protection to be] a very big part of [the nursing] role' (interviewee 1);
>
> …a lot of my role seems to revolve around care and protection cases' (interviewee 6).

When asked about for an example of a child protection case, interviewee 4 said,

> 'I'm just trying to think, there have been so many…we meet the full range of children whose needs are not being met, who are actively being abused in some capacity.'

Interviewee 2 had not had any experiences in her current role relating to child abuse or neglect, however had in previous nursing roles.

Grounded theory methods, such as theoretical sampling, were used during the interviews; early interviews were themed and subsequent interviews followed those themes. The perceptions that nurses have of their role in this sphere is integrated and blurred, but one possible way of examining the data and subsequent themes collected during the interview process is by dividing the findings into categories – outlined in the table below. These categories build on the information from the survey.

Table 26. Categories

Categories	Concepts	Properties	
Eyes and ears	Detecting and monitoring	Unique position	See child in a variety of contexts- home, school, hospital
			Long term relationships
			Flexibility
		Observe interactions with families	
		Pick up on physical injuries and signs of neglect	
		Have a variety of sources of information in order to see wider picture	Alert
			Computer system
			Schools
			Other professionals
Hands	Medical care post abuse or neglect		
	Ensuring safety		
	Referrals liaison with other services		Balancing roles and priorities
	Support	Practical support	
		Wherever/ whenever/ whatever	
	Documentation		
	Other	Giving positive experiences	
Head	Systems and processes	MDT - support	Te Puaruruhau
			ADHB/OT liaison
			Cultural support
			Social work – positive but also lack of 24/7 support in hospital
		Lack of integration and information sharing	Between medical services
			Between health and social services
			Between DHBs
		Training and education	
		Mandatory screening	

	Physical space and time	Privacy	
		Time to build rapport	
		Physical bed space	
	Uncertainty	Whether to report	
		Whether assumptions are founded	
	Frustration	With OT	
		School politics	
Heart	Emotions as a way of knowing		
	Depth of emotions		
	Range of emotions	Sadness	
		Disbelief	
		Anger/ frustration	
		Hopelessness	
		Disgust	
		Fear	
	Carrying on despite emotions	Lack of time to process	
	Dealing with emotions	Detachment	
		Avoidance	
		Focusing on positives	
		Teaching	
		Debriefing/ supervision/ EAP	
	Showing heart		
Gut	Role of gut feeling / instinct in decision making		
	Child at the centre	Nurses care deeply	
		Nurses go above and beyond	
		Nurses are the advocate for the child	

Eyes and ears

The first category, Eyes and Ears, focuses on the unique position of nurses in detecting and monitoring child maltreatment and the different ways in which they do so.

> '[Nurses] are the eyes and ears of what is going on, and can pick up on things that others may not have seen in terms of interactions with families or that sort of thing' (interviewee 1).

5 of the 6 nurses interviewed talked about nurses being in a prime physical position to detect child maltreatment. This takes place in the range of settings in which nurses work; in school settings:

> 'I'm identifying issues, concerns.. I tend to pick up stuff through the schools.. kids are referred to me for health issues but then you identify other concerns…' (interviewee 6),

In the tertiary setting:

> 'something I'm aware of, particularly in some of our smaller kiddies that present with either injuries or even non-injuries… taking family assessment and.. seeing if there is anything happening that shouldn't be' (interviewee 1).

And in the family's own setting (either in the home or in the community):

> 'if you go to home you see a slightly different picture, and again, those nurses often have different, they have more private environment, they can see things going on..' (interviewee 4); 'our nurse specialists have long term relationship with the families and they work very hard with non-attendance in clinic… they can get in the car and go round and find out what's going on' (interviewee 4).

Time and flexibility was also a key advantage. The nurse practitioner interviewed emphasised the fact that she had the ability to go into more depth than other clinicians,

> '…it doesn't worry me if I don't pick up as many children as other people do, because I kind of know the kids I'm going to see I'm going to sort out properly… to actually address those issues. Whereas I think sometimes when perhaps other clinicians may see them, they kind of deal with the problem of the skin infection and kind of don't actually ask a lot more questions…' (interviewee 1).

Not only having the time with the family, but also having lasting relationships was an advantage. These lasting contacts allowed for a trusting relationship to develop:

> 'we have a lot of families that we know over a long period of time' (interviewee 4), 'the mother has after a long time and she's got to know us, has admitted that she is in an abusive relationship' (interviewee 6).

A number of stories of nurses being the 'eyes and ears' and detecting child abuse and neglect were shared. Interviewee 1 shared a story of how she detected numerous non-accidental fractures during an ED assessment, interviewee 2 shared about how her colleague found a

baby on oxygen face down (medical neglect), and interviewee 5 shared about how in her clinic her colleague had been looking at a sore foot, when the little boy disclosed physical abuse.

In a sense, nurses acted as detectives;

> 'If we do suspect that there is something going on… we would increase our vigilance, and try and start documenting things that concerned us and putting together the information that we needed..' (interviewee 4).

Nurses used different sources of information to find out information - schools, other health professionals, and the computer systems. Interviewee 5 echoed the findings from the survey around using the child protection alert when looking into the background,

> 'if I see that alert I look to see what there may be.. and I'm just recording that on their notes so that if I'm, if something comes up, even if it's not current, I just know that that's there, yeah, so I take it into consideration when I'm looking at a holistic picture of the child'.

Hands

The second category points to the very practical hands on things that nurses 'do' when working with children who have experienced maltreatment.

Medical care

3 nurses interviewed discussed the medical care aspect of children who had experienced abuse or neglect:

> 'dealing with… the consequence of the physiological consequence of an NAI' (interviewee 3);

> 'A lot of [post-transplant teenagers] come back to us with rejection of their organs and illness because their families have not given the appropriate medication at the appropriate time, which in itself is neglect…' (interviewee 4).

Interviewee 5 discussed how she combed through the hair of sibling with

> 'extraordinarily bad head lice… one had an infected scalp'.

Ensuring safety

Ensuring the safety of the child and others was a vital concern for a number of the interviewees:

‘make sure she’s safe and everyone is safe’ (interviewee 1),

‘it’s paramount that the child’s kept safe,’ (interviewee 4);

‘At the end of the day just keep reminding myself that that child deserves to be looked after, you know, needs to be protected,’ (interviewee 6).

Interviewee 4 described where she

‘had to step into situations where there’s been a row on the ward…’

and another situation where she had

‘to code orange them to deal with the immediate aggression and abuse’.

Referrals/ liaison with services

Interviewee 3 perceived her role as a nurse in this sphere as centring around referrals;

‘probably more.. as in being a nurse, probably more referrals actually… [my role] is more referral based’ (interviewee 3).

and did not view her role as key to follow up,

‘it’s a specialist area… I don’t have the knowledge to follow that up at all’ (interviewee 3).

Conversely interviewee 6 felt that nurses not only had a responsibility

‘to make sure the right services are in there, especially social work and that kind of stuff…’

but also played a key role in follow up

‘…technically if I’m looking at the definition of a nurse, my follow up would be particularly around the health stuff… but I just find that often I’m not confident that things are gonna be followed up the way I think they should be and I’m the advocate for the child when no one else is, and so I tend to follow up… if nothing comes of a report of concern then I would probably keep following up and maybe make another report of concern in time if things escalated…’ (interviewee 6).

Support

The theme of support was mentioned a number of times throughout the interviews,

‘I guess, our role is to, yeah, just support whenever, you know, what we can do…’ (interviewee 5);

‘work out what the immediate stressors are in that person’s life and what we can do to support them’ (interviewee 4);

> ‘I want to be able to look to see how I can support them, because I mean, that’s what my whole role is isn’t it? I’m not trying to be above them, I’m trying to work in partnership with them’ (interviewee 5);
>
> ‘So I guess when you ask questions and often find out from people, well yeah, perhaps not that they want to be neglecting their kids but they’ve got no money for shoes and coats and clothes, then you can’t ignore that, you’ve got to do something about that… I guess it’s important that you then have the means to kind of actually deal with it,’ (interviewee 1).

Other

Other roles included documenting:

> ‘we were documenting very closely the mother and the mother’s behaviour’ (interviewee 4),

and one even saw giving children positive experiences as part of her role:

> ‘I would, with permission obviously from the parents, if I’m doing something with the child, I might take them to have a hot chocolate in a café or something like that… I can only think that you... that my role is to somehow give them some kind of experience which they may be able to draw on in the future’ (interviewee 5).

Not only did nurses discuss a wide range of roles and tasks they performed in this area, it was very evident that nurses had to balance these roles and priorities- which were sometimes seemingly conflicting:

> ‘she became very critical of us… so it was challenging to go in and to be able to still support that mother… keep the child safe, dealing with a distraught toddler, and there was a degree of discretion required because we had to put in the CYFSs watches... but also, still allow the mother to mother...that day you stop being the nurse and have to go in and be in a more judgmental and policing role is quite a hard one,’ (interviewee 4).

Head

The last three categories of the head, heart and gut point to the three ways of knowing. The category of ‘head’ talks to the knowledge nurses have around child abuse and neglect and the more concrete things such as physical time and space. It encompasses knowledge and the current systems and processes, and the numerous barriers and support that nurses experience within those spheres.

Systems and processes contribute to how nurses 'know' how to engage in this sphere and therefore experience this role.

The nurse practitioner in CED discussed the efficacy of current systems in place:

> 'I think our systems are pretty robust… part of our assessment is a mandatory child protection screen… I find that really, really helpful' (interviewee 1).

The ability to access the support of the multidisciplinary team was stated as a significant support:

> '[Te Puaruruhau] were amazing…I'd phoned them day and night and always found it really really helpful…' (interviewee 1);
>
> 'we have the excellent ADHB liaison person, the Oranga Tamariki liaison person… so I think we've got quite good support there' (interviewee 5).

And the ability to access cultural support was also mentioned:

> 'we can access the Pacific Island or the Māori support workers, they can get alongside that mother and will give a slightly different support' (interviewee 4).

However, sometimes access to the MDT fell short:

> 'We don't have 24-hour social work in our department which I think would be hugely beneficial' (interviewee 1).

There was also significant mention of the lack of integration of services. In all 6 of the interviews this lack of integration was mentioned, both between the social and health sectors, and also within the health sector.

Interviewee 3 and interviewee 1 mentioned the lack of medical information shared amongst health practitioners:

> '… you've got to actually contact that DHB to find out what the child protection alert is about. So, at 11 o'clock at night that's not easy… kind of visibility of primary health… and well child providers… [case that presented in first 6 weeks to] GPs, Plunket, another ED, and there'd be no kind of pulling together of that information…' (interviewee 1).

Interviewee 2 highlighted the frustration of Oranga Tamariki not releasing information to nurses, meaning that nurses were unknowingly going into homes known to be unsafe (she particularly mentioned gang homes with firearms). Interviewee 6 echoed this:

> 'there's this huge big barrier, a communication barrier, especially between the health team and the child protection team… we don't seem to be trusting of each other and

communicating very well… and that's the biggest thing that I find… I know we have the laws around confidentiality… and (have) to be really careful around the information sharing, but at the same time I think that gets taken to a point where it's to the detriment of the kids.'

Interviewee 2 also talked about the lack of sharing of information geographically. She told a story of a family about whom they had concerns who just 'up and left' Auckland. The lack of information sharing and subsequent lack of knowledge about specific situations, children, and families, is an obvious source of frustration and is perceived to put children at further risk.

Training and education contribute to knowing, and although not much was mentioned about training or education in the interviewees, interviewee 6

'…thought the training day here was really good.'

The importance of physical space and having enough time were emphasised during the interviews (echoing back to the results in the survey). Although having adequate time is not explicitly knowledge/head based, the systems, culture, and expectations in the area of work can increase or decrease the amount of time nurses have

'..if it's time to sit down and talk to someone, you need time to talk to them at length. It never seems so much of a priority as the IV drugs, but often if you can feed a baby and change it and sit with the mother for a while she'll open up to you… building rapport with the children, so again that's all time, time, time' (interviewee 4),

The importance of physical demands was reiterated by interviewee 3:

'sounds terrible but also depends on the demands of you on the day.. so whether you're pushed for a bed, whether you're not, whether you can keep that child in for an extra day to make sure that they're ok'.

'It's like, this is great, you've disclosed this, but… where does it go from there? Cause do we have beds?' (interviewee 2).

Interviewee two and three both talked about the difficulty of screening due to privacy,

'you can't sort of do family violence screening unless they're, you know, the mothers on their own and we very rarely got that opportunity…' (interviewee 2);

'It's quite busy and not particularly easy for somebody to disclose something and there's not really a lot of privacy…' (interviewee 5).

Uncertainty (lack of concrete knowledge), was also mentioned, echoing back to the findings of the survey. Interviewee 3 stated,

> ‘you’re never confident whether or not you’re actually making assumptions or you’re biased…’

Interviewee 4 discussed the challenge relating to neglect,

> ‘one of the biggest challenges is to unpack whether they are neglectful through lack of resources, or ignorance, or indifference to their child’s needs. It’s one of our biggest challenges.’

Interviewee 6 mentioned the difficulty in decided when something needed to be reported,

> ‘there’s no defined line…’ (interviewee 6).

A lack of confidence in social services was highlighted, again as found in the survey. In particular interviewee 6 expressed her frustration with Oranga Tamariki a number of times during the interview,

> ‘to be honest the biggest barrier has been this particular office of Oranga Tamariki… making reports of concern… knowing that if even if they do get past the contact centre they are so difficult to engage and so difficult to get any actual results…’

And finally, the difficulty of navigating school politics was mentioned in two of the interviews:

> ‘one of [the barriers] is probably the school space... it’s very political, the schools are very protective of their whānau, and obviously they’re trying to uphold their own image in the community as well…’ (interviewee 6);

> ‘then there is the school barrier, which is quite interesting, because you talk about it with school and sometimes the school don’t want to know, and sometimes the school want to be a bit more protective, and say oh no, we’ll talk to the parents first…’ (interviewee 5).

Heart

The category of heart talks to the importance of emotions as a way of knowing, and the emotions described by interviewees working in this sphere.

All interviewees described emotions experienced when dealing with child abuse and neglect; ‘…it is a very emotional thing’ (interviewee 1). Some interviewees described situations that they had been particularly emotionally affected by:

> ‘a real emotional rollercoaster and always for good reasons… I was really sad and angry and shocked, and yeah, surprisingly affected by it’ (interviewee 6).

Sadness was the overwhelming emotion, mentioned 14 times in the interviews (by 5 of the interviewees);

‘incredible sadness that these situations have occurred’ (interviewee 1);

‘it’s just devastating, it’s devastating what’s happening to all these kids... it’s depressing, it’s really sad…’ (interviewee 3);

‘I think sadness is overwhelming’ (interviewee 4).

A number of reasons were given as to why the participants felt sad: the realisation that

‘that’s just life… that’s a really harsh reality and a really hard thing to hear and to realise’ (interviewee 3); ‘you feel sorry for them because they are a long way from home, and are under a lot of stress’ (interviewee 4),

‘… personally, that was extremely upsetting because I had felt that I had given the father the knowledge to make himself safe with looking after his children…’ (interviewee 5),

‘if we miss a child, we’re often made to feel dreadful, and we certainly make ourselves feel dreadful’ (interviewee 4),

‘[a nurse] felt really distressed, and in some ways quite disheartened that she hadn’t picked it up…’ (interviewee 5), and ‘[a mother] abused us all round. She made our charge nurse cry... we had tears’.

The depth of the emotion was really highlighted over and over,

‘oh, looking at the baby you’re devastated... Absolutely devastated...’ (interviewee 4).

Three nurses described disbelief:

‘disbelief that somebody could actually, you know, harm an innocent child.’ Interviewee 1,

‘Complete disbelief… unbelievable’ (interviewee 3), ‘so that for me was a bit of a shock’ (interviewee 6).

Two interviewees described anger:

‘anger at people, I mean I wouldn’t let that show but inside you know, it’s you’d like to see, you know, them be dealt with what they’ve dealt to a child I guess’, (interviewee 1)

And three, frustration:

‘frustration… for these kids because they weren’t really being looked after and no one really wanted to do anything about it...’ (interviewee 6),

‘it’s that, you’ve seen it so many times… and you get that ‘not another one, not another one, not another one…’ (interviewee 4).

Hopelessness and a state of not knowing how to change the status quo was described in 3 of the interviews:

‘you do have that hopeless feeling that, you know that oh this is happening, this is happening, we have a whole generation now, where is NZ going to go, so it’s quite sad…’ (interviewee 3).

When asked about emotions, Interviewee 2 stated:

‘when everything goes to plan, everything’s in order, everything’s in place, you know, what’s the answer? If, you know, if the person that’s committing it, is still doing it with all those systems in place, how, how can you make it better?’;

‘I remember thinking, oh my goodness, I’m just sending them back to sleep on the sofas, that’s where they slept with a television going you know in the house and night, and thinking, what’s the... you know, how could that be different?’ (interviewee 5),

and hopelessness in terms of social services in general-

‘I don’t think they’re going to get better anytime soon’ (interviewee 3).

Other emotions included disgust,

‘disgust… that you would prey on a... weaker child, especially... because the majority of the NAIS that I’ve seen are in the nonverbal… how can you do that to a baby?’ (interviewee 3),

and fear,

‘I supposed scared... especially gang families and when you’ve got lots and lots of extended family who are really aggressive… she was too scared to go home and to the carpark… really scary especially when you’re only trying to do your best...’ interviewee 3

‘[nurses] do wear some of that initial aggression and denial’ (interviewee 4).

One interviewee also said she felt

‘…thankful that in fact the family did at some point present’ (interviewee 1).

From these responses, it is obvious that nurses feel a range of deep and taxing emotions. Despite this, nurses continue to carry out their job and

‘have to carry on working with those families despite the fact that there are many, many complex issues happening with the family, and support them’ (interviewee 4).

In a tertiary setting, nurses are not often given time to process this;

> '…[nurses] have a horrendous injury, we've all seen them, and, often it's short and sharp, and then you move on to the next patient.' Interviewee 4. 'often we all work so fast and so quickly… don't really sit down and thinking about it until [we] go home' (interviewee 4).

Despite the situation,

> 'you have to be professional and obviously nonjudgmental… but it's very human to want to respond to it… nurses have problems in terms of their responsibilities versus their feelings' (interviewee 4).

Interviewee 1 talked about the continued impact:

> 'I think sometimes it's even down the track a little bit when you rethink about it' (interviewee 1).
>
> 'you know we kind of carry that responsibility ourselves and that's really heavy sometimes…' (interviewee 6).
>
> 'Nurses have problems in terms of their responsibilities versus their feelings' (interviewee 4).

A couple of the nurses described how they currently deal with the 'heaviness' of these emotions, and deal with their responsibility despite these emotions: Interviewee 4 described how she avoids situations:

> 'I don't go to ICU very much anymore, it's too sad' (interviewee 4).

Interviewee 3 described becoming detached:

> 'it's about becoming completely detached and you know, you're probably not nursing them or giving them the same quality of nursing as what you should… I supposed it's a bit of a defense mechanism as well. Just focusing on the, you know, the physiological aspects of the child in the bed… distancing yourself… keeping it completely clinical... minimum interaction.…'

This was echoed by interviewee 2:

> '… it's hard but you have to… pull back and be a bit more sterile and professional…'

whereas interviewee 5 discussed how she focuses on the small positive interactions:

> '…I don't, you know, if it's worth it, or am I making any difference, I don't know, you don't know that, you can't judge that, but I think every interaction you have with the child is positive isn't it?... Whether it's sticking on a plaster and having a little chat while you're

doing it you know, and just think that you are somebody positive in that child's life. So, I think that's where you have to get your tiny moments of joy, haha… but you just have to be secure in yourself... and know that your actions are positive and you're always looking to see how you can improve the children… somewhere you, we have had something... you have made an action with that child…'

Interviewee 4 discussed another positive coping mechanism,

'you just have to balance it with knowing there are a lot of good parents, loving parents, and there are parents, you don't prejudge because there are parents who are not in a position to offer their children beautiful clothes and beautiful health care, but they love their children to bits, and that's the real reward…'

Interviewee 1 talked how she found teaching to be one way to offload a particularly harrowing case,

'I've actually used that case in quite a lot of teaching… which has probably been quite therapeutic for me as well actually.'

Having a supportive team (including supportive senior colleagues and management) was also mentioned by 4 of the interviewees:

'lucky to be part of a team where you're not alone so you can go and go and I just don't feel right' (interviewee 1);

'you've really got your consultants who back you with everything…that's a big thing' (interviewee 3); '

Just generally our team seems to be very aware of [care and protection] and very supportive around it, and it's kind of ok to talk about it within our team, and in other places it's still that taboo topic I think' (interviewee 6);

'There would always be somebody here that you could talk with' (interviewee 5).

Although supports were good, interviewee 1 indicated the need for a more formal way of debriefing:

'I mean I have good supports at work, I've got good supports at home, but you need some way of sort of offloading some of that stuff.'

The two interviewees who worked in the community talked about supervision. One was supportive of the concept, but often didn't actually find it very helpful, and the other had found it reasonably helpful.

One nurse also mentioned EAP, although also the lack of uptake of this-

> ‘we have the EAP system... it’s limited... and a lot of the young nurses will feel they almost fail, they’ve got to be right at the end of the tether to go…’ (interviewee 4).

Interviewee 1 also talked about the importance of ‘showing heart’:

> ‘you’ve never met this family before so basically you walk into a room and it’s about very quickly developing sort of that kind of relationship and rapport with someone where they’re actually going to feel comfortable to actually tell you stuff’.

Personal attributes such as communication skills, self-awareness, confidence and compassion for the child were also cited as assets.

Gut/ Child at the Centre

The third way of knowing is through the ‘gut’ or instinct. Two of the interviewees emphasised the role of the gut feeling, I had a

> ‘gut feeling was that there was a bit more to it than the family sort of saying …’ ‘I would always listen to that gut feeling’, ‘…that gut feeling is… an important part of nursing…’ (interviewee 1);

> ‘…it might sound a bit silly, but I kind of use my gut and instinct sometimes, nursing instinct sometimes tells me there is something more than just... you know... yeah, I don’t know how to put it into words’ (interviewee 6).

As well as relating to gut as a way of knowing, this category also relates to the fact that the child is always at the centre, regardless of the emotions nurses experience or the setting they work in; the well-being of the child is the ‘guts’ of it.

Ultimately, what was clear, was that nurses deeply cared about the children they work with and act as an advocate for the child;

> ‘I’m the advocate for the child when no one else is’ (interviewee 6); ‘at the end of the day [we] are here for that child, [we] are there to support that child and no one else can speak for it in terms of the fact that the child can’t speak for itself… at the end of the day it’s all about that child being in a safe position’ (interviewee 4).

And it is obvious that nurses regularly go above and beyond and take their responsibility of care seriously:

> ‘…I probably do a bit more than I should under the definition of a nurse, but if I don’t do it who’s going to…’ (interviewee 6).

Despite the aforementioned heavy and deep emotions, the caring heart of nursing came through time and time again,

> ‘I think the overwhelming is the sadness, but it’s something that we have to do in our job, and at the end of the day just keep reminding myself that that child deserves to be looked after, you know, needs to be protected’ (interviewee 6);
>
> ‘you just want to take the child home!’ (interviewee 4).

Recommendations

Interviewee 4 and interviewee 2 talked about the importance of supervision,

> ‘ I think there has to be more support for nurses in terms of psychological support… the parents are absolutely awful to deal with and the child has to be in hospital for about the next 6 weeks… and every nurse that went in there was on egg shells… it’s quite stressful, and needs to be talked about and to have the opportunity to sit down and be able to talk about it’ (interviewee 4).

Interviewee 4 talked about training in terms of feelings and emotional resilience:

> ‘there needs to be, I think, an opportunity, and people need to be encouraged to talk about it, they need more debriefings. We just had a debriefing for a sudden death on the ward, but not very often do they say does anyone want to sit down and talk about that child that turned up last week with syphilis... how do we feel about that?’.

Another suggestion given by five of the interviewees (1, 2, 3, 4 and 5) was that of information sharing between services - particularly on the computer system;

> ‘when I was in England... we actually had a register of the children that were, a little bit like the immunisation register that’s come in now… nationally based register of children who had come to the attention of… it would be really fantastic say they came through the emergency department, or wards… you could notify, say this child came to ED, so if they were going to Waitakere, and North Shore, and us… It’s nice to know sometimes if there’s an ongoing case with that family... or something has resolved… because the last thing you want to do is to make them feel that they are always going to be labelled… Even if it was just that he turned up in ED Friday night with a black eye... then he turned up at North Shore next week with a broken arm. You know, it would be so easy to put it all together… you don’t want poor things to have to tell you all their background…’ (interviewee 4);

‘it would be nice if you had a hot line to the social worker that the child has been assigned to’ (interviewee 5);

‘doing more around transparency of health information across the country. You know, with our alert system… it’s very slow…having more transparency…’ (interviewee 1)

Other suggestions included written clarification (a policy or guideline) around specific nursing following a ROC, a smaller work load (interviewee 5), more accessible social work within the tertiary system (interviewee 1), and interviewee 2 suggested that the family violence screening questions be ‘re-jigged’ as they are very direct.

Summary

This chapter has presented the wide range of results from the two-stage design process. From the very large amount of data that was collected from the comments in the questionnaires, it is possible to infer that the large majority of nurses view child protection as part of their job description and are well positioned to engage with child abuse and neglect. Consequently, nurses are involved, in a wide variety of ways, in keeping children safe - detecting and monitoring children who are at risk, supporting whānau, making referrals, acting as a liaison and care co-ordinator, and participating in the medical care.

It is clear that nurses have to balance a wide range of jobs while navigating the complexities of families. While there are some supportive features, there are obvious barriers which prevent nurses from feeling that they are able to maximise their role in this area.

It is also evident that nurses have a range and depth of emotion when dealing with children who have had suspected abuse or neglect. Despite this, the child is at the centre of the work that nurses do, and nurses ultimately care for the wellbeing of these children. The next chapter will discuss some of these findings and relate it back to existing research.

Chapter 5

Discussion

This chapter discusses the results outlined in chapter four. It initially discusses the sample population prior to discussing the main findings which are divided into the categories outlined in phase two of the results: eyes and ears, hands, head, heart and gut.

Sample

The response rate of the survey was 23.5%. Survey response rate is viewed as a key data-quality indicator (Meterko et al., 2015). While there is a large range of opinions as to what constitutes an acceptable response rate, it is generally thought a response rate of more than 10% should be aimed for (Daniel & Harland, 2018). Although high response rates are desirable due to their power and precision, some studies suggest that a 'low' response-rate survey may just as accurately represent a population (Meterko et al., 2015).

More than two thirds of the participants who completed the survey identified as New Zealand European. Although the breakdown of Starship nurse's ethnicity is unavailable, anecdotally the majority of nurses who work at Starship are NZ European. Just over 7% of participants identified as Māori, corresponding to the national statistic- 7% of registered nurses identify as Māori (The Nursing Council of New Zealand, 2015). One of nursing workforce priorities is to ensure that the workforce matches population demographics (Ministry of Health, 2016b), and although the percentage of Māori nurses within the nursing workforce is rising slowly (increased from 3.6% in 2009 to 6.5% in 2015), it remains below target; in 2013, 14.9% of the population identified as Māori (Statistics New Zealand, 2013).

Due to the low number of nurses identifying as Māori, it is crucial that local Māori health providers work in conjunction with nurses to ensure that tikanga is embedded into policy, procedure and decision making; not only as a matter of duty, but also in order to be effective. Solutions based on tikanga (Māori values and beliefs) and involving the wider whānau are more likely to be effective (Te Puni Kōkiri, 2010). Therefore, cultural support workers should consistently be engaged; this is particularly pertinent with child protection concerns. This is echoed in the Starship Clinical Guidelines (Kelly & Webb, 2016, p. 4), 'when working with Māori whānau, it is always appropriate to consult with Kaiatawhai'. About seventy-five per cent of the participants reported having engaged cultural services. As

outlined in chapter one, Māori are significantly overrepresented as both victims and perpetrators of family violence; this must be taken into consideration in order to achieve equity. While nurses have a responsibility to those from all cultural backgrounds who experience violence, it is vital to embrace tikanga, not only because of this overrepresentation, but also because of the commitment to the Treaty of Waitangi ("Treaty of Waitiangi," 1840). Addressing the Treaty obligations is also an explicitly stated priority of the Nursing Workforce (Ministry of Health, 2016b).

Overall, although participants varied widely in the time they had worked in child health, the majority were relatively junior. In the national nursing workforce statistics, 18% of nurses have been working for less than 6 years (The Nursing Council of New Zealand, 2015); however, in this cohort, almost 36% had been working for less than 6 years in child health. Despite this, a much higher percentage of participants possessed an additional qualification beyond their registration qualification as compared to the national average- 73% and 38% respectively (The Nursing Council of New Zealand, 2015).

Eyes and Ears

Considering New Zealand's statistics of abuse and neglect, it is unsurprising that three quarters of nurses responded that they had seen a case of suspected child abuse or neglect in the previous year.

The responses from participants emphasised the unique and privileged position held by nurses - professionally, culturally and philosophically - within the sphere of child protection. Nurses were the 'eyes and ears' of the health system, well situated to be able to detect child abuse and neglect. Paediatric nurses have frequent contact with children of all ages, in particular in the first years of life when children have regular visits for developmental evaluations and immunisations. They should therefore be one of the major groups identifying and referring children and families in crisis (Eisbach & Driessnack, 2010). This study, with participants in a wide variety of both in the community and tertiary settings, confirms nurses' opportune placement. Those in the community crossed boundaries into homes, General Practices, schools and hospitals, placing them in an ideal position to gain insight into the lives of children and whānau. Frequently nurses are the sole contact that the child or family has with the health care system, meaning they often have the first contact with children who have been abused (Herendeen, et al., 2014).This potential was recognised by a number of nurses who described being acutely aware of this. In addition, some nurses relate to families over an extended period of time, which not only gives them better insight, but also allows

formation of trusted relationships. There is a well-documented inherent public trust in nurses (Sadler et al., 2013).

Although nurses in the community appear to view child maltreatment as a greater proportion of their role than those in a tertiary setting, there was no significant difference between the workplace as to whether they had seen a case of suspected child abuse or neglect in the previous year. It may be assumed that those in the community setting see larger numbers of these children, as many will have a significant case load of children who are deemed 'vulnerable'. It is therefore unsurprising that more nurses working in the community felt confident in this area, particularly those working with children under 5 years of age. It is important that these nurses are particularly confident in this area, as young children have a higher rate of victimisation (Chihak, 2009).

When asked what enabled nurses to respond to suspected care and protection concerns, respondents cited access to information. It was evident that they collected information from a range of sources - including data already on record. All DHBs belong to the National Child Protection Alert System in order that abuse is not missed when children move between DHBs. According to the policy, if a health provider sees a Child Protection Alert, they should 'find the information which prompted the alert, take it into consideration, perform a thorough assessment and discuss the patient with a senior clinical prior to discharge' (Kelly & Webb, 2016, p. 30). Less than half of participants responded that they found more information if there was a Child Protection Alert, and just over one third responded that they took the alert into consideration when addressing the child's situation. However, as outlined, there were a number of respondents who did nothing differently; some due to the feeling that the alert lacked detail, and some due to the 'huge proportion' of children that they see with these alerts (this was in the community setting). With such a large proportion of nurses failing to follow the guidelines, it raises the question of the efficacy of child protection alerts.

Nurses can also be alerted to a child in an unsafe environment by routinely questioning mothers about intimate partner violence (IPV). While the majority of participants reported they had been trained to complete a routine enquiry (90%), according to the policy there should be 100% completion of this core training within 3 months of working at Starship (Kelly & Webb, 2016). Just over 40% of participants responded that they screen for family violence more than once a week. According to the policy 'routine enquiry for IPV should be completed with the accompanying caregiver of any child you see, whether or not you suspect abuse' (Kelly & Webb, 2016, p. 4). According to the 1st January to 30th June 2018 Audit Results for Starship Intimate Partner Violence Routine Enquiry Rates, the current routine

enquiry rate was 30% (with a target of 60%). It is possible that routine enquiry rate obtained by this study was higher because self-reporting is higher than actual completion. Another explanation is that those taking the time to answer the survey are more interested in this area, and therefore more likely to screen (Plowright, 2011).

It is unsurprising that the child and youth subsection of the cohort rarely completed a routine enquiry (screened for IPV), as they often interact with children at school, in the absence of their parents. It is similarly unsurprising that the 'well child' cohort complete a routine enquiry more commonly, as they are seeing mothers with young children (usually in a private setting) facilitating routine enquiry.

Hands

As well as being the 'eyes and ears' of the health service, well placed to detect child abuse and neglect, participants also acted as 'hands'. They actively participated across the spectrum of a child's interaction with the health care system, providing acute intervention after abuse, and ongoing support to families.

There was mention of typical 'nursing' roles including medical care of affected children, but nurses also crossed domains into other roles less typically associated with nursing: policing roles, care-coordinating roles, and social worker roles. Boundaries between professional roles have become more blurred and permeable (Brown, Crawford, & Darongkamas, 2000). There is an overt need for merging roles rather than maintaining division when recognising the patient as a whole (Baumann, Deber, Silverman, & Mallette, 1998).

Nurses in this study described intervening when there was aggression and abuse, closely documenting parental behavior, and acting to ensure that family, particularly children, were safe. There is a delicate balance and inherent ambiguity in holding a supporting and policing role simultaneously (Kent et al., 2011). As well as a policing role, nurses stepped into care coordination. Care coordinating involved not only making referrals but also ensuring that these are acted on.

Participants in the study also described offering care in any way possible - from giving children positive experiences, to ensuring that children were adequately fed and clothed. The field of social work in particular has opened up to nurses in the last decade – with the combining of roles based on economic efficiency, and recognition that sickness and socio-economic status are closely related (La Motte, 2012).

Head

The core category of head relates to nurses' training and knowledge in this sphere, and their understanding of their own role. It also encompasses supports and barriers faced by nurses.

Although almost 96% of participants viewed recognition of child protection concerns as part of their job description, only 79% reported having received training in how to recognise and respond to this, and only 50% felt confident. In New Zealand, according to the Ministry of Health's Violence Intervention Programme, nurses should receive training in child abuse and neglect (Fanslow & Kelly, 2016); this is also specific DHB policy. It is concerning that almost half the participants do not feel confident in what they perceive to be an essential component of their job. It is also concerning that some have not received adequate training in this. Given that child maltreatment has such significant health consequences, it is of at least equal importance to other traditional nursing roles and deserving of equal education and training. This finding is in line with other international studies; a high percentage of nurses do not believe they have been adequately prepared in this field (Herendeen et al., 2014).

Knowledge, experience, and clinical judgement were cited as enabling participants to respond to care and protection concerns. Lack of education and training in this area was seen as a barrier to this by six participants. Significantly, those who received training felt more confident. This is in accordance with studies which show that education increases nurses' ability to recognise and report child abuse and neglect (Chihak, 2009).

Despite nurses being so well positioned to work effectively in this area, this study highlighted the confusion and lack of clarity around their role in child abuse and neglect. The most obvious discrepancy in practice was around making reports of concern - with some nurses explicitly stating that this was not their responsibility, while others frequently made reports of concern. Although there are obvious differences between work place settings, this lack of standardization leads to confusion, both within the DHB and with other agencies and sectors liaising with DHB nurses. There was a particularly wide range of responses within the community setting - with 30% of respondents reporting never having completed a ROC, and 15% of respondents reporting doing them frequently. According to the Starship Clinical Guidelines, 'any ADHB clinician, after internal consultation, can make a Report of Concern to CYF' (Kelly & Webb, 2016, p. 21).

There was no clear understanding of a referral pathway, with a wide variety of responses as to whom nurses were referring. In the tertiary setting the most common referral made was to an ADHB social worker; in the community setting, most referred directly to Oranga Tamariki. It is logical that different settings should allow for different pathways of referral,

however, this lack of standardisation may mean a lack of efficiency (Hughes, 2008). Te Puaruruhau was contacted by participants in about 40% of responses. According to the policy, 'if [one] suspect[s] that a child or young person has already come to harm… ALWAYS consult directly with Te Puaruruhau… nor is a social work assessment a screening procedure for referral to Te Puaruruahu' (Kelly & Webb, 2016, p. 2). It is possible that the lack of direct referral to Te Puaruruhau is because the local practice is for this to be done by a senior colleague or social worker.

There is a notable difference in follow up between services, with community nurses much more likely to follow up, as they have long term relationships with families.

As well as a lack of standardisation, this study indicates that nurses perceive several barriers to addressing care and protection concerns. These included a lack of the aforementioned supports, but also uncertainty, inefficiencies of systems and process, lack of education, limited confidence in social services, and lack of integration of services. These barriers were similar in nature to those found by international studies (L. Lines et al., 2016).

Lack of certainty was the greatest perceived barrier, with almost one third of participants reporting this. There was an obvious tension between ensuring the wellbeing of the child and concern about overreaction or being incorrect. These concerns about suspicions being unfounded were echoed in a number of other studies (Eisbach & Driessnack, 2010; Rowse, 2009b). Ambiguity is inherent in the field of child protection (Munro, 2005), so this is potentially an unavoidable barrier. However there is significant risk involved when suspicions are not acted on.

In addition to concerns around unfounded suspicions of abuse, there was uncertainty of nurses' role within this. Some participants overtly stated that they were unsure of process, did not know what to do, and felt that there was disagreement about 'who does what'. Considering the stated discrepancy in practice, it follows that there is uncertainty and confusion around role clarity. This overt uncertainty may explain the expressed lack of confidence.

One way nurses dealt with this uncertainty was to use the support of their colleagues, seniors, and the multidisciplinary team. The immediate team, Te Puaruruhau, and the Oranga Tamariki liaison were cited as particularly supportive. Although the support of others was cited as helpful, it was also a source of frustration. In the tertiary setting there was frustration with the lack of 24/7 social work care.

While internal supports and access to the MDT were generally cited as a support, there was a lack of confidence in the child protection services. Although child protection services should arguably be the best-equipped sector for dealing with care and protection concerns, frustrations with and limited confidence in these services were outlined as a barrier to reporting suspected care and protection concerns by many respondents. The study based in New Zealand by Saltmarsh and Wilson (2017) also highlighted nurses' lack of confidence in child protection services (specifically neonatal nurses). Despite New Zealand's very different context and unique structure, this frustration appears to be universal. The frustration with lack of action, competence, resourcing, and communication is echoed in many studies exploring this topic (L. Lines et al., 2016). Many child protection services lack systemic procedures which would facilitate collaborative professional communication between health professionals and child protection services (Scott & Fraser, 2015). However, ADHB has an Oranga Tamariki Liaison role, which was cited as particularly helpful by a number of participants.

Similarly, there was frustration with lack of integration between services, both within the health sector, and between social and health services. This stemmed from lack of communication and information sharing between services, cited as often the main bottleneck (E. Louwers et al., 2012). There is a memorandum of understanding between ADHB, Oranga Tamariki and the Police who agree to 'share information with any party that could help to keep a child or young person safe and well, in a manner that is consistent with the law' ("Memorandum of Understanding Between Child, Youth and Family, New Zealand Police and the District Health Boards," 2011, p. 5). Despite this, there are continuing complaints of lack of information sharing between the services. A number of suggestions given by participants related to transparency of information within services and nationwide. Interprofessional collaborative practice is increasingly emphasised, both nationally and internationally (Brown et al., 2000).

It is clear that there is discrepancy between policy and practice, and between nurses perception of their role and their ability to act according to this perception.

Heart

The core category of heart reveals that nurses exposed to child abuse and neglect experience a range and depth of emotions which play a crucial role in their decision making. Each of these experienced emotions makes possible a distinct form of knowledge, and reveals some truth that is unavailable except through emotions (Furtak, 2018).

There is no doubt that working with children who have been abused or neglected makes high psychological demands on nurses. Working with children and families in distress exerts great emotional stress. Nurses interviewed described intense feelings of sadness- emphasized by the use of words like ‘devastating’, ‘overwhelming’ ‘distressed’ ‘tears’ and ‘heaviness’. Given the subject matter, it is unsurprising that these emotions are experienced; child abuse and neglect deeply offend contemporary moral and ethical code. A situation which contradicts a deeply held moral framework can lead to moral injury – a mismatch between core beliefs and events. This is known to contribute to feelings such as deep sadness, shame, guilt and rage (Haight, et al., 2017). Subjective beliefs about child abuse and neglect have been shown by some studies as more closely linked than knowledge or education about child abuse and neglect (Ben Natan et al., 2012; Ho & Gross, 2015). One study found that sexual abuse, death, and nonaccidental injury of a child were three of the top four stressful critical incidents (O'Connor & Jeavons, 2003), and there has been well documented secondary traumatic stress in nurses working in these areas (Beck, 2011).

As well as impacting on health and psychological well-being, emotions motivate behaviour (Jiwani, 2016) and thus, directly affect the quality of care given (Gómez-Díaz et al., 2017). In reality, feelings are as important as, often more than, thought in the process of decision making (Cadman & Brewer, 2001).

One nurse explicitly discussed how she became detached and disengaged in order to deal with these emotions. ‘Jading’ is a term that has been used to describe the occupational hazard occurring in health care when someone is ‘worn out’ and exhausted from work that is not only labor intensive, but also steeped in the complex social dynamics inherent in caring for humans (Ulrich et al., 2010). This exhaustion, coupled with the drive to make a difference which is compromised by repeated interactions remaining unresolved, can lead to moral apathy (Ulrich et al., 2010). This in turn leads people to distance themselves emotionally and cognitively. This leads on to decreased efficacy (Munro, 2005). The decrease in quality of care due to the emotions experienced was overtly recognized by one of the nurses interviewed. Nurses generally do not begin their professional career as callous and uncaring (Munro, 2005).

Fear was mentioned a number of times as a barrier to reporting suspected care and protection concerns. This included fear of family response - which, in the light of some cited examples, may be well founded.

Not only does emotional stress lead to decrease in quality of individual nursing care, but there is also research to suggest that there is an association between morally and ethically distressing events and high nursing staff turnover (Haight et al., 2017), which also leads to poorer quality of care.

Nurses do not and cannot practice as separate to their own lived experiences, values, concerns, and sense of reality. They need to recognize and embrace their humanness.

The recognition of humanness was summed up when one respondent, asked about their actions after seeing a child protection alert, stated '[I would] maybe cuddle that baby a little longer, and stronger….'

The undervaluing of the emotional dimension of the work may have significant adverse effects, both on nurses and on the children and families they are working with (Munro, 2005). Because of this, there is a strong case for the increased recognition of the role of emotional intelligence in improving outcomes. Embracing emotions as crucial for the effective assessment of risk helps nurses to efficiently simplify complex scenarios, and to resolve ambiguity (Cook, 2017). Professional supervision was identified by a number of participants as one way to do this; research confirms this as crucial (Dahlbo et al., 2017; Tingberg et al., 2008).

Gut

Closely related to emotions, two of the nurses discussed instinct and 'gut feelings' as an important part of nursing work and way of knowing in this area. Often suspicions around the well-being of a child starts with a nurse's intuition that something was amiss (Kraft & Eriksson, 2015; Rowse, 2009a; Saltmarsh & Wilson, 2017; Schols et al., 2013; Skarsaune & Bondas, 2015). As discussed in chapter 2, gut feelings should be taken seriously (Stolper et al., 2011) and there is increasing research showing intuition to be an advanced and effective way of decision making (Mikels et al., 2011). Where deliberative reasoning uses effortful thinking, judgements formed with intuition are fast, non-conscious and rely on past experience (Cook, 2017). Interestingly, both these nurses were very experienced in the world of child protection. Currently, nursing training is centred on reasoning in an analytical and systematic way, to the exclusion of intuition.

As well as intuition and gut feelings, the core category points to the child being at the centre of everything. Philosophically within nursing, good quality and responsible care starts with a holistic view of people (Sassen, 2018). Florence Nightingale (1820-1919), recognised as the

founder of modern nursing, specified that nursing is involved in health as well as illness (a feature that distinguishes it from medicine), and firmly embedded caring into nursing practice (Alligood, 2014).This caring heart of nursing really shone through in this research. There was an unmistakable, absolute passion for the well-being of the children whom the participants worked with. It was clear that the child was at the centre, and that 'the child's needs [were] paramount' (interviewee 4).

Summary

This chapter has discussed some of the findings from the research and related back to existing research and current policy. Nurses are uniquely and valuably placed to build and sustain relationships with children and families, and therefore to work within the complex area of child protection. Nurses engage in this sphere in numerous ways - detecting abuse and neglect, gathering information, coordinating care, monitoring, ensuring safety, making referrals, and supporting in any way possible. Decisions made by nurses in relation to child abuse and neglect are a complex integration of factual, experiential, relational and emotional knowledge. Finally, in order for care to be effective it is crucial that the emotional component is not disregarded. Many of the findings in this New Zealand context are consistent with international literature.

The next chapter will discuss the implications of this the research. It will outline recommendations for practice and future research, summarise the strengths and limitations of this research, and present the key areas of this study in some concluding remarks.

Chapter 6

Conclusion

‘Our children are our taonga. All children have a right to full emotional, spiritual and physical wellbeing, to develop their own potential in an environment which is nurturing and protective and in which they feel safe from abuse.’ (Kelly & Webb, 2016, p. 2).

This study fills an important gap in the literature examining perceptions of nurses who work with children about their role within child abuse and neglect. Due to the serious immediate and long-term effects of child maltreatment, for the individual, the whānau and the wider society, it is imperative that nurses are equipped in this area. This research provides a baseline understanding to build on.

Given the overwhelming statistics of child abuse and neglect in New Zealand and the increasingly understood lifelong effects on mental and physical health, the health system should have a much larger focus on preventing, identifying, and intervening in this area. Child abuse and neglect is a profoundly important health issue and should be a priority for in health care. Nurses are particularly well placed, skilled at working with families, and experienced working within multi-disciplinary teams.

Overview

The main findings of this research can be divided into the following categories:

Eyes and ears- Almost all nurses working with children viewed the area of child protection as part of their role, and most had witnessed a suspected case of child abuse or neglect in the previous year. Nurses are well position to detect abuse and neglect, and in many ways embody the ‘eyes and ears’ of the health service. Intimate partner violence is closely related to child abuse and neglect, and thus regularly completing a routine enquiry is relevant. Most nurses were trained to complete a routine enquiry, however, over half reported screening only very rarely.

Hands- there are numerous ways in which nurses engaged in this sphere. Nurses followed up on health needs and the required medical care of children who had suffered abuse or neglect, and they engaged in monitoring children and families. They were involved in care coordination and liaison roles, ensured safety of children and viewed themselves as a safety net. They made referrals to a variety of other professionals and agencies, and some nurses were directly involved in making reports of concern. It is apparent that many nurses working

with children supported them in any way possible -often acting ‘above and beyond’ their professional duty to support children and families.

Head- Most of the study participants had received training in this area, and those who had received training felt more confident in their ability to identify child maltreatment. Nurses working in the community also felt more confident than their counterparts in tertiary care. However, despite the view of working with child abuse and neglect as integral to their role, only half of the nurses felt confident in their ability to identify child maltreatment. This does not reflect well on the current situation.

It was clear that there was little standardisation in how engaged nurses were in this sphere, particularly across different settings. There was a wide variety in referrals (with significant differences depending on the setting in which they worked), and in the practice regarding reports of concern and response to child protection alerts.

Nurses encountered a range of barriers and supports- both personal and systematic. Having access to the multidisciplinary team was a significant support - in particular Te Puaruruahu, and those that felt their own team to be supportive. Time and space, and accessibility of information were supports when available, but barriers when limited. The two main barriers reported were lack of certainty (around being wrong, but also around process), and limited confidence in social services.

Heart- Nurses experienced a range of deep and profound emotions when engaging with children who had suffered abuse and neglect. This not only affected the nurses personally, but also affected decision making and quality of care. Emotional responses in nursing, particularly in the area of child abuse and neglect, should be considered as a central feature of quality nursing practice, not merely as an additional extra, or as something to be contained or repressed.

Gut- Nurses rely on gut feelings when making decisions in this area; gut feelings and intuition are an important and advanced way of knowing.

Furthermore, despite numerous barriers, challenges, and emotional pressures, nurses continually put children at the centre of what they do, and deeply care for the wellbeing of tamarkiki.

Strengths

The use of mixed methodology recognised the crucial role of individual experience, perception and perspective in knowledge, while maintaining the ability to measure and manipulate data. It created a space to engage with the complex context of child protection by gathering diverse data to offer a more complete understanding of nurse's perception of their role in child protection.

Conducting an online survey had a number of benefits: it was practical as it reduced the cost of questionnaire distribution and eliminated the influence of an interviewer. There was a good response rate from the survey, and the respondents demonstrated a breadth of experience in working with children. A range of departments, specialties, seniority and level of education were represented.

The subsequent interview questions were informed by the information gained in the survey - in particular the free text questions - and therefore added depth and detail to the data.

Limitations

The biggest limitation of this study was the amount of information gained to analyse. The volume of information meant that the study could only 'skim the surface' of many issues and did not have the scope to explore any one aspect in depth. In hindsight, the study could have focused on a smaller area- for example the effect of emotions on decision making in this area. There were also significant limitations when comparing different work places- comparing community nurses with those who work in theatre, roles too disparate to bear comparison.

Although there was a good response rate, it was a relatively small study and was limited to one DHB. The respondents were not a randomized selection of the population but were self-selected. It is probable that participants were more likely to be nurses with a specific interest or involvement in child protection, leading to a bias in research. Although those interviewed were the first to respond, in an attempt to make it fair and random, it became clear that all but one of the interviewees were senior nurses with a particular interest in child protection. Because of the size of the study and the non-probably sampling, I acknowledge that it does not necessarily represent the wider population of paediatric nurses in New Zealand.

As a beginning researcher, there are a number of specific improvements which could have been made. For example: instead of asking: 'have you been trained to screen for family violence?' the questionnaire should have asked: 'did you attend the 8-hour core training in family violence within the last 5 years?'. It is unclear if people who answered yes were

trained by the DHB, or when such training had occurred. The process is now called a routine enquiry as opposed to family violence screening (as screening has medical connotations). Instead of 'if yes, how any times per week (or per 40 hours worked) do you screen for family violence?' it would have been better to ask about completing routine enquiry. Not only is this up to date terminology, it would directly ask if the specific questions outlined by the Family violence Intervention team were used.

Despite these limitations, there are a number of recommendations for practice arising from the study.

Recommendations for practice

To conclude this study, the following recommendations are put forward:

Policy

- Given the extent of the prevalence of child abuse and neglect in New Zealand, significant resource should be allocated to prevention, identification and intervention of this.
- An increase in the number of Māori nurses working with children is recommended. Consistent and universal cultural support is endorsed - in particular when dealing with issues of child abuse and neglect.

Practice

- Nurses have a vital role in the prevention and detection of child abuse. It should be not only possible, but easy for nurses to engage in this sphere. Although permeable boundaries and blurred roles will always a feature when working with complex families, there needs to be increased clarity around roles and responsibilities. A more cohesive, unified approach would mean less duplication or admission of services.
- There is a need for standardisation of pathways; in particular referral pathways and expectations around Reports of Concern. This will be clarifying for nurses, and also for other professions and sectors in order to have clear expectations of the nursing contribution.
- It is clear that many services, both within the health sector and in other spheres, work in silos. Clearer lines of communication are required, where all parties feel they are privy to the information needed without jeopardizing the privacy of families.
- It has been highlighted that emotional support at every stage is important, and structures should be established to provide a framework for this - whether through

improved supervision, professional counselling, or a designated colleague. These structures should be evaluated as to effectiveness. Not only is this fundamental for wellbeing and retention of staff, it also impacts the quality of care provided. Within this, the role of gut feelings should be considered and taken seriously.

Education

- Support for nurses with continuing training and education to develop and expand skills and knowledge in this area is vital. Training and education strategies should consider the diversity of nursing settings and develop training programmes appropriate for different workplaces. In particular these strategies must support professionals to gain confidence in their skills, and to decrease fear around giving offence.
- The recognition that affective experience is a valid interpretation of reality, and that examination of emotion is crucial and central for quality of care is to be encouraged. Training and education around emotional intelligence, and management of emotion is vital, both for nursing students and for practising nursing professionals. Along with this, training around the specific role of intuition should be incorporated.
- To aid clearer lines of communication and trust between services, interprofessional education should begin during tertiary education.

Future research

- Future research should examine child protection alerts- and how to best ensure they are efficient and useable
- More investigation should be taken to understand why only not all participants engaged cultural services. This questions the adequacy of numbers of cultural workers, their accessibility, and participants' reluctance to engage their services.
- Additional research into the role of emotion in this area and in an New Zealand context is warranted- specifically how emotion influences decision making and outcomes.
- Research to identify protective factors which may be built on in interventions to educate, prevent, and/or address the emotional distress associated with this work is recommended.

Final thoughts

Child abuse and neglect is a profoundly important health issue and should be a priority for the New Zealand health care system. Health workers should play a key role in the area of family violence and child abuse and neglect, and not be seen as merely an adjunct to the social sector. Adverse childhood experiences increase the lifelong risk of poor health outcomes, and also represent risks for future generations. Hence, the question of safety for our tamariki should be taken no less seriously than workplace or airline transport safety.

There is an ethical imperative to advocate across all professions, in particular health professions, that keeping children safe is everybody's responsibility, not just the domain of social services. Nurses have a vital role in the prevention and detection of child abuse, but their full potential here has not been realised. They are well positioned to support children and whānau once abuse or neglect has been identified. Working within child protection should not be a sideline to other responsibilities, but a core part of nursing work. Strong strategic and inspirational clinical leadership is required to enable the cultural change which will ensure that keeping children safe is a central component for everyday nursing practice. This research provides a foundation on which to continue exploring the role of nurses in the journey toward delivering New Zealand's promise to the 1.1 million children in Aotearoa, New Zealand- for children to be 'loved, nurtured, and safe'.

Ahakoe he iti he pounamu. Although it is small, it is precious.

References

Action for Children and Youth Aotearoa. (2017). Annual Report 2017. Retrieved 23/05/18 from http://www.acya.org.nz/uploads/2/9/4/8/29482613/acya_annual_report_2017.pdf

Alligood, M. (2014). *Nursing Theory: Utilization and Application* (5 ed.). Missouri: Mosby.

Anda, R., Felitti, V., Bremner, J., Walker, J., Whitfield, C., Perry, B., . . . Giles, W. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*(3), 174-186. doi:10.1007/s00406-005-0624-4

Aragão, A., Ferriani, M., Vendruscollo, T., Souza, S., & Gomes, R. (2013). Primary care nurses' approach to cases of violence against children Aproximación de la violencia a los niños por enfermeras en la atención primaria Abordagem dos casos de violência à criança pela enfermagem na atenção básica. *Revista Latino-Americana De Enfermagem, 21*, 172-179.

Ardern, J. (2018). Our Plan for a modern and prosperous New Zealand. Retrieved 2018 from https://www.beehive.govt.nz/speech/our-plan-modern-and-prosperous-new-zealand

Award for Distinguished Scientific Contributions: Paul Ekman. (1992). *American Psychologist, 47*(4), 470-471. doi:10.1037/0003-066X.47.4.470

Balch, C. (2010). *Internet Survey Methodology*. Newcastle upon Tyne: Cambridge Scholars Publishing

Baumann, A., Deber, R., Silverman, B., & Mallette, C. (1998). Who cares? Who cures? The ongoing debate in the provision of health care. *Journal of Advanced Nursing, 28*(5), 1040-1045.

Beck, C. (2011). Secondary Traumatic Stress in Nurses: A Systematic Review. *Archives of Psychiatric Nursing, 25*(1), 1-10. doi:10.1016/j.apnu.2010.05.005

Ben Natan, M., Faour, C., Naamhah, S., Grinberg, K., & Klein-Kremer, A. (2012). Factors affecting medical and nursing staff reporting of child abuse. *International Nursing Review, 59*(3), 331-337. doi:10.1111/j.1466-7657.2012.00988.x

Ben Yehuda, Y., Attar-Schwartz, S., Ziv, A., Jedwab, M., & Benbenishty, R. (2010). Child Abuse and Neglect: Reporting by Health Professionals and their Need for Training. *12*(10), 598-602.

Birks, M., & Mills, J. (2011). *Grounded theory: a practical guide*. London: SAGE.

Borimnejad, L., & Fomani, F. (2015). Child Abuse Reporting Barriers: Iranian Nurses' Experiences. *Iran Red Crescent Medical Journal, 17*(8). doi:10.5812/ircmj.22296v2

Bowling, A., & Ebrahim, S. (2006). *Handbook of health research methods: investigation, measurement and analysis.* England: McGraw-Hill Education.

Boychuk Duchscher, J., & Morgan, D. (2004). Grounded theory: reflections on the emergence vs. forcing debate. *Journal of Advanced Nursing, 48*(6), 605-612. doi:10.1111/j.1365-2648.2004.03249.x

Brown, B., Crawford, P., & Darongkamas, J. (2000). Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health & Social Care in the Community, 8*(6), 425-435.

Browne, A., Doane, G., Reimer, J., MacLeod, M., & McLellan, E. (2010). Public health nursing practice with 'high priority' families: The significance of contextualizing 'risk'. *Nursing Inquiry, 17*(1), 27-38. doi:10.1111/j.1440-1800.2009.00478.x

Cadman, C., & Brewer, J. (2001). Emotional intelligence: A vital prerequisite for recruitment in nursing. *Journal of Nursing Management, 9*(6), 321-324. doi:10.1046/j.0966-0429.2001.00261.x

Charmaz, K., Thornberg, R., & Keane, E. (2018). *The Sage handbook of qualitative research* (N. K. Denzin & Y. S. Lincoln Eds. 5th ed.). Los Angeles: SAGE.

Chen, Y.-W., Huang, J.-J., Lu, T.-H., & Feng, J.-Y. (2015). Clinical competency in child maltreatment for community nurses in Taiwan. *International Journal Of Nursing Practice, 21*(1), 21-26. doi:10.1111/ijn.12395

Chihak, A. (2009). The nurse's role in suspected child abuse. *Paediatrics and child health, 19*(52), 211-213. doi:10.1016/j.paed.2009.08.005
Clark, T., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., . . . Utter, J. (2013). *Youth'12 Overview: The health and wellbeing of New Zealand secondary school students in 2012.* . Auckland, New Zealand: The University of Auckland
Clark, V., & Ivankova, N. (2016). *Mixed methods research: a guide to the field*. Los Angeles: SAGE.
Committee on the Rights of the Child. (2016). Concluding observations on the fifth periodic report of New Zealand. In.
Cook, L. (2017). Making Sense of the Initial Home visit: The Role of Intuition in Child and Family Social Workers' Assessments of Risk. *Journal of Social Work Practice, 31*(4), 431-444. doi:10.1080/02650533.2017.1394826
Creswell, J. (2014). *Research design: qualitative, quantitative, and mixed methods approaches* (4th ed.): Thousand Oaks: SAGE Publications.
Creswell, J., & Creswell, J. (2018). *Research design : qualitative, quantitative, and mixed methods approaches* (5th ed.). Los Angeles: SAGE.
Curtis, E. (2016). Indigenous positioning in health research: The importance of Kaupapa Māori theory-informed practice. *AlterNative: An International Journal of Indigenous Peoples, 12*(4), 396-406.
Dahlbo, M., Jakobsson, L., & Lundqvist, P. (2017). Keeping the child in focus while supporting the family: Swedish child healthcare nurses experiences of encountering families where child maltreatment is present or suspected. *Journal of Child Health Care, 21*(1), 103-111. doi:10.1177/1367493516686200
Dalley, B. (2018). Child Abuse. Te Ara- the Encyclopedia of New Zealand Retrieved 11 December 2018, from Te Ara - the Encyclopedia of New Zealand http://www.TeAra.govt.nz/en/child-abuse/print
Daniel, B., & Harland, T. (2018). *Higher education research methodology: a step-by-step guide to the research process*. New York: Routledge.
Davidov, D., & Jack, S. (2014). Nurse home visitors' perceived awareness of mandatory reporting requirements: pregnant women's and children's exposure to intimate partner violence. *Journal of Advanced Nursing, 70*(8), 1770- 1779. doi:10.1111/jan.12334
Davidov, D., Jack, S., Frost, S., & Coben, J. (2012). Mandatory Reporting in the Context of Home Visitation Programs: Intimate Partner Violence and Children's Exposure to Intimate Partner Violence. *Violence Against Women, 18*(5), 595-610. doi:10.1177/1077801212453278
Davidov, D., Nadorff, M., Jack, S., & Coben, J. (2012a). Nurse Home Visitors' Perceptions of Mandatory Reporting of Intimate Partner Violence to Law Enforcement Agencies. *Journal of Interpersonal Violence, 27*(12), 2484-2502.
Davidov, D., Nadorff, M., Jack, S., & Coben, J. (2012b). Nurse home visitors' perspectives of mandatory reporting of children's exposure to intimate partner violence to child protection agencies. *Public Health Nursing, 29*(5), 412-423. doi:10.1111/j.1525-1446.2011.01003.x
Davis, C. (2013). *SPSS for Applied Sciences: Basic Statistical Testing*. Victoria, Australia: CSIRO Publishing.
DePoy, E., & Gitlin, L. (2016). *Introduction to research: understanding and applying multiple strategies* (5th ed.). London: Elsevier Health Sciences.
Donald, T. (2012). Does mandatory reporting really help child protection? The view of a mandated Australian. *Journal of Primary Health Care, 4*(1), 80-82.
Duncanson, M., Oben, G., Wicken, A., Morris, S., McGee, M., & Simpson, J. (2017). *Child Poverty Monitor: Technical Report 2017 (National Report)*. Dunedin.
Eisbach, S., & Driessnack, M. (2010). Am I Sure I Want to Go Down This Road? Hesitations in the Reporting of Child Maltreatment by Nurses. *Journal for Specialists in Pediatric Nursing, 15*(4), 317-323.
Ekman, P. (1992). Are there basic emotions? *Psychological Review*(3), 550-553.

El-Radhi, A. (2015). Safeguarding the welfare of children: what is the nurse's role? . *British Journal of Nursing, 24*(15), 769-773.
Engh Kraft, L., Rahm, G., & Eriksson, U.-B. (2017). School Nurses Avoid Addressing Child Sexual Abuse. *The Journal Of School Nursing, 33*(2), 133-142. doi:10.1177/1059840516633729
Expert Panel- Modernising Child Youth and Family. (2015). *Expert Panel Final Report: Investing in New Zealand's Children and their Families*. Wellington: Ministry of Social Development. Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/corporate/expert-panel-cyf/investing-in-children-report.pdf
Family Violence Death Review Committee. (2014). *Fourth Annual Report: January 2013 to December 2013*. Wellington: Health Quality & Safety Commission.
Family Violence Death Review Committee. (2016). *Fifth Report: January 2014 to December 2015*. Wellington: Health Quality & Safety Commission. Retrieved from https://www.hqsc.govt.nz/our-programmes/mrc/fvdrc/
Fanslow, J., & Kelly, P. (2016). Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence. In (2nd ed.). Wellington, New Zealand: Ministry of Health.
Feng, J., Fetzer, S., Chen, Y., Yeh, L., & Huang, M. (2010). Multidisciplinary collaboration reporting child abuse: A grounded theory study. *International Journal of Nursing Studies, 47*(12), 1483-1490. doi:10.1016/j.ijnurstu.2010.05.007
Finn, C. (2011). Forensic nurses' experiences of receiving child abuse disclosures. *Journal for Specialists in Pediatric Nursing, 16*(4), 252-262. doi:10.1111/j.1744-6155.2011.00296.x
Flemington, T., & Fraser, J. (2016). Maternal involvement in a nurse home visiting programme to prevent child maltreatment. *Journal of Children's Services, 11*(2), 124-140. doi:10.1108/JCS-02-2015-0003
Francis, K., Chapman, Y., Sellick, K., James, A., Miles, M., Jones, J., & Grant, J. (2012). The decision-making processes adopted by rurally located mandated professionals when child abuse or neglect is suspected. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 41*(1), 58-59. doi:10.5172/conu.2012.41.1.58
Fraser, J., Mathews, B., Walsh, K., Chen, L., & Dunne, M. (2010). Factors influencing child abuse and neglect recognition and reporting by nurses: a multivariate analysis. *International Journal of Nursing Studies, 47*(2), 146-153. doi:10.1016/j.ijnurstu.2009.05.015
Furtak, R. A. (2018). *Knowing emotions : truthfulness and recognition in affective experience*. New York, NY: Oxford University Press.
Galletta, A., & Cross, W. (2013). *Mastering the semi-structured interview and beyond: from research design to analysis and publication*. New York: New York University Press.
Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory : strategies for qualitative research*. Chicago; New York: Aldine.
Gómez-Díaz, M., Delgado-Gómez, M., & Gómez, S., Rosario. (2017). Education, Emotions and Health: Emotional Education in Nursing. *Procedia - Social and Behavioral Sciences, 237*(2017), 492-498. doi:10.1016/j.sbspro.2017.02.095
Goodyear-Smith, F. (2012). Should New Zealand introduce mandatory reporting by general practitioners of suspected child abuse? NO. *Journal of Primary Health Care, 4*(1), 77-79.
Greene, J. (2005). The generative potential of mixed methods inquiry. *International Journal of Research and Method in Education, 28*(2), 207-211. doi:10.1080/01406720500256293
Hackett, A. (2013). The role of the school nurse in child protection. *Community Practitioner: The Journal Of The Community Practitioners' & Health Visitors' Association, 86*(12), 26-29.
Haight, W., Sugrue, E., & Calhoun, M. (2017). Moral injury among Child Protection Professionals: Implications for the ethical treatment and retention of workers. *Children and Youth Services Review, 82*, 27-41. doi:10.1016/j.childyouth.2017.08.030
Hanafin, S. (2013). Child protection reports: key issues arising for public health nurses. *Community Practitioner: The Journal Of The Community Practitioners' & Health Visitors' Association, 86*(10), 24-27.

Health and Disability Commissioner. (1996). Code of Health and Disability Services Consumers' Rights. Retrieved from https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/

Guidelines for Researchers on Health Research Involving Māori (2010).

HRC Research Ethics Guidelines (2017).

Herendeen, P., Blevins, R., Anson, E., & Smith, J. (2014). Barriers to and Consequences of Mandated Reporting of Child Abuse by Nurse Practitioners. *Journal of Pediatric Health Care, 28*(1), e1-e7. doi:10.1016/j.pedhc.2013.06.004

Hildyard, K., & Wolfe, D. (2002). Child neglect: developmental issues and outcomes. *Child abuse & neglect, 26*(6-7), 679-695. doi:10.1016/S0145-2134(02)00341-1

Ho, G., & Gross, D. (2015). Pediatric Nurses' Differentiations Between Acceptable and Unacceptable Parent Discipline Behaviors: A Q-Study. *Journal of Pediatric Health Care, 29*(3), 255-264. doi:10.1016/j.pedhc.2014.12.004

Hornor, G., Bretl, D., Chapman, E., Herendeen, P., Mitchel, N., Mulvaney, B., . . . VanGraafeiland, B. (2017). Child Maltreatment Screening and Anticipatory Guidance: A Description of Pediatric Nurse Practitioner Practice Behaviors. *Journal of Pediatric Health Care, 31*(6), 35-44. doi:10.1016/j.pedhc.2017.05.006

Hornor, G., & Herendeen, P. (2014). Advanced Practice Nursing in Child Maltreatment: Practice Characteristics. *Journal of Pediatric Health Care, 28*(5), 438-443. doi:10.1016/j.pedhc.2014.02.003

Hughes, R. (2008). *Patient safety and quality: an evidence-based handbook for nurses*. Rockville, Maryland: AHRQ Publication

IBM SPSS software. (2018). Retrieved from https://www.ibm.com/analytics/spss-statistics-software

Jiwani, K. (2016). Handling challenging emotions in nursing care. *i-manager's Journal on Nursing, 6*(2), 12-15.

Jordan, K., MacKay, P., & Woods, S. (2017). Child Maltreatment: Optimizing Recognition and Reporting by School Nurses. *NASN School Nurse, 32*(3), 192-199. doi:10.1177/1942602X16675932

Kate, K., Belinda, C., Vivienne, B., & John, S. (2003). Good practice in the conduct and reporting of survey research. *International Journal for Quality in Health Care, 15*(3), 261-266.

Kelly, P., & Webb, L. (2016). Starship Clinical Guidelines: Abuse and Negelct Retrieved October 2018

Kent, S., Dowling, M., & Byrne, G. (2011). Community nurses' child protection role: views of public health nurses in Ireland. *Community Practitioner: The Journal Of The Community Practitioners' & Health Visitors' Association, 84*(11), 33-36.

Koetting, C., Fitzpatrick, J., Lewin, L., & Kilanowski, J. (2012). Nurse practitioner knowledge of child sexual abuse in children with cognitive disabilities. *International Association of Forensic Nurses, 8*(2), 72-80. doi:10.111/j.193938.2011.01129.x

Koziol-McLain, J., Gardiner, J., Batty, P., Ramika, M., & Fyfe, E. (2004). Prevalence of intimate partner violence among women presenting to an urban adult and paediatric emergency care department. *The New Zealand Medical Journal, 117*(1206), 1-8.

Kraft, L., & Eriksson, U.-B. (2015). The School Nurse's Ability to Detect and Support Abused Children: A Trust-Creating Process. *Journal of School Nursing, 31*(5), 353-362.

La Motte, E. (2012). The nurse as a social worker. *Public Health Nursing, 29*(2), 185-187. doi:10.1111/j.1525-1446.2012.01011.x

Land, M., & Barclay, L. (2008). Nurses' contribution to child protection. *Neonatal, Paediatric and Child Health Nursing, 11*(1), 18-24.

Lavigne, J., Portwood, S., Warren-Findlow, J., & Brunner Huber, L. (2017). Pediatric Inpatient Nurses' Perceptions of Child Maltreatment. *Journal of Pediatric Nursing, 34*, 17-22. doi:10.1016/j.pedn.2017.01.010

Lines, L., Grant, J., & Hutton, A. (2018). How Do Nurses Keep Children Safe From Abuse and Neglect, and Does it Make a Difference? A Scoping Review. *Journal of Pediatric Nursing, 43*. doi:10.1016/j.pedn.2018.07.010

Lines, L., Hutton, A., & Grant, J. (2016). Integrative review: nurses' roles and experiences in keeping children safe. *Journal of Advanced Nursing, 73*(2). doi:10.1111/jan.13101

Little, A., & Logie, J. (2018). Reducing family violence harm top priority [Press release]

Liu, M., & Wronski, L. (2018). Examining Completion Rates in Web Surveys via Over 25,000 Real-World Surveys. *Social Science Computer Review, 36*(1), 116-124.

Louwers, E., Korfage, I., Affourtit, M., De Koning, H., & Moll, H. (2012). Facilitators and barriers to screening for child abuse in the emergency department. *BMC Pediatrics, 12*(1), 167-172. doi:10.1186/1471-2431-12-167

Louwers, E., Korfage, I., Vooijs-Moulaert, A., van den Elzen, A., Jongejan, M., Ruige, M., . . . de Koning, H. (2012). Effects of Systematic Screening and Detection of Child Abuse in Emergency Departments. *Pediatrics, 130*(3), 457-464. doi:10.1542/peds.2011-3527

Massey University. (2017). Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants: Revised Code 2017. In.

Matthews, B., Fraser, J., Walsh, K., Dunne, M., Kilby, S., & Chen, L. (2008). Queensland nurses' attitudes towards and knowledge of the legislative duty to report child abuse and neglect: results of a state-wide survey. *Journal of Law and Medicine, 16*(2), 228-304.

Maul, K., Naeem, R., Rahim Khan, U., Mian, A., Yousafzai, A., & Brown, N. (2018). Child abuse in Pakistan: A qualitative study of knowledge, attitudes and practice amongst health professionals. *Child Abuse and Neglect, 88*, 51-57. doi:10.1016/j.chiabu.2018.10.008

Memorandum of Understanding Between Child, Youth and Family, New Zealand Police and the District Health Boards. (2011).

Meterko, M., Restuccia, J. D., Stolzmann, K., Mohr, D., Kaboli, P., Brennan, C., & Glasgow, J. (2015). Response rates, nonresponse bias, and data quality: Results from a national survey of senior healthcare leaders. *Public Opinion Quarterly, 79*(1), 130-144. doi:10.1093/poq/nfu052

Mikels, J., Maglio, S., Reed, A., & Kaplowitz, L. (2011). Should I go with my gut? Investigating the benefits of emotion-focused decision making. *Emotion, 11*(4), 743-753. doi:10.1037/a0023986.

Mills, J., & Birks, M. (2014). *Qualitative methodology : a practical guide*. London: SAGE Publications Ltd.

Ministry of Health. (2016a). *Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence*. Retrieved from https://www.health.govt.nz/publication/family-violence-assessment-and-intervention-guideline-child-abuse-and-intimate-partner-violence

Ministry of Health. (2016b). *Health of the Health Workforce 2015*. Wellington: Ministry of Health. Retrieved from www.health.govt.nz

Ministry of Health. (2018). *Work Programme 2018: Government Priorities* Retrieved from https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2018

Ministry of Social Development. (2012). *Children's Action Plan: Identifying, Supporting and Protecting Vulnerable Children* Wellington. Retrieved from http://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/policy-development/white-paper-vulnerable-children/white-paper-for-vulnerable-children-childrens-action-plan-summaries.pdf

Ministry of Social Development. (2014). Better Public Services [Press release]. Retrieved from https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/corporate/annual-report/2013-2014/better-public-services.html#footnotes

Ministry of Social Development. (2015). *United Nations Convention on the Rights of the Child: Fifth Periodic Report by the Government of New Zealand 2015*. Ministry of social development Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-

work/publications-resources/monitoring/uncroc/nz-fifth-periodic-report-under-the-united-nations-convention-on-the-rights-of-the-child.pdf
Moreira, G., Vasconcelos, A., Marques, L., & Vieira, L. (2013). Training and knowledge of professionals of the health family team on reporting mistreatment of children and adolescents. *Revista Paulista De Pediatria, 31*(2), 223-230.
Munro, E. (2005). Improving practice: Child protection as a systems problem. *Children and Youth Services Review, 27*(4), 375-391. doi:10.1016/j.childyouth.2004.11.006
Murphy-Oikonen, J., Brownlee, K., Montelpare, W., & Gerlach, K. (2010). The Experiences of NICU Nurses in Caring for Infants with Neonatal Abstinence Syndrome. *Neonatal Network, 29*(5), 307-313.
National Institute for Health and Care Excellence. (2009). *When to suspect child maltreatment* Retrieved from https://www.nice.org.uk/guidance/cg89/evidence/full-guideline-pdf-243694625
NVivo qualitative analysis Software. (2012). In: QSR International Pty Ltd.
O'Connor, J., & Jeavons, S. (2003). Nurses' perceptions of critical incidents. *Journal of Advanced Nursing, 41*(1), 53-62. doi:10.1046/j.1365-2648.2003.02506.x
Office of the Minister for Child Poverty Reduction, & Office of the Minister for Children. (2018). Child Wellbeing Strategy- Scope and Public Engagement Process. In.
Oranga Tamariki Act 1989, (1989).
Ornstein, M. (2013). *A companion to survey research*. Los Angeles: SAGE.
Pabis, M., Wronska, I., Slusarska, B., & Cuber, T. (2011). Paediatric nurses' identification of violence against children. *Journal of Advanced Nursing, 67*(2), 384-393. doi:10.1111/j.1365-2648.2010.05473.x
Page, M., & Moher, D. (2017). Evaluations of the uptake and impact of the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) Statement and extensions: A scoping review. *Systematic Reviews, 6*(1). doi:10.1186/s13643-017-0663-8
Pakiş, I., Demir, F., Altun, U., & Yildirim, S. (2015). Investigation of the awareness and knowledge about child abuse and negligence among doctors and nurses working in the east part of Turkey. *Romanian Journal of Legal Medicine, 24*(2), 151-156. doi:10.4323/rjlm.2015.151
Peytchev, A., Couper, M., McCabe, S., & Crawford, S. (2006). Web Survey Design: Paging versus Scrolling. *The Public Opinion Quarterly, 70*(4), 596-607. doi:10.1093/poq/nfl028
Plowright, D. (2011). *Using mixed methods: frameworks for an integrated methodology*. London: SAGE.
Price, C. (2010). *Emotion* (2nd ed.). Milton Keynes: Open University Worldwide.
Radin, D., & Schlitz, M. (2005). Gut feelings, intuition, and emotions: an exploratory study. *Journal of Alternative & Complementary Medicine, 11*(1), 85-91. doi:10.1089/acm.2005.11.85
Raman, S., Holdgate, A., & Torrens, R. (2012). Are our Frontline Clinicians Equipped with the Ability and Confidence to Address Child Abuse and Neglect? *Child Abuse Review, 21*(2), 114-130. doi:10.1002/car.1180
Reijnders, U., Giannakopoulos, G., & de Bruin, K. (2008). Assessment of abuse-related injuries: A comparative study of forensic physicians, emergency room physicians, emergency room nurses and medical students. *Journal of Forensic and Legal Medicine, 15*(1), 15-19. doi:10.1016/j.jcfm.2006.06.029
Rettke, H., Pretto, M., Spichiger, E., Frei, I. A., & Spirig, R. (2018). Using Reflexive Thinking to Establish Rigor in Qualitative Research. *Nursing Research, 67*(6), 490-497. doi:10.1097/NNR.0000000000000307
Reupert, A., & Maybery, D. (2014). Practitioners' experiences of working with families with complex needs. *Journal of Psychiatric and Mental Health Nursing, 21*(7), 642-651. doi:10.1111/jpm.12149

Rolim, A., Moreira, G., Gondim, S., Paz, S., & Vieira, L. (2014). Factors associated with reporting of abuse against children and adolescents by nurses within Primary Health Care. *Revista Latino-Americana De Enfermagem, 22*(6), 1048-1055. doi:10.1590/0104-1169.0050.2515

Rouland, B., & Vaithianathan, R. (2018). Cumulative Prevalence of Maltreatment Among New Zealand Children, 1998-2015. *American Journal of Public Health, 108*(4), 511-513. doi:10.2105/AJPH.2017.304258

Rowse, V. (2009a). Children's nurses' experiences of child protection: what helps? *Child Abuse Review, 18*(3), 168-180. doi:10.1002/car.1073

Rowse, V. (2009b). Support needs of children's nurses involved in child protection cases. *Journal of Nursing Management, 17*(6), 659-666. doi:10.1111/j.1365-2834.2009.00987.x

Sadler, L., Slade, A., Close, N., Webb, D., Simpson, T., Fennie, K., & Mayes, L. (2013). Minding the Baby: Enhancing Reflectiveness to Improve Early Health and Relationship Outcomes in an Interdisciplinary Home-Visiting Program. *Infant Mental Health Journal, 34*(5), 391-405. doi:10.1002/imhj.21406

Saltmarsh, T., & Wilson, D. (2017). Dancing around families: neonatal nurses and their role in child protection. In (Vol. 26, pp. 2244-2255).

Sassen, B. (2018). *Nursing: health education and improving patient self-management*. Cham, Switzerland Palgrave Macmillan.

Sathiadas, M., Arunath, V., & Karunya, V. (2018). Child abuse and neglect in the Jaffna district of Sri Lanka – a study on knowledge attitude practices and behavior of health care professionals. *BMC Pediatrics,, 18*(1), 152-161. doi:10.1186/s12887-018-1138-3

Schols, M., de Ruiter, C., & Öry, F. (2013). How do public child healthcare professionals and primary school teachers identify and handle child abuse cases? A qualitative study. *BMC Public Health, 13*(1), 1-16. doi:10.1186/1471-2458-13-807

Scott, D., & Fraser, J. (2015). Mandatory Reporting of Child Abuse and Neglect by Health Professionals. In *Mandatory Reporting Laws and the Identification of Severe Child Abuse and Neglect* (pp. 381-393). Denver: Springer.

Silverman, D. (2013). *Doing qualitative research* (4th ed.). London: SAGE Publications Ltd.

Skarsaune, K., & Bondas, T. (2015). Neglected nursing responsibility when suspecting child abuse. *Clinical Nursing Studies, 4*(1). doi:10.5430/cns.v4n1p24

Statistics New Zealand. (2013). 2013 Census ethnic group profiles: Maori. Retrieved from http://archive.stats.govt.nz/Census/2013-census/profile-and-summary-reports/ethnic-profiles.aspx?request_value=24705&parent_id=24704&tabname=#24705

Stolper, E., Van de Wiel, M., Van Royen, P., Van Bokhoven, M., Van der Weijden, T., & Dinant, G. (2011). Gut Feelings as a Third Track in General Practitioners' Diagnostic Reasoning. *Journal of General Internal Medicine 26*(2), 197-203. doi:10.1007/s11606-010-1524-5

Sue, V., & Ritter, L. (2012). *Conducting online surveys* (2nd ed.). California: Thousand Oaks.

Taylor, J., & Bradbury-Jones, C. (2015). Child maltreatment: every nurse's business. *Nursing Standard, 29*(29), 53-58. doi:10.7748/ns.29.29.53.e9636

Te Puni Kōkiri. (2010). *Rangahau tūkino whānau: Māori Research Agenda on family violence*. Wellington, New Zealand: Te Puni Kokiri.

Thamlikitkul, S., Yunibhand, J., & Chaiyawat, W. (2009). Remolding Child: Process of Nursing Practice for Sexually Abused Children. *Journal of the Medical Association of Thailand, 92*(6), 787-805.

The Nursing Council of New Zealand. (2015). *The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2014-2015*. Wellington: The Nursing Council of New Zealand.

The UN Convention on the Rights of the Child Monitoring Group. (2017). *Getting It Right: The Children's Convention in Aotearoa* Wellington: Office of the Children's Commissioner. Retrieved from http://www.occ.org.nz/assets/Uploads/NOV-2017-UMG-Report-WEB-file.pdf

Tingberg, B., Bredlöv, B., & Ygge, B.-M. (2008). Nurses' experience in clinical encounters with children experiencing abuse and their parents. *Journal of Clinical Nursing, 17*(20), 2718-2724. doi:10.1111/j.1365-2702.2008.02353.x

Tourangeau, R., Conrad, F., & Couper, M. (2013). *The Science of Web Surveys*. Oxford: Oxford University Press.

Treaty of Waitiangi, (1840).

Ulrich, C., Taylor, C., Soeken, K., O'Donnell, P., Farrar, A., Danis, M., & Grady, C. (2010). Everyday ethics: Ethical issues and stress in nursing practice. *Journal of Advanced Nursing, 66*(11), 2510-2519. doi:10.1111/j.1365-2648.2010.05425.x

UNICEF. (2018a). Child Rights. Retrieved from https://www.unicef.org.nz/child-rights

UNICEF. (2018b). Convention on the Rights of the Child. Retrieved from https://www.unicef.org/crc/

UNICEF Office of Research. (2017). *Building the Future: Children and the Sustainable Development Goals in Rich Countries, Innocenti Report Card no. 14*. Florence: UNICEF Office of Research.

United Nations. (1989). *Convention on the Rights of the Child*. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

Visscher, S., & van Stel, H. (2017). Practice variation amongst preventive child healthcare professionals in the prevention of child maltreatment in the Netherlands: Qualitative and quantitative data. *Child abuse & neglect, 70*(665-686), 264-273. doi:10.1016/j.dib.2017.09.061

Vulnerable Children Act 2014. (2014). Retrieved from http://www.legislation.govt.nz/act/public/2014/0040/latest/whole.html

Walker, D. (2014). *An introduction to health services research*. Los Angeles: SAGE.

Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Maori research, its principles, processes and applications. *International Journal of Social Research Methodology, 9*(4), 331-344. doi:10.1080/13645570600916049

Whittemore, R., & Knafl, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553. doi:10.1111/j.1365-2648.2005.03621.x

Wilson, D. (2013). Promoting health partnerships with Indigenous communities of Australia and New Zealand In K. Francis, Y. Chapman, K. Hoare, & M. Birks (Eds.), *Australia and New Zealand Community as Partner: Theory and Practice in Nursing* (2nd ed.). Philadelpia: Lippincott Williams & Wilkins.

Wilson, D., Gonzalez-Guarda, R., & Campbell, J. (2017). Abuse and violence in families. *Journal of Clinical Nursing, 26*(15-16), 2097-2099. doi:10.1111/jocn.13829

Wilson, D., Smith, R., Tolmie, J., & de Haan, I. (2015). Becoming better helpers: rethinking language to move beyond simplistic responses to women experiencing intimate partner violence. *Policy quarterly, 11*(1), 25-31.

Wolf, C., Joye, D., Smith, T., & Fu, Y.-c. (Eds.). (2016). *The SAGE handbook of survey methodology*. London Sage Publications Ltd.

World Health Organisation. (2016). Child Maltreatment. In. Geneva, Switzerland: World Health Organisation.

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Appendices

Appendix 1 Participant Information Sheet- Survey

Kia ora, my name is Grace Shallard, and I am a postgraduate student at Massey University. I am currently enrolled in a Master of Philosophy in Nursing and undertaking this research project as part of my thesis for completion of this degree. I am currently employed as a staff nurse in Starship Children's Emergency Department and have worked previously in Starship Community as a public health nurse.

I have a particular interest in the area of child protection and, like all of you, would love to see all children in New Zealand given an opportunity to thrive. I believe that nurses have a unique and privileged position within families, and thus have a potentially vital role in the prevention of child abuse and neglect. I am interested in nurses' experience and perception of how they integrate child protection into their nursing practice, in order to understand what the current issues are for paediatric nurses within this area.

I invite you to participate in this mixed methods research study which will add to the body of literature on child abuse and neglect in New Zealand. It has the potential to inform future development of child protection practices within nursing. I am aiming to recruit as many paediatric nurses working within ADHB as possible to participate in an online survey. I am then aiming to recruit 10-20 paediatric nurses to participate in an interview.

You are eligible to participate in this study if

- You are a registered nurse working for ADHB within a paediatric setting
- You have been employed in your current place of work for more than 6 months

You are not eligible to participate in this study if you:

- Have a history of working with child protection agencies
- Have undertaken any child protection research projects

Your involvement

You are invited to participate in an anonymous online survey. This will take approximately 10 minutes and it is designed to gain an understanding of what nurses perceive as their role within child abuse and neglect, and what their previous experience has been in this sphere. It will also be accompanied by some basic demographic information. There will be a mixture of scales, free-text questions and drop-down boxes. At the end of the survey, you will then be invited to participate in one interview of approximately one-hour duration.

Support processes

I will have available information on EAP services for your area of employment should you feel distressed and need to talk to someone.

Please feel free to contact the researcher, and or the research supervisor, if you have any questions about this project:

Grace Shallard: Researcher
[redacted]

Dr Karen Hoare: Supervisor
Associate Professor
School of Health and Social Sciences
Massey University
k.j.hoare@massey.ac.nz
Direct dial: (09) 212 7034

Thank you for taking time to read this information sheet.

If you would like to participate in this study and are happy with the information you have been supplied, please fill out the survey. If you are happy to be approached later on this year about the possibility of being involved in a one-on-one interview, please provide your e-mail address in the space provided at the end of the survey.

Kind regards,

Grace Shallard

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application SOA 18/41. If you have any concerns about the conduct of this research, please contact Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 356 9099 x 85094, email humanethicsoutha@massey.ac.nz .

Appendix 2: Survey

The Nursing Role in Keeping Children Safe

This survey is part of a wider research project investigating how nurses working in paediatric settings in ADHB respond to children at risk of abuse and neglect. It is hoped that an enhanced understanding of how children's nurses keep children safe will help mobilise and support the nursing workforce to improve outcomes for children.

Submitting this survey implies consent. As outlined in the information sheet, please contact the researcher or the research supervisor if you have any questions about this project.

Thank you for taking the time to fill out this survey!

The Nursing Role in Keeping Children Safe

Tell us a bit about yourself

* 1. What area of child health are you working in?

(We realise that the Starship Community subgroups are being disbanded and that you may be working in more than one, tick all that apply)

- ☐ Starship Community- School nursing
- ☐ Starship Community- Home care
- ☐ Starship Community- Well child nursing
- ☐ Children's Emergency Department (CED)
- ☐ Paediatric Intensive Care (PICU)
- ☐ Cardiac (23B)
- ☐ Surgical (24B)
- ☐ Orthopaedic (24A)
- ☐ Medical (25)
- ☐ Neurology (26A)
- ☐ Medical specialties (26B)
- ☐ Oncology (27)
- ☐ Other (please specify)

* 2. What level of nursing practice are you?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ Senior nurse
- ☐ Nurse specialist
- ☐ Nurse practitioner

* 3. What is your highest level of university qualification?

- [ ] Undergraduate
- [ ] Masters
- [ ] Postgraduate certificate
- [ ] Higher
- [ ] Postgraduate diploma
- [ ] Hospital trained

* 4. Do you have a qualification (postgraduate or undergraduate) specific to child health?

- ◯ Yes
- ◯ No

* 5. How long have you worked in child health?

- ◯ <6 months
- ◯ 6-10 years
- ◯ 6 months- 2 years
- ◯ >10 years
- ◯ 3-5 years

* 6. What ethnic group or groups do you belong to?

- [ ] New Zealand European
- [ ] Niuean
- [ ] Maori
- [ ] Chinese
- [ ] Samoan
- [ ] Indian
- [ ] Cook Islands Maori
- [ ] Other
- [ ] Tongan

Other (eg, Dutch, Japanese, Tokelauan)
Please enter ethnicity:

The Nursing Role in Keeping Children Safe

Family Violence

There is a frequent co-occurrence of intimate partner violence with situations of child abuse, hence these issues should not be addressed in isolation.

* 7. Have you been trained to screen for family violence?

- ◯ Yes
- ◯ No

8. If yes, how many times per week (or per 40 hours worked) do you screen for family violence?

- ◯ Very rarely
- ◯ 1-2 times
- ◯ 3-5 times
- ◯ 6-10 times
- ◯ >10 times

The Nursing Role in Keeping Children Safe

Child Protection

* 9. Have you seen a case of suspected child abuse or neglect in the last year?

- ◯ Yes
- ◯ No
- ◯ Unsure

* 10. Are you cofident in your ability to identify child maltreatment

- ◯ Yes
- ◯ No
- ◯ Sometimes

* 11. Have you ever received training in how to recognise and respond to child abuse or neglect?

- ◯ Yes
- ◯ No
- ◯ Unsure

12. If yes, what training have you received?

- ☐ ADHB Family violence training day
- ☐ MEDSAC (Medical Sexual Assault Clinicians Aotearoa) training
- ☐ Department specific training
- ☐ Child Matters
- ☐ Other

Other (please specify)

* 13. Have you ever made a report of concern/ notification to Oranga Tamariki (formally known as Child Youth and Family)?

- ◯ Never
- ◯ Once or twice
- ◯ A number of times
- ◯ Frequently

14. If not, why not?

15. If you have referred child care and protection concerns on, who have you referred on to? (mark more than one if applicable)

- [ ] Oranga Tamariki (formally known as Child Youth and Family)
- [ ] A senior colleague
- [ ] An ADHB social worker
- [ ] Te Puaruruhau
- [ ] A social worker from another organisation
- [ ] The police
- [ ] Other (please specify)

16. Have you engaged cultural services if appropriate?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Sometimes

The Nursing Role in Keeping Children Safe

Final Questions

* 17. Do you see recognition and referral of child protection concerns as part of your job description?

- ◯ Yes
- ◯ Unsure
- ◯ No

18. What, if anything, do you do differently when you see a child protection alert?

19. What enables you to respond to suspected care and protection concerns? Please list.

20. What are the barriers, if any, that prevent you from reporting suspected care and protection concerns? Please list.

21. Once the referral is completed, what, if anything, do you see as your role within follow up?

22. Is there anything you would like to add or comment on?

The Nursing Role in Keeping Children Safe

Thank you so much for taking the time to complete this survey.

Please click here for final contact information.

Contact Details

Could we approach you later this year to conduct a one-on-one interview about the nursing role within child protection, the results of which would be anonymised?

- ◯ Yes
- ◯ No

If yes, please provide your e-mail address (only the researcher will have access to this).

If you are unwilling to participate in an interview, but you would like a summary of the research, please provide your e-mail address here (only the researcher will have access to this).

If participating in this survey has raised any issues for you, you may wish to seek confidential counselling services. EAP can be used to address issues of a work or personal nature that may be impacting on health and wellbeing. EAP contact details are: 0800 SELF HELP (0800 735 343).

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Appendix 3 Participant Information Sheet- Interview

Kia ora, my name is Grace Shallard, and I am a postgraduate student at Massey University. I am currently enrolled in a Master of Philosophy in Nursing and undertaking this research project as part of my thesis for completion of this degree. I am currently employed as a staff nurse in Starship Children's Emergency Department and have worked previously in Starship Community as a public health nurse.

I have a particular interest in the area of child protection and, like all of you, would love to see all children in New Zealand given an opportunity to thrive. I believe that nurses have a unique and privileged position within families, and thus have a potentially vital role in the prevention of child abuse and neglect. I am interested in nurses' experience and perception of how they integrate child protection into their nursing practice, in order to understand what the current issues are for paediatric nurses within this area.

I invite you to participate in this mixed methods research study which will add to the body of literature on child abuse and neglect in New Zealand. It has the potential to inform future development of child protection practices within nursing. I am aiming to recruit as many paediatric nurses working within ADHB as possible to participate in an online survey. I am then aiming to recruit up to 10 paediatric nurses to participate in an interview.

You are eligible to participate in this study if

- You are a registered nurse working for ADHB within a paediatric setting
- You have been employed in your current place of work for more than 6 months

You are not eligible to participate in this study if you:

- Have a history of working with child protection agencies
- Have undertaken any child protection research projects

Your involvement

You are invited to participate in one interview of approximately one-hour duration. This interview will involve a series of questions related to the study which allow you to share your experiences and thoughts. The interview will be audio-recorded to allow for later transcription and analysis of the data. I may also take notes during the interview. The interview will take place at a public venue of your choice and a negotiated time outside of your work hours and commitments.

Confidentiality is ensured. Any identifying information will be accessible only to my supervisor Dr. Karen Hoare (research supervisor), and myself. The interviews will be transcribed by myself or a Massey University recommended transcriber who will sign a confidentiality agreement. The recorded information will be erased once the transcripts have been checked for accuracy, and any information used in my thesis or any publications will contain no identifying information.

The interview information will be kept in a securely locked filing cabinet, on a computer and a USB flash drive which will be password protected. I will have access to this only during the study. All consent forms will be kept separately in a secure filing cabinet in a sealed envelope, and following the research all data will also be stored at Massey University in a secure location and disposed of as per the School of Health and Social Services protocol.

Your rights

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

- Contact me at any stage before signing consent or during the research if you have any further questions.
- Decline to answer any question.
- Stop the interview at any time and ask for the recording to be stopped.
- Withdraw from the study up to one week following your interview.
- Provide information on the understanding that your name will not be used.
- Request a copy of your transcript and a summary of the findings.

Support processes

I will have available information on EAP services for your area of employment should you feel distressed and need to talk to someone.

Please feel free to contact the researcher, and or the research supervisor, if you have any questions about this project:

Grace Shallard: Researcher
[redacted]

Dr Karen Hoare: Supervisor
Associate Professor
School of Health and Social Sciences
Massey University
k.j.hoare@massey.ac.nz
Direct dial: (09) 212 7034

Thank you for taking time to read this information sheet.

Kind regards,

Grace Shallard

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application SOA 18/41. If you have any concerns about the conduct of this research, please contact Dr Lesley Batten, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 356 9099 x 85094, email humanethicsoutha@massey.ac.nz .

Appendix 4: Guideline Questions for the Interview

Could you please tell me a little bit about your current nursing role?

Tell me about the role, if any, that care and protection has in your nursing practice.

What have been your experiences in in the work place, in relation to child protection or child abuse or neglect?

Can you tell me about how you felt about those experiences or about child protection in general?

Can you please tell me about the processes, if any, that you understand are required to be followed if you suspect child abuse in any of your clients?

What, if anything, are barriers to this, or gets in the way of you acting this way?

What do you see as your role within follow up of any care and protection concerns?

Do you have any suggestions as to how you think you could be better supported in this role?

Do you have any questions for me?

Appendix 5: Consent form

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

The role of Paediatric Nurses in Child Protection
Participant Consent Form

Researcher:
Grace Shallard
Massey University
[redacted]

I have read the information sheet and I understand the nature of the research.

I have been given the opportunity to ask questions and have them answered to my satisfaction.

I am aware that I may ask questions anytime throughout the study and I can contact the researcher and / or the research supervisor. I understand that I am able to request the findings of the study.

I am aware the interview will be audio recorded and transcribed. I also understand that recording can be stopped at any time.

I am aware that my participation in this study is confidential and no identifying information will be published, including any information pertaining to my area of employment.

I may withdraw from the study anytime up to one week following the interview.

My participation in this study is voluntary.

I agree to participate in this study under the conditions set out in the information sheet.

Signature _____ Date _____

Full name printed _____

Contacts details _____

_____

_____

Preferred method of contact _____

Appendix 6: Ethical Approval from Massey University

Date: 01 August 2018

Dear Grace Shallard

Re: Ethics Notification - **SOA 18/41** - **What are the perceptions of nurses working in child health in regards to their role in child protection?**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern A Committee** at their meeting held on **Tuesday, 31 July, 2018**.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Appendix 7: Ethics Approval ADHB

Auckland DHB
Research Office
Level 14, Support Bldg
Auckland City Hospital
PB 92024, Grafton, Auckland
Phone: 64 9 307 4949 Extn. 23854
Fax: 64 9 307 8913
Email: mwoodnorth@adhb.govt.nz
Website:
http://www.adhb.health.nz/health-professionals/research/

Institutional Approval

6th August 2018

Grace Shallard
Children's Emergency Department
Starship Children's Hospital

Dear Grace,

Re: Research project A+8147 What are the perceptions of nurses working in child health in regards to their role in child protection?

The Auckland DHB Research Review Committee (ADHB-RRC) would like to thank you for the opportunity to review your study and has given approval for your research project.

Your Institutional approval is dependent on the Research Office having up-to-date information and documentation relating to your research and being kept informed of any changes to your study. It is your responsibility to ensure you have kept Ethics and the Research Office up to date and have the appropriate approvals. ADHB approval may be withdrawn for your study if you do not keep the Research Office informed of the following:

- Any communication from Ethics Committees, including confirmation of annual ethics renewal
- Any amendment to study documentation
- Study completion, suspension or cancellation

More detailed information is included on the following page. If you have any questions please do not hesitate to contact the Research Office.

Yours sincerely

On behalf of the ADHB Research Review Committee Dr Mary-Anne Woodnorth
Manager, Research Office
ADHB
c.c. Sarah Little, Jo Peterson

..../continued next page

Appendix 8: Māori Review Approval

28 June 2018

Grace Shallard
Starship Children's Hospital
Auckland District Health Board
Auckland

Re: What are the perceptions of nurses working in child health in regards to their role in child protection?

Thank you for providing the following documents the:

- RRC low risk application
- Study protocol
- Evidence of consultation
- HDEC application

The study is part of the applicants study requirements. The aim of the study is to explore paediatric nurses' perceptions of their role in child protection. Approximately 180 participants will be recruited 15 have been identified as Māori and five of these are expected to be part of the study.

Comments:

- The study is of interest to Māori because as the investigator identifies Māori have a high incidence of family violence compared to other ethnicities in Aotearoa New Zealand. The investigator acknowledges the wider determinants of health that contribute to family violence.
- Ethnicity data will be collected
- A strong tikanga Māori process is built into the study
- The investigator has consulted with the Māori ethics person at Massey University who will provide on-going support as required.
- The Associate Nurse Director Workforce Development and Learning (Māori) is assisting with the recruitment of Māori nurses.
- Given there are only 15 Māori nurses in Starship I would encourage you to recruit all of them.

On behalf of the Waitematā and Auckland District Health Boards Māori Research Committee the study has been approved.

Heoi ano

H.A Wihongi

Dr Helen Wihongi

Research Advisor – Māori/Senior Research Fellow
He Kamaka Waiora/Waitematā and Auckland DHB
Level 1, Kahui Manaaki – Building 5
North Shore Hosptial/ Auckland 0740, New Zealand
p: +64 9 486 8920 ext. 43204, m: + 64 21 0203 1167
email helen.wihongi@waitematadhb.govt.nz