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**CHALLENGING THE BOUNDARIES:
AN INITIATIVE TO EXTEND PUBLIC HEALTH NURSING
PRACTICE**

AN ACTION RESEARCH STUDY

A thesis presented in partial fulfilment of the
requirements for the degree of Masters of Arts
in Nursing at Massey University

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ABSTRACT

CHALLENGING THE BOUNDARIES: AN INITIATIVE TO EXTEND PUBLIC HEALTH NURSING PRACTICE

Public health nurses working in the Child and Youth Team, Child and Family Services, Auckland Healthcare, view their practice in relation to children and their families, with the primary focus being on the child. Public health nurses could well provide other appropriate assistance and intervention for families and this is the focus of this research project.

The purpose for this Action Research project is to provide a process where public health nurses can examine their existing practice and ask: What knowledge and skills would an advanced public health nurse practitioner require to work autonomously and effectively in a 'family centred' clinic within a primary school environment?

A convenience sample of competency level III and IV public health nurses in the Child and Youth Team, Child and Family Services, Auckland Healthcare were invited to take part in a collaborative / participatory working group.

Using a process of collective inquiry and reflection the working group developed a 'portfolio' from which to define an advanced public health nurse practitioner. The recommendations made by the working group provide a vision of practice.

The challenge to public health nurses now is to make this practice a reality.

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GLOSSARY OF TERMS

ANP: Advanced Nurse Practitioner.

Hapu: An alliance of several whanau (extended Maori family) with a common ancestor.

Iwi: An alliance of several hapu with a common ancestor.

Mana Whenua: Maori people who have the traditional association with area, treasure and resources of the land. Associated with traditional land occupation.

Ottawa Charter: Health Promotion. Health promotion is the process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for every day life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being (World Health Organisation, 1986).

PHN: Public Health Nurse.

Rohe: The specific area (catchment) of Maori land.

SNP: Senior Nurse Practitioner, Public Health Nurse.

Tangata Whenua: Maori people of the land; host; the original inhabitants.

Taonga: Maori treasure and resources of the land.

Treaty of Waitangi: The Treaty of Waitangi is New Zealand's founding document. It established the relationship between the Crown and Maori as Tangata Whenua (first peoples) and requires both the Crown and Maori to act reasonably towards each other and with utmost good faith (Ministry of Health, 1997b).

CHAPTER ONE

INTRODUCTION

The focus of this study was to provide a process in which public health nurses could examine current PHN practice and extend this practice into a 'family centred' clinic - which could facilitate health for the entire family - within a primary school environment. The research question was: What knowledge and skills would an Advanced Public Health Nurse Practitioner require to work autonomously and effectively in this 'family centred' clinic? The Action Research study aimed to use a process of collective inquiry and reflection to produce a 'portfolio' that demonstrates clear articulated criteria with which to define an Advanced Public Health Nurse Practitioner, whose practice could encompass 'family centred' clinics within a primary school environment.

This research project has arisen from my own observation of public health nursing practice and the limitations public health nurses place on their knowledge and skills because of service delivery boundaries. The community receives a child and youth health service that is committed, professional and accountable - but restricted. Presently, public health nurses (PHNs) in the Child and Youth Team, Child and Family Services, Auckland Healthcare, work with children aged 5 years to 18 years and their families. Each school in the Auckland area is designated a specific public health nurse and it is through school teacher, general practitioner, hospital, and own self-referral, that children / young people are assigned to our care. Public health nurses are concerned that requests for assistance for children are generally not

generated by their families but by referring agents. This often results in the responsibility for problems not being owned by families. A school-based clinic would enable families to access health services directly, thus promoting families taking ownership of their children's health problems. Also, whilst the public health nurse can manage health and social issues for the child and its family, if there is a *specific* health issue with an adult or baby within the family, this care would then come under the scope of another health provider. Consequently, two or more professionals could be involved in the family's health care. The Auckland Healthcare, Child and Family Service has also recognised these service delivery restrictions and has approached the Health Funding Authority with initiatives to extend the practice of public health nurses working within the Child and Youth Team. This project provides background research for one such initiative.

My role within the research

My role within the study is that of a practising registered general nurse working as a public health nurse, exploring with public health nursing colleagues an issue of mutual concern. As such my role is that of researcher-participant, fully involved in the discussions but primarily involved in ensuring that the project is completed so the process can be written up for my master's thesis.

Within Action Research it is possible for the researcher-participant to initiate and organise activities / discussion within the group during the Action Research process (McTaggart, 1991). Stoecker (1997) identifies a range of roles within Action Research and suggests the researcher may have to take on a number of them in order for the group to complete the task. For example, the researcher may need to organise

and mobilise the group moving from a facilitative role to a directional role, guiding the process while always retaining accountability to the group. Therefore the role of the researcher-participant within Action Research is a complex role that moves within the situation and the Action Research cycle (Stoecker, 1997). This process needs to be differentiated from Participatory Action Research, a form of research that has evolved from within the Action Research theoretical framework. The researcher within Participatory Action Research is required to remain within one role in the process, that of facilitator, strongly participating in the research in a collaborative, co-operative manner (Reason, 1994). In contrast, the role of the researcher within Action Research changes in order to assist the group to complete the task (Dick, 1993). Other forms of research that have evolved from within the Action Research framework, as distinct from the methodology used in this study, will be discussed further in Chapter 3 of this thesis.

Definition of 'family centred' care

My vision for this nurse managed school-based clinic is that it could provide care for the entire family - so when parents / caregivers drop children off at school, they could access the clinic for their own health issues. These issues may not always be medical in origin, but health concerns surrounding the social / environmental reality of living in today's economic climate. The nurse may not always be able to provide the necessary advice or treatment him / herself but could refer to appropriate health agencies / professionals.

In community nursing the wellness of the family is an extremely influential component in the wellness of the individuals within the family structure. Public health nurses have long recognised the family as an important factor in an individual's growth and development. The concept of family nursing has been generally understood as nursing care given to the total family system or unit (Friedemann, 1989).

A working party of public health nurses working in the Child and Youth Team, Child and Family Services, Auckland Healthcare, met in 1997 to review the different community models of family nursing care. After consideration it was decided by the group that Wright and Leahey's (1994) Calgary Family Assessment Model be adopted into public health nursing practice because of the emphasis given in the model to family strengths. Within this model family nursing consists of actions that reinforce existing family strengths. The working group recognised the importance of making strengths visible to a family who may often be in a state of chaos or dysfunction. Health changes can evolve by articulating these strengths empowering the family to increase the use of existing strategies.

The Calgary Family Assessment Model is an integrated, multidimensional framework based upon the structure of the family and its developmental and functional level. The nurse in the Calgary model practises from within a clear framework, assessing the family and then guides the family towards the goals that have been set. The client is seen more in the context of their relationship within the family rather than as an entity on their own. The family unit is not defined, however common family problems that would benefit from assessment are defined, for

example family crisis and developmental issues and abuse. The health beliefs and behaviour of the family are intricately connected (Wright & Leahey, 1994), consequently it is the family's health belief that influences the way the nurse can implement care, assess it, then modify the principles of that care towards the family regaining optimum functioning. The environment within the Calgary model encompasses the home, the neighbourhood and the larger community (Wright & Leahey, 1994). The Calgary model looks at the problem facing the person and through 'adaptation' it seeks to promote health. It plans goals, formulates objectives, and provides the steps to achieve these. This is the nursing model of 'family centred' care that I envision for the school-based clinic described in this research.

Use of the first person

At times throughout this thesis I have described myself in the first person. There is some academic debate regarding the appropriateness of this stance. I concur with the argument proposed by Cornish (1995) who declares that use of the first person gives ownership of generated ideas and that presenting concepts in the first person empowers the writer to self-discovery. An important element of Action Research methodology is interpreting meaning to empower and attempt change. I believe, use of the first person is appropriate to this research methodology and acknowledges my own personal 'consciousness-raising'.

Technical Features

Identification and development of possible issues emerging from the research process have generated from within the Action Research methodology. Any comments made by the PHNs within the working group have come as a direct result of travelling through a reflection, action, and re-examination process. Therefore, as it is proper that the group (including myself) take ownership of the full process described in this thesis, as well as the research outcome, no comment will be attributed or coded to an individual group member.

Structure of the thesis

Having introduced the focus, aim and research question for this study the content of this thesis will encompass the following structure.

Chapter Two discusses the background literature to this study. The chapter explores New Zealand well child health statistics; overseas literature supporting the viability of school-based health clinics; 'competency' levels of nursing practice and professional development programmes; and the issues surrounding the definition of 'expert' nursing practice.

Chapter Three consists of two parts, the methodology of Action Research and the research design for this study. Part one examines the origin and composition of the methodology and previous nursing studies using Action Research are investigated to uncover the effectiveness of this methodology for nursing research. Part two of

this chapter outlines the research design for this study including an examination of issues relating to selection and rigor.

The analysis of the research is presented in three chapters with the findings summarised into steps of the Action Research process. Unlike other research methodologies the results from this process cannot be described in isolation from analysis because the two are inextricably linked.

Chapter Four examines the research process. What happened within the group and the variables that influenced the process for developing the 'portfolio'.

Chapter Five describes setting the scene. This chapter provides the framework on which the research process developed. Setting the scene describes the process that enabled the group to move from present public health nursing reality to extended future practice.

Chapter Six explores the vision. This is the working group's visualisation of what a 'family centred' school-based clinic could offer and the scope of practice of an advanced public health nurse practitioner working within this environment.

Chapter Seven outlines the outcome of this research study - The Advanced Public Health Nurse Practitioner 'Portfolio'.

Chapter Eight includes the discussion and recommendations of the research study. These are explored in two parts. The first part examines the emergent issues

as they relate to identified literature. The second part discusses the significance of the research outcome for future public health nursing studies. The thesis is concluded, limitations of the research are acknowledged and recommendations developed by the working group are outlined.

CHAPTER TWO

BACKGROUND INFORMATION

This chapter will provide a discussion on the relevant literature surrounding school-based clinics and the viability of this type of health care for New Zealand families. The 'competency levels' of nursing practice and the problems associated with defining advanced nursing practice will also be explored. This chapter reviews international literature and examines identified concepts from within a New Zealand perspective.

In New Zealand public health nurses work in a variety of clinical settings depending on the different contractual agreements with the Health Funding Authorities. Auckland Healthcare public health nurses practise within the field of communicable diseases, at risk babies and infants, and child and adolescent (youth) health. The child and youth public health nursing team addresses well health issues for children aged 5 years through to young adults of school leaving age. This nursing practice frequently extends to addressing the health and social needs of the child / young person's family and often the community as a whole. In schools, teachers can refer students for health assessment and treatment and the public health nurse will often home visit to assess a family's health situation. Public health nurses also run self-referral clinics for adolescents, in some instances specific clinics for conditions such as sore throats (in an attempt to eliminate rheumatic fever), as well as clinics addressing teenage family planning and contraception. Extending the role of the public health nurse to facilitate / manage 'family centred' clinics - which could

facilitate health care for the entire family within the school environment - would be a natural progression of existing public health nursing practice. This practice, when placed within a school-based clinic, could encompass the facilitation and management of well health for children and their families by networking with other health agencies to provide appropriate health assistance and intervention. The public health nursing role would be seen as complementary to these health services, not competitive. Public health nurses would work alongside and in consultation with General Practitioners and other health agencies / professionals, to ensure best health outcomes.

The health and wellness of children in New Zealand is a key Ministry of Health direction strategy (Ministry of Health, 1997a) yet, even with an increase in the allocation of resources, child health statistics reflect concerning trends of an increase in preventable infectious diseases; one of the highest incident rates for rheumatic fever and otitis media with effusion; and significant numbers of New Zealand children are exposed to either physical, sexual or emotional abuse (Ministry of Health, 1997a).

In an attempt to increase the coverage rate of childhood immunisation to protect children from preventable infectious diseases, an immunisation strategy, *Immunisation 2000*, was launched in February 1996. However, the strategy does not appear to have had the desired effect as the coverage levels for 1996 show that an immunisation plateau has been reached, and the optimum coverage rate for 1997 of 85 percent has yet to be attained (Ministry of Health, 1997a). Indeed, in 1997, New Zealand experienced a national measles epidemic despite the introduction of a two-

dose schedule for MMR (measles, mumps and rubella) in 1992. The measles epidemic of 1997 now appears to be contained, but of grave concern currently is the meningococcal disease which has also climbed to epidemic status in the northern region of New Zealand.

Children in New Zealand have one of the highest incidence rates for rheumatic fever in the world - 8.3 per 100 000 people (134 cases per year). For Maori it is over four times the national rate, and for Pacific Island children it is nearly six times the national rate. Morbidity associated with rheumatic fever such as chronic rheumatic heart disease is estimated to cost to the Auckland region alone over \$3 million per year in monetary value, notwithstanding the high cost of pain and suffering for the children concerned (Ministry of Health, 1997a).

Otitis media with effusion (OME), also known as Glue Ear, is one of the most common diseases of childhood. Figures show that 15-20 percent of New Zealand children suffer this condition (Watson et al., 1996). Characterised by ear infections, pain and fluctuating hearing loss, glue ear can be acute where the child suffers a single episode, or chronic where the child has persistent ear problems (Hornibrook, 1995). The current prevalence of hearing loss at school entry is 13.4 percent in Maori, 15.7 percent in Pacific Island and 6.7 percent for other children (Ministry of Health, 1997a).

Child health statistics indicate a significant number of children and young people are exposed to domestic violence or are the victims of physical, sexual or emotional abuse or neglect each year. There were 190 cases of physical harm to

children that resulted in hospitalisation in 1995 (a rate of 22.9 per 100 000) with an average of 10 deaths per annum among children aged 0-14 years (Ministry of Health, 1997a).

Children from low income families and school-aged children of working parents are at highest risk for limited access to health care. These children are often seen in hospital emergency departments for acute crisis health care intervention. The additional barriers of transportation difficulties, inconvenient clinic hours and unaffordable health care cost highlight the need for alternative primary health care for children and their families (Jones & Clark, 1997). Extending the role of the public health nurse into a 'family centred' clinic within a primary school environment could remove some of the health accessibility barriers of transport, affordability and inconvenient health clinic hours. Parents / caregivers accompanying their children to school would have easy access to the clinic; the clinic could operate throughout the day, starting before school commences and closing sometime after school finishes. The already established public health nursing role within New Zealand schools of vaccinating adolescents for their Form I immunisations could be extended to the Childhood Immunisation Schedule for children and babies, thereby increasing immunisation coverage. Assessment of family and child health issues within the nurse managed school-based clinic could provide complementary primary health care for children and their families.

There is a growing body of literature supporting the establishment of school-based health care clinics (Biester, 1994; Bocchino, 1991; Dryfoos, 1988; Dryfoos, 1994; Goldsmith, 1991; Jones & Clark, 1997; Keenan, 1986; Kenny, 1986; Kirby,

Waszak & Ziegler, 1989; Lightfoot & Bines, 1997; Schlitt, Rickett, Montgomery & Lear, 1995; Uphold & Graham, 1993; Velsor-Friedrich, 1995; Vessey & Swanson, 1993; Walter et al., 1995). These health clinics are proving to be an important strategy in overcoming the social barriers of acceptability, accessibility and affordability of essential primary health care for children and their families. Indeed, the environment of schools is seen as a natural location for health services because of the central position that schools play in the everyday lives of most families (Lightfoot & Bines, 1997).

North America has long seen the advantage of developing schools as reasonable and innovative sites for addressing the health needs of families. In the early 1970s the first comprehensive school-based health clinics emerged in Dallas, Texas and St Paul, Minnesota. By 1994, the school-based health clinics had increased to 607 sites in 41 states. These states invested technical and financial support in communities to conduct health needs analyses into existing health service delivery and to develop new services in an attempt to improve the health status of children and their families. From the survey results this has proved successful and there has been a significant increase in funding and expansion of school-based health clinics in North America (Schlitt et al., 1995).

England is currently undertaking an extensive school health service review commissioned by the Department of Health into the role of the nurse in providing professional advice and support in schools and how nursing practice might evolve and extend to family health services and health promotion (Lightfoot & Bines, 1997).

In order to provide recommendations regarding the establishment and maintenance of school-based clinics Fisher, Juszczak, Friedman, Schneider and Chapar (1992) examined a clinic set up in a New York City high school in 1988. During a 2½ year period 1283 students were seen. There were 7920 visits for consultation regarding a wide range of health issues - acute and chronic medical problems (44%), physical examination and immunisation (25%), gynecological or sexual-related issues (17%), and mental health concerns (14%). Psychological characteristics of the 378 students who enrolled during the 1989 – 1990 academic year indicate that only 27% lived with both natural parents, 55% were foreign born, 37% had repeated a grade at least once, 44% were sexually active, 13% drank alcohol, and 14% had past or present suicidal ideation. Fisher et al. (1992) conclude that the data analysed in the study demonstrates that school-based clinics can successfully be involved in the management of a wide range of health needs for large numbers of 'at risk' youth.

Walter et al. (1995) examined health clinics in four junior high schools in an economically disadvantaged, medically underserved New York school district. Of 5757 students enrolled in these schools, 96% gained parental consent to use the clinics. The clinic users were 11–15 year old children. In the 1991–1992 academic year, 16340 clinic visits were made by these children. The presenting problems ranged from mental health issues to physical examinations. Walter et al. recommend that junior high school-based clinics can provide a wide range of primary and preventative health care services for large numbers of medically underserved youth.

In 1993, the Texas Department of Health, Bureau of Maternal and Child Health awarded nine grants to Texas communities to initiate school-based / school linked health services. A travelling team composed of a paediatric nurse practitioner, social worker and classification clerk began providing on-site health care to children and their siblings younger than 13 years of age, one day per week in each school. In an attempt to evaluate the success of the Texas Department of Health initiative, Jones and Clark (1997) developed a comparison study of 104 elementary school students accessing the school-based scheme, compared to 176 elementary school students in a comparable school without access to the scheme. Jones and Clark found that children accessing the school-based clinic made up a significant proportion of non-insured children. Students participating in the scheme had significantly more health preventative visits and less acute visits to hospital emergency departments. Jones and Clark recommend that nurse practitioner managed, school-based clinics are pivotal in accomplishing the goal of universal access to health for children because of the scheme's ability to overcome income barriers and link children and families with existing health and social services in the community.

The public health nursing role in New Zealand emphasises prevention rather than cure. In today's political / social climate public health nursing practice is fast becoming an economic necessity. The specialist nursing skills of needs analysis, risk identification, disease prevention, networking facilitation and nursing clinical treatment are providing an essential component in community care. Zerwekh (1991) believes that the purpose of public health nursing is to be available to the community as a whole, collaborating with families to foster health. Often the public health nurse may be the only care giving option available to families who cannot afford, or have

no resources to access, other health professionals. Zerwekh believes that public health nursing practice is essential in community care because of the strategies public health nurses use to foster a family's empowerment. Public health nurses assist families to take control of their own health decisions by listening to what the family wants and starting from that point, even if their health choice is contrary to the health belief of the nurse. The public health nurse educates and informs families on the health options available to them and 'feeds back reality' to them so they understand the implications of their choices. The public health nurse believes in each family's ability to make health choices and helps the family to believe in themselves. By implementing these strategies, the public health nurse creates an environment where the family learns to manage their own health, where they become self sufficient and empowered to manage their own care (Zerwekh, 1991).

Anderson and McFarlane (1996) have developed a community conceptual model to extend the role of community nursing from 'family centred' nursing to community as partnership nursing. Adapted from Neuman's Health-Care Systems Model, the focus of the Community-as-Partner Model is on partnership and the nursing process. The model analyses data from a specific community and illustrates the "wellness" of the community, this leads to a community nursing diagnosis which then gives the direction for nursing goals and intervention. The environment is seen as an important component of health within the model, so the interactive process between families within the community and with the health environment has a direct influence on how families manage and cope with health issues. The partnership process of the model allows for family empowerment, and the three steps of nursing diagnosis, nursing goals and nursing outcome, provide a framework for the nurse to

assist the family, which in turn assists the community to move along the health continuum. Anderson and McFarlane believe the model provides the means to actualise an advocacy ethic in community health. Community nurses, through facilitating the partnership process, provide an access for health care to all representatives of the community. This advocacy returns power to the community - community values and differences guide health service delivery because the community has been consulted and, in most instances, participated in the health reform.

Billingham and Perkins (1997) believe that community health is best facilitated by public health nurses, rather than other health providers, because public health nurses understand the essential connections between what the client tells them and the social, economic and political environment in which they live. These authors challenge nurses working in primary health to understand public health nursing practice and learn to integrate this practice into their own health care approach.

Health professionals who perceive situations from a public health view, think about and do things differently. They ask questions such as: 'What is the social context?'; 'How often and why is this happening?'; 'What is behind this problem?'; 'What are others doing?'; and 'Who else should be involved?' (p. 43)

Nurses will not, however, gain this extensive holistic knowledge of communities simply by becoming a public health nurse. How then does one articulate the

attainment of this knowledge, and how does one define an experienced public health nurse?

In recent times the 'competency level' has been used to define the experience and ability of public health nurses. Levels of nursing practice have become increasingly popular, particularly since Benner's (1984) work which illuminated the richness of knowledge embedded in practice when nurses articulated how their practice evolved over time, from novice to expert practitioner.

Benner (1984), using a research methodology of interpretive inquiry based upon Heideggarian Phenomenology, analysed clinical nursing practice as described by participating nurses from seven schools of nursing and five hospitals in the San Francisco Bay area. From analysis of the interviews Benner identified five levels of competency in clinical nursing practice – novice, advanced beginner, competent, proficient and expert. Explaining the differences in the levels of competency, Benner describes the **Novice** practitioner as a nurse who has no experience of the situation in which they find themselves. The novice nurse vehemently adheres to guidelines and rules because they have little understanding of the contextual meaning of specific nursing practice; their clinical skills are limited and inflexible. The **Advanced Beginner** nurse is able to practise 'simplistic' nursing skills independently as this nurse has some experience in the nursing situation. However, assistance and support is still required, particularly in regard to time management, setting priorities and dealing with the unexpected. The **Competent** nurse is described by Benner as having worked in the nursing situation long enough to independently practise using a wide range of nursing skills. Although constant guidance is not necessary, these nurses see

situations in the form of isolated incidences and they practise in a reactive rather than proactive manner. Unlike the competent nurse, the **Proficient** nurse is able to practice holistically and with speed and flexibility. The proficient nurse is efficient and well organised, able to recognise an unusual occurrence or complication and intervene appropriately. The proficient nurse has an extensive knowledge and understanding of the nursing situation but, even with extensive nursing knowledge, the proficient nurse may never advance to the skill level of the expert nurse. The **Expert** nurse, as well as having a wealth of experience, is highly skilled in complex situations, understanding intuitively the subtlety and nuance in practice. Benner believes that, "expert clinicians are not difficult to recognise because they frequently make clinical judgements or manage complex clinical situations in a truly remarkable way" (Benner, 1984, p. 34).

Benner's (1984) specific levels of competency have been adopted into many professional development programmes to provide nurses with the process to advance through the clinical levels of practice criteria. There are those within the nursing discipline (Bradshaw, 1994; Mangan, 1994) who are concerned that Benner in her research only captured narrative that told of positive nursing practice - "only patient care situations where the nurse made a positive difference in the patient's outcome are included" (Benner, 1984, p. xvii). Does the capturing of nursing narrative illustrate critical thinking and knowledge development, or demonstrate contrived practice? Is narrative simply an isolated example from nursing experience that reflects well on the writer? Reflective narrative based purely on nurse's feelings and subjective experiences does not necessarily articulate nursing experience and

knowledge development - it does not, "provide a sufficient intellectual framework for nursing care" (Bradshaw, 1994, p. 31).

In reality, there would be few nursing professional development programmes that require only nursing narrative to demonstrate nursing experience. At present the levels of practice programme is promoted in my work place. As a public health nurse I have worked my way through the levels of practice competency workbooks as part of my professional development programme. These workbooks are not portfolios of narrative alone but demonstrate public health nursing competency along with audit of clinical practice; audit of teaching ability; written discussion of knowledge in specific service expectations, including clinical supervision and preceptorship; and evidence of personal professional development by means of furthering education and participation in clinical workshops. In this way it becomes possible to define an expert public health nurse and demonstrate specific expert public health nursing practice.

The use of nursing narrative within practice also provides an excellent strategy for describing specific contextual nursing environments. Copoorain (1986, cited in Moccia, 1986) believes that situations and environments need to be re-conceptualised from the individual's environment to that of a social landscape. Nurses need to be challenged to define environment in a more comprehensive way. The social landscape of New Zealand contains many diverse economic realities and multi-cultural populations. Written nursing narratives by New Zealand nurses can capture nursing practice that is unique and totally relevant to New Zealand, providing

a research-theory-practice framework that is not from the situational context of North America or the United Kingdom.

Defining expert nursing practice becomes even more confused in the literature when nursing uses the terms expert, specialist and advanced nurse practitioner interchangeably, to describe advanced nursing practice. Some clinical areas use all three terms to designate specific nursing roles in specific nursing environments. Sutton and Smith (1995a) believe that nurses need to explore and understand the differences of these concepts before we adopt them into our own nursing practices. They contend that nursing has become strongly influenced by events that are generated outside the Australasian experience. Specifically, the North America experience has significantly influenced the way in which Australian and New Zealand nurses use and understand the terms - expert, specialist and advanced nurse practitioner. In an attempt to understand the differences Sutton and Smith (1995a) examined these three terms.

The **Expert nurse** is described as being totally located in nursing practice. Technical ability and knowledge development has been developed from nursing experience. Expert nurses are immersed in practice. Therefore, only nurses actively engaged in a specific clinical field can develop and maintain expertise. Without the technological challenge of a specific clinical field the expert nurse would be less visible, creating definition difficulties in the less technical setting (Sutton & Smith, 1995a).

Specialist nursing, while also located in a field of practice, is developed from within formal education linked with nursing experience. As nurses continue to practise within a specific field of health care they develop specialised knowledge and skills. Sutton and Smith suggest that the specialist nurse gains knowledge not from within a nursing culture but from the knowledge and skills which were previously the domain of doctors. Therefore, the concept of specialist nurse has derived from the need to adapt nursing to medical ideology, where nurses in their need to share knowledge with each other come together in their own 'specialty' field (Sutton & Smith, 1995a).

Conversely, the **advanced nurse practitioner** generates from within the knowledge and experience that 'is' nursing. The patient / client is central to the advanced nurse practitioner, and all aspects of care are carefully considered and critically reflected to enhance positive outcomes. Nursing knowledge development is associated with caring and human communication. It is the individual nurse's personal attributes, disposition and exposure to clinical experiences that define the advanced nurse practitioner (Sutton & Smith, 1995a). Sutton and Smith believe the profession needs to think carefully which focus in nursing we adopt into our practice and they challenge nurses to articulate their contribution to nursing which, in turn, will illustrate the uniqueness which, Smith and Sutton believe, is advanced nursing practice.

Extending nursing practice by encouraging critical knowledge development and defining specialist skills is not new. As early as 1872, in New England, a nursing graduate course attempted to enhance the clinical credibility of the nurse, moving the

philosophy of nursing into specialist practice and expert nursing care (Elliot, 1995). Since then many American models of advanced nursing practice (Brown, 1983; Benner, 1984; Calkins, 1984, as cited in Elliot, 1995) have been developed. The advanced nurse practitioner (ANP) is described in these models as having an extensive scope of practice encompassing clinical knowledge, management skills, teaching ability and research implementation. Both the American Nurses Association (1986) and United Kingdom Central Council (1995) suggest that the ANP role should be at the Masters or PhD level, as the ANP acts as a consultant and policy developer for both the nursing profession and other health disciplines (Elliot, 1995).

Gee (1995) cautions that, as the competency level of the advanced nurse practitioner increases, the interface between nursing and the medical profession will overlap. The challenge for nurses is to establish their own frameworks and strategies with the central focus being the enhancement of patient care. The advancement of nursing practice and the shift in health boundaries can promote greater understanding between the disciplines - collaborative practice is the way forward.

The purpose of this selected literature review has been to highlight the issues surrounding the establishment of nurse managed school-based clinics, possible advantages such clinics could have on New Zealand children's health and to examine some of the issues surrounding public health nursing advanced practice – how nurses attain, through competency levels, advanced nursing skills, and how these advanced nursing skills can be defined. Children's learning and wellness are inextricably linked. By establishing 'family centred' clinics within the primary school environment, managed by public health nurses, children and their families would

have ready access to an appropriate, affordable health care service. The focus of this review is to provide the theoretical foundation from which to investigate the research study question: What knowledge and skills would an advanced public health nursing practitioner require, to work autonomously and effectively in a 'family centred' clinic within a primary school environment?

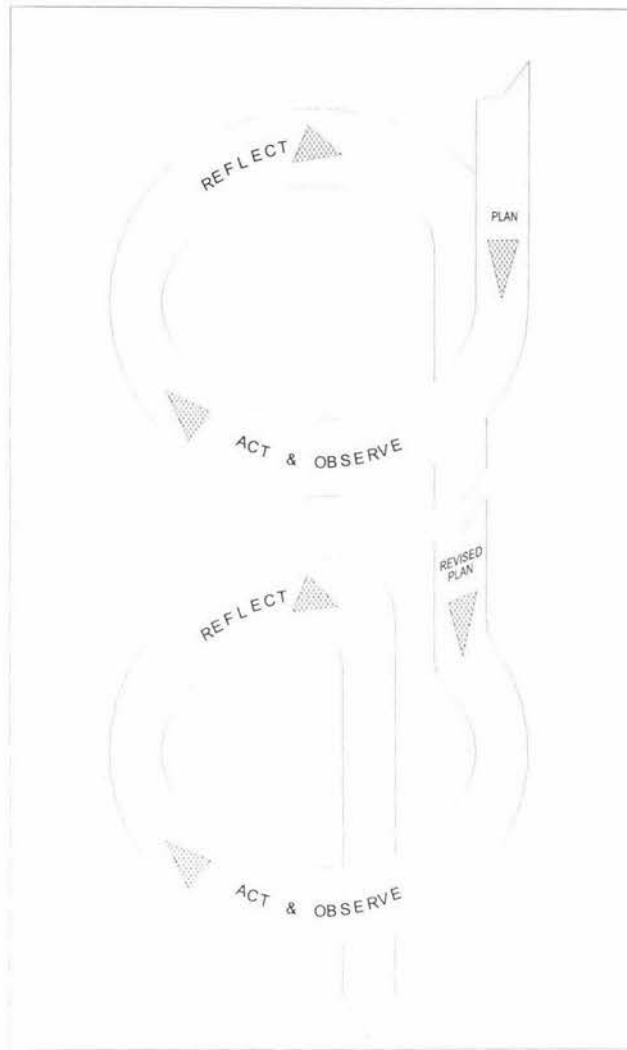
CHAPTER THREE

METHODOLOGY AND RESEARCH PROCESS

This chapter consists of two parts, the methodology of Action Research and the Research Design for this study. The origin and composition of the methodology is explored, and previous nursing studies using Action Research are investigated to uncover the effectiveness of the approach for this research process. The second part to this chapter will examine the research design - the issues relating to selection of participants and the rigor of the research process will be discussed.

The concept of Action Research has its origins in the work of social psychologist Kurt Lewin (1946), who developed and applied his theory over the postwar years of America in a series of community experiments. Two ideas that were crucial in Lewin's work were the ideas of group decisions and commitment to improvement. Lewin applied his research in contexts as diverse as integrated housing, equalisation of opportunity for employment, and the attempt to cure prejudice in children (Kemmis & McTaggart, 1988).

Lewin described Action Research as proceeding in a spiral of steps, each of which is composed of planning, action, and evaluation of the results of that action:



(Kemmis & McTaggart, 1988, p.11)

The cyclic nature of the Lewinian approach recognised the need for action plans to be flexible and responsive. Lewin recognised that, given the complexity of real social situations, in practice, it is never possible to anticipate everything that needs to be done. Therefore, the deliberate overlapping of action and reflection was designed to allow changes in the plans for action as the people involved learned from their own experience (Kemmis & McTaggart, 1988).

Another major contributor to the early works of Action Research was John Collier. Like Lewin, Collier believed that the process of inquiry would have greater effectiveness if the researcher and practitioner worked together in the research process. This was totally revolutionary when compared with the traditional view of research where the researcher stands as a neutral observer, isolated from the object under investigation (Reason, 1994). While Lewin and Collier were formulating their ideas in America, in England a group of social psychologists got together and formed the Tavistock Institute for Human Relations. This group initiated a wealth of social theories around Action Research (Holter & Schwartz-Barcott, 1993). Humanistic psychology then expanded the Action Research Theory. Researchers such as Torbet, Tandon, and Argyris are names that have been influential in the creation of the Action Research process (Reason, 1994). Torbert (1991, as cited in Reason, 1994) describes Action Research as:

...a kind of scientific inquiry that is conducted in everyday life. Action inquiry differs from orthodox science in that it is concerned with 'primary' data, collected 'on-line' and 'in the midst of perception and action' and only secondarily with recorded information. Action inquiry is 'consciousness in the midst of action'. (p.330)

Action Research is then the application of fact finding to practical problem solving in a social situation with a view to improving the quality of the action within the environment. The process involves collaboration and co-operation between the researchers and practitioners. **Participatory Action Research** has evolved from

within the Action Research theoretical framework. This form of Action Research is characterised by the strong involvement and participation of the researcher and participants in the research process. Indeed, the participation begins with the initial identification of the research problem, the actual research design, and continues up to the publication of the research findings. The aim of Participatory Action Research is to produce knowledge and action, which is directly useful to a group of people, through research, education and socio-political action. Another important aim is to empower people at a second and deeper level through the process of constructing and using the practitioners' own knowledge for the benefit of others (Reason, 1994).

Another form of Action Research is **Social-Critical Action Research**. This research comes from the view of two basic tenets; that society is just but capable, through action, of becoming less just; and that justice and equality themselves need to be subjected to philosophical examination. Social-Critical Action Research is seen to be the best means of opposing, modifying and replacing common social practices with action that will increase the possibility for social justice (Tripp, 1990). The difference between Social-Critical Action Research and other Action Research philosophies is that the emphasis is not only on challenging the system but in seeking to understand what makes the system the way it is. Tripp (1990) explains that it is important to challenge the system, but in Social-Critical Action Research, it is essential that a consciousness of one's own sense of justice and equality are themselves open to question.

According to Burns (1990) there are four specific criteria essential for Action Research to proceed. The research needs to have a **situational** context, where the

research diagnoses a problem and attempts to solve it; the research needs to be a **collaborative** and **participatory** process which requires the efforts of both researcher and practitioners; and it is essential for the research to be **self-evaluative**, concerned with a constant evaluation and modification of the research process.

Within the four criteria of Action Research theorists have developed three conceptualised models – technical, practical and emancipatory. **Technical Action Research** derives from the positivistic paradigm, where the inquiry is controlled by the researcher through explanation and prediction (Martin, 1994). This research is directed from someone outside the issue of inquiry and is often used to test out generalisations that have originated from other research studies. However, the direction and control of the research can create concern because the research has not originated from the practitioners within the practice. McTaggart (1991) believes Technical Action Research should not be regarded as Action Research - in the more developed sense of the methodology - because it does not meet the criterion of developing from the researcher's own practical reality.

Practical Action Research is derived from within the interpretive paradigm where the research inquiry illuminates practice, therefore creating meaning and purpose. The researcher facilitates the process of inquiry in a reflective way, uncovering and acknowledging the perspectives of others. However, should this inquiry create an environment where the participants, through the interpretation of meaning decide upon change, the Action Research then becomes Emancipatory Action Research (McTaggart, 1991).

Emancipatory Action Research has evolved from within the social critical theory paradigm, where reflection upon the constraints of a social situation is investigated in an attempt to change, liberate and empower (Martin, 1994). This inquiry provides the ability to see through problems by a process of consciousness-raising through collective inquiry and reflection. Emancipatory Action Research extends beyond the interpretation of meaning for participants to an understanding of the social, political and economic conditions of their reality (McTaggart, 1991).

Action Research is research that focuses on specific issues or problems identified in a local situation. An action plan is developed to introduce change to resolve the problems identified, and subsequently the results are evaluated. In nursing, Action Research has become of increasing interest over the past ten years (Holter & Schwartz-Barcott, 1993). But how effective is this type of research? Is the methodological framework of Action Research sound?

DISADVANTAGES TO ACTION RESEARCH

When examining collaboration and participation, extremely important concepts in Action Research, Rutledge-Sheilds and Dervin (1993) question whether the act of collaboration can, in some instances, result in the research becoming exploitative and intrusive. Rutledge-Sheilds and Dervin contend that the appropriateness of the collaborative process is highly dependent on the nature of the research problem and, particularly, the social status of the researcher in relation to the participants. For instance, if choosing Action Research to assist in the knowledge development in a specific clinical area of nursing, the researcher must have credibility

amongst the participants of that specific working group. A nurse researcher with only public health nursing knowledge and experience would have little credibility to a working group trying to develop strategies to assist colleagues who are working in the midst of death and dying in a hospice situation. The public health nurse may well have the skills necessary to assist the working group, but it may prove difficult for this group to acknowledge those skills. Gibbings (1993) observes that staff may also not accept the presence of a researcher in their environment. They may be uncomfortable and suspicious of the researcher, which in turn may change their normal behaviour.

Another problem within the collaborative process is in the establishment of the process. Sometimes, individuals in the collective working group may well perceive the problem from within different perspectives and from a different agenda. Infighting within the group can result in the breakdown of achieving a workable solution to the common problem (Kemmis & McTaggart, 1988).

There are also problems of generalisability with Action Research. Because the research is specific to a situational environment, some critics maintain that findings from this research cannot be applied to other studies, and this limits the application and use of the research (Clifford & Gough, 1990). Gibbings (1993), however, argues that the purpose of Action Research is to investigate the *process* enabling the change, not necessarily the *result* incurred by the change. Gibbings also believes that the flexibility and adaptiveness of the self-evaluative process assists in the generalisability of the research to other research studies.

Achieving change can also be complex, lengthy, and difficult. Often, the complexity of the problem in Action Research does not provide the researcher with the usual parameters in which to work, which can mean the researcher feels less secure and because of the very nature of the collaborative, participative process, less in control. There is also the problem of change, and the time it takes to affect change. The time-lag between the completion of the field work and the final report of the research project can result in the nature of the research problem changing before any firm recommendations can be made (Rutledge-Sheilds & Dervin, 1993).

As the literature illustrates, there are undoubtedly some problems associated with this research process, but there are problems associated with any research methodology. As long as the researcher acknowledges the possibility of these problems arising, it should not invalidate the discoveries and revelations that action research is uniquely suited to explore.

ADVANTAGES TO ACTION RESEARCH

The theory-research-practice gap is of great concern within the nursing discipline. Gibbings (1993) believes that nurses in clinical environments often do what they do, without really understanding why. It has been my observation within the field of nursing that often when existing clinical practice is questioned, rather than using evidenced based research to support practice, the reply too often is that it's traditional, "this is the way it has always been done". This isolation of theory and practice can also extend to the researcher who investigates a nursing situation to develop a nursing theory from research, but often this theory does not adequately

describe the nursing reality. Gibbings (1993) describes the great strength of the inter-connectiveness between nursing research, theory and practice in Action Research. Nursing practice is examined and researched by a collaborative, participative working group - nursing concepts are generated - which in turn explains and develops nursing practice. The theory is not divorced from the practice and the practice is directly clarified by the research.

In Action Research, the single loop of planning, acting, observing and reflecting is only a beginning. If the process stops there it should not be regarded as Action Research at all. The Lewinian notion of a self-reflective spiral of cycles, generating further action, further observing and further reflection, creates the environment where the risk of making poor judgements and, therefore, undesired action is lessened. Reflection allows reconnaissance and builds a more vivid picture of life and of the work situation. This process enables the researcher and participants to establish a programme where there is a better developed rationale for practice. This critical reflection not only benefits the research group but also through this enlightenment, their organisation (Carr & Kemmis, 1983). But, perhaps the greatest benefit of the Action Research process is that it empowers its participants to take control of their work situations. Action Research discovers the process that enables the change to occur, not just the outcome of the change. This, in itself, can become a powerful lesson (Gibbings, 1993). Maloney (1992) believes it is essential for nurses to understand that, to be part of the decision to produce change, and to have some 'say' into the form the change will take, nurses need to be active participants in the process of that change. By constructing a way for nurses to use their knowledge,

Action Research provides the ability to 'see through' problems, particularly when associated with management or establishment issues (Reason, 1994).

In summary, Action Research is a process that can empower its participants to take control of their work situations. It aims to enlighten nurses about the relationship between circumstance, action and consequence in their environment. It also aims to provide a process of emancipation, where nurses are able to lift the constraints of institutional and personal barriers, and challenge a system which limits their power to use their own knowledge (Reason, 1994).

EXAMPLES OF ACTION RESEARCH IN PRACTICE

To clarify and understand how Action Research can be applied in a practical nursing environment the following is a review of three Action Research studies, specifically designed for the nursing domain.

Using a participative nursing working group, Cornish (1995) examined the viability of combining the roles of District Nurse and Public Health Nurse in a rural setting in New Zealand. The purpose of this research was to ensure the survival of a nursing service during the competitive environment of health reforms. The group reflected on their roles and created a model which represented combined nursing practice while still retaining their specialist roles. The study resulted in the participants acknowledging the differences between the two roles and the value of their specific work in the community. The group developed a strong cohesiveness and better co-ordinated communication network, while gaining confidence in their

ability to make decisions themselves. This resulted in the empowerment of the nurses to present a stronger nursing representation within their multi-disciplinary team and, consequently, their organisation.

Cayne (1995) identified that a group of qualified nurses working in an orthopedic / trauma unit did not plan their continuing education in a systematic way, or record the effects of their education and experience on their personal development. Cayne recognised that one way of addressing this problem was by developing a portfolio. Two research questions were explored in this study: Is the process of portfolio preparation in itself developmental, and if so, what factors influence this developmental process? The action involved meeting as a learning group to explore the process and discuss the problems. By using questionnaires and interviews the data was then analysed through a research process of 'thematic concern'. Caynes' findings indicated that apart from some clarification of content requirement and guidelines for assessment criteria, the portfolios developed by the nursing staff did help the nurses to learn to value their experiences in a positive manner through a process of reflection. In describing why she chose Action Research as the research design for her study, Cayne explained that by working with learners in a participative rather than in an observatory way, the Action Research becomes research for the researcher as well as research for the group through the learning process. By being able to understand the learners' world, and the meaning it has for them, the researcher is better able to monitor and modify nursing practice.

In an attempt to provide a healthier work environment a research team, Diemert-Moch, Roth, Pederson, Groh-Demers and Siler (1994) used Action Research

and Newman's Health Theory to develop the process for creating a healthier work environment. The researchers invited a ward / staff team from an acute care facility to participate in a working group to produce a structure for a healthier work environment. As a result of several group meetings, the group found that reflection and a focus on the positive aspects of their work, rather than the negative aspects of their work resulted. Feelings of empowerment and engagement in the organisation also seemed to emerge. Diemert-Moch et al. discovered that, through the group process, the researchers became the participants, increasing their awareness and knowledge about themselves and the intervention process. As facilitators they became empowered and engaged in creating change within the organisation.

CHOICE OF ACTION RESEARCH FOR THIS STUDY

The purpose of this research study was to provide a process where public health nurses could examine their existing practice and ask: What knowledge and skills would an advanced public health nurse practitioner require to work autonomously and effectively in a 'family centred' clinic within a primary school environment? The methodology of Action Research definitely provided an appropriate framework from which to investigate this question.

To re-visit the four specific criteria of Action Research as outlined by Burns (1990); there was a **situational** problem of concern, namely that public health nurses working in the Child and Youth Team, Child and Family Services, Auckland Healthcare, could well provide comprehensive assistance and intervention for families but presently are contracted to the Health Funding Authority in such a way

that knowledge and skills are restricted by service delivery boundaries. The investigation into the viability of extending public health nursing practice would be a **collaborative** process involving both myself as researcher and the working group participants as co-researchers in a **participatory** process of inquiry. The research question necessitated that the working group reflect and explore their public health nursing practice in a **self-evaluative / reflective** way, that would facilitate a collective self-awareness which questions existing practice. The public health nursing working group would *describe* their concerns, *explore* what others think, and *probe* to find what it might be possible to do. Group members would *plan* action together, *act* and *observe* individually or collectively, and then *reflect* together (Kemmis & McTaggart, 1988).

The theoretical framework of the study was to encompass the **practical** and **emancipatory** models of Action Research, where the inquiry would facilitate interpreting meaning and purpose of public health nursing practice, and through this awareness challenge the boundaries of existing practice reality. The practical action research model as discussed by McTaggart (1991) will provide a process where PHNs can articulate their practice. This articulation is essential – if you cannot articulate what it is that you do, or why you do it, or how successful it is, how can nursing knowledge develop to support change and growth? Following on from practical action research, the emancipatory action research model provides the framework where PHNs can question their practice reality, it provides the steps for the liberation of freedom of thought - moving beyond what exists today (Kemmis & McTaggart, 1988).

THE RESEARCH DESIGN

The service delivery of nurse managed 'family centred' school-based clinics has been a vision for extending public health nursing practice within the Child and Youth Team, Child and Family Services, Auckland Healthcare, for the past two years. This initiative was in fact developed to proposal stage by Auckland Healthcare and presented to the North Health, Health Funding Authority, who encouraged further development of the concept.

When deciding upon a topic of investigation for my masters thesis this initiative presented the obvious focus for study. A public health nursing colleague, was also in the process of commencing a master's thesis for a nursing degree. Together we decided to develop a strategy to investigate this project simultaneously. Each study would be discrete but the two would complement each other. Clendon (1999) sought to undertake a Community Needs Analysis to investigate whether a nurse managed 'family centred' school-based clinic would be a viable health delivery service to the community. This research study sought to provide an Action Research process where public health nurses could examine their existing practice and develop a 'portfolio' defining the practice of an Advanced Public Health Nurse Practitioner working within a nurse managed, school-based clinic. One study examined the viability of this health service option from the community's perspective the other study took a nursing knowledge development perspective to examine scope of practice, clinical skill and nursing knowledge base. There was an expectation by myself and Clendon (1991) that the convergence of research results from these two studies would provide the influence to extend public health nursing practice into a

nurse managed school-based clinic. In discussion with the Team Leader for the Child and Youth Team, Child and Family Services, Auckland Healthcare, we were extended full support and encouragement for these dual projects.

It has been my observation that most parents / caregivers have involvement with a primary school at some point in the child's school life – whether it be to transport the child to school, attend school concerts or teacher / parent interviews or to assist in school programmes. This participation of the family does not appear to extend at the same level to secondary schools. Therefore the environment of a primary school was chosen for this research because of the central position that primary schools play in the everyday lives of most families.

THE PROPOSAL

Having decided upon the specific focus for this research, I set about developing my research proposal. The proposal outlined the research purpose, aim and format for investigating this study. The research would examine public health nursing practice boundaries and, through a process of collective inquiry and reflection, produce a 'portfolio' which would identify criteria which would define an advanced public health nurse practitioner whose practice could encompass a 'family centred' clinic within the primary school environment.

The issue was to be researched by myself - as principal researcher- and a group of Auckland Healthcare, Public Health Nurses as co-researcher / participants, within service delivery hours. Therefore, it was necessary to gain approval from the

Auckland Healthcare Research Development Unit and, specifically, from the Manager of Community Health Services. Once approval was granted and letters of support obtained, the proposal was discussed with the Chairperson for the North Health Ethics Committee. Because there was no identifiable potential for harm to the participants in the public health nursing working group, the North Health Ethics Committee Chairperson decided there was no need for the proposal to go before their committee. Ethical approval was then sought and granted from the Massey University Ethics Committee.

THE ACTION RESEARCH PROCESS

It was no secret amongst the Child and Youth Team, Child and Family Services, Auckland Healthcare, that nurse managed 'family centred' clinics within a primary school environment was one area where management believed public health nursing practice could extend. However, more research was required to develop the concept. The team was aware that Clendon (1999) and I intended to explore this potential service initiative. Therefore, we decided to be very open and discuss our individual research projects during one of our regular team meetings. This proved to be very successful and, even before I had sent out invitations to join the working group, I had been approached by several public health nurses voicing their interest in participating in the study.

Recruiting the co-researcher participants and obtaining informed consent

It is essential when using the methodology of Action Research that the researcher has credibility amongst the participants of the working group. I had

worked as a Public Health Nurse in Auckland Healthcare for four years and during that time had facilitated many working parties. I had enjoyed the process of working collaboratively with my colleagues and I believed I had the credibility required to complete an Action Research project with them. Consequently, I chose to invite colleagues from within the Child and Youth Team to participate / co-research in this project.

An Information Sheet (appendix 1) outlining the purpose and aim of the research was mailed internally to all 14 public health nurses employed in the Child and Youth Team, whose skill and knowledge base was at competency level III (proficient) and IV (expert) public health nursing practice. Competency levels of practice as developed by Benner (1984) have been used by the service to demonstrate clinical skill and nursing knowledge for the past five years. Most of the public health nurses employed within the Child and Youth Team had already 'worked' through their Professional Development Programme (PDP) and attained Level III competency (proficient) and a few had attained Level IV competency (expert).

A period of not less than one week and not more than four weeks was set aside for the participants to consider participating in the research as co-researchers. Those acknowledging interest by approaching myself were invited to participate in the working group. It was explained at this time that anonymity and confidentiality within the research could not be guaranteed as it would prove difficult keeping this knowledge from the rest of the Child and Youth Team, particularly as this was an area of keen interest and we were meeting during working hours. However, it was explained that identification of the specific participants in the working group would

only be documented if collectively the working group agreed. It was made clear that the participants had the right to decline to take part in the research or withdraw at any time. Written consent of agreement to take part in the study was then obtained (appendix 2).

The working group sessions were tape-recorded and field notes were kept. Generally as principal researcher I would write the field notes however, if I was collating the group ideas on the white board one of the other group co-researchers would take the notes. After each session I would summarise the issues and ideas discussed and circulate this summary document to each of the group members to assist the reflective process. Prior to commencing the discussion at the next session the group was asked to comment on, and clarify, any issue of concern raised from the previous session. During these sessions group members as co-researchers, individually and collectively, obtained / investigated different literature and reviewed the appropriateness of this information for the development of the 'portfolio'.

Eight public health nurses agreed to take part in the research, one public health nurse withdrew after the third session.

Data Collection and Analysis Methods

The first time we met as a group 'housekeeping' issues were discussed. We developed ground rules regarding punctuality and attendance for the sessions. During this first meeting the frequency and length of the meetings was decided.

The research study spanned the period from July through to October 1998 encompassing two school holiday periods. This meant the group was able to accommodate four of the working party sessions during the school holidays (although public health nurses work in schools they do not have school holidays off). We met six times, two sessions were held in my home during the school holidays, one session was held in one of the PHN office rooms, and three sessions were held in the conference room at our workplace - in total we met for a period of ten hours.

As previously discussed the working party sessions were recorded using a small but functional tape-recorder, and issues / themes uncovered were documented in field notes. The tapes and notes were kept in a locked cupboard in my private dwelling. The working group was aware that both the tapes and notes would be destroyed after my research thesis had been successfully completed.

Potential to harm

The rights of members of the working group were upheld throughout the research at all times. Group members had the right to decline participation and withdraw from the research at any time. Questions regarding the research process or the issues under investigation could be asked at any time. The tape recorder was switched off at any time when requested.

As public health nurses we were actively encouraged to reflect upon our practice and develop new initiatives that would benefit the delivery of our service. This research posed no conflict of interest or conflict of roles.

The research study was guided by Massey University, School of Health Science, Research Supervisor, Dr. Judith Christensen and all appropriate ethic committee approval was sought and gained.

The Researcher

I graduated as a Registered General Obstetric Nurse eighteen years ago and have worked in full time employment in a wide variety of nursing fields. I obtained my Bachelor of Health Science Degree in 1995 and have been working towards my Master of Arts Degree since that time.

My position within the Child and Youth Team, Child and Family Services, Auckland Healthcare, was that of a Level IV Competency (Expert) Public Health Nurse. I had facilitated many new team initiatives investigated by Child and Youth Team working parties so I was an accepted leader of these groups.

Use of the study information

This research fulfills the thesis requirement for a Masters of Arts in Nursing Degree. Acknowledgement was made to the working group that the information obtained through this research process could be extended by myself to future research studies. The working group may also wish to use the results from this project for some future study. However, the actual data from this research will be destroyed on the successful completion and acceptance of this thesis.

This research provides the process for public health nurses to examine their practice and ask: What knowledge and skills would an Advanced Public Health Nurse

Practitioner require to work autonomously and effectively in a 'family centred' clinic within a primary school environment?

CHAPTER FOUR

THE RESEARCH PROCESS: THE GROUP AT WORK

The purpose of this chapter is to describe what happened within the working group during the research process. Unlike other research methodologies the findings and results that emerge from Action Research cannot be seen in isolation from analysis. The reflective action spiral where themes are explored, actioned then re-examined constructs a process of analysis that is embedded in the finding process. This next chapter is not a discussion on the themes that evolved from the research but analysis of what happened within the group and the influences that effected the progress of the research outcome.

It is important to describe the different venues used by the group and the subsequent impact these environments had on the process development; it is important to discuss the group dynamics - the formation of conflict situations and the ultimate unity when group members' thoughts and opinions converged into a shared vision; and it is also important to discuss the literature used by the group that provided the foundation on which the 'portfolio' evolved.

THE DIFFERENT VENUES

First Venue

Our first and second meetings took place during the holiday following the second term of the school calendar year. In an attempt to provide a 'warm friendly'

place in which to encourage the development of 'meaningful' dialogue these sessions were held in my home. On both occasions the weather was typically mid winter - cold and wet. We set ourselves up in the lounge, sprawling around the couches and floor in front of the gas fire, drinking copious quantities of coffee / tea / milo and munching on delectable goodies. Conversation flowed and the atmosphere was relaxed.

In hindsight, this venue was not conducive to initiating concepts for discussion and development. The people sitting on the floor soon became uncomfortable and moved around continuously. The food and drink, although necessary to sustain energy, should have been provided after the session - it was distracting reaching across for food while at the same time attempting to think through ideas. Documents were piled around the floor because there was not enough room on the coffee table because of the food. The realisation that this was possibly not the best choice of venue to meet in did not occur to us until well into the research process.

The Second Venue

The next time the working group met, schools had returned for the third school term. With the return of the schools, we decided to meet in one of the PHN offices rather than disrupt the PHNs' working day. The office was quite a large room with six PHN desks. We formed a circle around the middle of the room, took the phones off the hook, and balanced the tape recorder on an upside down rubbish bin. Again we had nowhere to spread our papers, so any note taking was scribed on knees. We could not brainstorm thoughts or use diagrams to structure concepts

because of the visual constraints of the room. Although the conversation did not appear at the time inhibited, in hindsight, this was another poor choice of venue.

Third Venue

The fourth, fifth and sixth times we met – because of the problems associated with the space in the PHN office – we met in the Conference Room of the building. This is a large room with a large ‘boardroom’ type table with a white board extending right across one wall. The room is highly utilised within the service, so we decided to rearrange our meeting times around the room’s availability. It appeared that the use of this room proved an important turning point in the acceleration and cohesive development of the ‘portfolio’. Individuals could express themselves diagrammatically on the white board, literature could be examined with ease, and the tape recording acoustics improved dramatically.

GROUP DYNAMICS

The nine members of the research team (including myself) were well known to each other. Many had been in PHN working groups together in the past, some shared offices - all shared the same building. There was a collegial spirit within the group from the very first meeting and, although through some of the sessions opinions would vary and arguments would become heated, there was never any anger or intolerance of differing points of view. Whilst the outcome for the group co-researchers was to complete the ‘portfolio’, as principal researcher my involvement was more complex. Not only was I the researcher-participant as described by Stroecker (1997) facilitating and guiding / directing the group to move the research

process along, but also my main interest was to complete the project to be written up as my master's thesis within a designated time frame. Other members of the team may have wanted to develop the 'portfolio' over a longer period of time. This did not appear to be the case. However, this raised the possibility of a conflict of interest.

As a service, over the past year we had spent a lot of time developing the "Health Promoting Schools" concept. This is a process based upon the Community Development Model where a needs analysis is undertaken with a school community and, in consultation with school stake-holders, a plan of action is developed, implemented and evaluated in an attempt to address and improve health concerns. The "Health Promoting Schools" project had been approved by the Health Funding Authority, and Auckland Healthcare PHNs were implementing this process within their schools. The whole philosophy of this model is that the community forms the issues that are investigated and the community owns the process.

Although the working group research project was structured around a 'family centred' clinic within a primary school environment, it was not situated within a community development paradigm. What the community looked like, or what health services were needed within the community, had no impact on the competency level of the nurse in regard to their practice. However, because of the previous emphasis within the service on the effectiveness of working within a community development framework, some PHNs found it difficult coming to terms with not consulting the community:

...but we don't even have an indication from the community that

they want this...

.....

...every community is different how can we know what skills the nurse will need?

.....

...are we doing this for the community or are we doing this for our practice?

.....

...well I'm doing this for the community...

.....

...that's why you are getting so frustrated.

Understanding the differences between advancing our practice through nursing knowledge development and extending our practice through community development took time. One of the PHNs within the group was too involved in developing the "Health Promoting Schools" project to have the capacity to explore new concepts in advancing nursing practice. Therefore, this PHN decided to leave the group after the third session.

At the start of the fourth session we re-visited the community development framework versus the advancing of nursing practice from within a nursing knowledge development framework. The group acknowledged that practising within a

community development framework is vital when working within the community, however the community development framework was not the most appropriate framework to use when investigating the knowledge and skill base required for the 'portfolio'. Rather, a nursing knowledge approach as described by Benner (1984) was needed. The co-researchers were familiar with Benner's work as this is the model that Auckland Healthcare uses for the nursing Professional Development Programme. Also, during the research process the group had previously discussed Benner and the application of this nursing knowledge approach, when attempting to define an advanced nursing practice role. From this point the group began to cohesively examine the practice of the nurse without clouding the issue with community profiles and needs.

I had led two large working parties in the past for our service, and several members within this working group had been participants in these different initiative developments. From the outset I was aware that using an Action Research methodology meant that the group needed to have a collegial and cooperative climate. To this end, I tried to take a back seat role and encourage the group to formulate the direction. I had not recognised the need to 'lead' within the Action Research cycle. Dick (1993) discusses how this is not an uncommon occurrence as most Action Research studies use the terms participatory, collaborative and co-operation to describe the research process. These principles of researcher behaviour apply but more than this Action Research needs to be responsive. It has to be able to respond to the emergent needs of the situation. The 'action' evolving from the process is paramount (Dick, 1993; Stoecker, 1997). After the second session it became apparent that we were not really moving forward. We had spent two sessions reviewing our

practice and looking towards what a school-based clinic could offer without extending this discussion into a role 'portfolio'. Therefore, at the commencement of the third session I discussed with the group my taking more of a directing role, and they agreed.

...I came into this thinking it was going to be relatively easy because we've been on working parties before, but those working parties we had something really concrete to work on, we knew what we were trying to develop...this is really new, we don't know what form it is going to take.

Even though my role became more directional, this change of emphasis in my participation enhanced and moved the group along the Action Research cyclic spiral. This move to a more directional role was instigated by the group after reflection on our previous performance.

It was not only my role that changed within the group dynamic. As we progressed through the development of the 'portfolio', rather than accepting comments on their face value, the group began to question, and they asked each other to qualify what they meant by certain statements. This challenging of ideas brought about, in my opinion, some wonderful articulation of practice:

...use a collaborative approach which is based on active participation, negotiation and partnership with clients and their families, with the focus on strengths and potential.

.....

...practices nursing in accord with principles which promote client interest and acknowledges the clients individuality, abilities, culture and choice.

The group also navigated their way through themes that emerged from the research process. These themes will be discussed in depth in the following chapters. However, the examination and reflection upon these themes, enlightened concepts, and through this enlightenment, re-defined PHN practice.

LITERATURE USED TO ASSIST IN THE DEVELOPMENT OF THE 'PORTFOLIO'

It is important to discuss the literature critiqued by the working group as it is in part, the theoretical framework from the literature that assisted the group to develop the Advanced PHN Practitioner 'portfolio' which is presented in chapter seven.

As already stated, prior to our first meeting I gave the group the literature review chapter of this thesis so they had some background knowledge on which to begin the process of reflection and investigation.

The literature examined in Session One

During the first session we discussed the criteria within the competency workbooks of our PHN Professional Development Programme. We decided that we needed to review, in detail, not only the workbooks but also the PHN and Senior

Nurse Practitioner (PHN) job description documents and the Health Funding Authority contract on which our practice is based.

The literature examined in Sessions Two and Three

Although the PHN competency workbooks were due for review, the audits and exemplar criteria of the different competencies gave an excellent articulation of PHN practice. It was, in part, due to this measurable audit of practice that we decided the Advanced PHN Practitioner needed to continue through an extension of our professional development programme. Unlike the competency workbooks, the PHN and Senior Nurse Practitioner (PHN) Job Descriptions were not specific, they were very generalised and, in our opinion, not documents that described practice or illustrated the expected knowledge and skills required for these roles.

At present we have two contracts with the Health Funding Authority (HFA). One is for Health Promotion - five pages long; the other is for Personalised Care - one and a half pages long. The group believed that the emphasis of the HFA is clearly indicated by the length of these two contracts. This was a very subjective observation by the group as it is the quality of a document not the quantity that is important. However, the sparseness of the Personalised Care contract did appear to indicate that the HFA was not as concerned about Personalised Care as it was for Health Promotion. While everyone in the group strongly believed in the philosophy of Health Promotion, the question was mooted: How can families who are struggling within the confines of poor health, poverty and social isolation have the capacity to take on health promotion concepts? It was recognised that we need to assist in the empowerment of people to take responsibility for their own well health but, with

many of our families existing at basic life sustaining levels, there needs to be a greater emphasis on personalised care. As a group we believed that the contracts needed to be reversed and the issue championed to our managers. It may appear that in discussing this issue the group wandered slightly from the research purpose of developing a 'portfolio' however, it is important that the working group had a clear understanding of the meaning and purpose of public health nursing practice today. This is an essential element of **Practical** Action Research. Uncovering meaning and purpose enabled the group to move towards **Emancipatory** Action Research where change could occur (McTaggart, 1991). You cannot build upon something that is not articulated or understood. Therefore reviewing the HFA contracts proved an important step in developing the 'portfolio'.

The literature examined in Session Four

In session four the group reviewed the Auckland Healthcare Job Descriptions developed by Carroll, Roud and McArthur (1997) designed for:

- Charge Nurse Consultant
- Charge Nurse Manager
- Clinical Charge Nurse
- Clinical Nurse Educator

Specifically, we were interested in the description of the accountabilities and key tasks required within each role. It was interesting to note that these roles all required masters level education, either having completed or working towards a Masters Degree. The documents were outlined in a comprehensive, concise format that clearly articulated the 'profile' of the different nursing roles.

One of the group also obtained the Report on the Western Heights High School Health and Wellness Center (Hohaia & Shaffelburg, 1997). This was a report presented at the New Zealand 1998 PHN Conference where a New Zealand Public Health Nurse established a health clinic in a Rotorua College. The nurses' experience of establishing the school health clinic was extremely positive and successful. The PHN had networked with other adolescent health consultants within the community, like the Family Planning Association and Specialist Youth Services, whom she coordinated to run health sessions at the clinic. Very soon, however, the PHN found that she had coordinated herself out of a job; the clinic remained very successful and well utilised but the PHN was not delivering the health care. On further discussion the working group concluded that, as long as the clinic was successful, the PHN had facilitated the health care, which in itself was an accomplishment. Maybe, with regard to her own 'redundancy' in the clinic, the PHN needed to think with more innovation to develop practices that would require her specific knowledge and skills which would be of value to the service users.

The literature examined in Sessions Five and Six

In an attempt to clarify the definition of terms regarding advanced practice roles within nursing the group reviewed the Nurse Executives of New Zealand (1998) document outlining the different emphasis in the practice of Clinical Nurse Specialists and Nurse Practitioners. The document describes the Clinical Nurse Specialist role as being:

...undertaken by a nurse with experience in the clinical specialty and advanced learning in that area of specialist care. The nurse...initiates care to meet the special needs

of an individual or group of patients with particular health problems. (p. 3)

The document describes the Nurse Practitioner role as a nurse who:

...provides care for a patient or group of patients over an extended period of time across the community-inpatient-community continuum or may involve engaging the client/families in the pursuit of health behaviour and healthful living. (p. 4)

Although the discussion on this document was useful, the group felt the Advanced PHN Practitioner role could well result in an amalgamation of these two practices, depending on the knowledge and skill base of the nurse.

As part of determining the scope of practice of the Advanced PHN Practitioner the group examined Chapter Two of the Report of the Ministerial Taskforce on Nursing (Ministerial Taskforce on Nursing, 1998) which specifically discusses expanding the scope of nursing practice. The document examines the definition of an advanced nursing role, attitudinal barriers regarding the perception of nurse's knowledge and skill, prescribing rights, nurse competencies and strategies to assist in the development of advanced nursing roles. This document assisted the group to understand the depth of advanced nursing practice and the extensive knowledge and skills that would be required of the Advanced PHN Practitioner. It

also assisted the group to acknowledge the need for a masters level qualification for the role.

The group also examined the Nursing Council draft document on competency based practising certificates (Nursing Council of New Zealand, 1998). This document was tabled to add weight to the requirement for advanced competencies to be developed for the Advanced PHN Practitioner, as in the near future the Nursing Council will require proof that individual nurses are working within a regulated level and are progressing through some form of a professional development programme.

Lastly, the group decided to use the 'domain' format from the American Association of Colleges of Nursing (1996) document to structure the 'portfolio' description. This document examines the essential core content for masters education and describes specific 'competencies for the programme'. Prior to the review of this document the group had difficulty developing a framework in which we could 'hang' all the Advanced PHN Practitioner competencies that were developing during the course of the research process. The competencies described in this document and the organisation of these competencies into a 'domain' format, provided the group with a shape and design which we could easily adapt to our purpose.

The group reviewed this literature during the four month period of the research project. Readings were distributed between sessions so the group could continue to reflect while developing new issues to discuss at the next session. It was noted by some of the group members that they would not have accessed this amount of literature in the course of their normal working day, therefore this investigative

process provided an environment of increased knowledge development - specifically in regard to topical issues within the political arena of nursing today.

This chapter has examined the different influences that effected the progress of the research outcome. The next two chapters will examine the issues that evolved during the reflective action spiral of the Action Research process

CHAPTER FIVE

THE RESEARCH PROCESS: SETTING THE SCENE

This chapter examines setting the scene - how the group initiated the research process. This chapter describes the process that enabled the group to move from present PHN reality towards extended future practice. The research findings from this study are described within an analysis framework. As previously discussed, results cannot be seen in isolation, as analysis is integral to the whole research process.

SETTING THE SCENE

Prior to the first working party session we met as a group and decided the best times to meet. We were meeting during service delivery hours but to prevent disruption to our working day we decided to meet firstly during the second term holidays of the school calendar year. As already discussed, at this meeting I gave the group the background information chapter from my thesis, so they had a basis of knowledge around the topic from which to be able to reference and expand upon.

Initially, I described the process of Action Research and the implications of this type of methodology in research. I described the collaborative, collegial process and the problems that can arise when people have their own agendas around the topic that can destroy the purpose of the working party.

We discussed an Action Research project specific to PHNs in New Zealand, Cornish's (1995) study, in order to provide some background information. We

discussed the theme of *change* around Action Research and how, by examining our practice and re-discovering the purpose of public health nursing, we can become empowered to challenge the boundaries of our practice. I described the purpose of the working party - to produce a document 'portfolio' that would describe what skills and knowledge an Advanced PHN Practitioner would need to work autonomously and effectively in a 'family centred' clinic within a primary school environment.

Before we could examine what this PHN would 'look like' it became apparent that we needed to have a general discussion around the whole philosophy of nurse managed, school-based clinics.

NURSE MANAGED HEALTH INITIATIVES WITHIN THE COMMUNITY

We examined the concept of nurse managed school-based health clinics from within New Zealand's perspective. As previously mentioned, one of the group members related the story of the PHN from Rotorua, New Zealand, who spoke at the 1998 PHN Conference about a health clinic she established in a Rotorua College. With the actual document to review, the group remained of the opinion that the PHN role was essential in this clinic environment. Whilst the PHN made referrals to specialist and other health professionals to deliver the actual care, she did not need to 'do herself out of a job' if she developed relevant practices requiring specific nursing knowledge and skills. For example, the group believed that the nursing practice involved in assessing adolescent health needs for referral, would be pivotal to the success and effectiveness of the clinic.

One of the group thought the possibility of a travelling health team to move between communities, as described by Jones and Clark (1997), was a viable model of nurse managed health care for New Zealand families:

...a roving / mobile PHN position – a free health service.

The group believed that a huge problem for families accessing health care was not lack of motivation so much as the attached financial cost, and the often inaccessibility of the health care service to the community.

In the Islands you have the District Nurse come round once a week and she will hold a clinic and everybody would just go...it's a real community thing...the women counsel health and they bring their babies, the old people get checked out by the District Nurse ... the babies would play together, there would be a real gossip session, arts and crafts would be done...

The health clinic offered in the islands, as described by the group member, is a 'full health care' service developed for an under resourced area. While accessibility is an issue, acceptability clearly is not, so there must be fundamental differences within the health care structure. Even if community health care were physically accessible to New Zealand families, it is not acceptable - the barriers of financial, language and cultural constraints would prevent many families from accessing this care (Ministry of Health, 1997b).

The group discussed the centralisation of the public health nursing service versus de-centralisation. Presently, Public Health Nurses working for Auckland

Healthcare in the Child and Family Service are based in the one office in Newmarket, Auckland. The geographical area that these Auckland Healthcare PHNs cover extends from Otahuhu in South Auckland, across to Panmure in East Auckland, and up to Avondale in West Auckland - an area of approximately fifty square kilometres. The last of the PHNs in decentralised Child and Family Services, Auckland Healthcare offices, amalgamated in 1996. It was noted by the group that, while decentralisation creates accessibility barriers for the community, centralisation has lessened the isolation of PHNs. Debriefing following crisis situations can be immediate because there is always an experienced PHN available. Increased collegial support and new service initiatives have developed because of the proximity of team members and the ease in which working groups can get together. The referral process between the different community service groups – Maori Community Health Workers, Pacific Island Support Workers, Medical Officers, Dietitian and other PHN services – is facilitated because it is literally just a walk down the corridor. Concern was raised by the group that school-based clinics could isolate the PHN from her colleagues. However, it was also noted that isolation could occur anywhere, even in a setting where the nurse is surrounded by many people. What is needed is a win - win situation where the existing centralised PHN infrastructure facilitates the delivery of a decentralised / local practice within the community.

THE PRACTICE OF THE CHILD AND YOUTH TEAM PHN OF TODAY

It was decided by the group that we needed to describe 'what was' PHN practice so we had a reference on which to build. We began to examine the concept

of articulating our practice. However, the exercise caused great consternation within the group.

How do we articulate something which is so intangible and diverse?

One PHN who came from another public health nursing area in New Zealand stated that, as a PHN group, they had spent many hours in numerous meetings trying to quantify 'what it is that PHNs do'. They ended up with a very long 'waffly' document that articulated very little of actual practice. Another PHN had attempted in one of her Bachelor Degree assignments to articulate PHN practice. She found it very difficult and complex because:

We are a 'Jack of all Trades' and specialist of none.

It was decided that part of the problem is that we have such a low profile.

PHNs never get a mention in the media...we are constantly doing sexuality teaching in the schools – we have a contractual agreement with the Health Funding Authority that we are a provider...but if the media talks about sexuality teaching, they talk about Family Planning...we don't get mentioned.

We discussed the need to raise our profile by writing and publishing our own articles.

Writing is all well and good, but nurses write articles for other nurses...we need to raise our profile within our communities. If we are doing something in the community, how many PHNs contact the press? We need to let people know of the

neat things that we do.

.

However, we can't release information that is really topical like the squalid conditions in which New Zealanders live because Auckland Healthcare would be on top of us for discussing things at that political level. We are not independent and our jobs would be on the line.

.

I once released an article and I just about lost my job over it. Looking at meeting the needs of the community, I released statistics about the community and how people were isolated and living in poverty... the community got up in arms, they were really upset, it was like – “you labelled us and we don't want to be labelled, okay yes we are poor, we are struggling, but we don't want you to say that”. The area got stigmatised...I regret that big time because I lost the trust of the people...I was seen as the person who blew the whistle on their living conditions.

This comment caused much discussion within the group around the whole ‘whistle blowing’ scenario and the need to be an advocate for the family and the community. The group decided that, whilst raising issues of deprivation can be necessary at times,

...[you have to] keep the vision of what you can change and what you can't.

The group recognised that sometimes this is very difficult to do even with vast experience and knowledge.

Raising our profile can create problems...we are dealing with social problems, sure health comes into it but we are dealing with social issues. We need to raise our profile not politically but within our communities so there is ownership of the problems. The problem is the community doesn't know what we do."

The group agreed that articulation of our practice was vital to our survival because:

...how can we build on something that we can't even articulate?

So the group brainstormed concepts, separating the identified key words into actual practice and PHN philosophy as indicated in the table which follows:

PHN Clinical Practice	PHN Philosophical Practice
Paediatric /child focus Primary School focus Secondary School focus Child assessment – social / family dynamics Child assessment – medical / physical Adolescent assessment Treatment / intervention (scabies etc) 5 year old health screening Health education in schools Health promotion Immunisation Mental health issues Stress management for Mums / caregivers Stress management for kids Parenting groups	Autonomous Not medical model Not budget or profit focused Networking / Liasing / Facilitating Commitment to Community Development Commitment to the Ottawa Charter enabling advocating mediating supporting strengthening empowering Working in partnership with other Community agencies (CYPS) Working within a multi disciplinary team

The group developed these concepts further and began to articulate PHN practice compared to other nursing disciplines and agencies who work within the community.

We are one of the few people who work within people's realities... if I go into a house to talk about nutrition and there is b..... all there to eat, you work within that reality...you know what is in the cupboards so you talk about real basic lunches...you teach them basic strategies.

.....

We go to people's homes [and] we're the visitor. It's humbling. You're actually quite dis-empowered in a way...you have to quickly get into their norms...We meet the client's agenda. In a hospital or GP practice the client is meeting the hospital's or Doctor's agenda. We might go in with our agenda but if it's not the client's agenda, if it's not at their level, we won't get them on board. We might have to play a few games for them to go along with it, we often have to ignore glaring deficiencies and often the reason you've gone to the house isn't the thing you end up talking about because it is not appropriate at the time.

There was great discussion within the group around working within each family's reality being non-judgemental and 'walking beside' them, even if you may not agree with the course of action the family decides to take.

If you have a subconscious desire to change the family to your own values and standards then you can never work with them because the family will interpret that and they'll put up barriers...

.....

...the family might chose to use herbal medicine, massage, whatever, that can be a real ethical dilemma. But you follow up and ensure well health.

The group also acknowledged, however, that we are not always so altruistic. Sometimes, due to the nature of the issue facing the family, we have to be directive and enforcing. When it comes to child abuse our mandate is very clear – it is the wellness of the child, not the family. Therefore, in the first instance you ensure the child's safety, but you also continue to work with the family because eventually, the child will return to the family environment. Often, it is necessary to take control and advise CYPS (Children and Young Persons Service) to uplift children, but generally this is only a short term solution.

Families can have lots of knowledge and know they are doing wrong, but knowledge doesn't always translate into behaviour... What they need is skills and strategies to act upon this knowledge and change... It's looking at the family's lifestyle too and recognising that lifestyle has an effect.

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Social work is a huge part of our role. When I first started this job I would say that we are a cross between a social worker and a missionary. Having come from a missionary background I see so many similarities to what we did in the communities of Pakistan and India. We're in a third world environment.

.

It's really hard when you have teachers on your back about poor hygiene or airy-fairy issues...[we have to] put it into perspective for the teacher and say: "That's really not a priority in their life right now. There are other issues which are far more encompassing and overbearing for the family." They [the teachers] should really pat the family on the back for getting the kids to school in the first place.

The discussion then turned to the political arena and how organisations are unable to meet service demands because of governmental constraints.

Plunket has become inaccessible [to the public]...A lot of babies under Plunket don't get their checks, and certainly not after the age of two. There is no ongoing follow-up. With Plunket if you don't turn up for your appointment you never get contacted again. We don't drop our clients even if they don't show, we actually continue contacting them 'ad nauseam' until we do get them...it might even be at the TAB, we have an ethical mandate to follow-up. Not many agencies do that to the extent that we do, we don't give up, we are very persistent...

.....

I feel so b..... frustrated...I feel as if I'm putting a band-aid on an aneurysm all the time...You are working with all these health and social problems - you can see where they come from but the political position restricts you in your role.

.....

It may look like band-aids but, often, the key things you are doing may be putting a lot back into the community...By emphasising healthy lunches within schools the kids know what is healthy eating and what is not healthy eating. They may still eat poor nutritional food but they have the choice not to because they have the knowledge. Its also really important not to flit from one issue to another - you have to stick with the emphasis otherwise it will reverse.

.....

We are too stretched...we know the value in picking up potential health problems with New Entrant Assessments. Presently there is no way we have the PHN numbers to access every 5 year old.

Being part of the community means you can seize opportunities to inform people, using what is familiar to them and building on it. We are opportunists for health promotion, we see a window of opportunity and go for it.

As an extension to this last comment, the PHN went on to describe how she set up a health information stall outside a school hall when the school was presenting a concert. Many people took brochures and she saw it as an extremely successful strategy in overcoming accessibility problems.

The group then decided to brainstorm key concepts that describe the uniqueness of PHN practice. These are listed in the table that follows:

Uniqueness of PHN Practice.	
Mobile Family focused even though our client is the child or adolescent Flexible Adaptable 'Jack of all Trades' Referral Service Humble – always the visitor in people's homes Professional Non-judgemental Persistent Quickly access norms Outgoing Dynamic Persuasive "selling" Ad hoc – unsystematic rather than systematic Grass roots of health care Facilitation Sense of humour Sense of 'dark' humour Thick skinned Community orientated	Holistic Follow-up Networking Creative Opportunistic Try to be proactive – tend to be reactive We do tasks but we're not task orientated There is no end, no start, no finish Moral perspective left behind – work within others realities. Adaptable Historical Emphasis on well health rather than ill health Families have to trust you, you have to foster that trust

PROBLEMS ASSOCIATED WITH PHN PRACTICE

Out of this discussion the group began to describe problems and constraints associated with PHN practice.

We can't walk away, we can't even discharge files. We can try, we can even put a 'D' on them for discharge but they'll just keep coming back.

.

Sometimes it's really hard to keep your optimism...sometimes there seems to be no end.

.

We're like an intermediary...I describe it as being a bit like a train station – come and see the guard, come and see the conductor, come and see the director of the traffic if you like, or you can just buy a ticket and go right on around...

.

Do we create an unrealistic expectation? Are we actually setting families up to fail - when they are never going to be able to achieve change because of their family dynamics?

The group again discussed the whole philosophy of 'walking beside' families even if their values are different from your own. Giving families informed choice and the strategies and skills to make change is the essence of PHN practice.

I really believe in Community Development. The way we work now makes it very difficult because we are so focused on schools.

The group discussed the process of the “Health Promoting Schools” project where PHNs in the Child and Youth Team are working within schools trying to raise the philosophy of ‘ownership’ of health issues by implementing ‘school community’ needs analyses. The group discussed how effective this process is for facilitating health change because the ownership of the process is with the school stakeholders. Change within the school environment is only successful if there is ‘buy in’ and these changes can influence the wider community. Again, resourcing and contractual constraints create frustration for the PHN who believes in the process but who cannot implement the process to its full potential due to workload constraints.

NAME CHANGE

Out of the discussion around the problems surrounding PHN practice came the question as to the relevance of our name – Public Health Nurse. What does this title mean to today’s society?

The title could well mean we are the surveyor and maintenance of public health services like drains and sewers!

In the past, a group of PHNs in the Child and Family Service had investigated changing the PHN title to Community Child Health Nurses, but their PHN colleagues were resistant to the idea. Their colleagues felt there was a certain kudos to the PHN

title – everyone around the world has a perception of the role of the PHN and losing this historic identity made a lot of nurses nervous.

People resist change but change is necessary and, by hanging onto an old name, it is stopping us from evolving into specialist nursing within our own field.

Conversely, the group noted that keeping the PHN title is about the only constant thing in our ever changing environment.

We change localities, we change managers, we change contracts, we even change the cars that PHNs drive!

It was decided that this was too extensive an issue to debate further, but it was interesting to note that most group members felt that the PHN title did little to describe our role within the community, thus compounding our ‘profile’ problems. It was recognised by the group that Clendon’s (1999) research would allow fuller exploration of the community’s perception of the current PHN role and whether the community would acknowledge the ability of PHN’s to expand their role to provide appropriate health care within a nurse managed school-based clinic.

The public health nursing practice of the Child and Youth Team, Child and Family Service, Auckland Healthcare, was described and explored by the working group to provide meaning and purpose. As mentioned above this formed the Practical aspect of the Action Research project. Articulating practice in this way provided the

framework from which the working group could extend and progress, and thereby challenge existing practice. This formed the Emancipatory aspect of the Action Research project. This second step is explored in the next chapter, where the working group described a possible service delivery format and scope of practice for an Advanced PHN Practitioner.

CHAPTER SIX

THE VISION

This chapter explores 'the vision', the spiralling process of the Action Research outcome of developing the 'portfolio'. This is the visualisation of what a 'family centred' school-based clinic could offer and the scope of practice of the Advanced PHN Practitioner working within this environment.

Although this research project was not focused upon developing the structure for a 'family centred' school-based clinic, it soon became apparent that the group needed to visualise what could be offered at such a clinic before they could develop the actual scope of practice of the nurse. This chapter describes this 'visualisation' process.

The visualisation process provided a helpful strategy in progressing the group towards the development of an Advanced PHN Practitioner 'portfolio'. However, this produced a debate with implications extending throughout the whole of the research process. Should the nurse have a facilitation / generalist role or a treatment / specialist role? There were a variety of opposing views.

If you don't offer something specific you are not going to get the community to access you.

.....

For funding it is not going to be good enough to be a 'Jack of all Trades' ...basically a traffic warden, because the HFA will tell you that a GP can do the same.

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There needs to be identifiable specialist skills...immunisation, ear health...there is a huge accessibility and health service gap...this is a key area we should be targeting.

.

Nurses are classic at undervaluing their skill. Our expertise is assessing health problems and ensuring that appropriate treatment is obtained. The nurse does not have to provide the treatment but provide options of care...I mean we do that now.

.

One of the main problems within specialist agencies today is fragmentation and seeing people within the anatomical landscape of their problem. Ears go there, broken bones go there, food banks you access from over there. Our strength is not being the expert at doing it all but having the skills to co-ordinate numerous solutions to meet numerous health needs.

.

Each community is different and nurses have different interests as well if we make the role too prescriptive, too specialist, you not only limit the scope of the practice but you leave yourself very vulnerable... you'd have to be very good at what you do otherwise you'll have the GPs jumping all over you.

.

I think being too specialist narrows the whole focus for care...its very bio-medical model.

In order to resolve this issue we decided to brainstorm what the clinic and the nurse could look like if we combined both specialist and generalist practice. It was decided the nurse would have to have a good knowledge of the community development model and be able to work within the Ottawa Charter – empowering, enabling, strengthening, facilitating communities. The nurse would have to have an extensive knowledge of health promotion. Comment was made that the practice of the PHN within the “Health Promoting School” Programme would go a long way towards preparing nurses for this health promotion role.

If we make a blue print of this new role we have to keep our uniqueness of practice otherwise we will loose our purpose...there is a huge skill ability of GP Practice Nurses, they too could facilitate this role but I see them as very biomedical model – extending their practice would just be extending the Doctor type role, we have to keep very focused on health promotion and we have to keep nursing the structure we build upon.

.....

We could offer specific clinics at specific times and bring in experts to do the ‘treating’. We’d have to work in partnership with other health agencies within the community.

The group identified specific service areas where the practice of the Advanced PHN Practitioner could extend. Possible characteristics of a school-based, nurse managed clinic are presented in the following table:

What the school-based nurse managed clinic would look like:	
Link between the clinic and the community Home visits as well as clinic visits Pre 0900hrs and post 1500hrs health sessions School referrals Well child checks Paediatric clinics Immunisation Screening ears/eyes Ear health Blood pressure checks / Warrant of fitness for adults Diabetes Womens health Breast screening Smear screening Family Planning Antenatal Male health Physio Dental	Parenting workshops Consultations Coffee mornings for health promotion – nutrition, health issues Community drop in Video library Support group Community resource – Income / Housing Community houses – washing machines etc Counselors CAD's Stress management Networking with the business district (eg. Rotary) Maori health workers Pacific Island health workers Traditional healing Naturopath / massage Food co-operatives – vege plots

Clearly, the issues of access and ownership were important for the group.

With a clinic people are going to come to us - they choose to access us - this would be a far more reciprocal arrangement with families than we do now.

.....

The ownership of the problem would be with the client...

It was decided that a pilot project was needed to see whether the clinic concept was a viable option. A Community Assessment would have to be implemented first to see

what services are available in the community and what services you would want to provide. There would have to be a formative outcome and evaluation process. The group believed that too many community projects were evaluated on anecdotal evidence and this would not be good enough. Base line data would need to be collected and collated prior to the commencement of the project. At this point we discussed Clendon's (1999) research study of undertaking a Needs Analysis within a community to investigate whether a nurse managed 'family centred' primary school-based clinic was a viable concept.

DEVELOPING THE SCOPE OF PRACTICE

From this point the group began to formulate ideas as to what structure the PHN role within the school-based clinic would take. It was decided that the present PHN role in schools needed to continue. Teacher referrals, health promotion teaching and home visits had proved to be an essential strategy in advancing the health of school children. It was also recognised that this basic PHN practice would provide the experience necessary on which to build expert practice for the future. The group saw it as a two-tiered layer where there would be a PHN working within the school and an Advanced Public Health Nurse Practitioner working within the clinic. The PHN would gain skills and knowledge from the Advanced PHN Practitioner, and the Advanced PHN Practitioner could call upon the PHN for support and assistance. Both roles would merge at times but the group visualised an apprentice type structure evolving.

COMPETENCY LEVEL

Presently, within PHN practice a levels of practice programme is promoted. PHNs work their way through levels of practice workbooks as part of their professional development programme. As previously discussed, these 'levels of practice' demonstrate competent public health nursing by audit of clinical practice, teaching ability, discussion of knowledge in specific service expectations and the evidence of personal professional development through further education and participation in clinical workshops. The levels range from Level I - novice practice to Level IV - expert practice. At this time within Auckland Healthcare, Child and Family Service, Child and Youth Team, there were three PHNs working at Level IV competency.

The group spent some time discussing the competency level of the Advanced PHN Practitioner and the leveling structure that could be initiated to ensure advancement of knowledge and practice. Through discussion the group decided that the Advanced PHN Practitioner would be at a higher level than the present Level IV. An advanced leveling programme could be placed on top of the present structure where the Advanced PHN Practitioner would work through these higher levels of practice - Advanced PHN Practitioner novice through to Advanced PHN Practitioner expert. The group felt it was essential that the nurse continued through professional development programmes.

...you don't want someone to reach the pinnacle of their professional career and go no further

Naturally, a professional development programme would have to be developed. However, development of this programme is outside the scope of this research.

SENIOR NURSE PRACTITIONER ROLE

At present, within the Child and Youth Team we have a Senior Nurse Practitioner (SNP). Her practice is divided 0.5 FTE (full time equivalent) into PHN clinical practice and 0.5 FTE into professional development for the team. The group saw the Advanced PHN Practitioner role as complementary to this particular practice. There would be two pathways within the career development for a PHN – one the Advanced PHN Practitioner working in a clinic within the primary school environment, the other a Senior PHN Practitioner working within the team, mentoring and developing quality initiatives. Both roles would be comparable in skills and experience; both roles should have a comparable salary. This would change the structure of the existing Senior Nurse Practitioner role considerably.

If we're saying that the SNP role within the team is at the same level as the Advanced PHN Practitioner, shouldn't the SNP also be doing research and development?

The group felt that bringing new standards into the existing Senior Nurse Practitioner role would be unfair. Therefore, it was felt that the role should be disestablished, redefined then readvertised.

We don't have much of a career pathway past that of Level IV PHN practice. Having two pathways to choose means we can move away from the historical PHN role of remaining within the same scope of

practice for 'life'.

.

I think it's really exciting...there will be nurses standing in line for this role which is great because it will keep the calibre high. It will also raise the profile of the PHN.

While developing the criteria for the 'portfolio' the following question was asked:

Are we making this into an elitist role?

The group decided that, as long as the criteria for the role remained flexible and acknowledged individual professional and academic strengths, the role would not become elitist. Conversely, the role 'profile' would need to be relatively descriptive to ensure the attributes of the nurse met the criteria for this scope of advanced practice. The role need not be an isolated form of PHN practice. There could be two or more PHNs at this level of practice within school-based clinics. However, the group agreed that the role had to be a choice, and that not all PHNs would want to aspire to it. Indeed, in their contract PHNs need only reach and maintain Level III practice within the Professional Development Programme. Extending their practice is a personal choice at the present time.

EXPERIENCE VERSES MASTERS DEGREE

During the course of developing the 'portfolio' the requirement for the PHN to have a Masters Degree was a cause for great contention within the group. Apart from one other PHN, I was the only member of the group who strongly advocated the need for this level of tertiary education for the role.

At present, most PHNs have the qualification of Registered General and Obstetric Nurse (RGON) or Registered Comprehensive Nurse (RCpN). Some PHNs have already obtained a Bachelors Degree by undertaking bridging courses, others are working towards it. With the implementation in New Zealand of a Bachelors Degree in Nursing as the basic academic qualification and as entry to practice, the next step for nurses wanting to further their education will be a Masters Degree. If we limit the educational criteria for the Advanced PHN Practitioner to a Bachelors Degree we would limit the scope of practice, particularly in relation to research and development. Overseas literature and, indeed, present trends within Auckland Healthcare indicated that nurses in specialist, management or educational roles all require either a Masters Degree or to be working towards one. However, others in the group were concerned that raising the criteria to a masters level could result in alienating many experienced PHNs from taking on the role.

Masters limits the role because there are expert nurses who would be fantastic in this role but for whatever reason they choose not to start a Masters. They may do other post graduate study, shorter courses, individual papers whatever...I think that is just as valid as masters.

Experience does not necessarily make a person an expert!

.....

This is not an academic position...if it was going to be more of a managerial role perhaps a masters would be a requirement...

.....

What we are saying is don't limit the role to the word masterate. You need to use the word post graduate...I think the words 'Post Graduate' adds richness to the role.

.....

Let's move away from the thinking of continuous studying... attending conferences and presenting papers should also be an acceptable method of showing scholarship. Writing an article could be even more relevant than tertiary study.

.....

If we start to compare the job description of Senior Nurse Practitioner and Clinical Nurse Specialist or whatever, this is still only a PHN role right. I mean they are up there in a whole different pay frame and everything. This position is still within the realm of normal PHN practice.

.....

No, no, let's try and break the boundaries. Let's try and create something that is new, that really extends our practice, which has a remuneration that is applicable to the role.

It has only been a year since all nurses have come out with a degree, and any employer would take that into consideration. What I am saying is that we are composing a document. Let's base it on what we would aspire to and not what we have presently.

We went on to discuss a 'Grandparenting Scheme' where, if an employee who was already employed by the organisation applied for the position, it would be at the employer's discretion whether or not to employ them for the role. However, all new employees employed after the adoption of the document would have to meet the stated criteria.

The discussion on the requirement for masters level preparation was raised by the group almost every time we met. However, as the 'portfolio' began to take form and the group developed their expectation of knowledge and articulated the high level of skill required by this nurse, a change of position occurred within the group.

If we want to call this role an Advanced PHN Practitioner, according to the readings we will have to broaden the job description to include more research because it just can't be clinical work. She would have to have a strong research focus.

.....

Masters is that whole opening to nursing knowledge...literature, research...the whole boundary really to knowledge...it is only in a formalised setting that nurses are initiated into this kind of scope of knowledge.

.....

Research needs to be embedded in the role; explorative research to

improve the quality of the nursing practice, not just keeping data but evaluation of ongoing needs, assessments...

.....

...in five years down the track the nurses that are coming out today with a degree are going to be experienced, they are going to be looking for further education...that education, naturally I guess, would fall into a masters programme.

.....

I agree...the essential qualifications needed for this role would have to be at the post graduate level. This is specialist study at the 8000 level...the preferred, a masters degree.

.....

I think the problem is that there is no suitable masters programme provided yet in New Zealand with a community development focus.

This comment provoked a discussion on available postgraduate courses to Auckland Healthcare PHNs. This issue will be explored further in the discussion chapter of this thesis.

ALIENATING WOMEN

As the discussion on the Advanced PHN Practitioner continued some members of the group articulated their concerns over the work commitment that would be necessary from the nurse undertaking this role.

I don't want to discriminate against people who would meet this criteria but nurses because of their family situation could be disadvantaged 'cause they are forced into doing more study.

.....

...it actually means that you are creating a certain stereotype to be in this role, you can't have a family, you can't have outside commitments...it's not going to be achievable...

.....

We are basically a profession of women...this is not women friendly.

After much discussion the group agreed that the nurse wanting this role would be just as time constrained as any other high level career nurse. The complexity of the role could inspire many nurses who require an extra challenge, who in the past would have extended their practice into management roles, but who could now remain within clinical nursing practice. It was also decided that research and study time could be built into the role.

PRESCRIBING

The group decided that one of the prerequisites that would be necessary in order to enable the nurse to work effectively within the school-based clinic would be that they would have to have prescribing rights. The group was in total agreement that prescribing would be essential in this environment. This issue is extremely

topical at present and the group felt that the scope of the prescribing practice would naturally come under the scope of planned government legislation. It was recognised that, in order to ensure safe practice, post registration study in pharmacology would be required. Again, not all nurses are interested in undertaking extra study, therefore it would have to be written into the 'portfolio' to ensure nurses would know what was expected of them should they decide to take on the role.

BI CULTURAL AWARENESS

Bi cultural awareness and sensitivity was also seen by the working party as an attribute that would be essential for the Advanced PHN Practitioner role when facilitating health for New Zealand families.

We can work in a multi cultural way but we need to have a commitment to bi culturalism because there are two people in Maori, the tangata whenua [and pakeha]...we have to have a commitment to work alongside as partners.

.

*It's about having respect for Maori...it's not enough that we put it in our vision, we have to do something with it.
Attendance at a Treaty of Waitangi workshop would go towards providing a small measure to indicate awareness...although demonstrated knowledge and work practising alongside Maori would be advantageous.*

The nurse would have to be aware of the principles of consultation with *mana whenua*, the Maori people who have the traditional association with their *rohe* - the

area, and *taonga* - their treasure and resources, of the community in which the Advanced PHN Practitioner would be practising. It was agreed that the Advanced PHN Practitioner would have to work closely in partnership with the Maori Community Health Workers within both the clinic environment as well as when visiting families in their homes. This would be the case even if the Advanced PHN Practitioner were *tangata whenua*, associated with a *hapu* or *iwi* of the *rohe* - because the clinical practice of the role could not provide the extensive support and guidance which the Maori Community Health Workers are presently able to provide to families.

This chapter has explored the **Emancipatory** Action Research framework where PHN practice reality was challenged. The ability to move beyond present PHN practice reality was achieved by creating an environment where the group members, through previous interpretation of meaning, could investigate change. The working group visualised what a 'family centred' school-based clinic could offer and explored the possible scope of practice of an Advanced Public Health Nursing Practitioner working within this environment. The following chapter will examine the 'portfolio' as developed by the working group.

CHAPTER SEVEN

ADVANCED PUBLIC HEALTH NURSE PRACTITIONER

THE 'PORTFOLIO'

The outcome of this Action Research study was a 'portfolio' comprising of person specifications and core competencies required for the role of an Advanced Public Health Nurse Practitioner working within a primary school environment. The working group articulated their belief in the overall concept of an Advanced Public Health Nurse Practitioner – the role was seen as a viable initiative. This chapter will present the role description generated by the working group.

The 'portfolio' has been organised by the group into two sections, person specification and core competencies. The first section, person specification, is broken down into four categories – education, experience / knowledge, specific competencies and personal competencies.

The result from the working groups debate around the education level for the Advanced PHN Practitioner position is that, whilst a masters degree would be preferable, the role would not be compromised if the nurse was in the process of undertaking this degree. The group also recommended that a 'Grandparenting Scheme' exist. If a competency level IV PHN already employed by the service applied for this position, it would be up to the employer's discretion whether or not to employ them for the role. However, all new employees in the position would have to meet the stated criteria.

The nurse would need to have an understanding and knowledge of working within the social landscape of New Zealand, particularly in regard to working with Maori. The group emphasised the requirement for advanced leadership skills and commitment to working within a community development framework.

The second section to the 'portfolio' outlines the core competencies of the role. The working group assigned six specific categories of Advanced Public Health Nurse Practitioner practice – facilitate family centred care, facilitation of the health promotion process, service / clinic management, professional practice, research based practice and professional education. The development of the characteristics for these categories came from review of the available literature and from the working group's personal journey of collective inquiry and reflection. The final shape of the position outline for the 'portfolio' is as follows:

Portfolio of Skills Required by an Advanced Public Health Nurse

Practitioner

Person Specifications

	Essential	Preferred
Education	<ul style="list-style-type: none"> • RGON, RCpN and/or Bachelors Degree. • Relevant postgraduate specialist study at 8000 level on the New Zealand Qualifications Authority Framework. 	<ul style="list-style-type: none"> • Masters degree.
Experience/ Knowledge	<ul style="list-style-type: none"> • 2 years at Level 4 (expert) Public Health Nursing professional competency level. • Ability to work in an appropriate/culturally safe manner. • In-depth understanding of the Treaty of Waitangi. 	
Specific Competencies	<ul style="list-style-type: none"> • Proven ability to work effectively in a leadership role. • Ability to work effectively in autonomous practice. • Advanced clinical assessment skills. • Proven skills in: <ul style="list-style-type: none"> - Health promotion - Networking/communication - Time management - Organisational skills. • Qualified in: <ul style="list-style-type: none"> - Prescribing medications - Ordering and interpreting diagnostic tests - Specialist referral. • Research embedded practice. • Project development skills. • Current drivers license. 	
Personal Competencies	<ul style="list-style-type: none"> • Commitment to professional development. • Facilitator/negotiation skills. • Accountable/adaptable. • Motivator/innovative practice. • Commitment to primary health care 	

Core Competencies

1. Facilitate Family Centred Care	2. Facilitation Of The Health Promotion Process
<ul style="list-style-type: none"> Assesses the health needs of the individual or family. Provides appropriate intervention or facilitation of identified health issues. Practices in a culturally appropriate manner. Demonstrates commitment to working in 'partnership' within the principals of the Treaty of Waitangi. Uses advanced knowledge linked to evidence based intervention that is supportive of positive health outcomes. Uses a collaborative approach, which is based on active participation, negotiation and partnership with clients and their families focusing on strengths and potential. 	<ul style="list-style-type: none"> Demonstrates commitment to health promotion that fosters productive health behaviours and disease prevention. Works within a community development framework as per the strands of the Ottawa Charter: <ul style="list-style-type: none"> - enabling - advocating - mediating - supporting - strengthening - empowering

3. Service/Clinic Management	4. Professional Practice
<ul style="list-style-type: none"> Co-case manages with specialist providers as appropriate. Makes appropriate specialist referral as required. Works in an independent collaborative manner. Effectively manages use of resources within the clinic. Uses formative process and outcome evaluation measures. Demonstrates clinical leadership and teamwork skills. Maintains client database for follow-up consultation, referral and outcomes. Monitors self, peers and health delivery system through quality assurance, total quality management and as part of continuous quality improvement. 	<ul style="list-style-type: none"> Incorporates professional and legal standards into practice. Develops a base for personal ethics in practice as related to client issues and professional code. Practices nursing in accord with principals that promote client interest and that acknowledges the clients' individuality, abilities, culture and choice. Receives formal and ongoing clinical and professional supervision.

5. Research Based Practice	6. Professional Education
<ul style="list-style-type: none">• Shows scholarly research inquiry into practice, this includes:<ul style="list-style-type: none">- Developing best practice principles based on evidence- facilitating the creation and evolution of nursing practice and nursing knowledge- demonstrating commitment to the evaluation of current/topical nursing literature.	<ul style="list-style-type: none">• Undertakes personal responsibility for ongoing development of own nursing knowledge.• Demonstrates commitment to the ongoing knowledge development of the nursing team.

The collaborative process involved in developing the ‘portfolio’ was a participatory process of inquiry that facilitated the working groups collective self-awareness to challenge the boundaries of existing public health nursing practice.

The following discussion and recommendation chapter will combine the findings from the research process and explore the emergent issues as they relate to extending public health nursing practice as described in the ‘portfolio’.

CHAPTER EIGHT

DISCUSSION AND RECOMMENDATIONS

This Action Research study was undertaken to provide a process for public health nurses to examine their existing practice and ask: What knowledge and skills would an advanced public health nurse practitioner require to work autonomously and effectively in a 'family centred' clinic within a primary school environment. Using a process of collective inquiry and reflection the public health nursing working party developed a 'portfolio' from which to define the work of an Advanced Public Health Nurse Practitioner in this particular setting.

The following chapter will be explored in two parts. The first part will examine the specific issues and emergent themes from the research process as they relate to identified literature. The second part of this chapter will discuss the possible significance of this research outcome for future public health nursing studies, the limitations of the research are acknowledged and the recommendations developed by the working group are outlined.

THE EMERGENT ISSUES FROM THE STUDY

The Action Research Lewin Spiral of planning, implementing, observing and reflecting provided the theoretical framework for the developmental progress of this investigation. During each session field notes were kept. These notes were documented into a summary format and distributed to the group after each meeting. Prior to commencing the next session the group would reflect on previous issues and

question any poorly defined concepts. This process of re-examination and reflection generated the process and the ultimate development of the Advanced Public Health Nurse Practitioner 'portfolio'. The research study encompassed both the **practical** and **emancipatory** models of Action Research. Inquiry facilitated an interpretation of meaning and purpose of public health nursing practice, and through this discovery the boundaries of existing practice were challenged.

The promotion of *Change* is an important concept in Action Research. Change occurred within the research process in a variety of ways. There were changes within the group dynamic itself, including the development of my role within the group, and the circumstances surrounding the departure of one of the group members. As the research process developed members of the group began to qualify statements rather than just accept issues on their face value. Travelling through the research process produced change within the group and its individual members as their knowledge developed during the exploration of the emergent issues.

After describing present PHN practice and 'visualising' the possible services that could be provided within a school-based clinic, the group then possessed the knowledge to formulate a set of competencies that could extend PHN practice into an advanced practitioner role. Acknowledging the possibility of this reality caused the working group to change their focus on practice and challenge the boundaries that encompass their role today. The group also articulated that they intended to champion management to change the Health Funding Authority contract which emphasises Health Promotion rather than Personalised Care.

Difficulty Articulating Practice

Interpreting the meaning and purpose of PHN practice required much discussion and reflection within the group and, initially, this articulation caused consternation. The group described how previous attempts had been made to document 'what it is that PHNs do' but, due to the intangible nature of PHN practice, this had generally proved difficult. This was an important phase in the process of developing the 'portfolio'.

The difficulty associated with articulating the meaning and purpose of nursing practice is not just a problem associated with public health nursing. Worrall-Carter (1995) believes there is not enough articulation and documentation within all domains of nursing. Worrall-Carter states that nursing knowledge needs to be documented and communicated to other nurses and other disciplines, through writing and publication, in order to give credibility to nursing as a profession. Yet, many nurses are not accustomed to documenting practice or writing journal articles. The articulation of practice needs to be promoted from within nursing itself. Nursing in-service could be provided by employers to teach writing skills to nurses. This would encourage the development of skills not only in academic / professional writing, but also in nursing documentation. In-service education could lead to the development of nursing projects which will demonstrate evidence based practice - an initiation into research which would not be so threatening. Worrall-Carter makes the salient comment that there is also a need for nurses to be encouraged to reflect on practice, and this will allow for critical analysis and promote creativity in the workplace which, in turn, will develop both nursing knowledge and practice.

All the group members agreed that articulating practice was difficult because of the nature of the diversity of PHN practice. However, when we brainstormed the different aspects of this diversity, and mapped it onto paper, there was clarity and substance to PHN practice. The meaning and purpose that came from this articulation enabled the group to build a framework on which to develop the Advanced PHN Practitioner 'portfolio'. Articulating their practice also gave the group a sense of empowerment and purpose, "*we need to let people know of the neat things that we do*". Reaffirmation that PHN practice makes a difference to children and their families is an important aspect of job satisfaction. If you cannot articulate what it is that you do, or why you do it, or how successful it is, how can nursing knowledge develop to support change? The articulation of practice was vitally important in this Action Research process where the theoretical framework of this study encompasses the **practical** and **emancipatory** models of Action Research – where inquiry facilitates the interpretation of meaning and purpose of PHN practice, and through this awareness challenges the boundaries of existing practice reality (McTaggart, 1991). The process allowed both the articulation of current practice and the development of the 'portfolio' as planned.

The Masters Degree Debate

When discussing the validity of co-operative inquiry in Action Research, Reason (1994) discusses the behaviour of *unaware protection* within the group. This is a process where critical inquiry into issues that we care about provokes anxiety that can give rise to self deception. *Consensus collusion* occurs when the group bands together in defence of these anxieties so the issues are not challenged or explored (Reason, 1994). Unaware protection and consensus collusion occurred in the group

when the level of education for the Advanced PHN Practitioner was raised. The group became defensive and quite vocal in their belief that masters level criteria could alienate some experienced nurses who had not had the opportunity to further their education. The Ministerial Taskforce on Nursing (1998) also draws the conclusion that nurses appear to be resistant to promoting tertiary education for higher nursing roles.

There is an unfortunate tendency for many nurses
themselves to question the value of postgraduate education
and to challenge the views and approaches of nurses who
have become highly educated in nursing. (p. 56)

The Taskforce recommends that there needs to be a strategic direction implemented in all areas of the nursing domain so nurses do not perceive education as isolated from nursing practice.

In an attempt to explore and counteract the defensive tendency regarding the masters level criteria, I raised the issue for further examination several times. The cycling and recycling process of reflection, action, and re-examination, resulted in the group's acknowledgment of the necessity for masters level education because of the complexity of the Advanced PHN Practitioner role. Enlightenment came through active discussion and review of the literature.

The Effectiveness of the Senior Nurse Practitioner (PHN) role

While exploring the necessity of research and development for the Advanced PHN Practitioner role, the working group began to question the effectiveness of the present Senior Nurse Practitioner (PHN) position within the Child and Youth Team, when examined in relation to the 'portfolio'. The present Senior Nurse Practitioner (PHN) role has evolved out of the redesign of past public health nursing services. The role has no criteria for 'expert' PHN practice other than length of experience (time) within the clinical field of public health nursing. Indeed, there is no requirement in the present contract for the Senior Nurse Practitioner (PHN) to advance through a professional development programme. The working group could see the validity of the Senior Nurse Practitioner (PHN) role - for mentoring, support and advancing PHN knowledge and development within the team. However, the group believed the present role needed review to extend the criteria for this position to represent current nursing requirements for advanced practice.

Community Development Model

Over the past year we had spent a lot of time developing the "Health Promoting Schools" concept. As previously mentioned, this is a process based upon the Community Development Model.

Community development is the term most frequently used to describe an approach which aims to maximise community participation in the planning and implementation of health-enhancing activities (O'Gorman, 1996, p. 504).

The “Health Promoting Schools” project takes the form of a School Community Needs Analysis where, in consultation with key school stakeholders, the community is questioned regarding their health needs, a plan of action is developed, implemented and evaluated in an attempt to address and improve the health concerns of the school community. Since the instigation of the “Health Promoting Schools” project, PHNs have become very focused on working within a community development framework, where the school community takes ownership of the health-enhancing initiatives.

The emphasis of this study was to develop advanced nursing practice from within a nursing knowledge development framework, not from within the framework of community development. Understandably the concept of extending PHN practice without consulting the community about possible health related issues, was initially a cause of concern to the group.

Understanding the difference in emphasis between these two projects was hindered also by the working group’s knowledge that Clendon (1999) was undertaking a Community Needs Analysis in an Auckland community. Clendon’s study had been presented to the Child and Youth Team and there had been many discussions within the working group regarding this study.

I explained the difference in emphasis between these two projects several times and by the process of reflection, action, then re-examination, enlightenment occurred within the group. Understanding the differences between these processes led to one of the group leaving the project. The PHN was very involved in

developing the “Health Promoting Schools” project from within a community development model and had difficulty exploring new concepts in advancing nursing practice. As previously noted, the departure of this PHN caused the group to re-examine the purpose of this study and move beyond a community development approach and begin to use a nursing knowledge framework. It was from this point that clarity of process was uncovered, and the group began to work cohesively to develop the Advanced PHN Practitioner ‘portfolio’. The working group recognised that consulting the community was not the intention of this research study, however the community was researched in Clendon’s (1999) Community Needs Analysis, which was researched at the same time as this project. This eliminated the group’s concern that the community was isolated from the process of investigating the viability of a nurse managed school-based clinic.

The Ability to Empower Families

The concern of the group surrounding PHN contracts which have greater emphasis on Health Promotion than in Personalised Care, has arisen out of the recognition that it is difficult to empower families to take responsibility for their own health when they are living within the constraints of poor health, poverty and social isolation. This is not a new phenomenon – Abraham Maslow, a leader in the development of humanistic psychology constructed a model classifying human motives – a *hierarchy of needs* (Atkinson, Atkinson & Hilard, 1983). The needs at one level must be at least partially satisfied before motivation for action can exist at the next level. Therefore, it is only when basic needs (food, shelter, safety) are satisfied that the individual person has the time and energy to devote to comprehending health promotion. This is not to say that teaching is a waste of time -

but the first priority in PHN practice is to assist in meeting the immediate *needs* of the family. That is the reality of PHN practice today. Tension is created for PHNs when the emphasis of practice is increasingly placed within the realm of health promotion.

There is also the problem that health promotion strategies can stand alone from community development. Organisations and services have been known, in my experience, to promote health-enhancing programmes within a community or school, without any assessment as to whether the issue is of concern, or in some cases, whether the issue even exists. If PHNs continue to practise within a community development framework, perhaps the emphasis of health promotion needs to be revised and removed from the PHN contract completely. This issue is too extensive to explore in this study so further investigation and discussion into this topic is recommended for future studies.

Alienating Women

While progressing through the development of the advanced competencies for the 'portfolio' the group highlighted the level of commitment the nurse would require to practise within the role. This raised the concern that the role was not 'women friendly'. Nurses with family responsibilities could be disadvantaged because of the high work performance required in the role.

About 95% of nurses are women. Whether the image of nursing as a feminist role has evolved out of women's predominance in the nursing domain or whether nurses are women because of its nurturing, caring image is uncertain. What is certain is that women are often conditioned to consider a professional career as secondary to

the family and home. Even when nurses break away from this stereotype and succeed in management and scholarly pursuits, the societal expectations of other nurses negatively influence this achievement. Women prejudice each other and reinforce the myth of their inability to perform (Meleis, 1991).

Doering (1992) categorises feminist philosophy into three main perspectives, that of *liberal*, *cultural* and *radical* feminist theory. *Liberal* feminism is the belief that equality for women can be achieved within the systems of the existing social structure. *Cultural* feminism is the belief that there are basic differences between the genders, women are non-violent and nurturing, men are associated with wars, terrorism and environmental disregard. Doering describes *radical* feminism as the philosophy that women are oppressed, and they feel deep grief and rage over this oppression. Many nurses have adopted varying forms of feminist philosophy. Kleffel (1991) believes that nurses need to rise above the confines of their personal life and address the larger social, political, economic and global issues that affect their professional work. By moving away from perpetuating the philosophy of domination and oppression, Kleffel believes that nursing has the potential for liberation and evolution.

Working through the implications of this issue the group realised that not all PHNs would aspire to an Advanced PHN Practitioner role, and the degree of commitment would be no different from any other high-level career nurse. In the past, PHNs who required further challenge within their practice had moved into nursing management roles. The implementation of this role could entice future

nurses to remain within the realm of clinical PHN practice. The group also decided that research and study time could be built into the role.

Generalist verses Specialist Nursing

When the group visualised the possible services the school-based clinic could offer, initially there was dissention as to whether the nurses role should be one of generalist / facilitation or specialist / treatment. After much debate the group concluded that, although the clinic could easily offer specific specialist sessions for treatment and intervention, the essential role of the Advanced PHN Practitioner would be to 'facilitate' health care for individuals and families. Initially, the group defined this as generalist practice and, indeed, the practice would have to encompass a variety of knowledge and skill. However, by defining this extensive scope of practice the role evolves into 'specialisation'. Sutton and Smith (1995b) believe that specialisation is a process which occurs naturally through maturation in a profession. It arises through improved knowledge and expertise gained over time. Sutton and Smith believe that nursing needs to challenge the definition that specialist nursing practice is specialist care offered within a specific field of medicine and look beyond our present understanding to acknowledge that specialist nursing practice is intrinsic in the true essence of 'nursing'.

...we are arguing that specialist knowledge as currently perceived is not specialist nursing knowledge, rather it is still 'the crumbs of scientific knowledge spread by the doctors teaching (Colliere, 1986, as cited in Sutton & Smith, 1995b, p. 141).

Nursing continues to debate the definition of terms in 'expert' nursing practice, but perhaps the scope of practice of 'generalist' far out-weighs that of 'specialist' in regards to nursing expertise.

'Walking Beside' Families

The group gave great emphasis to working within each family's reality, of being non-judgemental and being able 'walk beside' families even when their values are different from those of the nurse. In a previous article for publication I reviewed this PHN practice and conceptualised the nursing behaviour as "accompanying". This accompanying in PHN practice is assisting families by support, sharing knowledge and escorting families through the health process. This is not a partnership of equality but a relationship of assistance, where the family controls their own health experience with facilitation of some aspects by the public health nurse (Hinder, 1997). The concept of 'being' with the client rather than 'doing for' the client is not new. Benner (1984) describes this process as *presencing*, Parse (1981) describes it as *dwelling*. This theoretical framework comes from within the interpretive approach to nursing practice. The nurse helps the individual or family to explore their health circumstance, and new insights are gained as the nurse guides the family through a negotiated process of change. The focus is not on the belief and assumptions of the nurse but on where the family 'is' at that particular moment of time (Mitchell, 1990).

The Different Venues

An interesting outcome from this research was the effect the different physical environments had on the progress of the working group. I had thought my home

would have provided an environment where the peaceful setting would have assisted the research process. Instead, the environment proved distracting. Group members lounging on the floor soon became uncomfortable and needed to change positions continuously and the constant reaching across for food on the coffee table also distracted attention from the work in progress.

I am not surprised however, that the second venue, the PHN room, was not conducive to thought development. This was the venue where we formed a circle around the middle of one of the PHN offices. The tape recorder rested on an upside down rubbish bin and papers were spread around the floor because there was no table space. The visual constraints of the room also prevented the use of diagrams to structure concepts for discussion.

The third and final meeting place, the Conference Room of the Child and Family Service, proved the most effective venue. Individuals could express themselves diagrammatically on the large white board, literature could be spread across the board room table and the tape recording acoustics improved dramatically. These were elements I had not considered when constructing the research design.

Many authors believe that Action Research is suited to the domain of nursing, Martin (1994) cites several Action Research studies that have specifically focused on the nursing practice environment. However, research sited in an area of nursing practice is very different from the actual environment where an Action Research process takes place. Polit and Hungler (1991) believe researchers need to give importance to the environmental context where studies are to be conducted as the

environment can exert a powerful influence on people's emotions and behaviour. Naturally, when conducting experimental studies controlling for external factors within an environment would be crucial to the scientific design.

External factors influencing the environment within an Action Research study obviously has a profound effect as well. The different environments in this study certainly influenced the productivity of the working group. This is a factor in Action Research that other researchers may need to consider in more detail in future studies.

The first part of this chapter has examined the specific emergent issues generated from within the research process and their significance to public health nursing practice as they relate to identified literature. The following pages will discuss the implications of these findings within the general arena of public health nursing knowledge and practice. The limitations of this study are discussed and the recommendations developed by the working group are outlined.

LIMITATIONS OF THIS STUDY

The issues emerging from this study are grounded in public health nursing practice. Therefore, the assumptions and expectations made in this study can not be extended to other areas of nursing practice - even though the clinical knowledge of other community-based nurses could well extend into this role.

There is also a problem with generalisability of this research. The dialogical nature of the working group and the development of the outcome created a unique

and singular process that could not be repeated, even in a group of other public health nurses. This is the nature of Action Research; the development of the research process is dependent on the composition of the participants within the group and the issues that emerge.

The whole philosophy of a 'family centred' school-based clinic was a service initiative prior to the development of this research. The time frame of this study from its inception through to the final writing of this thesis has been two years. The two year time frame has been too long for the Child and Youth Team to wait. The service has already investigated the formation of a 'family centred' school-based clinic within a primary school in Central Auckland and a pilot project will be in operation by mid 2000. As previously discussed, Rutledge-Sheilds and Dervin (1993) believe that the time lag between the completion of the research and the writing up of the findings in Action Research can be problematic, where the nature of the problem can change before any firm recommendations are made. However, even if some of the findings from this research have been delayed the recommendations from this research can still be implemented into PHN practice. In addition, the group processes have been developmental and prepared the way for the new initiative.

IMPACT OF RESEARCH ON PHN PRACTICE TODAY

Even though this research proved to be a lengthy process, the visualisation of a PHN working within a 'family centred' school-based clinic led to the development of knowledge and understanding for the role and provided support for the project about to be initiated in an Auckland school.

The working group has an increased understanding of the ramifications of the PHN Health Funding Authority contracts and will champion, where possible, the extension of these contracts into personalised care.

It is heartening also that four PHNs from this working group have enrolled into postgraduate papers at masters level. The decision to enrol into these papers is not necessarily a consequence of this research. However, raising and exploring this issue brought enlightenment to the group and changed their opinion of the importance of masters level education for public health nursing practice.

IMPLICATIONS OF THIS STUDY FOR NURSING EDUCATION

Evolving from the masters versus experience debate were issues of accessibility and acceptability of present masters programmes for nurses in New Zealand. Certainly, the group believed there were no masters programmes available in New Zealand with a specific community focus. The group acknowledged the existence of post graduate nursing papers and diplomas offered with a community focus; and there is a Master of Public Health programme available, but this is strongly focused towards medicine rather than the community. If New Zealand nurses are to advance their practice within New Zealand communities it is essential that nursing education provides the framework for developing this community knowledge through theory and research offered at masters level. The Ministerial Taskforce on Nursing (1998) recommended that the New Zealand Government increase the financing of post registration nursing education by 60% of the total budget available for CTA (Clinical Training Agency) funding. If this recommendation became a reality one

path New Zealand could follow is the example from the Council of Ontario Universities of Canada (1999) who have just developed a Primary Health Care Nurse Practitioner Education Programme. This programme covers competencies for an Extended Class, Registered Nurse, Primary Health Care Practitioner whose training includes: standards for prescribing drugs and ordering laboratory tests, x-ray and ultrasound; and consultation / referral to physicians. Primary Health Care Practitioners are defined as:

...generalists who offer comprehensive and continuous care to clients across the health continuum and throughout the client's life span. The client is defined as individual, family and community...Emphasis is placed on holistic care, health promotion and disease prevention, taking into account the health care needs, abilities and resources of the whole person. (p. 1)

A community based, primary health care nursing masters programme would provide many New Zealand nurses with the knowledge and skills essential to advance their practice in community care. In turn, this would comprehensively improve the health of families and ultimately increase the overall health of New Zealand people.

FUTURE STUDIES

An important aspect of undertaking any research is that the research study should lead to further investigations. This indicates the validity and significance of

the research findings. Several themes emerged from this study that require further investigation. Firstly, there is the question of the health promotion contracts for public health nursing practice. Public health nurses are committed to working within a community development philosophy rather than health promotion. The evident success observed by PHNs when the community owns health-enhancing initiatives is an important aspect to consider for the future direction of PHN practice. Further studies could provide the foundation from which to re-examine and revise the appropriateness of present PHN contracts.

Secondly, exploration into the substance of meaning of the 'walking beside' behavior of public health nurses, could give further articulation and purpose to public health nursing practice. The 'walking beside' aspect of PHN practice is a necessary component of the role. The nurse would soon alienate families and schools if their practice became judgmental and discriminatory. Therefore, this is more than a statement of philosophical stance, or theoretical concept, 'walking beside' is *intrinsic* to the practice of public health nursing. I believe this is another area that requires further investigation. The practice of PHNs 'walking beside' could provide the framework for future nursing studies. Investigating this practice could provide a wealth of meaning and understanding which would advance public health nursing knowledge and practice.

Thirdly, from a research design perspective, the impact of the different venues in this study requires examination, so that future Action Research studies are not compromised in their progress by inappropriate meeting places.

RECOMMENDATIONS

The working group concluded that the Advanced PHN Practitioner role is a viable proposition and made a number of recommendations for this role - The Advanced Public Health Nurse Practitioner:

1. Focuses nursing practice on facilitation and referral rather than treatment specialisation.
2. Practises within a community development framework such as the strands of the Ottawa Charter – enabling / advocating / mediating / supporting / strengthening / empowering.
3. Demonstrates commitment to working in ‘partnership’ within the principals of the Treaty of Waitangi.
4. Demonstrates commitment to masters level tertiary education.
5. Demonstrates commitment to prescribing rights within the scope of government legislation undertaking any necessary pharmacological / physiological study.
6. Demonstrates knowledge of Health Promotion philosophies.

Other recommendations include

1. Specific research and study ‘time’ to be written into the role.
2. Development of a two-tiered apprenticeship type role - the Advanced PHN Practitioner mentoring the PHN within the school in a mutually supportive working relationship.
3. Re-evaluation of the effectiveness of the Senior Nurse Practitioner role within the team.

A PERSONAL REFLECTION

Since the completion of this research study I have left the field of public health nursing. As I write these pages I feel a sense of privilege and honour that I was part of this public health nursing working group, who demonstrate such obvious passion and commitment to their practice. It is my hope that the contribution of this thesis will assist in the acknowledgment of other health sectors to the immense value and community need, for public health nursing in New Zealand.

CONCLUDING STATEMENT

The emphasis in this research process was to challenge public health nursing practice through reflection and to develop change. While some results are immediate, the contribution of this research to public health nursing practice is yet to be fully realised. The recommendations made by the working group could provide a vision of practice for an Advanced PHN Practitioner. This vision provides a journey where nursing theory, practice and research unite, and where professional and personal knowledge development is advanced, breaking down the boundaries to comprehensive 'family centred' care within the community.

The challenge to public health nurses now is to make this practice a reality!

APPENDIX 1

“CHALLENGING THE BOUNDARIES: A SERVICE INITIATIVE TO EXTEND PUBLIC HEALTH NURSING PRACTICE”.

INFORMATION SHEET.

Researcher: Grace Hinder. RGON., BHSc.

Supervisor: Judith Christensen., RCpN., BA., MSc(App)., PhD.

Massey University, Albany Campus, Telephone Number: 09 4439700

I am working towards my Master of Arts in Nursing through Massey University, Albany Campus. As part of this degree I would like to invite you to take part in a research project.

This study will provide a process where public health nurses can examine their practice and identify the type of knowledge and skills required by a public health nurse, to enable him/her to work in a ‘family centred’ clinic - which would facilitate health care for the entire family - within a primary school environment.

The study aims to use a process of collective inquiry and reflection to produce a ‘portfolio’ which would demonstrate clear articulated criteria with which to define an advanced public health nurse practitioner, whose practice could encompass family centered clinics within the primary school environment.

This is an invitation for you to participate in this research. You will not be personally approached unless you actually indicate your willingness to participate. If after reading this information you decide you would like to participate, please approach the researcher on an individual basis. She will then arrange a meeting to discuss your participation and formal consent. Following this meeting you will be invited to sign a written agreement for participation in the research project. A period of not less than one week and not more than four weeks is set aside for you to consider your participation as the research will commence in

July 1998. This invitation is given to potential participants in mid-May 1998 with an invitation to reply before 15 June 1998.

Justification for the Research:

Public health nurses working in the Child and Youth Team, Child and Family Services, Auckland Healthcare, view their practice as centering on children and their families with the primary focus being on the child. Public health nurses could well provide other appropriate assistance and intervention for families, but presently we are contracted through North Health, Health Funding Authority, in such a way that our knowledge and skills are restricted by service delivery boundaries.

The Process and Involvement:

You are invited to take part in a participatory/collaborative working group to examine our public health nursing practice. The frequency and length of the sessions will be decided upon by the working group, as will be the participation of the working group in developing the issues raised. However, I would like the research to begin in July 1998 and be completed by December 1998.

The methodology for this study is Action Research.

This is participatory/collaborative research, which arises from concerns generally shared by a group. People describe their concerns, explore what others think, and probe to find what it might be possible to do. The group identifies a thematic concern - which is the area in which the group decides to focus its improvement strategies. Group members plan action together, act and observe individually or collectively, and then reflect together.

Sessions will be tape-recorded and working project notes will be kept and transcribed by myself for writing up the project. The tapes and project notes will be kept by the myself in a locked cupboard in my secure private dwelling, until the successful completion of my thesis, when both will be destroyed.

The signed consent forms of your participation in the study will be kept by the School of Social Sciences, Massey University, Albany Campus. This is for security reasons as the consent forms and data should not be kept together.

Anonymity and confidentiality of your participation in this research cannot be guaranteed as it may prove difficult keeping this knowledge from the rest of the Child and Youth Team. However, acknowledgement and identification of the individual participants in the working party would only be *documented* if collectively the working party agreed.

Acknowledgement is made by the researcher that the 'portfolio' developed through the working group may be extended to further research studies, but not the actual data itself. This data will be destroyed on successful completion of my thesis.

It is agreed that as co-researchers in the study you may use the results from this research for your own future information and study.

This research may also provide the evidence for the contract between the Child and Youth Team, Child and Family Services, Auckland Healthcare and the North Health, Health Funding Authority to be examined and revised, therefore supporting the extension of the boundaries of our existing practice.

Your Rights:

Observation of your rights will be upheld throughout the research. You have the right:

- to decline to participate at any time.
- to refuse to answer any particular questions.
- to withdraw from the study at any time.
- to ask questions about the study at any time during the participation.
- to provide information on the understanding that your name will not be used unless you give permission to the researcher.
- to be given access to a summary of the findings of the study on completion.

Thank you for taking the time to read this document.

Grace Hinder.

APPENDIX 2

**CHALLENGING THE BOUNDARIES: AN INITIATIVE TO EXTEND
PUBLIC HEALTH NURSING PRACTICE.**

CONSENT FORM

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

I understand I have the right to withdraw from the study at any time and decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission. (The information will be used only for this research and publications arising from this research study).

I agree to maintain confidentiality within the working group.

I understand that anonymity and confidentiality of my participation in the research cannot be guaranteed as it may prove difficult keeping this knowledge from the rest of the Child and Youth Team, Child and Family Services, Auckland Healthcare.

I agree/do not agree to the working group being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the working group sessions.

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

Signed:

Name:

Date:

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