Am I doing the right thing?

Plunket Nurses' experience in making decisions to report suspected child abuse and neglect.

A dissertation in partial fulfillment of the

Requirements of the Degree

Master of Nursing

Waikato Institute of Technology

New Zealand

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December 2010

Dedication

For Plunket Nurses Everywhere

Child Protection Work Is The Most Important Work

You Will Ever Do

Acknowledgments

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Key and Definitions

For confidentiality the numbers and letters beside participant Responses are used as an anonymous identification system. For Example [PN 1]

PN = Plunket Nurse. A New Zealand Registered Nurse who has completed a Post Graduate Certificate in Primary Health Care Specialty Nursing–Well Child/Tamariki Ora Strand or equivalent.

CK = Community Karitane are qualified paraprofessional/health workers, who have completed a Tamariki Ora Certificate that is recognized by the New Zealand Qualification Authority (Level Four). They focus on enhancing family/whanau strengths and capacity, to meet the needs of their children through health promotion, health education, health protection and illness prevention concepts in their work. CK's work under the guidance of Plunket Nurses.

PK = Plunket Kaiawhina –are qualified paraprofessional/Maori health workers who have completed a Tamariki Ora/Well Child Certificate that is recognized by the New Zealand Qualifications Authority (Level Four). They work predominately with whanau Maori and focus on supporting whanau to build their capacity. They use health promotion, health education, health protection and illness prevention concepts in their work. PK's work under the guidance of Plunket Nurses.

CYF = Child, Youth and Family. Child Youth and Family is the leading central government agency responsible for delivering and funding social services to support children, young people and their families who are at risk.

Tamariki = Child/ren

Whanau = Family

[ ] indicates researcher inserted words to enhance meaning of participants verbatim excerpts.

…indicates abridged passages.

Abstract

Suspected child abuse and neglect is not a new phenomenon in community nursing. Child abuse and/or neglect is prevalent globally and is a major community concern. Plunket Nurses have a primary responsibility to protect the health and well being of the women and children with whom they come into contact. Detecting suspected child abuse and/or neglect and making decisions to report to Child, Youth and Family, New Zealand's Statutory Agency, is difficult. There are professional, legal, ethical and moral complexities in this work. Boyne (2003) states that there has not been enough research about what it is like to work with and manage risks in child protection work. This study set out to report these experiences in view of understanding them and finding possible gaps in literature, policy, and education.

Hermeneutic phenomenology was the methodology thought most appropriate to study the experiences of Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertain situations. A purposeful sample was selected to ensure participants were able to provide rich data that was captured in semi-structured, face to face and telephone recorded interviews. Data analysis was guided by the framework developed by van Manen (1990) to formulate meaning from participant experiences. Four major themes developed.

Ethical considerations were extensively explored due to the sensitive nature of the study. Management of possible ethical situation have been described, with a planned approach to an ongoing consent process throughout the data collection. The results have identified gaps in the literature, Plunket policy and the educational needs of Plunket Nurses. Opportunities for future research are suggested.

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CHAPTER ONE

Introducing the Study

Introduction

Plunket Nurses have as a paramount priority, child safety, woven throughout their Standards of Practice (Royal New Zealand Plunket Society, (RNZPS), 2009). This work includes protecting children from accidental and non accidental injury. There has not been enough research about what it is like to work with and manage risks in child protection work (Boyne, 2003), and little has been written about the experiences of Plunket Nurses engaged in child abuse and neglect practice situations. Many nurses suspect child abuse and/or neglect (also known as child maltreatment) and experience feelings of uncertainty when faced with deciding to report or not, resulting in professional dilemmas. Often there is no concrete evidence, only intuitive feelings that something is not right. Real challenges are faced. This study set out to record their experiences and the research question developed into "The experiences of Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertainty in New Zealand".

This chapter introduces the study, the background, purpose, and aims. The application of Heidegger's (1927/1962) three modes of engagement; Unready-to-Hand, Present-to-Hand, and Ready-to-Hand are described and how they can be applied to this study are outlined. I discuss the importance of addressing my pre-understandings and fore-structures, the study's importance to nursing, and conclude with a mapping of this dissertation.

Background to study development

The research question originated from experience within my role of Clinical Leader working with nurses who were attempting to make reporting decisions. Plunket Nurses are exposed to decision making every day when they engage with families. They see approximately 91 percent of all new born babies in New Zealand (RNZPS, 2009a).   Screening for family violence is part of the requirements of the Ministry of Health (MoH) Well Child/Tamariki Ora National Schedule: Four to six weeks, to five years (2010). Screening is undertaken by Plunket Nurses at every core contact and as necessary. This screen forms part

of the overall clinical assessment of child/tamariki and family/whanau. Following a full assessment, nurses in partnership with family/whanau, formulate a plan of care. Family violence screening is not always possible, for example, when children over the age of two years, or other adults are present (RNZPS, 2008). Often nurses have an intuitive sense that all is not as it seems in a home, and they suspect that a child is possibly being abused or neglected in some way. The lack of concrete evidence becomes problematic causing professional and ethic dilemmas.

In my role as Clinical Leader Plunket Nurses came and discussed situations they had encountered in their working day that involved suspected child abuse/neglect situations. Plunket's Family Violence Prevention Policy and Protocols (2008) outlines the need for conversations with Clinical Leaders as necessary for supporting the nurse, keeping nurse and child 'safe,' and keeping the Clinical Leader informed. Both senior and more recently qualified Plunket Nurses have described practice situations involving potential or actual risk indicators, ending the conversation with 'I'm not sure where to go with this'. Each situation has included an element of 'grey' or uncertainty. Nurses often felt policy or protocols did not directly address the scenario they were describing.

There are tensions for the nurse between making decisions to report and risk losing access to the family and not reporting and take risks around their own professional ethics and the safety of the child. Each aspect is seen as important to the nurses. Sometimes the outcome of these conversations results in the nurse acquiring moral support and a boost of confidence in their own clinical judgment skills to proceed with the decision making process. At other times the issues are more complex and uncertain and decision making is problematic. This requires time for reflection, support from colleagues and myself for possible solutions to their professional dilemmas.

Child abuse and/or neglect often go undetected by health professionals. It can be hidden, less certain, ambiguous and can go undetected until there is something more obvious, certain or in some cases serious injury or death (Barton, 2000; Carlton, 2006; Henry, Ueda, Shinjo & Yoshikawa, 2003; Jose,

2005). From the complexities of ambiguity, nurses' intuitive feelings may grow into suspicion. When nurses add their observations of environment, actions or words of caregiver or child, and identify 'red flags' in previous documentation, the nurse begins to build a picture. This study is aimed at capturing those experiences of uncertainly in making decisions to report.

I have experienced in these conversations that obscurity and uncertainty add stress and anxiety to nurses emotional wellbeing and can hinder nurse's decisions to report. This study reveals that some nurses take a 'wait and see' approach and others consider that reporting will end what has been a hard to build nurse-client relationship and do not wish to jeopardise this.

Plunket Nurses have a professional responsibility and accountability to promote safe environments for the zero to five year old children in New Zealand (RNZPS, 2008). This includes promoting abuse and neglect free homes. Where there is reason to believe there is abuse or neglect, nurses have an obligation to report to Child, Youth and Family, (CYF) New Zealand's statutory child protection agency. To protect the right of every child (United Nations, 1989) nurses must have a knowledge base to identify risks and then manage them in a safe and professional way.

As clinical leader for the past four years, I have noticed these 'grey' or uncertain scenarios have increased and have thus became a phenomenon of interest to me. No two scenarios are ever the same. This led to my research topic. Formulation of my research question developed around what I wanted to understand and find meaning of within the context of the Plunket Nurses world when making decisions to report suspected child abuse and/or neglect in uncertain situations.

Purpose and aims of this study

Ferguson (2004, p. 220) presents the idea that research needs to provide the 'smells of practice' in order to add to knowledge about how the work of child protection is carried out in the homes and forums where families, children and nurses engage. Studies around the dilemmas of nurses who try to engage with unwilling families, is missing from the New Zealand nursing literature. Unwilling families from Plunket Nurses experiences tend to be very transient,

and, nonresponsive to phone or written messages. These families do not seek to engage with the Plunket Well Child Service, it is the Plunket Nurse who does the searching to engage. I agree with Ferguson, that it is important to provide the 'smells of practice' through the voices of nurses in an aim to add to nursing knowledge which this study aims to do.

Ferguson (2004) also states that:

"relationships and what happens when worker meets client, invariably by stepping across the threshold of their home and into their lives, should provide the core concerns for training, understanding practice and policy development" (p. 214).

Nurses often walk into 'unknown territory' when they step across the threshold of homes. Yet there are times when unexpected situations arise for which it seems that nurses should be prepared (Zinn, 2008).

Not all nurses have developed practice wisdom or professional judgment skills to the same level, (Benner, 2001) or at the same pace. It is an assumption to think otherwise. Plunket Nurses develop levels of skill parallel to Benner's (2001) novice to expert framework.

Balancing therapeutic and research imperatives provides a fuller human understanding of the phenomenon under investigation and of the care required in practice. Munhall (2007) claims that nurses who gain human understanding facilitate human caring. Sensitive issues such as child abuse can then be explored with clients in an empathetic way. This understanding coupled with the therapeutic use of self may provide care that is fully informed, more sensitive, timely, and for care that is more appropriately responded to by the nurses. These are attributes that are important and required by Plunket Nurses who are making decisions about reporting to the New Zealand statutory agency, (CYF).

Heidegger's three modes of engagement

Many practice situations are unexpected and interrupt the process of making logical step by step decisions in a systematic way. When logical steps are interrupted nurses face situations where their automatic and systematic

response mechanisms have 'gone on strike' and they struggle to make sense of what is happening, how to respond, and are left wondering what action to take.

This interruption to the automatic process of thinking is what Heidegger (1927/1999), referred to as Unready-to-Hand experience. Unready-to-Hand experiences can be identified in this study through the voices of the nurse participants. The experiences provide professional practice knowledge, through reflection on those experiences, and, according to Benner (2001) results also in practice wisdom and professional judgment skills.

Through the nurses' narratives I was able to relate to and reflect on my own experiences of Plunket Nursing and previous acute medical/surgical paediatric nursing and recall my Unready-to-Hand experiences. Some of these experiences left me feeling totally inadequate as a person and at times I worried about my competence as a Registered Nurse. On reflection the experiences I recall were always those that interrupted what was otherwise a smooth beginning to the day's work, and most often were a result of knowledge deficit.

This smooth activity is described by Polanyi and Prosch (1959) as a valid correspondence or link between the theoretical facts, the 'know-what', and the practice activity of 'know-how'. Plunket Nurses complete a one year Post Graduate Certificate in Primary Health Care Specialty Nursing-Well Child/Tamariki Ora Strand thereby being theoretically prepared in the first mode of 'know-what' and the second mode of 'know-how', which is the practical knowing. It is the action between the two modes that creates the smooth activity in practice situations. The nurse knows what is needed to be undertaken to progress an activity to a smooth ending as usually expected.

For example, a Plunket Nurse will assess hearing development via a hearing screen. If the nurse assesses a five month old infant for hearing development via a hearing screen and identifies the absence of the infant turning her/his head towards voices, the practice would progress automatically on to confirming the absence with the caregiver. This is the 'know-what' in nursing, the theory behind the assessment acknowledges a possible developmental issue for the infant. The nurse may progress this assessment on with the next

stage of 'know-how' to an audiology referral. This is 'smooth practice' or practice knowledge in action.

Heidegger (1927/1962) refers to the three modes of engagement in the application of theoretical knowing in any given situation, as in the above example. The first is Ready-to-Hand mode (know-what) which is the smooth course of an activity. The second is Present-to-Hand, (know-how). This is the thinking and action working smoothly together. The third Unready-to-Hand (know-what) mode is when that smooth activity becomes an unexpected 'bumpy' road. When a Plunket Nurse enters a practice situation with an understanding or 'knowing', this allows a planned course of action to be carried out.

Prior to this study, I was unaware of Heidegger's three modes of engagement. Through reading of Heidegger's work, I became aware that these three modes were a 'fit' with this study when looking at the experiences of Plunket Nurses making decisions to report suspected child abuse and/or neglect. In particular the parallel between the Unready-to-Hand mode of engagement and making difficult practice decisions align closely and became the framework for my reflection and analysis of the raw data and later in the discussion chapter.

Nurses in this study working within the Unready-To-Hand mode of engagement found themselves in difficult, stressful, and often complex decision making situations. Present-to-Hand and Ready-to-Hand modes of engagement are acquired through theoretical knowledge and situational practice experience and equip nurses with skills to deal with the Unready-to-Hand situations in a more prepared approach. A further aim of this study was to provide rich, detailed, insightful descriptions, of the way that individual nurses use their professional judgment and develop practice wisdom.

Addressing Pre-understanding and Fore-structures

Heideggerian hermeneutic research required me to address my pre-understanding and fore-structures by bringing to consciousness the phenomena under study to provide the greatest opportunity to reveal itself (Geanellos, 1998). This is not in an attempt to bracket off prior knowledge relative to the study as in Husserl's phenomenological methodology, but to

make transparent to self and reader, the position, context, and knowledge of the researcher prior to commencing hermeneutic research (van Manen, 1990).

To not engage in these processes places me at risk of confirming my own truth of fore-knowledge, assumptions, biases and beliefs, rather than veiling the truth of the phenomenon under investigation. To address this, I asked myself 'What are my pre-understandings in relation to my previous experiences as a Plunket Nurse reporting suspected child abuse and/or neglect?' I spent time reflecting on this and noted in my research journal my own experiences, my thoughts, feelings and deficits in practice knowledge related to my study question.

My own position in the study is that of Clinical Leader (see Appendix One for role description). Being available to support and guide professional judgment decisions is one aspect of my role. I have arrived at this research study after 34 years of nursing experience, 25 of those years have been experienced within maternal, neonatal, infant and child nursing. The last ten years I have been a Plunket Nurse with the last four years as Clinical Leader. I have worked both in the private and public health systems and in the community having practiced in urban and rural settings in New Zealand. Child protection work has been experienced in different ways in all these practice settings. The most challenging has been my work as a Plunket Nurse. The immediate support of a colleague was not always at hand, and mobile phones were yet to be part of staff equipment. My previous experience goes some way towards understanding what Plunket Nurses experience at the coal face of their work. There are moral and ethical decisions to make, when uncertain child protection situations arise. Intuition, often lead me to ask the silent question 'what is going on here'? I assumed that Plunket Nurse education would have prepared me for this work and that I would know what to do when faced with decision making in suspected child abuse. When faced with actual situations I reflected on how little I was prepared.

It is an assumption that all Plunket Nurses cope with this type of work and know what to do when faced with suspected child abuse and/or neglect and actually recognise it. It is also an assumption that nurses know how to

document intuitive feelings and manage time to achieve everything within their hours of work. In reality nurses are practicing at different levels of skill and knowledge (Benner, 2001). Managing the unexpected is a challenge, and was a challenge in my practice. Managing suspected child abuse and/or neglect presents nurses with different challenges around management of time, coping skills, ethical and legal aspects of this work as this study aims to discover.

Significance of this study for nursing

Plunket Nurses are required to report suspected child abuse and/or neglect, according to Plunket policy and as part of their practice standards and competencies (RNZPS, 2008). Developing skills in decision making to report is essential in any child protection work, and no less so for Plunket Nurses. According to Stanley (2005), there is a dearth of research into how those who are required to assess risk actually do so. Therefore, I propose that this research is necessary to add to the limited research previously undertaken in this area, especially in the New Zealand context.

Results from a phenomenological study can be used for recommendations for political, social, cultural, health care, nursing policy development and changes in nursing practice. Knowledge gained this way increases nurses' capacity for care and compassion, and raises our consciousness to what was not known or otherwise erroneous and leads itself to future nursing possibilities (Burns & Grove, 2001; Munhall, 2007; Roberts & Taylor, 1999; Streubert-Speziale & Carpenter, 2007). This study may be useful in reviewing and planning future education that further supports and develops new and experienced Plunket Nurses in the area of making decisions to report suspected child abuse and/or neglect.

Results of this study may provide helpful nursing practice decision strategies in determining interventions that support or enhance the practice of Plunket Nurses and other primary health care nurses. The results may enhance or correct experiences of assessing 'at risk' children and making decisions where suspicion of child abuse and/or neglect is possible. Opportunities to build on and improve nursing knowledge and practice, through the use of Heidegger's

(1927/1966) three modes of engagement could be used as a teaching tool to reflect on practice scenarios, actual experiences, and decision making.

Finding My Way- Reflection/Reflexivity and keeping a Research Journal

To aid my learning as a novice researcher, I referred to Clarke (2009) and Munhall (2007) who recommend researchers keep a written journal of their journey through a phenomenological study. Both Munhall and Clarke stress the point of keeping an ongoing personal journal that includes reflection from the time one first starts to think about the research. I began my research journal from the outset of the formation of my research question. The literature suggested that the journal should include thoughts, feelings, responses, and associations that situate the researcher in the life-world of ones research continuously from before, during and after data collection and analysis. In addition it should include descriptions and meanings of 'what is going on' and the meanings of various experiences the researcher may have throughout the study. The end result is described as bringing personal growth and awareness of meaning and of being human (Clarke, 2009; Munhall, 2007; Smith, 1999).

From the beginning of my research proposal, I began a journal. I included questions to and responses from conversations with my research supervisor. These were either face to face or over the telephone and I kept all email correspondence. I included lists of things to do, on line searches to complete or books to request from the Wintec library. My journal was never far from my side, even beside by bed for jotting those night time inspirations. It became my life line, both containing lines of thought, direction, and reflection at every stage of developing this report, but also importantly a source of encouragement when, in those moments of despair I needed to turn to something that spurred me onward.

Reflection can be understood as 'thinking about' something else (an object). The process is described by Finlay and Gough (2003, p. 108) as a "distanced one and takes place after the event". Reflexivity, "in contrast, involves a more immediate, continuing, dynamic and subjective self-awareness" (p. 108).

Both reflection and reflexivity played an important and intriguing part from the very conception of my research topic. I wanted to make transparent my individuality and its effects on this entire journey. The attempt to highlight my motivations, attitudes and interests brings a personal dimension enriching and informing this study. Such a personal dimension is recognised in the world of qualitative research (Finlay & Gough, 2003; Clarke, 2009).

Reflexivity also extended beyond my personal domain into a functional reflexivity which related to my role as researcher. It included the effects this role might have on the research process including concerns relating to the interactions between participant and researcher and the distribution of power and status within the research process. It was important to me that I reflected on my position as a Clinical Leader and thus came to the conclusion that I would not interview any Plunket Nurses with whom I was direct line manager of, or any Plunket Nurse with whom I had worked with in the past as a Plunket Nurse myself. I felt this would add a comfortable distance between known and unknown pre-understandings of personal friendships or work relationships reducing possible bias. Considering the different levels of reflexivity situates the research within relevant interpersonal, institutional and cultural contexts and as a result the data analysis can be undertaken within a broad context. Focusing solely on a personal reflexive process would limit the interpretation of the data and conclusions.

Throughout writing this dissertation, I have referred back to and quoted from my journal to inform the reader of the process the research journey has taken me. The journal provided a place to question myself, challenge my thoughts and feelings and a time to reflect. It helped me to develop critical thinking opportunities and assisted me in thinking in a phenomenological way as this excerpt demonstrates.

I cannot begin to understand how to 'think' in a phenomenological way. Sallie tells me I need to think in this way to analyse the data. I was still confused after two telephone calls to Sallie. I needed to see her face to face to understand what Sallie really was trying her best to explain to me. We met at my home. Sallie sat me down and in her Ready-to-Hand

knowledge, made me close my eyes and asked that I 'think' and 'do' in my mind what she asked of me. In this way Sallie 'unpicked' my current mode of thinking, and took my thinking to a new place, that of 'thinking' and 'feeling' and not 'doing' anything with the data, just feeling it. That exercise enabled me to proceed forward.

It was also a source of self encouragement when I felt I was unable to move forward or bogged down with so many ideas. This often resulted in a visual map of ideas from where I could progress my writing. It became as if my 'second mind', a place to retreat to more and more as I moved through the research journey. In particular it was invaluable as a place to reflect as soon as possible following every interview, for now reading back I had captured the atmosphere, the attitude of the participant, and recorded my immediate thoughts and feelings, which now on recall are very vague. As Clarke (2009), Munhall (2007) and Smith (1999) advocate, the end result of keeping a personal research journal will result in, and has bought, personal growth and awareness of meaning and that of being human.

Mapping out the journey ahead

This dissertation is divided into six chapters. This first chapter has outlined the background, purpose, and aims and introduced Heidegger's three modes of engagement as relevant to this study. I address the importance of pre-understandings and fore-structures and why this study is important and significant to nursing. The use of a research journal and how I used reflection and reflexivity as a tool to finding my way in this research journey is presented.

Chapter Two discusses the methodology in detail outlining the strategies implemented to undertake this study. This covers the philosophical underpinnings of Heideggerian hermeneutic phenomenology, Heidegger's concept of 'Being', and ethical considerations. Also covered is the scope of the literature review, sample selection strategy, and how data was collected, transcribed and analysed. Chapter Three reviews the literature around Heidegger's hermeneutic phenomenology, child abuse and neglect statistics internationally and in New Zealand. It also reviews suspected child abuse

and/or neglect, nurse-client relationships, clinical judgment, and intuitiveness as implemented into clinical practice decision making. Nursing ethics that underpin nursing practice, stress, anxiety, resilience, hardiness and time are explored. Nursing documentation is also reviewed with regard to suspected child abuse and/or neglect reporting.

Chapter Four describes the findings of the data collection. van Manen's (1990) framework for analysis was used as a guide throughout this process. The four major themes that emerged are described. These were 1) The nurse-client relationship and protecting children. 2) Stress plus anxiety and resilience plus hardiness. 3) Relational time and lineal time. 4) Gut feelings, documentation and personal safety. Excerpts from the raw data are presented that provide examples of participant experiences in making decisions to report or not, child abuses and/or neglect situations.

Bringing together the current literature and the findings of the study is presented as a discussion in chapter Five. The challenges that this work brings to Plunket Nurses are many including stress, anxiety, and pressure of time, intuitive feelings and documentation.

Chapter Six brings the study to a close with suggestions for future research opportunities, recommendations for further education in the areas identified by the nurses and the literature. Gaps within the literature are outlined along with a recommendation for guidelines to be developed and included in Plunket policy around the risks to the unborn child where there is already suspected child abuse and/or neglect in a home.

CHAPTER TWO

Methodology

Introduction:

This chapter outlines the methodology of this study and includes a description of hermeneutic phenomenology, philosophical underpinnings and Heidegger's concept of 'Being'. Ethical considerations are also addressed. Decisions informing the literature review, sample selection strategy, and data collection, transcribing and analysis are described. The chapter ends with a discussion of my use of a research journal, and reflection and reflexivity as a tool for guiding my way along this research journey.

Research design

The research question 'The experiences of Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertainty in New Zealand' determined the design and methodology chosen for this study, that of phenomenology. According to Powers and Knapp (1990), phenomenology is a way of thinking about investigating what life experiences are like for people. Roberts and Taylor (1998) add that phenomenology acknowledges and values the meanings that people ascribe to their own existence and context. This includes those receiving nursing care as well as those 'doing' the nursing care. Roberts and Taylor (1998) emphasise that the central role in phenomenological research is to generate knowledge that is personal, practical and from the perspective of people actively engaged in the phenomena of interest. Further, it values what participants have to say about what they believe and feel based on their experiences.

Streubert-Speziale and Carpenter (2007) describe phenomenology as a research approach that brings to language, perceptions of human experience with all types of phenomena that allows nursing to explore, describe and investigate phenomena important to the nursing discipline. Crotty (1996) describes a goal of phenomenological inquiry as going "beyond identifying, appreciating, and explaining current and shared meanings. It also seeks to critique these meanings" (p.5). Phenomenologist's want to know what the phenomena are

like, the meaning of what it is like and to seek an understanding of the meaning of 'things' to individuals.

In considering which branch of phenomenology to utilise for this study, I considered both Husserl's descriptive phenomenology and Heidegger's interpretive methods of inquiry (Holloway & Wheeler, 2010). My research question and aims lead me to lean towards Heidegger's interpretive or hermeneutic method. I believed that I could not bracket off my own personal experiences, prior assumptions and preconceptions as is required by Husserl's method of descriptive phenomenology.

Heidegger's method of incorporating ones own personal experiences, becomes something that informs the research (van Manen, 1990). This was essential towards adding value and understanding of participant's context and situatedness of their experience. "Interpretive phenomenology uses the subjectivity, one horizon being that of the 'text' and the other that of the interpreter of the text" (Holloway & Wheeler, 2010, p. 228). What the researcher knows prior to the research should be acknowledged in writing. The researcher is asked to "see the phenomena as if seeing for the very first time" (Munhall, 2007, p. 221). This involves explicating assumptions and pre-understandings. My ultimate goal of being transparent about prior knowledge was to be fully present with an intention to understand and care. To acquire the richest possible data, that is data with the greatest complexity and variety, and to discover and develop an understanding of Plunket Nurses' experiences in making decisions to report suspected child abuse and/or neglect, hermeneutic phenomenology was the methodology of choice.

Congruency between choosing a methodology and generating a certain type of knowledge was an important consideration from the outset. I was committed to using the means that most appropriately explained the phenomena of interest. The assumption here is that if a methodology is a set of theoretical assumptions, and a method is a certain way of generating knowledge, then there needs to be a 'fit' between the type of knowledge that is to be generated and the method of achieving this (Roberts & Taylor, 1998).

The advantage of using a qualitative approach is that the phenomenon may be studied holistically and contextually. The focus is on Plunket Nurses experiences and realities taken from their work environment that allowed the development of a rich description and deep understanding of the phenomena under investigation. The emphasis of this study is on achieving understanding that may open up new perspectives in knowledge building and practice development for all primary health care nurses working where suspected child abuse and/or neglect may be recognised.

Gerrish and Lacey (2006) state that phenomenological research has the potential to 'see something' differently, unearth fresh insights, or view experiences from new perspectives, from the rich details given from participants forming the 'smells of practice' as described by Ferguson (2004). The findings of phenomenological research have potential to richly describe experiences that human beings can either identify with, or alternatively, understand something more about. Rather than searching for one reality or one truth, multiple realities exist and create meaning in different ways for individual participants. The crucial aim of phenomenology is the understanding of being human and becoming more human (Munhall, 2007). We can become more human only through understanding self and others in individual life-worlds, situated contexts, contingencies and caring about it all. Phenomenology therefore offers the best methodology for the purpose and aims of this study and provided the framework and philosophical foundations to guide me to achieve the best possible outcomes from this study.

Hermeneutic phenomenology focuses on the lived experience of individuals through their senses, and attempts to capture, in language, and presents as true or real in his or her life, the meaning of human experience (van Manen, 1997). It is this lived experience that gives meaning to each individual's perception of a particular phenomenon and is influenced by everything internal and external to the individual (LoBiondo-Wood & Haber, 1994; Parahoo, 2006; Streubert-Speziale & Carpenter, 2007).

I wanted to be taken on a journey of discovery and participation, one that would be rich and rewarding, with a desire to understand more about the phenomena of Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertain situations. The overall aim was to describe, explain, and generate insightful meaning of these experiences that may bring about beneficial change in making decisions to report suspected child abuse and/or neglect. The hermeneutic framework has the potential to develop new nursing theories and practice knowledge.   Improving knowledge through the experiences of nurses is needed to ensure that the work of Plunket Nurses remains effective for children/tamariki and families/whanau in New Zealand/Aotearoa.

An underlying assumption of this hermeneutic phenomenological study was that trustworthiness and real knowledge is found by paying attention to what participants say and do about their experiences (Roberts & Taylor, 1998). This study is based on the assumption that the participants are able to interpret their experiences from their contextual positions and relationships and make sense of their own 'being-in-the-world' (van Manen, 1990). To understand the lived experience of Plunket Nurses making practice decisions around reporting child abuse/neglect, the most appropriate method to achieve this needed to be considered in allowing these nurses to express their experiences. The study purpose was to develop understanding and meaning from participants who have experienced the phenomena of study.

A further assumption of phenomenology is that 'truth' is relative and context-dependant. What is seen to be true may change with time, place, and circumstances in which participants find themselves (Coroy, 2003).   The subjectivity that the study participants brought to this study is acknowledged and valued in the knowledge they shared of their experiences.

Heidegger's Concept of 'Being' and 'Being-in-the-world'
The work of Martin Heidegger [1889-1976], who is considered the prime instigator of modern hermeneutics, arose from the work of the phenomenologist Edmund Husserl [1859-1938] under whom Heidegger studied

in Germany in the first quarter of the twentieth century (Heidegger, 1962). Heidegger uses the fundamental term of 'Being' or 'Dasein' which translates as 'Human Being' and refers to how we as human beings exist in the world, make sense of the world, know our place in it and are involved in the world (Conroy, 2003; Munhall, 1994). Individuals bring unique experiences to phenomenological research. They describe experiences from their perspective of social, cultural, environmental and historical contexts of the world and as such are said to be 'being–in-the-world' (van Manen, 1990). For example as a parent, woman, man, student, and as in this study a Plunket Nurse, perspectives had different 'being-in-the-world' interpretations (van Manen, 1990). Participants in this study stated that the fact of being not only nurses but mothers made them 'see' differently and 'think' differently. It appeared to shape their thoughts around decision making within child protection work. I chose Van Manen's (1990) explication of Heidegger's (1927/1962) hermeneutic phenomenology as the approach most rooted in the 'everyday lived experience' of human beings in nursing situations. Reading van Manen's book "Researching Lived Experience" (1990), I was impressed to use his approach for discovering the unique nature of each human situation.

Philosophical Underpinnings

Crotty (1996) states that researchers undertaking phenomenological studies should offer a philosophical critique that outlines what the researcher wishes to accomplish in conducting the study, therefore one is included here. Phenomenology is an integral field of qualitative research inquiry that spans across philosophic, sociologic, and psychological disciplines (Streubert-Speziale & Carpenter, 2007). An assumption is that this interdisciplinary builds up knowledge (Sadala & Adorno, 2002).

Becoming phenomenological, means to 'think' and 'be' phenomenological, and to situate ones self in a "context embedded in time, space, embodiment and relationships" (Munhall, 2007, p. 148). Munhall goes on to describe that this not only means hearing language and believing something is being revealed that might be valid, but hearing and contemplating what might be concealed in responses. Researcher and participants see 'things' from and through different

lenses and social constructions of reality, using language differently. An important phenomenological realisation is that two different perspectives of 'living' and 'being' are going to result in two or more explicated interpretations from what seemingly looked like one reality (Conroy, 2003; O'Leary, 2004). Exploring phenomena in this research involved Plunket Nurses generating descriptions of lived phenomena as they present themselves in direct experiences. In reality those that have the experiences are the most knowledgeable about them (Conroy, 2003; van Manen, 1990). Individuals create their own subjective realities and thus the knower and the knowledge are interrelated and interdependent. Ideas are the lenses though which each individual knows the universe. It is through these ideas that we come to understand and define the world (van Manen, 1990). This epistemological viewpoint is based on the fundamental assumption that it is not possible to separate the outside world from an individual's ideas and perceptions of that world (DePoy & Gitlin, 1998). Knowledge is based on how the individual perceives experiences and how he or she understands his or her world.

Role of the researcher

Munhall (2007) describes the researcher as the instrument of the methodology used. It is through the researcher's thinking and processing that meanings in experience are explicated and more fully and deeply explored and understood. Accepting the researcher as a co-participant in the discovery of the realities of the studied phenomena is a characteristic of phenomenological research (Streubert-Spezial & Carpenter, 2007). My intent was to engage in a dialogue with the data, to become immersed in the participant's descriptions to identify essences, themes, and meaning of the lived experience (Fain, 2004).

To prepare for this new research experience, it required me to become acquainted with the literature (Gillham, 2008) describing hermeneutic interviewing strategies and skills that would place me in a confident position to proceed with interviews. I wanted to stimulate in-depth conversation with participants of their experiences making decisions to report/not to report child abuse and/or neglect. My interview questions were developed through

insightful thought and reflexion in order to gain the greatest understanding and meaning of participants' experiences.

The decentering of self is described by Munhall (2007) as critical to the process of producing authentic and effective research therefore adding to the research credibility. An assurance that one has accomplished decentering is obtained through using practice listening/interview/conversation sessions (Munhall). To obtain this skill I practiced decentering with a colleague by asking them to describe an experience to me. I listened to grasp meaning and to get inside the person's perceptions. After listening, I wrote a description of what was heard and what meaning the colleague ascribed to the experience. My colleague then evaluated how accurately I grasped the essence of what was said. This served as a learning exercise in preparation for decentering me from the phenomena of study. It prepared me for the participant interviews and the next stage, interpretive analysis of the data.

Munhall (2007) states that qualitative nurse researchers need to grasp the complexity of an 'experience', its wholeness, and not compartmentalise the 'experience' and turn it into variables as in experimental research. The researcher needs to be the one who comes to the research with openness and who is unknowing and the participant the expert who imparts their existing knowledge. The researcher interprets the 'experience' into meaning for developing practice knowledge. Horsfall (1995) describes the mutual recognition between researcher and research participants that is fostered and valued by the researcher, in an effort to uncover deeper meaning during interviews.

Being mindful of the emotive topic of child abuse, a support system for debriefing with a peer highly experienced in child abuse work, education, and support, was factored into the research for the benefit to me. The RNZPS supports debriefing for all staff working with child abuse as written in their Family Violence Prevention Policy and Protocols (2008). I found at times I needed to debrief to both research supervisor and a willing peer. Both made

themselves available for this purpose. Confidentiality was maintained during these sessions by not referring to names of nurses or specific work areas.

Literature Review

The purpose and aim of the literature review in this phenomenological study was to compare and combine findings from this study with the literature to determine the current state of evidence for the phenomena of interest and defend current professional practices (Burns & Grove, 2005; Fink, 2005; Holloway & Wheeler, 2010; Munhall, 2007). An initial review of the literature was undertaken to inform and provide awareness of any previous studies. Also previous research perspectives in related research were viewed to improve understanding of the research phenomena, and look at any recommendations that were documented for further research (Polit & Hungler, 1999; Walker, 2007). Familiarisation with previous studies was useful to alert me to unresolved research problems and provide a foundation upon which to base new knowledge discovered through this research (Polit & Hungler). Clifford (1997) supports this view by suggesting that searching the literature can help researchers determine whether their study is an original piece of work; an important consideration for a Masters research study.

Munhall (2007) writes extensively about the literature review being something that is undertaken following data collection, but as an alternative recommends a 'literature review' that describes the philosophy of phenomenology and how the researcher plans to follow the underpinnings and suppositions. The 'literature review' then becomes part of the researcher's existential investigation.

Phenomenologists in general believe the literature should be extensively reviewed after data collection and analysis so that the information in the literature will not influence the researcher's openness (Burns & Grove, 2005; Holloway & Wheeler, 2010; Munhall, 2007). Munhall goes on to say that delaying the literature review until the completion of participant interviews assists the researcher in "staying close" (p.191) to the participants' narratives as much as possible without the influence of a literature review. Burns and

Grove and Gillis and Jackson (2002) support Munhall by further adding that knowing the details from other research prior to interviewing participants could influence the way the researcher views the phenomenon during data collection and analysis. Further, after data analysis, the information from the literature is compared with findings from the researchers own study to determine similarities and differences. The findings are combined to reflect the current knowledge of the phenomenon. The goal of the research is discovery of, or, a new view of a phenomenon; therefore literature should not influence the mindset of the researcher during initial data collection.

Contrary to this view, Streubert-Speziale and Carpenter (2007) advocate postponing the literature review until after interviews and data analysis is complete in order to obtain the purest description of the phenomena under investigation. Undertaking a literature review at the outset only serves the purpose of obtaining additional knowledge from which the researcher must separate oneself to remain open and receptive to phenomenological material. By not conducting a literature review initially the phenomenologist is protected from leading participants in the direction of what has previously been known. I considered the views presented here by the various authors around the literature review process, and decided not to conduct an in-depth literature review pre-interviews or data analysis, but rather review the philosophy of phenomenology, the underpinnings and suppositions that deepen understanding and support the undertaking of this methodology.

Ethical Considerations:

The personal nature of phenomenological research requires some additional considerations of ethical issues that may emerge using this methodology for gaining insight into the essence or structure of the lived experience (Rose, 1995). The topic of Plunket Nurses making decisions to report suspected child abuse and/or neglect may be classified as a 'sensitive' area of inquiry due to the potential for intrusion into the private sphere of nurses' experiences and thinking. This in itself draws attention to issues of ethical significance that may be encountered throughout the research process. Issues of dignity, rights, safety, anxiety, distress, wellbeing, exploitation, misrepresentation, and or

identification of the participants in published papers are of paramount consideration (Parahoo, 2006; Richards & Schwartz, 2002).

Walker (2007) describes a critical ethical obligation of qualitative researchers as being "faithful" in describing the experiences of others in every possible way (p. 42). Therefore according to Jasper (1994) and Walker (2007) the researcher should decentre or suspend oneself from ones own knowledge and beliefs of the phenomena being studied in order to avoid influencing both the collection and interpretation of the data. However Burns and Grove (1999), taking the interpretive approach, argue that there is a commitment on the part of the researcher to identify beliefs, assumptions and preconceptions about the topic of research at the beginning of the study for the purpose of self-reflection and external review. Protecting the uniqueness of participants lived experience in this way is appropriate for the framework of this study, that of hermeneutic phenomenology.

Two of the most fundamental ethical principles applicable to research are beneficence and non-maleficence (Burns & Grove 2005; Munhall, 2007) which encompass the concept of 'above all, do no harm'. In assessing the potential adverse effects or risks for the research participants, it is acknowledged that the recollection of child abuse cases for Plunket Nurses might be distressing. This research is a 'sensitive' topic, that is, one that has the potential to arouse strong emotional responses (Kavanagh & Ayres, 1998; Schneider, Elliott, LoBiondo-Wood & Haber, 2003). Practical concerns for the researcher include recognition that discussing child abuse may be distressing and painful for people who have had personal experience as a child/adult, therefore any participant falling into this category, was excluded. However the Plunket Ethics Committee disagreed with this exclusion criterion and asked that I include these participants as they add a different aspect to the research. I did not ask participants if they had ever experienced personal, or been witness to, any abuse or neglect, as it was not in my schedule of participant questions when sent to the ethics committees for approval.

Kavanagh and Ayres (1998) discuss the importance of assessing participants for signs of distress throughout interviews that involve issues of sensitive topics. Researchers must be equipped to address distress from sensitive issues, so as not to be placed in an unethical practice situation (Walker, 2007). Holloway and Wheeler (1995) suggest that research interviews can be therapeutic, however therapy was not the purpose of this study and therefore I made it clear to the participants that this benefit would not be guaranteed.

Strategies to minimise distress were included by discussing this possibility before interviewing commenced. I ensured the participant that, their welfare would take priority over the research by stopping the interview and the audio tape if I identified signs of participant distress. For example, if I observed hesitation to continue and restless behavior I would end the interview and offer follow up support. The interview would only continue with the consent of the participant. One participant began to show some physical and psychological signs of painful emotion with the wavering of voice and slowing of speech and some moments of silence while showing signs of re-composure. I asked the participant if they wished to continue, they responded that they did.

Participants who acknowledge distress would be offered free counseling through Employer Assistance Programme (EAP). If participants reacted to recall of events from their child abuse/neglect work, this suggested perhaps some stress being brought to the surface due to previous work related situation(s) that had not been resolved as part of a debriefing and had remained hidden. The responsibility of Plunket is to support staff practicing in child abuse/neglect work and to highlight the need not to attempt to make decisions on their own. Plunket acknowledges child abuse and neglect work as demanding and stressful and encourages staff to seek support via their Clinical Leader or request EAP early and to continue this consultation until the process is resolved (RNZPS, 2008). The consultation is imperative to ensure safe practice. Additional support could also come from peer supervision and Clinical Advisors. (Appendix Two).

Despite efforts to predict all the risks at the outset of the study, Parahoo (2006) warns that it cannot be known for certain what might transpire during an interview. I could not state in advance all possible questions I may ask, therefore informed consent was to be an ongoing re-negotiated process known as ongoing, transactional process, as unexpected events or consequences arose (Parahoo; Richards & Schwartz, 2002; Streubert-Speziale & Carpenter, 2007). Participants had the continued right to refuse to answer any question throughout interviews.

In phenomenological studies the opportunity for participants to share 'confidences' are real. Balancing 'harm' of participants and 'benefits' of the research was always a consideration I faced when developing my questions. For example, when I asked the question "Describe to me what it feels like for you when you find out that a child is being abused?" I knew by asking I risked opening up old wounds. I felt that the nurses understood their rights as participants and that I had informed them of measures I had put in place should 'harm' evolve from opening up old wounds and so I felt 'safe' in asking. However the rights, well-being and safety of participants always took precedence over my research objectives (Munhall, 2007; Parahoo, 2006).

Continually informing and asking permission establishes trust between researcher and participant and allows the research to proceed in an ethical manner with the opportunity to uncover deeper more insightful and significant data (Kavanaugh & Ayres, 1998). The participants in this study were explicitly told of their rights for the questioning to be discontinued and their contribution to the study to be withdrawn as their right (Burns & Grove 2001; Johnston, 2004; Parahoo, 2006). (See Appendix Two & Three). At the end of each interview I asked participants how they felt after sharing their experiences. Was I leaving them in a 'safe place' and could I offer EAP? All participants felt the interviewing process had been beneficial in serving as an additional de-briefing session and they felt I was leaving them in a better space than prior to the interview.

Confidentiality of the exchanges of information between the participants and myself was managed through the process of informed consent with assurance of confidentiality, privacy and anonymity. Participants were informed that in the written report I would be careful not to identify the area where they worked, by stating participants were from areas within the North Island. I considered the possibility of participants sharing 'secrets' with me or of unethical/unprofessional practice and how I would address this. I would have a responsibility to address this with participants and this was stated in the information sheet (Appendix Two).

The consent process contained adequate information regarding all aspects of the research, enabling participants to consent to or decline participation in the research voluntarily (Walker, 2007). Questions about the process were encouraged but none were asked. Participants were given my contact details and those of my primary research supervisor, including telephone and email, with an invitation to make contact at any time for any reason (Appendix Two). All participants were required to sign the consent form to indicate that they understood their rights and involvement in the study and were given a copy (Appendix Three).

Informed consent is based on the principle of respect for persons, and incorporates the ethical concept of autonomy, or the prospective participant's right to self-determination if he or she wishes to participate in a research study or not (Dempsey & Dempsey, 2000; Gillis & Jackson, 2002; Munhall, 2007; Oman, Krugman & Fink, 2003). No participant contacted me to withdraw any information from the study. Participants were reminded that all communication shared with me would form part of the study (Munhall). However participants would always have the right to withdraw any information or withdraw from the study up to 14 days after their interview date as stated in the consent form (Appendix Three).

My position of Clinical Leader made me reflect on how respondents would engage with me. Would they share their true feelings about experiences and decisions about reporting or not reporting? Briggs (2002) discusses the roles

and power dynamics of interviewer and respondent, with their respective agendas. This power differential may have prevented respondents from saying anything they feared might place them in positions of practice scrutiny. I reflected on this and thought it to be a potential limitation of the study, in that their moral or professional judgment decisions might be examined for what they did or did not do. It became a need for me to clarify to participants before interviewing that their practice was not under scrutiny.   However if any unprofessional or unethical practice was revealed to me during the interviews, that was not in keeping with the legal responsibilities and competencies of a Registered Nurse/Plunket Nurse, I would have a legal, ethical and moral responsibility to address this with the participant (Appendix Two).   By being transparent about this I protected my own professional and ethical stance as well as the participant's integrity. Participants were reminded that all communication during interviews becomes reportable data, therefore termination of an interview in an unethical/unprofessional situation would be seriously considered. No participant hesitated in sharing experiences, and no unprofessional or unethical practice was identified during any of the interviews.

Measures to ensure confidentiality of personal information included the storage of audio recordings and transcribed data in a locked cabinet only accessible to myself.   Audio recordings of interviews were destroyed on completion of the study. Participants were offered the opportunity to have their tape returned to them to do with as they wish, or be destroyed by way of Plunket's professional destruction bin, provided for staff to destroy items of confidential nature.   All participants asked that I place their tape into the destruction bin.

The use of a coding system to protect the individual's identity during the process of data transcribing, analysis and in the publication of the research results was explained in the information sheet (Appendix Two). Data has been presented within this report with accuracy, yet I have been very careful not to reveal participants identities either by way of name, or specific work location (Streubert-Speziale & Carpenter, 2007), thereby assuring anonymity.   Some details within the raw data I felt could not be shared as identity of participants

could have easily occurred. To conceal or obscure and thus protect the participants in these circumstances, the raw data would have needed altering, risking inaccurate reporting. All matters of confidentiality have been described in the participants' information sheet (Burns & Grove, 2005; Holloway & Wheeler; Munhall, 2007; Nieswiadomy, 2008).

The research proposal was presented to the required Project Review Groups both at Waikato Institute of Technology (Wintec) and the RNZPS. Following approval from these groups, ethical approval was sought and gained from the required ethics committees. This included Wintec (Appendix Four) and the RNZPS (Appendix Five).

Managing Commitment to Biculturalism

New Zealand has a commitment to Maori as the tangata whenua of Aotearoa. As a population, it was critical that Maori where given the opportunity to be involved in this health research. This was to enable the most appropriate health interventions to contribute to increasing the current disproportionately negative health and well-being statistics for Maori (Health Research Council of New Zealand, 2008). Guidelines developed by the Health Research Council of New Zealand (HRCNZ) focus on the importance of consultations, the foundation on which co-operation and collaborative working relationships between researchers and Maori organisations and groups develop in respectful and acknowledging ways. The guidelines inform researchers about the process of consultation and its purpose, where Maori choose to be participants in research and to ensure that research contributes to Maori health development, and research processes maintain or enhance mana Maori (Health Research Council of New Zealand, 2008).

Consideration of and addressing any cultural issues, forms part of Plunket's Research and Evaluation Policy (2006) for ethics committees and the protecting principles of the Treaty of Waitangi (RNZPS, 2007). As part of the process preparing for this study, consultation with a Plunket Maori Caucus member was undertaken to discuss how best to approach this topic with Maori participants, what was appropriate and what was not to ensure Maori cultural concepts,

values and practices were safeguarded (HRCNZ; RNZPS). No Maori participants came forward. However some of the families involved in the nurses' stories may have involved Maori whanau and tamariki therefore this study may be of interest to Maori for this reason. Disseminated of this study will to Maori groups will be achieved through Plunket networks.

Sample Selection Strategy

The research question guided my sample selection strategy, that of purposive sampling. The sample was selected from populations of Plunket Nurses. This was then narrowed down by the inclusion criteria, to include Plunket Nurses with at least two years post Plunket Nurse Qualification who had experienced the phenomena in question, reporting suspected child abuse and/or neglect in uncertainty.

Purposive sampling was used to enable the selection of information rich participants from which can be learned a great deal about the central focus or purpose of the study (dePoy & Gitlin, 1998; Holloway & wheeler, 2010; Patton, 2002). Purposive sampling allowed selection of participants who could reliably inform the research question rather than represent an overall population. Participants who were willing to share their experiences, express inner feelings and describe the physiologic experiences of the phenomena of study were considered for their potential to add depth to this research (Burns & Grove, 2001).

Having a correct sampling strategy was central to establishing credibility. It contributes to trustworthiness, accuracy of the results, limits the introduction of bias, and is critical for the confident application of the study findings in adding potential value to nursing practice (Houser, 2008). As Polit and Tatano-Beck (2004) state, the sample is deemed appropriate if it results in participants who have experienced, and can describe, the phenomena under study. This was confirmed by the examples of practice situations shared with me in interviews.

Although samples are usually small in phenomenological research, when considering sample size, it could not be exactly determined before interviews

were commenced. I considered that the selection of participants who had the potential for illuminating their experiences of decision making in reporting child abuse and/or neglect was the priority over deciding on an actual number of participants to interview. It was also restricted by the studies timeframe.

Determining when an adequate sample size has been reached is the researcher's responsibility. Houser suggests that this may well be achieved with six to eight participants; however she also suggests that if the complexity of the phenomena under study increases it is more likely that a larger number of participants will be required to achieve an adequate amount of data. Reporting on sample size and when data becomes repetitive such as descriptions of the same theme, according to Houser (2008) and Patton (2002), improves the trustworthiness of the study and increases the confidence with which one can incorporate results into practice and expect the same outcomes. I was mindful that the amount of data that could be collected would be limited to the time restraints of this study and therefore be a limitation.

My goal in selecting a sample from the sampling frame was to support the trustworthiness of the study, and enhance the credibility of the results (Borbasi, Jackson & Langford, 2004; Houser, 2008; O'Leary, 2004). In selecting a sample, I based decisions around the focus and aims of the question and phenomena of study. It was important that participants were not members of my staff or colleagues with whom I had previously worked as a Plunket Nurse. This was to avoid preconceived ideas or judgments of a known nurse that may have contributed to the bias of the study through me. (Allen & Lyne, 2006; Wood & Ross-Kerr, 2006).

It is also acknowledged that being the researcher and Clinical Leader, placed me in an arena where conflicts between these two positions could occur; therefore management of this was carefully considered. It is acknowledged that this may have reduced the number of nurses willing to be participants, however, it ensured that the legal, ethical, and moral obligations of the researcher were maintained and bias was minimised.

Recruiting participants

I contacted Area Managers within regions of North Island and outlined the study's aim and purpose, and to seek consent to approach their Clinical Leaders. Clinical Leaders were invited to outline the study at their team meetings and provide the written invitation by way of the participants information sheet (Appendix Two) to all Plunket Nurses who were known to have two or more years experience post Plunket Nurse Qualification. Plunket Nurses who met the inclusion criteria and who wished to find out more or register their interest in participating were asked to contact me by telephone or email within a two week time frame. This ensured no un-toward pressure or coercion was applied to potential participants when making a choice to participate or not (Walker, 2007). Non-response was deemed as an indication of an unwillingness to participate and no further contact was made.

At the end of the two week period, four of the anticipated sample number of six participants had been recruited, therefore I contacted other Area Managers and Clinical Leaders using the same recruitment process which resulted in two more participants totaling six altogether.

Data Collection:

The strategy for generating knowledge in this hermeneutic phenomenological study involved conversational techniques. A semi-structured, in-depth interview is identified as a valuable approach for collecting data on sensitive topics (Gillis & Jackson, 2002; Parahoo, 2006). The aim of data collection is to capture both the researcher and participants' reflexivity, and reflect on the process of the data collection. Interviewing was considered the most appropriate method for participants to express themselves through the opportunity to say how they feel and think based on their personal experiences of the phenomena of study.

"Heidegger placed particular emphasis on language as the vehicle with which human beings encounter 'being' and language is a way of being; one is one's language" (Fain, 2004, p. 222). The assumption here is that "language captures" participants "essence of the lived experience as understood by the

individual" (p. 222). Potential participants were informed that their involvement in the interview process would last approximately one to one and a half hours and with their consent, an audio tape recording would be made to collect data accurately (Appendix Two).

In considering the best time for interviewing participants, I reflected on my own Plunket Nurse experience. Generally nurses want to get home and turn work off until the next work day. But would nurses want to be interviewed on their precious days off when personal and social activities were welcomed after busy and stressful work days?   It was important to me that participants felt they had the time to be involved in the study. Sandelowski (1995) indicated that the researcher is more likely to obtain data with greater depth and breadth if participants are not feeling under the pressure of time to be involved. Morse (2000) implies that the more sensitive and complex the phenomena of study, the more time should be allowed for interviews.

Participants were invited to choose a time and place that was most comfortable for them and where they would not be interrupted. This allowed the participant to choose a place that felt comfortable and 'safe' for them with maximum privacy. Four participants chose to be interviewed in their own personal space, their home. Two other interviews were held via telephone with a speaker facility so that the interview could be recorded word for word and no verbal expressions could be lost. One telephone interview occurred after an initial face to face interview had been arranged, but due to the participants personal circumstances and my timeframe, this had to be changed to an arranged telephone interview. The second telephone participant had been away on leave and had just returned to learn of the research and wanted the opportunity to participate. I am indebted to these participants who re-arranged their usual family activities to incorporate an interview time.

The tool of data collection in semi-structured interviews is an interview schedule (Appendix Six). According to Parahoo (2006) this includes the main interview question central to the research phenomena as well as allowing new and interesting responses to be explored. The six main types of questions that

have been identified with qualitative research as outlined by Parahoo and include, behaviour or experience, opinion or belief, feeling, knowledge, sensory experience and background information such as demographics. The interview schedule (Appendix Six) and demographics form (Appendix Seven) were designed with these six types of questions in mind.

All interviews were arranged in partnership to allow for flexibility for both participant and myself in off duty time. Each participant already had a copy of the consent form (Appendix Three) and the information sheet (Appendix Two). Before interviewing all participants, the information was re-read and full explanation of the interview process was given with the opportunity to have any questions fully answered.

Signing the consent form indicated participant understanding and consent to the research, interview audio recording and voluntary participation. Signing also indicated the participant understood the option of withdrawing all or some of the interview data before a fourteen day period expired from the interview date (Appendix Three). Completion of a participant's demographic details included information on: previous nursing experience and qualification, ethnicity and whether they would like to receive and executive summary of the research (Appendix Seven). Signed consent forms were posted back to me prior to the two telephone interviews and reviewed again before recording commenced via speaker phone. I also considered it my obligation to remind participants prior to interviews of their responsibility to maintain the confidentiality and anonymity of clients, peers and colleagues when re-living their experiences (Holloway & Wheeler, 2002; Johnstone, 2004; Walker, 2007).

Figure 1. Summary of Demographics of Participants

Number of participants	6
Minimum Years as a Registered Nurse	3 years
Maximum Years as a Registered Nurse	38 years
Minimum Length of Service as a Plunket Nurse	2 years
Maximum Length of Service as a Plunket Nurse	27 years
All Participants stated Ethnicity as European or New Zealand European	

Face to face semi-structured interviews using open-ended questions were conducted. Audio recording was undertaken. Semi-structured questions were chosen as the means of data collection. This is considered well suited for hermeneutic phenomenology. It allows exploration of perceptions and opinions of respondents regarding complex and sensitive issues and enables probing for more information and clarification of answers (Burns & Grove, 2005; Gillham, 2008; Munhall, 2007; Parahoo, 2006). I was mindful that the interviewer can influence the interviewee in terms of "how she or he listens, attends, encourages, interrupts, digresses, initiates topics and terminates reposes" (McEvoy, 2001, p. 51).

The design of hermeneutic phenomenology allows changes in the data collection instrument, that being the researcher. This allowed me to think of and formulate some questions as the interview progressed to obtain the richest data when participants described experiences that required further clarification, exploration or new perspectives.

Interviews lasted between 60 – 90 minutes, with the average length being 75 minutes. Parahoo (2006) suggests that interviews of this duration allow for exploration of phenomenon in depth without casting doubt on both respondent and researcher's ability to maintain concentration on the phenomena without tiring. According to Perry, Thurston, and Green (2004) the balance between freedom and opportunity for respondents to talk and the difficulty that researchers face in keeping them 'on track' often makes

qualitative interviews last longer than they should. Respondents cannot be hurried as this will affect the quality of data gathered. I was mindful of these issues when undertaking the interviews but found that participants only momentarily wandered off course to provide additional background information, and bought themselves back to the question.

Although spontaneous descriptions from participants were encouraged, where a participant was having difficulty getting started, I used a prompt, for example 'Describe how it feels for you when you think a child is being abused or neglected' (Appendix Six) or simply 'go on'. I had developed a personal list of prompts to promote participant continuation where there was some hesitation. These hesitations were often around recalling actual facts in their experiences or exact feelings and emotions. Searching for a word that described these appeared to be difficult at times, which I described in my research journal as:

There were times when a participant would seem to stumble over finding just the right word to explain an emotion or describe a feeling in some detail that would give explicit meaning. I found my list of words to use as prompts extremely helpful in these moments of suspended thought. I was careful however not to jump in too early with these as I was anxious that the descriptions would always remain the participants, that interrupting their thoughts too quickly may take those accumulating thoughts from their mind.

Semi-structured interviews allow for opportunities to change words but not the meaning of the questions because it acknowledges that not every respondent uses the same vocabulary. Trustworthiness is enhanced because respondents can be helped to understand the questions and interviewers can ask for clarification and probe for further responses if necessary (Burns & Grove, 2005; Munhall, 2007). Clarification and verification can be sought again following data transcription by returning to the participant. I found it necessary to ask all participants for further clarification of words that had unclear, ambiguous or multiple meaning.

I found that during earlier interviews a broad understanding of the phenomena was beginning to take shape as new perspectives were uncovered and new insights were gained. Accumulative perspectives and experiences expanded with each respondent.   I discovered that during the first interview I had subconsciously started the process of data analysis, reflecting on shared experiences, undergoing a form of comparative analysis and forming themes in my mind. At times I had 'light bulb' moments that both excited me and encouraged me and would record these in my reflective journal. I continually referred to my interview schedule throughout each interview to ensure that no main question had escaped data collection and to provide for consistency between interviews.

I found that jotting single words down during interviews became memory joggers that enabled me to ask for clarification or further explanation after the participant appeared to exhaust their thoughts around a particular experience or thought sequence. This reduced interruptions to participants' flow of thoughts and the chance of a reduced collection of descriptive experiences. I wanted to 'allow' participants to talk without too many interruptions, and facilitate the process by listening and probing as appropriate to gather rich data (Parahoo, 2006). Writing down notes rather than single words may have been a distraction for the participants.

There is debate between researchers about allowing personal values and experience to enter the conversation. Perry, Thruston and Green (2004) argue that allowing the researcher to share their own experiences, which they refer to as 'involvement-detachment' interaction with the respondent, has shown that their 'disclosures' help build a trust between themselves and the respondent. Parahoo (2006) adds that some people feel they have to divulge a little bit of themselves in order for others to be more forthcoming with their own disclosures and that this sort of 'give and take' brings people closer when they know that both of them have some experience of the same phenomena. Wilde (1992) comments that sharing part of one's personal life would seem to have an effect on the participants view of the researcher, who becomes, in the participants eyes, less of a professional and more of a human being.

During my interviews there was a place where I felt I needed to step momentarily out of my researchers shoes and into my nursing shoes and offer something from my own experience to bridge a gap in a sensitive moment of recall for the participant. At these times I experienced the feeling that the respondent needed something from me that let them know I really understood what it might be like for them. In my journal I noted:

> *There were moments in this interview where I had choices to make. I could either be still and silent when the participant was overwhelmed with a wave of emotion, and wait for it to pass with all the uneasiness and awareness in the room it created, or I could enter the participants 'space' and provide some words that separated me as researcher into the real world of child protection work, the every-day-ness of a nurse and offer some words of empathy from my own practice experience. I used the words "Yes I understand, I have experienced that, it was not easy to decide". The response from the participant was "You have experienced that too?" From that moment it felt like that small sharing of personal experience allowed the participant to believe I was, a 'real' nurse with 'real' experiences of child neglect/abuse having experienced hard to make decisions. It started to feel more like a colleague sharing in-depth information with me rather than two strangers meeting for the first time. That was a reassuring moment for us both.*

This minimal disclosure of personal experiences allowed sharing and trust to develop between the respondent and myself which enhanced the opportunity to gather richer data.

Observational data collection is a recognised phenomenological method (Burns & Grove, 2001). I observed verbal and non-verbal behavior, such as facial expressions, gestures, and elements of emotion and captured this by taking observational notes. Part of data interpretation requires the researcher to describe their observations rather than evaluate them (Parahoo, 2006). I sensed that data saturation was near when in the last interview repetitive information was verbalised more than new information being forth coming (Burns & Grove, 2005; Munhall, 2007). Transcription of each interview occurred the following day.

Transcribing the interviews

According to Macleod (2002) the process of transcribing requires

> "Decisions concerning where to place a full stop, a comma, a pause, inverted commas, etcetera so as to reflect as closely as possible what I as listener heard, so that you as reader may 'hear' the same thing when reading the material" (p. 21).

It is impossible for a reader to 'hear' the recorded words no matter how detailed the transcript; therefore no written transcript could be a single authoritative version.

I chose to transcribe all interviews verbatim including all hesitations, pauses, repetitions and grammatical errors. I made bracketed notes where observations of quiet emotion or emphasis on words were used forming part of the data analysis process. I re-read many times all transcriptions. I wanted to immerse myself completely in the data as a collective whole to reflect on it. Before writing a first draft, it became apparent that some of the grammatical errors hindered my understanding and my analysis.

Data can be verified in phenomenology research, by asking participants to read their transcripts of the audio tape for accuracy and provide opportunity for clarification by either researcher or participant (Burns & Grove 2005; Munhall, 2007; Parahoo, 2006). This adds trustworthiness to this study by allowing participants to confirm that the data included was what they wanted to describe to me and provided opportunity to add, delete or change any data. With consent from each participant I emailed their transcript back to them. I included some questions where I required further explanation of sentences, phrases or words so clarity was gained to ensure interpretation of the data could be unambiguous. Each participant read their transcript, corrected minor grammatical errors in conversation, added some further information, and answered any of my questions. No data was asked to be removed by participants and all data was confirmed as true and correct by each participant. This was an invaluable process, not only did I gain clarity and some additional

data, but each participant verified that their data was indeed a true reflection of their experiences. The process allowed for continuation onto a complete data analysis.

Data Analysis

The main aim of data analysis is to move from the raw data to meaningful understanding. In hermeneutic phenomenology analysis, understanding the experience is through the identification of themes that run through the raw data, and by interpreting the implications of those themes (O'Leary, 2004). To understand the 'lived experience' of participants, the accurate interpretation of the data is paramount to further the knowledge of the phenomena of study. Misunderstanding can threaten the quality of the data for analysis (Burns & Grove 2005; Parhoo, 2006).

To assist and guide my data analysis, I used van Manens' framework as outlined below by Streubert-Speziale and Carpenter (2007) to guide the data analysis. This aligned with Heidegger's hermeneutic phenomenological methodology.

(1) Turn to the nature of lived experience by orienting to the phenomenon, formulating the phenomenological question, and explicating assumptions and pre-understandings.

(2) Engage in existential investigation, which involves exploring the Phenomenon: generating data, using personal experience as a starting point, tracing etymologic sources, searching idiomatic phrases, obtaining experiential descriptions from participants, locating experiential descriptions in the literature, and consulting phenomenological literature …

(3) Engage in phenomenological reflection, which involves conducting hermeneutic analysis, uncovering thematic aspects in life-world descriptions, isolating thematic statements…

(4) Engage in phenomenological writing, which includes attending to the speaking of language, varying the examples, writing, and rewriting. (p. 84)

Analysis involved categorising data and selecting particular sections or excerpts that convey the most significant information following re-reading of the data many times (Sjostrom & Dahlgrem, 2002). This interpretative process refines the phenomena and the experience through which new meaning may be identified and the implications of this new understanding can be disseminated and utilised to contribute to theories and nursing practice.

Rigor in the analysis of qualitative data firstly required me to transcribe the interviews accurately from the audiotapes, then reading the transcription while re-listening to the audio tape. The transcripts were coded by being printed out on different coloured paper for example interview one on yellow paper, interview two on pink paper, and given codes so individuals could not be identified ensuring anonymity.

Cutcliffe and McKenna (2004) and Koch (2004) recommend that to ensure rigor the researcher should produce an audit trail, by giving details and rationale for the key decisions taken in the research such as the analytical process and methodological decisions. I recorded reflective notes in my research journal concerning the questions and responses to provide further critical reflection in aiding the interpretation of the raw data. The reported findings of qualitative studies according to Streubert-Speziale and Carpenter (2007) should be written up in a rich literary style and include quotes, commentaries and stories that add richness and understanding of what the social interactions of those studies have been.

As I was collecting the data during interviews, I found myself mentally processing some of it. Mental images and maps began to develop as phenomena were being described to me by participants. A careful deliberate process of constantly being reflective about whether I was making assumptions based on my prior knowledge from fabricating the data was a real focus in my

thinking. I was careful not to add to participants experiences with those of my own. The point in which data was becoming repetitive became obvious following interviews five and six. Some themes were beginning to become repetitive more than new data coming to light.

Organising the raw data

The interviews provided 130 pages of data, with each interview copied out on different coloured paper. Using six A4 exercise books, one for each interview, I cut out each question and the response to it and placed them the left side of the book. On the opposite page I drew up two columns. The first column I used to write line by line identified metaphors, phrases, and possible developing themes that I wanted to return to later. On subsequent readings and reflection of the raw data the second column I found invaluable in recording additional notes and sub-themes from which the final main themes developed. Close reading and re-reading of the data allowed me to sort the material by extracting themes developed from reading, writing, re-reading and re-writing numerous times to extract clusters of repeated phrases and ideas. A continual process of reflection was intermingled with the reading, writing, reading and re-writing as described in van Manens' framework (Speziale & Carpenter, 2007). Heidegger's Hermeneutic Circle (Holloway & Wheeler, 2010) was incorporated as the means to reach understanding of the possibilities that the text can reveal from the experiences participants shared. It required me to look at the parts of nurses' individual experiences, then at the whole of the data, and then back at the parts again, continuing in a spiraling process until gaining an understanding and meaning of the raw data. I entered into a dialogue with the text in which I continually questioned the meaning (Polit & Beck, 2006).

Considerations throughout the Research

I engaged in a process of drawing mind maps very early on in the research study, a way for me to see the bigger picture of all the components and the subsets within main headings. The two headings were considerations and limitations of undertaking a phenomenology study. Subsets of these headings included understanding self-awareness and my own situation in the context of

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the phenomena of the study; otherwise I risked mixing my influence and interpretation from my own perspectives (Munhall, 2007). Therefore I considered my own position in context to the phenomena throughout the study which has added to the credibility of the results.

Interpreting participants lived experiences, Munhall (2007) notes, often leads researchers to list 'reactions' rather than 'meanings' to 'things', which is the primary focus of phenomenology. An example Munhall gives is in the word 'isolation', which has different meanings for different experiences. Munhall explains that the researcher must be able to narrate for the reader the understanding that enlightens the meaning of isolation in the experience of, for instance, losing a newborn. Uncovering the reasons for this 'lived' experience gives new direction to practice and more importantly to understand human beings experience over time. This was a consideration during the data analysis.

A further consideration developed while analysing the data. How was I to stay true to the data and maintain validity yet report negative, uncomplimentary and critical viewpoints that described an external agency to which nurses referred to for child abuse/neglect situations? This was problematic for me as I felt uncomfortable in reporting these finding yet knew I must address them within the analysis and findings. I feared offending by remaining true to the data. My intention was not to bring disrepute or offend, however, I was aware that it would also be immoral and against research ethics not to report problems my study revealed (Morse & Field, 1996). I took this dilemma to my supervisor. Together we explored the possible options and along with further reading around the tensions described, I became aware of advice that Morse and Field described. One can either write the critical portions more 'softly' or with more justification, or place all negative comments in the quotations, so that the reader understands that these are the participants speaking. My decision was to use the quotes from participants and interpret 'softly'.

Trustworthiness concerning data collection and data analysis was increased in several ways. The richness of the data was maximised by selecting Plunket Nurses who had the experience of the phenomena of study. All the participants

were very willing to share their experiences of making decisions to report suspected or child abuse and/ or neglect in uncertain situations.

Conclusion

This chapter has described the processes that allowed the methodology of hermeneutic phenomenology to guide the research, from the background to the question development through to the collection of the raw data and analysis. I have outlined the various steps taken with ethical approval, sample selection, and interviews with participants. I have provided extracts from my research journal of the interviewing experience. The transcribing of the interviews and the method of analysis has been detailed and I end with a section on the necessary process of reflection and reflexivity in an attempt to provide transparency throughout the research steps with the use of a research journal.

CHAPTER THREE

Literature Review

Introduction

This chapter reviews the literature from an extensive search of various databases. Journals, books, policies and Acts were accessed to analyse current literature both from nursing, education, psychology, and social work perspectives. The wider disciplinary view was an attempt to enhance understanding of decision making and suspected child abuse/neglect. Due to the limited time frame and word limit for this study, it was not possible to review all possible literature; therefore the search was limited to the last ten years (2000 – 2010).

Hermeneutic phenomenological research undertaken around the experiences of Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertain situations is absent in the literature. There is limited New Zealand research that studied child abuse and neglect reporting (Rodriguez, 2002; Sye, 2008) involving health professionals that work with children under five years of age. This included community health professionals such as General Practitioners, Public Health Nurses, Neonatal Home Care Nurses and Plunket Nurses as well as nurses in emergency departments, and paediatric wards within general hospitals. Most research has been based on mental health nurses (Rodriguez). In reviewing the literature I looked to international nursing literature as well as social work, psychology, and educational research around the phenomena of study.

A comprehensive literature review followed participant interviews and data analysis. A search of electronic databases including CINAHL (the Cumulative Index to Nursing and Allied Health Literature), Proquest, Medline and the Cochrane Library for literature from journals, reports, theses, conference papers, government publications and web-based resources was undertaken. Key words and concepts were taken from both the research question and from the transcript of participants' interviews. I narrowed the search by only reviewing literature related to community nurses and child abuse and/or

neglect. Synonymous terms and subheadings also assisted the search. This assisted me to manage research timeframes by limiting the return of irrelevant literature. Books related to the research topic were also accessed for background information. A manual search through reference lists of relevant articles to identify other literature was also undertaken.

The purpose behind the literature review was to determine what was already known about the phenomena of interest, and the evidence that may be lacking, inconclusive, inconsistent, contradictory or too limited. Literature reviews have potential to uncover consensus or significant debate on issues and the various positions individuals or groups have taken concerning the phenomena of study. I was also looking to uncover the direction other researchers had taken, characteristics of the key concepts or variables and relationships among themes that may have previously been uncovered. Further, I wanted to know about any existing theories around my research topic and how my research study could contribute to any existing knowledge (Burns & Grove, 2005; Munhall, 2007; Parahoo, 2006; Polit & Beck, 2006; Streubert-Speziale & Carpenter, 2007). The overall aim of the literature review was to identify key points, results and themes from previous research, and compare with my own study results in formulating the discussion of the findings and future recommendations that evolved from this study.

Key words used to locate relevant research papers were child abuse, neglect, maltreatment, child protection, community nurses, home visitors, and Plunket Nurses. Other associated words included uncertainty, decision making, tacit knowledge, intuition, and professional judgment. I eliminated hospital child abuse/neglect literature to limit return of pertinent research relating to community nursing. When I limited the search to reporting child abuse/neglect in uncertain, unclear or suspected incidences, the current literature return was minimal which highlights the lack of research undertaken specific to my question in more recent years.

Child Maltreatment: A Global Issue

Child abuse and neglect are global issues (Campbell, 2005; Westby, 2007). The United Nations maintains that violence is one of the most serious problems affecting children today (Campbell; Chan, Elliott, Chow & Thomas, 2002). The World Health Organization estimates that 40 million children below the age of 15 experience abuse and neglect requiring health and social care (World Health Organization, 2010). Child abuse and neglect is also referred to as child maltreatment, and includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished: physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation (World Health Organization).

In New Zealand our Child, Youth and Family (CYF) statutory Agency statistics are growing annually. In 1999/2000 ten years ago, the total notifications received by the Child, Youth & Family Service was 19,521. In 2007/2008 that number had increased to 89,461. Almost half of these notifications required further action. The number of children placed in alternative care was 4,522.

In August a new report was published (Child, Youth and Family, 2010) stating that between 1 July 2009 and 30 June 2010 CYF received over 125,000 reports from people concerned enough about a child's safety to notify authorities. In over 21,000 of these cases, child abuse or neglect was confirmed. That is 57 confirmed serious abuse and neglect cases every day. On average 23 infants are admitted to New Zealand hospitals each year from being shaken and four will die. An average of 9 infant/child deaths are recorded annually (New Zealand Police, 2005).

Infants under one year are the most vulnerable group. The average annual rate of child maltreatment deaths in New Zealand for these infants is 4.6 deaths per 100,000, more than three times higher than the one to four year old age group. This is eight times higher than for children in the five to 14 year age group

(Child, Youth, and Family & Ministry of Social Development, 2006; Connolly & Doolan, 2007).

The police are the primary referrer to CYF however, health professionals, and education providers are also significant notifiers (Child, Youth and Family, 2010). Police notify CYF every time they attend a domestic violence case and find a child present. This change in practice is a significant driver in the 24 percent increase in notifications occurring each year (Child, Youth, and Family, 2010). These statistics reflect the work that needs to be done by health professionals who come into contact with children. Plunket nurses come into contract with 91% of all New Zealand children between zero to five years of age (RNZPS, 2009) so therefore can have a major part in prevention and early intervention in child abuse and/or neglect work.

The legal definition of Child abuse/neglect is:

> "Child abuse means the harming (whether physically, emotionally or sexually), ill-treatment, abuse, neglect or deprivation of any child or young person" and "child neglect is defined as any act or omission that results in impaired physical functioning, injury, and/or development of a child or young person" (Office of the Children's Commissioner, 2004, p. 20).

Child abuse and neglect which includes witnessing violence can have severe and long lasting implications for children's development even when it does not lead to obvious injury or death. Violence, abuse and neglect affect children's health, their ability to learn, and even their willingness to engage in social activities and attend pre-school and school. The evidence is clear from the research recorded that child abuse and neglect is both prevalent in communities and debilitating for the child. (Bifulco, kwon, Jacobs, Moran, Bunn & Beer, 2006; Cicchetti, 2004; De Bellis, 2005; Glaser, 2000; Sylvestre & Merette, 2010; Westby, 2007). It is essential that nurses who report suspected abuse and/or neglect do so early because with early intervention there is a greater chance of reducing the

morbidity and mortality rates (Dubowitz, 2002; Grant-Mackie, 2003; Polonko, 2006).

Community nurses worldwide, come in contact with suspected abused and/or neglected children while visiting homes in the course of their work. The literature states that community nurses have been reported as most often the first professional to identify children who are at significant risk of abuse or who suspect there is child abuse and/or neglect in the child's home (Clarke, 2000; Lazenbatt & Freeman, 2006; Nayda, 2002;). There is less literature that reports what it is like for nurses to work in this environment. In particular what leads them to their decisions to report, or not, suspected abuse and/or neglect.

Legal and ethical frameworks are written into law that consider the rights of a child (Department of Child, Youth and Family Service, 1989; Ministry of Health, 1998; Ministry of Social Development, 2002; Ministry of Social Development, 2002a; New Zealand Nurses Association, 1995; United Nations, 1989). Decision making in child protection work is influenced by the values, beliefs and attitudes of the individuals involved (Barnes & Rowe, 2008). Acting as an advocate for victims of abuse is a professional responsibility (Nursing Council of New Zealand, 2005). Nurses must however understand and work within these frameworks to ensure decision making is legal, moral, ethical and protects the right of the child and safe practice of the nurse.

Screening for Family Violence

In 2003, the Royal New Zealand Plunket Society, (RNZPS) was one of the first health providers to introduce family violence screening in New Zealand (Vallant, Koziol-Mclain & Hynes, 2007). All clinical staff employed by the RNZPS are trained in asking a family violence screening question at each new baby case visit and only if there were no children over the age of two years or other adult present. In 2007, the screening criteria were amended to asking a question at every core contact visit and whenever there was a change in partners or suspicion of family violence (RNZPS, 2008).

Research indicates that in other countries when women are questioned directly in the context of a professional relationship they will commonly disclose family violence (Bacchus, Mezey & Bewley, 2003; Bateman & Whitehead, 2004; Peckover, 2003; Waibel-Duncan, 2006). Disclosure rates are much higher than when women are not questioned directly (Ministry of Health, 2002). Although the screening question is not directly aimed at assessing child abuse and neglect, research links family violence to the effect it has on the health and wellbeing of children. The answer can guide the nurse to ask further questions about the safety of both caregiver and the child/tamariki. Suspicions of child abuse and neglect may be identified and decisions to report made, using Plunket Policy (RNZPS, 2008) and nurses ethical obligation to protect children from abuse (Maxwell, Barthauer & Julian, 2000; Nursing Council of New Zealand, 2001).

Nurse-client relationship

There is a wide variety of international literature supporting the importance of developing nurse-client relationships to enhance health outcomes of families (Hartrick-Doane & Varcoe, 2005; Rowe, 1996; Tapp, 2000). Indeed Plunket has invested resources in training clinical staff through Family Partnership Model workshops (Davis, Day, & Bidmead, 2002) to enhance working nurse-client relationships and family centered care. Plunket Nurses are predominately focused on building respectful two way nurse-client relationships and maintaining these to enable on-going access to infants and children to assess their health needs. The essential aim of the Family Partnership Model is to enable all people working with children and parents to improve their understanding of the helping processes. It also provides opportunity to practice the skills of engaging parents and developing supportive and effective relationships with them. The model has been evaluated in a number of research projects (Davis & Rushton, 1991; Davis & Spurr, 1998) and implemented in a variety of settings both in the United Kingdom, Australia and New Zealand. It has been used as a basis for early intervention (Davis, Spurr, Cox, Lynch, von Roenne & Hahn, 1997) and in preventative work (Barlow et al, 2003; Puura, Davis, & Papadopoulou, 2002).

The theoretical framework underlying the Family Partnership Model emphasises the need for highly skilled professional communication (Davis & Rushton, 1991; Barnes & Rowe, 2008). It also assumes that a respectful partnership between parent and potential helper is a powerful support in its own right and the means by which parents' self-esteem may be increased. Such a relationship is assumed to be the vehicle by which parents may be able to explore difficulties they face, to clarify their situation and to develop the most helpful and effective strategies for optimising the psychosocial development of their children. Such strategies include both the parents' ability to relate to, and interact with their children appropriately, and also their ability to deal with other circumstances and problems that might interfere with parenting (Bifulco, Kwon, Jacobs, Moran, Bunn & Beer, 2006; Taylor, Baldwin & Spencer, 2008). The nature of relationships between nurses and clients varies considerably. The personality of the nurse and the characteristics of a client and the nature of their issues differ. The literature is clear that supporting others is a complex activity that requires well developed communication skills (Davis, Day, & Bidmead, 2002; Egan, 1998; Hartrick-Doane & Varcoe, 2005; Meiers & Tomlinson, 2003; Seible, 2009).

In New Zealand a study surveyed 381 Plunket Nurses and General Practitioners to determine how they respond to possible child protection issues (Maxwell, Barthauer & Julian, 2000). Results recorded barriers similar to Nayda (2002) where reporting suspected abuse risked alienation, or losing the client and future involvement with the child and family. Other difficulties reported were substantiating abuse, discomfort with asking questions about abuse and violence, and risk to nurses personal safety.

Developing and sustaining effective relationships is a key to successful intervention when working with vulnerable families (Rodriguez, 2002; Scott, 2010). Creating potential to develop solution-finding collaborative partnerships with parents is, according to Scott, essential to supporting or inhibiting relationships. This also includes the values and ethics of organisations. An example given by Hartrick-Doane and Varcoe, (2005) is the tension for the nurse between concerns for client and commitments to the organization they

work for. Organisational objectives increasingly steer nurses and their work. Efficient use of resources dominates over the promotion of health in nursing practice. The health promoting role of the nurse/family/whanau, working collaboratively and being client driven, clashes with organisational objectives, such as targets. This leads the nurse to draw an encounter with a client to an early close rather than it being controlled by the client (Hartrick-Doane & Vercoe).

Other research by Trotter (2004) and Seible (2009) also indicates that good outcomes for children/tamariki depend on a collaborative problem solving approach and a sound professional-family/whanau centered relationship. deBoer and Coady (2007) similarly found that establishing positive relationships with clients was rooted in genuine care and respect. According to deBoer and Coady client helper relationships that failed were prescriptive and technique driven, and lacked empathy and supportiveness.

Seible (2009) and Samwell (2005) support the importance of developing strong nurse-client relationships to enable families struggling with child protection issues. Seible reports that a strong nurse-client relationship influenced the caliber of risk assessment made by nurses. Quality communication was the bridge to improved risk assessment. However they also report that the ever-closer involvement with families can blur the boundaries between being friendly and professional, and between becoming a friend and maintaining a professional stance.

The blurring of professional and personal boundaries was also reported in Katzenberger, Ruesch and Winch's (2000) study of nurses reporting emotive social issues such as suspected abuse. Jackson-Barton and Froese-Fretz (2000) highlight that when nurses had no choice but to report suspicions of abuse, relationships with clients may be damaged or severed altogether and this concerned nurses and for some, influenced their decision making. Samwell (2005) states that over-stepping professional and personal boundaries can either help or hinder a nurse who is struggling to maintain balance in her

relationships with clients. For example a nurse being too close to the problem and not wanting to believe that the carer may be abusing the child (Bannon & Carter, 2003).

The fine line between commitment to a family and over-involvement requires the nurse to manage her sensitivity, emotional intelligence, and communication skills. This enables the nurse to have confidence and assertiveness to act promptly on concerns, always putting the child first (Condliffe, 2008; Hartrick-Doane, 2005; Samwell, 2005). In New Zealand the Ministry of Health (2002) guidelines for family violence are prescriptive about the responsibility for reporting. They warn health care providers that… "your role is to keep the child safe" (p. 47). The boundaries have been clearly set for nurses.

Child Protection work: The impact on nurses

A study undertaken in England using interpretive phenomenology interviewed 15 children's nurses and midwives to explore their views and feelings of child protection experiences (Rowse, 2009). The results indicated that nurses involvement in child protection work had a lasting impact on them eliciting a range of emotions such as stress and anxiety. Nurses had doubts about their professional ability to identify suspected abuse and/or neglect and feared attending case conferences or court. Stress was also linked to the amount of 'time' the nurse perceived she had to manage this extra work (Rowse). Sye (2008) adds that nurses working in the community are very time pressured and many are working long hours (Beatson, 2007). Specific research relating to nurses and 'time' is mainly anecdotal. Empirical investigations are scant (Waterworth, 2003). Scant literature was located specifically studying nurses' time and child abuse reporting.

Hunt and Joslyn (2000) suggest that the pressure of time can have negative effects on decision making. This impacts on quality decisions, as reflection on alternative decisions can be perceived as wasting time. The tensions around time incorporate important performance standards and reflect a nurse's ability to manage time in a competent manner (Waterworth, 2003). Young (2002) reported that nurses identified that they could manage time in a linear,

chronological way, however nurses complained that linear time compromised caring, that linear time management objectified caring into tasks rather than subjectified caring into building relationships. Time is also stated as a barrier by Brush and Daly (2000) and briefly mentioned within child abuse/neglect literature as written earlier.

There is also evidence in the literature that supports nurses consistently referring to the pressures of coping with work load, job demand, and reporting procedures (Lazenbatt & Freeman, 2006). Time constraints and organisational commitments impact on nurses making decisions to report (Condliffe, 2008). Time is reported as a requirement needed for reflection on contributing factors described by nurses as intuition and gut feelings, before a decision to report or not could be reached (Appleton, 1996; Lazenbatt &Freeman, 2006).

The stressors of moral distress of health care professionals are well reported (Harlow & Shardlow, 2006; Patronis-Jones, 2007; Rowse, 2009; Taylor & Barling, 2004). Some of the signs of stress and moral distress are exhaustion, tiredness, anger, time pressure, self-criticism, cynicism, negativity, irritability, gastrointestinal disturbances, sleeplessness and feelings of helplessness (Patronis-Jones, 2007; Taylor & Barling). Within nursing the literature suggests a strong correlation between moral distress and burnout (Skovholt, 2001; Taylor & Barling).

In addition to workplace stressors some personal traits associated with burnout have been identified. These are low hardiness, passive defensive coping styles, low self-esteem, a feeling of vulnerability, powerlessness, and sensitivity (Edward & Hercelinsky, 2007; Gustafsson, Norberg & Stradberg, 2008).   In reality it may be difficult to clearly separate environmental stressors from personal coping styles. Burnout is associated with job performance, for example, reduced job satisfaction, lower effectiveness and productivity, and intention to leave (Edward & Hercelinsky; Gustafsson et al; Taylor & Barling, 2004). Health care professionals with burnout symptoms frequently valued positive outcomes produced by their own efforts and try too hard to achieve health outcomes through their own efforts. Another aspect reported by

Gusafsson et al., is that burnout was the result of healthcare professionals desire to be liked and accepted for who they were as a person and professional. The fear of not being liked made them strive to be liked and for confirmation that they were liked.

Rowse (2009) identified that the overarching mechanism that was crucial to helping nurses cope was the 'Named Nurse' or nurse mentor. This nurse was knowledgeable, supportive, visible, trustworthy, non-judgmental, approachable, accessible and easy to talk to. These attributes were seen by nurses as pivotal to practical management and emotional ability to cope in suspected child/tamarki abuse/neglect situations. This view is confirmed by Mainey and Crimmins, (2006) who add that staff found it crucial for their manager to communicate with them. This transferred a feeling of being valued and supported towards the work nurses did within the area of suspected child/tamariki abuse.

Littlechild (2005) who studied social workers and their stress relating to child abuse work, concluded that managers need to demonstrate they value and care for staff by being concerned for their personal and professional well-being. A further outcome linked to nurses' well-being supported in child abuse work was identified by Brandon, Dodsworth, and Rumball (2005), in their study of 20 serious case reviews in England. They concluded that nurses who receive supervision, are well supported and have access to child abuse training were more likely to think clearly and exercise professional judgment decisions. The value of an experienced colleague who would listen to and challenge staff was also a finding for Hall (2007).

In the United Kingdom, Crisp and Green-Lister (2004) interviewed 99 community nurses to study professional responsibilities in child protection work. The nurses' responses included the need for ongoing support from nurse colleagues and supervision as crucial components of feeling enabled to continue with the work. Harlow and Shardlow (2006) studied social workers in England and identified child protection work as emotionally distressing and

risky for all professionals involved. The study concluded that the carers needed caring for by someone.

The emotional aspects of reporting child abuse/neglect frequently appears in the literature (Lazenblatt & Freeman, 2006; Rowse, 2009). Self doubt is related to making professional judgments and tends to be linked to the ethical principle of doing no harm (Rowse). In Rowse's study strong feelings of self doubt emerged when nurses had a gut feeling that something was wrong but colleagues disagreed. Internal conflict over whether nurses had the 'right feeling' and were acting for the right reasons is also reported by Lazenblatt and Freeman (2006).

Intuition, tacit knowledge, and gut feelings

Nevertheless, when nurses' intuition feels well supported decision making in child protection cases is enhanced. (Ling & Luker, 2000). Nurses in Ling and Luker's study stated that these feelings acted both as a 'silent alarm' awakening their senses to probe further into the situation and as an 'invisible searchlight' highlighting and exposing hidden meanings. Zinn (2008) also supports the idea of gut feelings that often catch our attention and can prevent further harm in a situation. Gut feelings are expressed by Zinn as "an immediate resource to guide action…as a kind of alarm bell" (p. 447). Whilst intuition was seen as a form of knowledge not necessarily linked to experience, experienced nurses viewed it as enhancing the value of knowledge (Ling & Luker, 2000).

Intuition is frequently debated and challenged in the literature. It is described by Zinn (2008) as a central source in decision making where decisions need to be made when uncertainty is identified. Zinn states that "intuition complements rational considerations to reduce and manage uncertainty (p.447). Standing (2008) takes this a step further by adding that reliance on intuition without analysis, can limit the availability and use of knowledge where personal experience influences judgement, and relevant research evidence is ignored. According to Dowding and Thompson (2002) ignoring evidence may result in over or under estimation of the probability of judgement outcomes

and could undermine nurses' ability to present a coherent rationale in defending and justifying their clinical decisions.

It is a widely held view that health professionals should not make clinical decisions based simply on intuition because of the possible far reaching consequences (Welsh & Lyons, 2001). However, Welsh and Lyons also argue that intuitive judgements of experienced nurses should be valued, not ignored. Nurses who engage in reflective practice over time, accumulate clinical experience that can be synthesized with formal knowledge which builds up a tacit knowledge base. This in turn informs intuitive judgment for professional decision making.

The non-scientific nature of intuition limited some nurses consideration of their gut feelings when it was supported by more concrete evidence (Ling & Luker, 2000, Welsh & Lyons, 2001). This appeared to be linked to more serious cases of suspicion which were thought to require a higher degree of proof before reporting. Similar results are supported by Paavilainen and Tarkka, (2003) in a Finnish Public Health Nurse study.

Nayda's (2002) Australian study of decision making with ten community nurses working with children noted a number of concerns that influenced reporting of suspected child abuse. These included the breakdown of nurse-client relationship, the consequences of reporting, identification of the reporter, having to give evidence in court, anger that nurses perceived they were sometimes not believed by social workers and negative perceptions of the services that may be offered to the family after a report of child abuse was filed. The nurses also preferred to offer other avenues of support first rather than report and nurses carried unresolved grief. Nurses also reported that their perceptions of families changed over time with this type of work. The weekly exposure to the 'suspicions' of child abuse/neglect circumstances, increase nurses risk of 'normalising' families. Nurses can begin to think this is 'normal' and become complacent or have 'blinkers' on and risk not 'seeing' or 'hearing' the risk factors that actually exist. Positive outcomes recorded by Nayda

included colleague support which influenced decisions to report. Limited colleague support correlated to an increased reluctance to report.

Professional supervision or peer support

The literature reports the importance of nurses having access to regular support while engaged in and following the reporting of child protection events (Crisp & Green-Lister, 2004; Hadfield, 2000; Littlechild, 2005; Hall, 2007; Harlow & Shardlow, 2006). Employers consider it important that front-line practitioners have set times for supervision sessions (Sines & McNally, 2007). Supervision may influence retention of families in services (McGuigan, Katzev & Pratt, 2003). It is suggested that this is due to well supervised practitioners working confidently with professional boundaries in complex situations, which in turn can maintain the trust and engagement of parents. Supervision is important in keeping practitioners 'safe' in their decision making (Goddard, Saunders, Stanley & Tucci, 1999) because it allows time for reflection on practice. In supervision thoughts, feelings, actions and consequences can be discussed in a 'safe' and supportive environment (Hadfield).

The links to making decisions to report

Making decisions to report child abuse/neglect in suspected cases is identified as difficult (Barton, 2000; Carleton, 2006; Henry, Ueda, Shinjo & Yoshikawa, 2003). Compounding this difficulty is the subjective or elusive nature of this phenomenon and the contexts and cultures in which they occur (Gold, Benbemishty & Osmo, 2001). Any form of abuse can be difficult to recognise particularly emotional or neglect as there is often a lack of visible evidence (Jose, 2005). Identifying the risks are not certainties in prediction of abuse.

Henry et al., (2003) states that detecting abuse is difficult and requires nurses to be supportive, attentive, and in a neutral atmosphere that encourages disclosure by asking direct but empathetic questions. Asking more direct questions was also reported by Paavilainen and Tarkka, (2003) who interviewed Finnish Public Health Nurses. These nurses reported they could not afford to jump to conclusions. They wanted to find out more before making decisions to

report which included obtaining more information from outside agencies and an increase in home visitation.

Nurses require a theoretical knowledge of the contributing factors that are linked to possible child abuse, and neglect (Taylor, Baldwin & Spencer, 2008) for example, maternal mental health, drug and alcohol use, the mother's history of having been abused, living in abusive relationships, and low socio-economic status. The literature also reports that abuse is not restricted to these groups. Child abuse and neglect occurs across all ethnicities, socio-economic and educational background, single, partnered, or young parents. Parents can present as caring and interested in their child when the opposite is the norm (Russell, Lazenbatt, Freeman & Marcenes, 2004; Standing, 2008).

How risks are perceived is a "subjective process, not random, and influenced by research, theory and wisdom acquired through experience" (Coles, 2008, p. 23). Johns (1995) states that practitioners never respond in "exactly the same way as to a previous similar situation" (p. 228). Unconsciously they have done some learning and this unconscious learning adds to their practice wisdom which is drawn on in the next similar practice situation. Zinn (2008) adds to Johns description that experiencing similar experiences shapes an individual response to risk, uncertainty and ultimately decision making.

Benner (2001) in her study of professional decision-making wrote that continual practice allows professionals to develop an ability to respond rapidly and effectively to complex situations without conscious deliberation. They acquire an intuitive grasp of situations and the necessary response. Therefore Benner concludes that intuition is a valuable resource for experienced nurses and forms the basis of their expert judgment. Klein (1998) and McKinnon (2005) add that professionals develop complex skills to recognise patterns or deviations from patterns on the basis of accumulating experience. Both Benner and Klein have described intuition in ways that could be transformed into any practice setting including use in making decisions to report suspected child abuse and/or neglect in uncertain situations.

Nurses who suspect abuse and/or neglect are reported to say that the lack of concrete evidence does not allow them to feel confident in making make a notification to the statutory agency (Barton, 2000; Rodriguez, 2002). Rodriguez adds that reporting decisions is affected by the professional's confidence in their suspicion that the situation is actually abusive. Studies have identified nurses as stating they know they have an obligation to report (Crisp & Green-Lister, 2004; Lazenblatt & Freeman, 2006; Ling & Luker, 2004; Nayda, 2002). However, if they cannot provide objective evidence or enough evidence to support the notification of suspected abuse and/or neglect they are reluctant to report (Barton, 2000; Rodriguez). There is fear of misdiagnosis and the possible consequences for the nurse, child and nurse-client relationship (Russell, Lazenbatt, Freeman & Marcenes, 2005). This indicates that professionals tend to assess their level of certainty before making a decision to report suspected abuse. According to Rodriguez individual reporter characteristics such as being a parent or having a personal history of maltreatment, may also influence or bias professionals reporting decisions.

Experience in reporting suspected child abuse and/or neglect is said to increase with the number of years experience a nurse has in working with children and families in the community (Adams, 2005; Appleton, 1996). Brosig and Kalichman (1992) argue there is evidence that more recently trained health professionals appear to have more knowledge about child abuse issues, whereas the more experienced professional may feel more confident to report their suspicions, but further research was required. Rodriguez (2002) in his New Zealand study did not find any relationship between age and experience with attitude, accuracy or certainty in reporting. Rodriguez concludes that further research should be undertaken to investigate the influencing factors on professionals' decisions to report or not to report including whether more comprehensive training could improve accuracy and reporting behavior.

A study undertaken by Laznebatt and Freeman (2006) which surveyed 410 health care professionals reported that community nurses were most likely to recognise and report child abuse. This view is confirmed by Appleton (1996).

Appleton also identified barriers to reporting as anxieties, lack of knowledge and experience and unclear organisational policies pertaining to child abuse/neglect. One in five respondents were worried about being wrong in their identification and some nurses described they felt moral discomfort as they played the role of 'health police' (Marcellus, 2005). The respondents all identified the need for further education, training and support in this work (Appleton; Laznebatt & Freeman; Marcellus).

Signs and symptoms of abuse and neglect

Some examples of suspicious abuse or neglect in the literature include a child's appearance. For example unkempt appearance, unexplainable bruises, lack of warm clothes, significant weight loss, on-going sickness, refusal to give medication, lack of medical attention, or signs of developmental delay. Behaviour signs included violent or disruptive behaviour, cowering, fearfulness or displaying protective stances. Family behaviours are described as often defensive or avoidant in nature, repeatedly not keeping appointments, and the child never at home or always asleep when a health professional calls. There can be a reluctance to answer questions or share information, the families can be transient, children can be left home alone and older children may not be attending school. Rough handling of an infant/child, lack of attention, and use of abusive language aimed at the child and neglectful or cruelty to animals are also indicators. Also consistent threatening, belittling or forcing a child to assume an adult role and unrealistic expectations of a child are further indicators. A caregiver's alcohol and/or drug use, mental health issues, little or no antenatal care, harsh discipline as a child, poor relationships with own parents, past or present spousal abuse also place children at risk. Premature or disabled children are also associated with risk factors. Indicators can include: a lack of social support or family networks, rare involvements out of home, history of unemployment, financial stressors, improvised living conditions, unlisted or no telephone, parenting under the age of 20 years, high school education or less, difficulty communicating with family, and family involvements with police (Adams, 2005; Barton, 2000; CYF, 2010; Brown, 2003; Hall, Sachs, & Rayens, 1998; Lazenbatt & Freeman, 2006; Lewin & Herron, 2007; Paavilainen & Tarkka, 2003; Waibel-Duncan, 2006). Nurses must consider all

these factors when making assessments around suspecting child abuse and/or neglect. Although social class may be considered an indicator it is not necessarily one because abuse/neglect occurs across all sectors of society (Adams; Barton; CYF).

Cultural aspects

Cultural differences may affect nurses' judgements about what is and is not acceptable behaviour and adds to the moral and ethical dilemma of reporting (Campbell, 2005; Jose, 2005; Maxwell, Barthauer & Julian, 2000). As populations become even more diverse Campbell states that preventing, recognising and reporting suspected abuse is a growing concern. Affinity to one's own cultural values and child-rearing practices sometimes conflict with the legal interpretation of acceptable child-rearing practices. This is evident in families that do not conform to the concepts of children's rights (United Nations, 1989). Safety of care in New Zealand includes cultural safety. The concern here is with the practitioner as "the bearer of his or her own culture and attitudes, and consciously or unconsciously exercised power" (Ramsden, 2002, p. 109). Tolich (2002, p. 164) adds practitioners should "understand her/his culture and the theory of power relations" to be culturally safe in any setting. It is important that front-line practitioners examine their relationship with families in the light of Ramsden's statement (Wilson & Huntington, 2009).

Variations across cultures in how children are viewed and valued, makes children's rights contestable (Conrad, 2006). The rights and wrongs of cultural practices within child rearing practices although important for nurses to have knowledge of are not what should influence reporting obligations. Despite the contestable differences, nurses in New Zealand must work within legal, ethical and moral Codes and Acts (New Zealand Nurses Association, 1995; Nursing Council of New Zealand, 2005). Parental practices that are informed by belief, superstition, or tradition have been challenged in courts of law. Parents have faced criminal charges for failing to provide the necessities of life (Wood, 2007). Nurses are also called to account for the nature and quality of information provided to the family (Wood).

Documenting suspected abuse and neglect

Very little research could be located that informed nurses how to document, nor how nurses did document suspected child abuse or neglect, suggesting a gap in the literature. Land and Barclay (2008) found that nurses were criticised for failing to make adequate documentation about child abuse and nurses feared appearing in courts where their documentation was under scrutiny. Adams (2005) in her study discovered a lack of assessment of significant risk factors that are predictive of parenting difficulties. Low documentation, less than 40 percent of nurse assessments, reported the risk factors. Significant risk factors of low income and relationships with family members were seldom documented.

Results from Rowse's (2009) study revealed participants concerns for their documentation of suspected abuse. One participant described some suspicious abuse as 'soft' concerns, being 'intangible' (p. 175) and therefore difficult to document. Judgments based on gut feelings caused frustration for nurses and caused disagreements between professionals as pinpointing the concern was difficult. Nurses were left feeling like they needed to convince other professionals that action may be required.

The formation of a professional opinion that involves suspected child abuse and/or neglect by health professionals is, according to Ling and Luker (2000) complex. Intuitive assumptions described by nurses in this ethnography study over a 2 year period are echoed in other studies (Standing, 2008; Welsh & Lyons, 2001; Zinn, 2008). All participants in Ling and Luker's study understood the distinction between the interpretative knowledge used to understand situations in practice, and the more factual or 'objective' knowledge they were expected to display when writing client notes. These nurses found intuitive awareness was difficult to document in official reports and client notes with one respondent saying "you can't put intuition or intuitive awareness down, it is something you experience" (Ling & Luker, p. 576). Munro (2002) advocates that community nurses describe in writing their basic cause for concern, recording risk and protective factors, when abuse uncertainly is identified. To

record in client notes the strategies used for the purpose of prevention is part of effective practice.

The Office of the Children's Commissioner and UNICEF New Zealand (2004) in their document that includes information for organisations working with children and families outlines briefly some points on documentation.

"All suspicions and concerns must be recorded because an accumulation of information can give a comprehensive picture of a child's circumstances and help in official investigations". In making records it is important that the record clearly identifies anything that has been said by another individual (including a child) and any physical signs and symptoms that have been observed or reported by someone else. Any options or personal concerns not based on information given or observation must be identified as personal opinion and not fact…care with accuracy is essential" (p. 14).

'Inter-professional communication'

The majority of the literature reviewed reported the lack of reciprocal reporting back from statutory agencies with information about 'what happened next' and this frustrated and hindered nurses ongoing care (Land & Barcly, 2008; Nayda, 2005; Rowse, 2009; Seibie, 2009). In New Zealand, Sye (2008) interviewed a group of Plunket Nurses and Public Health Nurses. These nurses felt like they were in a 'go-between' position between the family and the authorities. The "go-between position is also an anomalous position because the child protection activities of the nurse are often obscured or unacknowledged" (p.109). Similar experiences are also described by Evans (2003) and Marcellus (2005).

From a different perspective, nurses report in Land and Barclay's (2008) study, they experienced frustration with the lack of communication between midwives and community nurses where known or suspected child/abuse or family violence was known. Of more concern was the lack of obvious reporting to authorities by midwives before referral of clients to community nurses.

Concerns after reporting: The nurse prospective

It is reported by Crisp and Green-Lister (2005) that nurses who have reported suspicions of child abuse and/or neglect where no action was taken by the statutory agency, may refrain from reporting future suspicions. The literature reports nurses as being significantly concerned about the consequences of reporting, including non-achievement of safety for the child (Nayda, 2002a/2005; Piltz & Wachtel, 2009; Rowse, 2009). Although in most states in Australia nurses are mandated notifiers, Nayda (2005) reports that these nurses feel marginalised from the investigation as they receive little or no feedback about the outcomes of their report. The nurses then have concerns that protection services do not always achieve the appropriate measures to protect the safety of the child. Rowse (2009) also reports nurses felt they were banging 'their heads against a brick wall' (p. 176) to get any information from the statutory agency after submitting a report.

Reports from several studies (Condliffe, 2008; Lazenbatt & Freeman, 2006; Rodriguez, 2002; Russell et al., 2005; Seible, 2009) state that nurses lacked confidence in the statutory agency they report suspected abuse to. Often suspected abuse or neglect was reported several times over a period of one year and nothing was done by the statutory agency. Frustration through a perceived lack of regard toward nurses' ability to correctly assess a child suspected of abuse or neglect and the lack of follow up with nurses from the statutory agency is frequently reported. The perceived lack of confidence in nurses only resulted in them feeling less confident in their ability to 'get it right'. This often lead to a 'wait and see' approach rather than raising their anxiety over misidentifying possible abuse or neglect. Studies also confirm that these issues are shared with general practitioners, paediatricians and dentists (Rodriguez; Valliamy & Sullivan, 2000).

Risk Management

One of the key responsibilities for any health organization involves risk management (Seible, 2009) and the responsibility attributed to nurses work in suspected child abuse and/or neglect. Seible interviewed health visitors in three focus groups with three participants each. Participants were asked

questions about their understanding of 'risk analysis'. Nurses were slow to respond with "uncertainty and hesitation" indicating a "lack of familiarity and confidence" (p. 29) with this concept. Further questioning found that the nurses were able to use analytic skills when making decisions to report, though the formal analysis process was not identified.

Although only a small sample size, other studies have identified similar responses (Adams, 2005; Appleton & Cowley; 2008a/2008b; Lazenbatt & Freeman, 2006) in that nurse-client relationship and identification of 'risk' or 'red flags' was seen as being the key to the risk management of children. Nurses are aware of the legal obligations and disciplinary forces as the Health Practitioners Disciplinary Tribunal established under section 84 of the Health Practitioners Competence Assurance Act (2003). The quality of professional decision making and overall risk management in an agency is an accountability for all health authorities.

Educational needs:

The majority of studies reviewed indicated nurses required ongoing and regular education to support families in child protection work (Land & Barclay, 2008; Nayda, 2005; Rowse, 2009). This is supported by Piltz and Wachtel's (2009) study of barriers that inhibit nurses reporting of suspected abuse and/or neglect. These include signs and symptoms to recognise abuse/neglect, and documentation skills to record their suspicions. Crisp and Green-Lister (2004) noted that nurses needed specialist training in child protection work that went beyond technical skills and knowledge for detection and identity of child abuse/neglect. They considered that education needed to include the expectations related to providing support to vulnerable families and at the same time undertaking a surveillance role. Also identified was how nurses should respond to alleged or suspected abuse with families. Ongoing support from line managers and supervision were crucial for nurses managing continuing exposure to this work (Russell et al, 2005). Cultural competence working within ethnic diversity was also identified as a critical educational component (Campbell, 2005).

Nurses are reported to be considerably concerned about the consequences of reporting if they live close to their workplace or in a small community. Nurses being marginalised by a small community can have significant professional and personal affects (Nayda, 2005). Nayda suggests that health organisations should include strategies to prevent and address these possibilities in policy. Some acknowledgment of the 'human' impact of child protection upon nurses as a 'normal' side effect of child protection work was identified by Rowse (2009) and should be addressed in nurses education.

Of 491 community nurses, doctors and dentists responding to a postal questionnaire on reporting child abuse, 332 requested further education (Lazenbatt & Freeman, 2006). This included education in recognising benign conditions that might inadvertently be mistaken as abuse so that unnecessary distress is averted for both reporter and client. The participants also asked that they participate in education days that included inter-agency sharing of experiences and insight on how these agencies assisted in supporting families.

This need for ongoing education is also validated by Russell et al. (2005) who surveyed 419 primary health professionals including 139 community nurses in Northern Ireland. The majority of participants requested multidisciplinary education and training with accessible tools such as CD-ROMs and appropriate teaching aids. Participants commented that they felt there were deficiencies in their training and that it was irregular. They identified that the training, especially at the undergraduate level, in relation to child protection was not meeting the needs of health professionals. Participants also identified the need for simplification of protocols and clear definitions and awareness of systems that support legal frameworks to increase their understanding and knowledge levels. Verbal communication skill training was also requested to allow asking and probing for information that was sensitive. This suggests gaps in the wider education of health professionals which may be contributing to the barriers of making reporting decisions. Educational strategies suggested following Rodriguez (2002) study included increasing professionals' accuracy of reporting, and legal and ethical reporting obligations, with a focus on how neglect is particularly ignored by health professionals.

Conclusion

The literature relevant to Plunket Nursing and identifying suspected child abuse and/or neglect and reporting has been reviewed. It presents both a New Zealand and international perspective and presents the statistics of child abuse and neglect. The aim was to identify key points and themes from previous research that represents current knowledge. The nurse-client relationship, the role of culture, the impact of this work on nurses, the inclusion of nurses' intuitive feelings and the need for ongoing education are presented. Additionally, support for nurses, signs of abuse, risk management and documentation are outlined. The next chapter describes the study findings from the data collected from participant interviews.

CHAPTER FOUR

Findings

Introduction:

Chapter four provides the results from the data analysis. van Manen's (Streubert-Speziale & Carpenter, 2007) framework for analysis of hermeneutic phenomenology was used to guide this process as described in chapter two. Excerpts from the raw data provide examples of participant experiences in making decisions to report suspected child/tamariki abuse and/or neglect. Four themes emerged.

Theme One: **The Nurse-Client Relationship AND Protecting Children**

One of the strongest talking points that all participants valued and worked hard at was developing and maintaining client relationships. Nurses spoke openly of the difficulty they had in firstly locating some families and the time consuming process that this was. They voiced their frustration at not finding families. They questioned themselves why might that be? I could feel from their emotional and passionate stance in their voices that they were 'beating themselves up' over the importance for them to find families so they could carry out the Well Child Service. Their comments conveyed to me that they felt a deep sense of responsibility to 'find' families, they carried a concern and a commitment that left them feeling they had 'let the children/tamariki down' in some way if they could not locate families. Nurses questioned their abilities to locate families and felt if they could not, they needed somehow to work harder to do this.

> *What barriers do I need to remove to gain access to this family? How can I gain their trust? It frustrates me when I appear to be making no progress. I know I need to work harder at it [finding clients]. [PN 5]*

> *I often suspect…have hunches, but over the years you develop experience, so where there is a resistance of an onset of engagement, I feel like I'm being given the run around or there is a substantial reason why someone would not want me to see them and their baby or their child. Immediately in the back of my grey mater, I put a little flag, because I think now I've got to work harder here to be the nice girl on the block to appeal to this*

family to be non threatening, non judgmental, but at the end of the day you want to get there for the wellbeing of that child. That is sometimes like going over hot coals…so I work hard at this. [PN 5]

I had been trying to make contact to see this new baby case and I didn't know what the matter was because she doesn't want me to come in. I've tried phone calls, I've done a house call, it wasn't convenient. I left a card. I invited them into clinic and said an appointment wasn't necessary. I thought I can't make head way here and I don't know what the matter is. [Later on] I got feedback. She didn't want me, she had heard things about me and [the client] didn't like it. I was very taken a-back by that, and I work really hard to get on with people, and I thought, how odd I didn't know this woman at all. I really wasn't happy because I was concerned for that family. I sensed there was more to it. I was in a very tricky position because I had to do something about that. I decided rightly or wrongly to send in a para-professional, you know, and just check, you know how they were doing, who the kids were and at least look and see how things were. After six weeks or so there was a change of heart and this woman said [to the para-professional], I do want her, I don't know why she hasn't been! It was almost like, where have you been nurse. I picked up on that and when I visited, the children were immediately very friendly, the older children really were overly affectionate. They initially threw themselves at me, you know, to be picked up and cuddled. So there was my second indicator because that is not normal. [PN 5].

The frustrated feelings continued even after families were located. Four participants described that following the time consuming and hard work to locate families there followed the difficulties of maintaining a connection with them.

Building relationships is so very important. [PN 3]

I feel anxious at a first visit with hard to find families, you consume a lot of your time and energy making it this far. [PN 4]

You put in extra effort [and you have] got to work harder' [to get the relationship to work] I know I need to go deeper to get this relationship to work. [PN 5]

How can I gain their trust? [PN 2]

The need to *'go deeper'* described by the nurse suggests not leaving one stone unturned, similar to being an investigating detective searching for more information and to gain trust to enter into the family dynamics. The nurses described this extra time and energy consumed as additional pressure and stress of the job, a wearing down of their daily energy levels.

Along with the time and energy already spent locating the families, after the initial contact the nurses sometimes left with suspicions of child/tamariki neglect or abuse, that something was 'amiss'. Something 'was not right in that house'. The nurses all spoke about the 'balancing act' of building and maintaining those difficult relationships and gaining trust verses their legal responsibility to maintain the safety of the children/tamariki and self without compromising that 'hard to develop' relationship.

What makes these relationships difficult to build I wondered? The nurses described the elusiveness of families/whanau, like the families were running from them, or had something to hide and did not wish to be found. One nurse spoke of the frustration of spending a lot of time doing phone and leg work finding new addresses, only to visit the home to find they have moved again, or that there were signs of someone at home, but the occupants would not respond to knocking or calling from the nurse.

When I can't find families, I know that I need to work harder at finding them. [PN5]

The nurses seemed to be referring to a gut feeling, a sense that made the urge to keep looking, to keep knocking on doors. The nurses were not easily put off by unopened doors. They had an inner drive that pushed them on and on. Not one of the participants described a time where they just 'gave up' from frustration and unproductive avenues to locate clients.

When I don't find families I experience a sense of self failure somehow, for the child.   [PN 2]

This nurse placed a lot of blame upon her shoulders and seems to be saying it is her fault in some way.

As each nurse continued to talk they started to develop questions around moral and legal dilemmas. For example one nurse said:

I worry if I report, will I get my foot back into the door. Who will be there for them [the child/ren] if I can't get back in? [PN 2]

As I listened to the nurses, a picture built, of a mounting battle, a struggle between moral and professional judgments' and maintaining a working relationship wanting desperately to avoid being shut out of the families/whanau lives through reporting suspicions of child abuse/neglect when no actual hard evidence could be reported.

Participants were asked the question, "What does it feel like when you think a child is being abused or neglected?" Each participant responded quickly initially with an '*I feel sick or I feel really awful'.*

Then they appeared to become more reflective in thought as they considered what that really felt like and then added further comment.

One nurse said:

I feel very sad but not to the point that anything is hopeless. [PN 5]

For this nurse there was always some way to work with a family no matter how small or hard, there was a way forward. This particular nurse had many years of experience working in community settings. Her experience and ability to see past the hopelessness to a more hopeful outcome was different to the less experienced nurses interviewed as this example suggests.

Realising that I can't do everything to help some families, for some there is nothing I can do and that makes me feel totally hopeless as a nurse and as a person. That is hard to come to terms with. [PN 2]

And for another nurse:

You know you are a professional skilled helper, but still you feel helpless. [PN 1]

The underlying thought comes to mind of the 'hardiness' of the more experienced nurse, nothing was too hard or too hopeless that she couldn't find a way through whatever the situation. I was curious about whether a longer experience working in the community, gave nurses this hardiness and resilience. They worked at finding ways to locate hard to find families/whanau and found ways to develop and maintain relationships and support families in suspected or actual child/tamariki abuse situations. Does this account for the attitude of 'nothing is hopeless'? Do more experienced nurses wait longer to report, trying other options when they suspect abuse/neglect than the less experienced nurse? Do they take more risks in waiting? Are they prepared to take more of a risk by waiting?

The nurses described different feelings when they suspected child/tamariki abuse/neglect in families they saw.

Sometimes I'm very worried. [PN 1]

It's just awful. [PN 2]

The unknown makes me feel anxious. [PN 4]

I feel quite angry. [PN 6]

I actually feel real sick in the stomach. I find it hard to get it out of my mind. It troubles me a lot, I take it home. I can't turn it off. When it troubles me it's like in the back of my mind I'm thinking, is this child safe, is this child still going to be safe tomorrow. Is there something I should be

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doing right now? Am I doing the right thing? Have I made the right decisions? [PN 6]

I just really take it to heart and I think that's because I'm a parent myself, that it is just not on. I feel really uncomfortable for the child. [PN 2]

There is real uncertainty experienced here, that causes nurses to doubt they have done enough in keeping the child safe after leaving the family/whanau**.** For one nurse her description illustrates van Manens (1990) lived body or corporality extremely vividly. These bodily emotions where welling up inside the nurse and she was trying hard not to 'show' the extent of her feeling in outward emotions, thus incorporating emotional intelligence.

There is a lot of pressure and stress. You always feel that stress. You feel a lot of responsibility, an incredible amount of responsibility. You are at a heightened level of alertness. You just draw on everything you know as a nurse, all your skills and communication. When you find out you are shocked, visualising what that child is going through, that suffering, what's going on in their lives comes hurtling at you, that's the shock, that it is now real. You can't show you are shocked, that your mouth is dropping open to the ground. [PN 1]

Other nurses described it this way:

When I have to report, I feel like I have stabbed the family in the back.

[PN 2]

The use of the metaphor 'stabbed the family in the back' describes the underpinning or overall feeling of ripping that trust right out from under the families feet. The nurse had struggled over a period of time to develop a working relationship with this family, who had come to place their trust in her. When the family placed their trust in her they viewed the nurse as 'their' trusted health professional. But now the nurse has 'turned' on them and reported them, that trust is now broken. The nurse did not want the

relationship to end and feels she has led the family under false pretenses of trust.

They shared information, they let me into their home, I feel like they trusted me, and now I'm going to throw it back in their faces. [PN 2]

When I think there is something going on I always have it in the back of my mind what's going to be the best outcome for this family.[PN 1]

Should I report or should I wait, and that's a bit to carry, that feels horrible and makes the job stressful. [PN 6]

There was an incredible amount of emotional energy being expressed and exerted in what the nurses told me, as well as a deep sense of 'caring' expressed by them. This was particularly displayed by one nurse who not only expressed words of emotion, but outwardly displayed her distress with a wavering voice and stopping the conversation momentarily to regain self composure as she re-lived the experiences. She stated:

I have quite often worked in parallel care with a Plunket para-professional (see Key in Contents) and so that has been great, as I have an extra set of eyes as well and someone to bounce ideas off for what I've seen and for what she has seen. She was very good at picking up some of the things that as I've been growing up, have never known about and I was very naïve going into a very high deprivation area to work as a Plunket Nurse. So she was great with that. She knew what to look for with drugs, alcohol and even gangs, which I had no real idea about. [PN 3].

Previous exposure to risk factors that contribute to child protection issues, be it personal or practice experiences could be a precursor to experiencing 'gut feelings' as the above illustrates. The naivety that this nurse brought to child protection was a major barrier for her in identifying potential or actual risks. It also highlighted for this nurse the increased risk she had placed herself and the child in with that naivety.

All six nurses referred to their experience with the Child Youth and Family (CYF) organisation. As nurses described their experiences of this service, they voiced their frustration as they felt CYF inhibited to some degree collaborative client care. Theses nurses felt there was a lack of information sharing between CYF and Plunket nurses which was viewed as a barrier towards a working relationship between family/whanau and health professional. The nurses felt that the CYF organisation may not have a full understanding of the role of Plunket Nurses within child protection work. The following comments were relayed in the interviews:

I'm quite disenchanted with them, they give us no information, it is all one sided, leaving me to feel unsafe to enter clients homes when I know that CYF have asked for information [from us] urgently. [PN 6]

CYF are not very forthcoming with information and that makes me so frustrated, how can I do my job safely and make decisions to the best of my ability for the best outcomes for the child/family? [PN 5]

The reason you want information from CYF is that you are always wondering, is that man in there going to beat me up? [PN 1]

I get so frustrated when I have no idea what is going on and I don't believe that would make me judgmental, going into the home knowing stuff, it just makes me more aware of what to look for. I would like to know a little background and that would help me in my job. [PN 5]

When I am really anxious about children, I don't trust CYF to act quickly. I'm unsure of their confidentiality and in small communities, word gets around quickly and often families can pin point exactly who would have reported. That makes me feel vulnerable as the only Plunket nurse in a large rural community that is a strongly knit one. [PN 5]

I lost my faith in CYF, I don't have a lot of respect in CYF. [PN 6]

My families have no faith in CYF, they regard them with fear. [PN 1]

Then another nurse felt that because some families/whanau have a fear of CYF and their authority she described how she felt uncomfortable when working with the families/whanau.

I always get the sense that you're [thought of as] one of 'them' anyway, as you are [seen as] authority, you are very much an outsider so I find that uncomfortable. You get a sense that they are very closed and difficult to engage and things, so I feel I've got to put a bit of extra effort in. I'm sort of conscious of that, but also conscious that whenever I am in that situation when you have got a family that you can feel their discomfort, I have that discomfort as well, that I'm not rubbing them up the wrong way and there is a personal safety thing. Cause what if they all of a sudden just take complete exception to me for whatever reason, so I guess it's human nature, that you want to be well liked and well received and of help to the family so you put in all the ground work to try and build that relationship'. [PN 2]

Theme Two: Stress plus Anxiety AND Resilience plus Hardiness

The second main theme presented from the interviews was the stress and anxiety caused by trying to locate hard to find families and child protection work and the resilience and hardiness of individual nurses. Stress is the major metaphor used throughout all the interviews. It was referred to time and time again. Although only six nurses were interviewed, it became apparent that stress affected all the nurses and that there was a huge variance in the way that stress and anxiety uniquely affected the individual nurses. This was evident in the ways that they talked about their resilience and hardiness when describing their experiences.

The emphasis that nurses placed on stress was summed up by one nurse in the following statement:

Stress is something that is incredibly under-rated in this job, the whole nature of this job, even with low deprivation people, there is a lot of stress that we carry because we have so many things shared with us from clients. What we carry for families is incredibly under-rated. [PN 1]

This nurse describes the stressful nature of the role of a Plunket Nurse working across all sectors of society, not just the families experiencing high deprivation. The nurses did not feel that the level of stress is fully understood or appreciated by the general public, the Child Youth and Family Agency or the organisation for which they work. This made nurses feel that their skills were under-rated and under-valued.

One nurse described the general public perception of Plunket Nurses as the 'Fluffy Option'.

> *I think that all of us in Plunket know that we have a great deal of skill when it comes to child protection work, but we are often seen as the FLUFFY option, for example, we do the 'nice' stuff. [PN 1]*

This referred to what is often heard from the general public, the vision of Plunket Nurses as visiting healthy well supported families/whanau, weighing and measuring babies as their main work, that Plunket Nurses were not involved with the *'ugly stuff'* as one nurse put it*.*

Another nurse spoke of the Manitoba Risk Scale *(RNZPS, 2008; Appendix Eight) and that* there was an emphasis on making referrals but thought that managing risk was so much more:

> *I think there is a lack of understanding around the intricacies around it [the Manitoba Risk Scale] for the person who is working with the family. And our skill level and what we hold in, you know what we hold in that relationship with that family is sometimes quite special and quite positive for the family and that could be compromised. If we purely looked at policy you know and obviously we have to work within policy and that is the framework that we work under. But it's not as simple as policy you know. If we just purely went on policy I'd be reporting every second person I saw! [PN 1]*

*S*tress for the participants was described to be personal, emotional, physical and psychological. There were variances in the levels of stress described but there was no doubt that all the participants experienced stress and anxiety to some degree. Although each nurse had to some level their own personal resilience factors or escape routes to de-stress, there mostly remained an imbalance between the two with more stress and anxiety than resilience factors such as hardiness reported.

Stress and anxiety were described in the following ways:

I feel depleted of self. It is something that we have to really watch and watching staff burn out and leave because of the high stress and a lot of it is around child protection work. [PN 1]

Instantly I felt this nurse had nothing left for herself or her family, nothing more to give at the end of a working day. Child protection work had consumed her very being. She was rung out void of any further energy to engage with her family.

I feel like I have minor burnouts all the time and say to myself, shall I stay or shall I leave this job. Some days it's just too hard. [PN 1]

The results of carrying this stress revealed itself in different ways, through a break down in bodily function, not sleeping, guilt feelings, anxiety, and taking it out on their own family as the following excerpts illustrate:

I don't sleep [PN 6]

Sometimes I take it out on my children and husband, it isn't fair on them. [PN 6]

My body goes bonkers. My body systems shut down, my skin shuts down, my bowels shut down. Stress is not good for me. [PN 3]

It does get to you [this type of work] and you need a break from it. I think that all nurses should not work any longer than two years in a high deprivation area. [PN 3]

What a nurse needed was:

When families tell us everything, that is a huge load to carry and obviously we are looking at how we can support them. But also we need to have that cut off, that we can walk home at the end of the day and feel we can sleep and we can get up and do it all over again the next day. [PN 1]

This possibly suggests a cry for additional support. Nurses who ask themselves daily 'should I stay or should I go' may perhaps be heading towards burnout. Although nurses identified avenues of support for their individual needs, I could sense that what was available was not quite enough to prevent burnout, bodily dysfunction, reaction towards own family members at the end of a day, the feeling of carrying a huge load, that some days it was just too much. The '*cut off*' is described as the need to shut that work out of your inner self so you can walk away, leave it at work and go home being about to be at peace with yourself.

One nurse stated:

I think to be a good Plunket Nurse working with child protection issues you need to have a hardiness about you. You can't be too surprised by what people say, how they live, what they do. You need to be accepting of where people are at, that you are quite willing to listen, you are not afraid. That you [need to be] aware of your own vulnerability, being able to take care of yourself and being able to think on your feet in acute/crisis and sometimes ordinary situations. [PN 4]

Not all the participants felt they had this hardiness about them. Two of the nurses said they were not tough enough or too naive:

Sometimes I don't think I'm tough enough. Feedback from families has said I'm a gentle person. That is my approach, that's part of who I am as a person. That's how I work with families. But maybe I need to be tougher, that my approach to child protection issues is too soft with families. [PN 2]

I was so naïve, I just didn't know what to look for…the work got to me and I had to ask for a transfer to work in another area. [PN 3]

The comments from the participants built a picture of one stress building on another stress, upon another little stress. This often progressed on from the inability to firstly locate clients. Trying to locate clients, meeting clients, being made to feel uncomfortable in their presence, deciding to report, writing the report and the notes in the Patient Health Record was stressful enough. However attending family/whanau group conferences, and or court and for some the week after week of requests for information from CYF, put immense pressure and stress on them. The cumulated effects displayed itself in mood changes, bodily function change, altered sleep patterns, confidence in self and wanting to resign.

Theme Three: Relational Time AND Lineal Time

Nurses throughout all the interviews expressed various aspects around the amount of time they had in any one day to meet expectations of what they viewed as an unrealistic Ministry of Health (MoH) Well Child Contract that was aimed at a target number of contacts with clients over a 12 month period. Time was described as a stressor to the nurses daily work as the following statements verify.

If I had been cut and dry [at my visit] as per the MoH contract solely, then I would be doing these families a disservice. Now that is a huge stress to carry. I know the time factor we have with a family and the inflexibility

we have around it, finding the balance between needs assessment and cost of and availability of resources is so stressful. [PN 1]

I worry about what sort of time I have to stay longer with this client who needs extra assistance. I need to be heading to my next appointment as they might need extra time too. [PN 2]

Nurses worried about the time they had scheduled to see clients, always asking themselves, 'what sort of time do I have'? The pressure of time revealed other concerns for nurses as the following extracts identify.

Do we have enough time to see little symptoms of stuff. [PN 6]

I think one of our biggest issues is probably getting too small a snap shot of clients in the time we have, and not enough visits. [PN 2]

Time is a factor and nurses need time to process stuff. [PN 3]

Time is a challenging part of our work and when it's not done you end up taking it home. [PN 3]

I have to clear my mind and focus on this type of documentation. It takes a lot of time. [PN 2]

For one nurse she described the nurses daily role had turned into one where:

We are just whizzing around seeing families when the level of complexity is increasing and I ask myself, what might I be missing? [PN 1]

I feel the concern expressed by this nurse, one of rushing from one client to the next; never feeling that what she has done with a family is her very best care. The feeling that there is never time enough, was based on the need to assess the increasing levels of complexity in family lives and the risks from that which the nurse might have to face in the future. Another nurse added to these thoughts when she said:

Do we sometimes disregard those symptoms that we see because of how we don't feel like on that day opening up a can of worms because of the way we are feeling? [PN 6]

You hear of a family violence incident for one of your clients via another means and you question yourself, how many other things have I missed? [PN 6]

Another challenge and frustration for all the nurses was the time factor involved with writing out Requests For Information (RFI) from CYF. All the nurses emphasized the large amounts of time to review client records and write a detailed report. Fitting this task into an already full days work of planned visits or clinic appointments placed further pressure on them. They spoke of how it felt at the end of a challenging day to arrive back to their desk and find one or more RFI awaiting their attention. The time factor again in these circumstances adds to the pressure the nurses feel and some described they felt there was an unwritten expectation of nurses to stay back at the end of the day to complete this work.

It can be two-three hours of work to write a CYF 'Request For Information' report for say a 3 year old with high needs. Can you imagine those hours of work on top of your days work load with no allowances made for the extra work you have to do? I don't feel nurses are encouraged or supported with this extra work. It is quite depressing and frustrating to get two or three requests for information on your desk at the end of the day on top of a full days work load and you say, oh goodness how am I going to get all this done. [PN 6]

There are unwritten expectations that you will stay behind and do CYF work and this makes you feel unsupported. There is no provision in our work time for this type of work. [PN 1]

There seems to be an unwritten expectation that nurses will stay back in their own time to complete this type of work and that you will just get on with it. I don't think that is right. [PN 6]

Oh, great, how much time is this going to take me when I've already got my days paper work to do? [PN 6]

That is just another thing to do [notification to, or request for information from CYF], more time, more work, more pressure. [PN 2]

Nurses felt there were unwritten expectations being directed at them from the organisation which made them feel de-valued and unsupported in this part of their work loads. Once again time was voiced as the major missing element in enabling them to undertake report writing in a professional and legally safe manner. This work was just too hard at the end of a day and they felt that without quality time to reflect on documentation they became stressed and worried about how well they could document events in a child/rens life that was a true reflection on reality.

I don't think that on the ground there is enough support and I think Plunket is unrealistic in their expectations of nurses. This adds to their stress and very soon you are having minor burn outs and you start thinking will I stay or will I go. [PN 1]

Time was referred to often when nurses assessed that some families/whanau needed additional visits more often, when aware of their gut feelings but were unable to pin-point why they felt that way. This then became an important factor when balancing out relational time with clients and lineal time, against the expectations of the organisation in restrictions of resources to meet contractual requirements. Nurses were up front in describing their battle with both time concepts. Although these nurses described how hard they worked to complete their days work within work hours, it always seemed that the unexpected could not be factored into their day, no short cuts could be taken, and even delegating visits to Community Karitane (CK) or Plunket Kaiawhina (PK) did not always sit comfortably with the nurse. The ownership of the 'gut feeling' was always described as sitting with them. Participants mentioned that they did delegate additional visits to the CK or PK as their experience was viewed as another set of eyes perhaps seeing or sensing something more than the Plunket Nurse had.

It was not long before nurses started to voice their concerns around their quality of documentation especially concerning child protection work and this will be covered in the next major theme identified from the transcripts of interviews.

Theme Four: Gut Feelings, Documentation AND Personal Safety as a Registered Nurse/Plunket Nurse

Gut feelings, documentation and personal safety were common threads throughout each interview and the narration from each nurse included many examples of the tensions between each of these concepts. There were many instances around the difficulties the nurses had in documenting gut feelings. Nurses used the words 'gut feelings', 'gut instincts' and 'gut reaction' interchangeably when answering the question I asked "Describe to me, what is a gut feeling?" As nurses tried to describe gut feelings, they did so with difficulty, they struggled and grappled for adequate words because it was something that they described as not concrete, not black or white, rather many shades of grey because it was, just that, a gut feeling.

It's hard to explain [gut feeling] and even harder to document. [PN 3]

Well it was a gut feeling, but it came from processing information I think. It was doing the weighing up. It was, what do I know about this family, what and how did that conversation go, how open were they with me, how direct was I with them. [PN 4]

A gut feeling is MY feeling. [PN 5]

I noted the emphases on the 'MY' during one interview. It was strong and sure. The nurse owned this feeling; it was no one else's. She needed to deal with it. She could not move that feeling onto someone else and no one else could feel what she was feeling. It was unique to her.

You just have difficulty describing it, it's not concrete. [PN 2]

It's a feeling of being worried, don't know what is happening, can't 'name' it, it's a feeling of something that isn't right. [PN 4]

It became obvious to me as the descriptions continued that gut feelings left nurses feeling unsure, tense, and worried both for the child/tamariki and themselves. They appeared to 'own' these feelings as in something they could not 'share' with another in a meaningful description. Drawing on all their knowledge and skills as a nurse, did not allow them to walk away from a situation feeling comfortable and in control.   They could not put a comprehensive or adequate plan of care in place that aligned with their gut feelings. Rather I sensed they were feeling, 'what have I missed' and 'why can't I see what is going on if I can feel it in my gut'?

> *I question myself when I have a gut feeling, what have I missed, what do I know/don't know? [PN 3]*

> *You have all this knowledge behind you, but you still can't quite pin point what it is [from your gut feeling]. I would feel somehow, inadequate.[PN2]*

> *I think I began to trust my gut feelings from my years of experience in this role. [PN 2]*

> *I have become quite open and frank about asking any questions I have that might open the way for a client to give me more information when I suspect something isn't right. Mostly clients seem to appreciate this directness. [PN 6]*

> *I believe that we have got to keep asking the question to screen for family violence but I know many nurses who don't ask it. [PN 1]*

When nurses came to document their visit with a family/whanau after experiencing a gut feeling, it was described by nurses as a dilemma and problematic. It challenged their ability to describe accurately, what was an unheard, unobserved, immeasurable, un-screened, non-concrete, un-assessable feeling. They voiced that they understood that they needed to document something, but what that something was and how to write that in words that described some nebulous feeling became a more difficult exercise. Documentation was considered to be very important.

Documenting gut feelings is not easy. I don't know how to do this, it's not concrete. I need help with this. [PN 3]

Gut feelings are hard to explain and even harder to document. [PN 3]

Through the interviews nurses constantly referred back to their worry of documenting child/tamariki protection issues when there was ambiguity and uncertainly around a lack of concrete evidence. These tensions existed as they thought through the wider implications of their responsibility firstly as a Registered Nurse, secondly in their nursing role as case manager and Plunket Nurse, thirdly as a child advocate and fourthly how their documentation might be used in a court of law at any time in the future.

I've got to make sure it's right [documentation], you [have] got to protect yourself. [PN 2]

It's something you have to get right. We can end up in court. [PN 3]

I work hard on documentation. You have to get it water tight. [PN 6]

I found the use of the metaphor 'water tight' interesting. Instantly I had a picture of that giant sea going vessel, doomed to sink, the Titanic. The surety the passengers were given, that the ship was 'water tight' gave them the 'no worries' feeling. No iceberg could penetrate it, nothing, could go wrong. But it did and it was a catastrophic disaster. It was not 'water tight'. So too for these nurses, they want their documentation to be 'water tight', that nothing will be found inaccurately recorded or the lack of documentation would not find them in positions of professional risk. They worried that their documentation if called upon in a court of law would not stand up to the test of defense lawyers, knowing that documentation is looked at very closely for discrepancies. Inaccurate, judgmental comments or lack of documentation relating to the protection of a child as a Plunket Nurse worried participants. On the other hand what and how to write nebulous or gut feelings produced further dilemmas.

One nurse described her situation of going to court as a worrying and anxious time.

> *Going to court was stressful. I was anxious of the unknown although the policeman tried to explain before I went in, it was too little too late. [PN 3]*

'Too little, too late', describes the lack of information the police gave to the nurse and having left this to just prior to entering the courtroom to give evidence. This made the nurse feel unprepared for the proceedings of the court room. The lack of police briefing increased her anxiety, that fear of the unknown, left her with overwhelming feelings that the whole process was just too much of a burden. The information she carried was more to do with gut feelings, something that she had found difficult to document with any accuracy, feelings that could not be described in a concrete objective way. She tormented herself with questions before the court appearance:

> *Did I write enough to convey my feelings at the time of the event? If I had only… taken more time to reflect on the feelings I had? What will they [the lawyers, judge, jury] think of me as a nurse? Did I do enough to protect that child? Did I look hard enough, long enough? [PN 3]*

Another nurse described that having gut feelings affected her practice.

> *It affects how I work, I've got to see this family more, I've got to go deeper, work harder, listen more. [PN 5]*

The anxious feelings of 'getting it right' and making documentation 'water tight' brought other significant tensions for the nurses. These two tensions combined with the fact that difficult or ambiguous situations involving 'gut feelings' took more time than can be factored beforehand into any given days work schedule.

> *It is hard at the end of a days' work to then start and write up your gut feelings. You are tired, you have other things at home to focus on, but you can't, you still have to face this formidable documentation and that obligation to document 'feelings' never leaves me, it sort of haunts me until I think I've done the best I can. [PN 6]*

The pulling forces between 'having to get it right' and 'water tight' together with the pressure felt by time constraints, another life outside of work hours, and legal implications could be felt as struggles between the rationale of nurses time and professional responsibilities. Two nurses added how they felt at the end of their actual working hours, and still faced daunting documentation. They left me with a clear understanding that 'getting everything right' was just more pressure, and that can be heard in the nurse's voices as an audible expression of the stress of their roles.

It's amazing after a few visits you think, something is not quit right here. I just had this gut feeling at the time that something just wasn't right and it wasn't until I had done a few visits and put more layers on an onion so to speak and watching the child's development and finding the mother comatose on the couch that sort of layered it up, the gut feelings [I had] to make sort of an actual thing. But sometimes you don't have time to do that. [PN 3]

Sometimes you find out later that your gut feeling turns out to be a whole lot worse than you thought and you start questioning yourself and asking 'what if'? I don't like the sick feeling I get in that situation. [PN 3]

You need time to follow up and do a really good job. [PN 2]

When it came to nurses documenting gut feelings both in the Plunket Health Record and in notifications to CYF, they deliberated on choosing language that would adequately describe their gut feelings that which was not visible yet something that made them feel worried and weary but as yet was hidden from them. The nurses knew that something was not right about a particular situation despite *'drawing on everything you know as a nurse' [PN 1].* Yet they found it was very difficult to use words that were not just professional judgments or personal assumptions.

Reflection is so important to me before I document anything, but that takes up time, often my own time, not paid time. [PN 2]

One method that the participants used to try and protect themselves from professional miss-judgments and personal assumptions was to try and 'keep an open mind'. The balance between 'keeping an open mind' and not reading more into a situation than was actually there was described by one nurse as:

Not coming to a quick conclusion. [PN 2]

The fear of 'getting it wrong' or 'missing something' through a quick conclusion equated to nurses wanting more time to dwell and reflect on situations where something was amiss, having not yet identified what that might be.

There may be other reasons other than what seems obvious to you, for example it might just be the family, it might be cultural. There are lots of factors to take in. After a few visits you think something isn't right but it's keeping an open mind the whole time. [PN 2]

I always go into a visit with an open mind, but am conscious of watching for signs of physical, emotional, psychological abuse/neglect. [PN 2]

Getting as much information as I can without looking like I am, is important to me, as I don't wish to look like I'm trying to get more from them in some situations. This makes me anxious. [PN 2]

This was seen as very important, that gaining as much information as possible before making reporting decisions was a critical skill. In the ambiguous/uncertain cases of suspected child abuse/neglect, the nurses interviewed tended to adopt a 'wait and see' approach. This was not seen as the 'soft' approach or that the issue would simply 'go away', as the nurses stressed to me that the decision to report or not, 'is always there'.

I feel like making these decisions is always there. It's just part of the job, the tricky stuff you have to deal with. [PN 2]

It's tough making these decisions, it makes me feel like I have become a CYF worker as that is effectively what we are doing. [PN 6]

I tend to adopt a 'wait and see' approach when a gut instinct happens, I'm afraid of jumping in too soon and destroying what relationship I might have with the client. [PN 2]

I worry if I report will I get my foot back in to the door, who will be there for them if I can't get back in? [PN 2]

Making decisions to report or not to report is about weighing up and measuring up those protective and resilience factors, and sometimes that is really hard, really hard to carry that load around with you. [PN 4]

Sometimes I ask myself 'is this a cultural norm for this whanau? I need to know more. Should I report this? [PN 5]

There came a point where nurses realized that playing the 'wait and see' game was not always in the best interest for either nurse or client. As they described this self awareness I saw this as their 'wake-up call'.

When I assess a case as border line, the way I am feeling towards CYF as an organisation I would probably monitor rather than report. But there is a point when I think, gosh you are taking a risk here, then obviously I would talk to someone else about it. You have got to keep yourself safe; I don't want to end up in court. [PN 6]

Another nurse described feelings of guilt when she discovered information about the family that she felt she should have discovered much earlier. The information she realized would have assisted her in making decisions to support and/or report a family/whanau.

Sometimes I feel guilty, I should have probed more to have found out that the partner was in jail, I didn't know for three years, I should have tried harder to find out about the partner, I could have done more. [PN 5]

The guilt expressed by the nurse highlights some of the effects this type of work leaves with nurses for long periods of time. During her interview she took the time to reflect on the lost opportunities from not having tried harder and to dig

deeper to unravel the family dynamics. During the interview some nurses started to question their own skills around communication, was it effective enough? Should they pry further? Or did they risk being shut out of the family and closing the channels of communication. Some of the nurses expressed that hard lessons had been learned from these types of experiences.

I'm very conscious of not rubbing them up the wrong way and what if they suddenly take exception to me for whatever reason [PN 2]

That's always in the back of my head [personal safety]. It's just human nature that you want to be liked, well received and to help. [PN 2]

Nurses wanted to be 'liked'. They wanted to be trusted, welcomed and to feel like they have made a difference towards the health and well being of families/whanau. They wanted this to be a reciprocal relationship.

Nurses talked about personal safety from a variety of perspectives and I found it overlapped with how nurses described the 'hardiness' they required to 'keep themselves safe'. When the participants were describing in general their day to day work and the practice situations they found themselves in with regard to suspected child abuse and/or neglect, personal safety was never too distant from their minds, as this nurse described:

We have got our policy we can go back to. It is something I haven't read in great depth. So that is something that I realize through doing this interview that I probably need to do. [PN 2]

We have processes that may make you feel safe, but often you have to think on the spot, you have to implement something there and then or plan how will I get out of this house if something goes wrong, what will I do, how will I respond? That makes me very anxious for both my safely and whoever is in that home. [PN 4]

This nurse gives an example of the three modes of engagement the Ready-to-Hand, Present-to-Hand, and Unready-to-Hand described earlier in this report. In her first comment she referred to Plunket policies that outline processes and

guidelines in both child protection work and personal safety issues. This is the information that allows nurses to proceed from the Ready-at-Hand (armed with the information required) to proceed to the Present-to-Hand, the action required to remove oneself from an unsafe situation. The Unready-to-Hand example is illustrated when the nurse states 'what will I do if something goes wrong; how will I respond?' The nurse has thought about it but as yet does not have a plan of action to allow that smooth ending to a situation.

> *I feel uncomfortable doing child protection work, it's a personal safety thing when you are dealing with child protection issues. I always get the feeling that the family thinks I'm one of 'them' a Child Youth and Family Personal Authority like [figure] so you feel very much an outsider. I find that uncomfortable. [PN 2]*

This nurse feels that in her child protection role the rights of the child/tamariki must be upheld but through this she feels that some families see her colluding with CYF. Nurses were anxious about this perception from some families. It interfered with the relationship building process, it hindered that trust and respected integrity between health professional and family, but mostly it was seen as a barrier to being the 'skilled helper' for the child/tamariki.

Summary

Four major themes have been identified from the transcripts of the participant interviews. It was difficult to separate the data into themes. Each theme overlapped and intermingled with each other. The themes formed a part of the whole experience of nurses making decisions to report suspected child abuse and/or neglect in their practice. Theme one looked at building and maintaining nurse-client relationships and protecting children/tamariki. Theme two looked at stress, anxiety, resilience and hardiness of nurses. Theme three was identified as relational time and lineal time as a factor within child protection work. Theme four explored gut feeling, documentation and personal safety issues that where problematic for nurses when suspecting child/tamariki abuse and/or neglect. Chapter five will provide a discussion of the findings and explore the meaning of these for Plunket nurses.

CHAPTER FIVE

Discussion

Introduction

The aim of this chapter is to discuss the findings in relation to the four identified themes. The challenges that nurses face are brought together from the findings and current literature in discovering the meaning of the experiences of Plunket Nurses making decisions to report suspected child/tamariki abuse and/or neglect. The tensions between uncertainty, certainty, legal and ethical obligations and suspected child/tamariki abuse and/or neglect within nursing practice are discussed.

The Challenges nurses face

This study brings together the views and tensions of Plunket Nurses who have experienced making decisions to report suspected child abuse and/or neglect. The complexities and 'every-day-ness' of Plunket Nurses working in communities is not straight forward. This work uncovers an unknown and often uncertain pathway from the moment the nurse attempts to make contact with the prospective client. The participants of this study have provided many examples of the Unready-to-Hand mode of engagement (Heidegger, 1927/1962).

The Ministry of Health funds Plunket to deliver a Universal Well Child Service to children/tamariki 0-5 years. Nurses book clients in knowing that for a first visit with a client and new baby they need to allow one hour. Subsequent visits either home visits or clinic appointments are approximately of 30 minutes duration. In reality nurses identified that their daily expected work load is affected when the flow of smooth or 'Ready-to-Hand' (Heidegger, 1927/1962) practice is interrupted and that this was real and tangible and was often the 'norm' of their days work. This concerned them because they felt some clients 'missed out' on the full entitled visits. If they spent too long with clients that required more time unraveling the complex uncertainties the family presented with there was limited time for less complex clients. The nurses felt that if one

visit took longer than anticipated, then the clients for the rest of the day would need to get shorter visits if the nurses day was to end 'on time'.

Time aligned with stress, working long hours and nurses being pressured for time (Beatson, 2007; Rowse, 2009; Sye, 2008) was identified as a significant barrier that impinged on reaching self determined and organisational goals. The lack of time was described as impacting on the amount of reflection they could put into making decisions to report. Nurses wanted more time to consider what they suspected. They did not wish to rush into the decision making for fear of 'getting it wrong'. This parallels with Lazenblatt and Freeman (2006) and Rowse's (2009) studies that identified nurses experience internal conflict when wondering it they had acted for the right reasons, resulting in self doubt. The pressure of time was also described as just 'whizzing around' from client to client with the possibility of missing subtle signs of child/tamariki abuse and/or neglect. This just compounded the stresses encountered throughout the days work.

Plunket Nurses are case managers. To be effective at managing their case load they need strategies to manage time efficiently and effectively. The Standards of Practice for Plunket Nurses (RNZPS, 2009)

> define the desired and achievable range of performance with which actual performance can be compared...therefore they (nurses) must be continually mindful of professional responsibilities to themselves, colleagues, volunteers, clients and the organisation. (p. 3)

One of the competencies states "Provides adequate time for discussion (with client) in the Well Child/Tamariki Ora setting mindful of the responsibilities of case management" (RNZPS, 2009, p. 22). Balancing case management time as per Standards of Practice and delivering the universal service across all clients in caseload in a timely manner brings challenges. Nurses were mindful of the tensions between time and demands, but were at odds to know how to manage both successfully within work hours.

When the Unready-to-Hand (Heidegger, 1927/1962) experiences of suspected child abuse/neglect impinge on time, Plunket Nurses experiences tell of staying behind after hours to complete reporting obligations. Nurses described needing time for reflection and discussion with a colleague or Clinical Leader before documenting their suspicions. Hunt and Joslyn (2000) and others (Appleton, 1996; Brush & Daly, 2000; Condiffe, 2008; Lazenbatt & Freeman, 2006; Rowse, 2009; Sye, 2008) discussed pressure of time, work load, and organisational targets having negative effects on allowing for reflection and quality decision making. Incomplete or inadequate documentation made participants fear court appearances where their documentation would be under inspection and inadequacies drawn into public scrutiny and challenged. This was described by the Plunket Nurses as uncomfortable, frightening and having a desire to avoid those situations. One nurse felt unprepared for her court experience, not knowing what to expect once in the witness box. This was an anxious and stressful time. Although feeling unprepared she felt supported by her Clinical Leaders presence [PN 3]. These experiences align with a recent study by Land and Barclay, (2008) who state that nurses have been criticised following scrutiny of their documentation in courts of law for failing to make adequate documentation regarding child abuse and neglect.

Of real concern was the 'how' to document subjective or intuitive feelings of suspicions when no objective signs exist. The literature confirms that professional opinion involves suspected child abuse and/or neglect is complex (Ling & Luker, 2000; Munro, 2002). Only two studies were found that contained a sentence or two on the 'how' to document suggesting a gap in current literature. Munro advocates nurses must write in client notes their basic cause for concern, risk and protective factors, when abuse or neglect is uncertain. This includes strategies they used for the purpose of preventions as part of effective practice.

Building nurse-client relationships is presented in the literature as the corner stone or foundation to maintaining a trusted working relationship (Davis et al, 1997; Keatinge et al, 2004; Seible, 2009; Samwell, 2005; Wilson & Huntington, 2009). In nursing it is linked to health outcomes so is pivotal to child/family

health and especially important when working with vulnerable families (Lambert, 1992; Rodriguez, 2002; Scott, 2010; Wilson & Huntington). This understanding was confirmed by the nurses in this study through their consistent perseverance in first locating clients who were elusive and secondly the importance they gave to building and maintaining a trusted relationship. They all understood the powerful underpinning characteristics of relationships linking to health outcomes for children and families in community nursing. The emphasis nurses placed on this was understandable and at the same time consumed a lot of time and energy.

Nurses consistently referred to the barriers to accessing some clients for their first Well Child/Tamariki Ora visit and on-going visits, and the time factors involved. One nurse in particular described immense self determination in finding clients and the great lengths she went to. Along with this went feelings of frustration, anguish and self questioning about 'why can't I find this family'? [PN 5]. I sensed that although this nurse vented frustration she also seemed in control of the situation and this control displayed characteristics of self confidence. Self confidence is linked to cognitive features such as optimism, intelligence and humor (Edward & Hercelinsky, 2006) and leads itself to a resilience and hardiness. Nurses in this study described the need for both these attributes. One nurse stated that resilience and hardiness is what makes a 'good' Plunket Nurse [PN 4]. Additional features of nurses' resilience and hardiness is the ability to be flexible, goal orientated, have coping skills and be active in problem-solving. This study confirms previous findings (Edwards & Hercelinsky) and indicates qualities perhaps ideally suited to Plunket Nursing. Low hardiness is associated with burnout in nurses (Edwards & Hercelinsky) Gustafsson, et al. (2008), stated "that one is torn between what one wants to be, the ideal, and what one manages, one's reality, ideals have become more like demands" (p. 525). The reflection is that this struggle to live up to one's ideal, maintaining an accepted image of managing, is burden-some in itself. As one falls short among all the never-ending increasing demands, one limits the space for inadequacy. What the literature does not reveal is the question of what are reasonable demands versus unreasonable demands?

Nurse-client relationships are reported in this study and the literature (Davis, Day & Bidmead, 2002; Hartrick-Doane & Varcoe, 2005; Rowe, 1996; Tapp, 2000) as being foundational to building trusting and lasting professional relationships. The family partnership model is proven through studies (Davis & Rushton, 1991; Davis & Spurr, 1998; Wilson & Huntington, 2009) to enhance the building of effective, respectful, helping professional relationships. It is ideally suited to sensitive and difficult conversations and therefore ideal for nurses suspecting situations of child abuse and/or neglect.

The nurse-client relationship was felt to be broken by one nurse [PN 2] who said when she made a decision to report it was like she had 'stabbed the client in the back'. Rather than working in the family partnership model of care, the nurse has changed the 'power' dynamics. The nurse has made the decision outside the family partnership model. It concerned her that this decision would mean she would not be able to get her foot back into the home, and who would be there to keep a professional eye on the children. It felt like a betrayal of professional trust and made the nurse feel like she had just installed a barrier for access to the family, in particular the children. The nurse-client partnership relationship was felt to 'hang in the balance'. If the nurse chose not to report, the relationship and access to the children probably remained and she could continue to 'monitor' or 'wait and see' what happened. If the nurse reported it may result in a severing of the relationship. In that event nurses felt concerned if their report was not considered significant by CYF, because they had now been cut off by the family and they worried about the children left in a possibly unsafe environment.

The literature supports these concerns as moral decisions nurses battle with and the over-all desire to protect both child and client relationship. However this is not always possible when a decision to report is made (Bannon & Carter, 2003; Jackson-Barton & Froese-Fretz, 2000; Samwell, 2005). Given the complexity of making the decision to report where the evidence of neglect or abuse is unclear, it was evident in this study that some nurses were prepared to 'wait and see'. Nayda's (2002) study also confirmed that nurses sometimes took this approach. The complexities nurses face in making decisions to report

are blurred by professional accountability and responsibility and as the nurse tries to protect the child and save the nurse-client relationship (Bannon & Carter; Samwell; Katzenberger, Ruesch & Winch, 2000).   One nurse spoke of the importance for her to 'be liked' by clients [PN 2] not only as a means of building relationships and maintaining them, but she felt it was a basic human need.   Being liked made her feel comfortable in whatever context she was working in. I could only find one study that reported health care workers feared being 'un-liked' by clients.   Being 'unliked' made health care workers feel uncomfortable and felt like a barrier to building client-worker therapeutic relationships. (Gustafsson et al., 2008).

The participants spoke of becoming more 'bold' or 'frank' or 'direct' as they gained experience and confidence screening clients for family violence and when suspecting child abuse and/or neglect. Three nurses believed that they more frequently experienced positive results from being upfront, open and transparent in most situations. They were more hesitant to screen or ask sensitive questions if they thought the environment felt unsafe to ask.   Two nurses reported that they did not like asking. Some days they just didn't feel like opening up a 'can of worms', they didn't feel in the right 'space' so they didn't ask [PN 1; PN 6].   Screening is however reported as increasing rates of disclosure (Bacchus, Mezey & Bewley, 2003; Bateman & Whitehead, 2004; Ministry of Health, 2002; Peckover, 2003).

The pressure of time impacted on writing quality reports or client notes, when in suspected child/tamariki abuse and/or neglect it mattered most.   Nurses know that what they record, or do not record, can be called upon in a court of law.   Whilst this concerns them they also want to demonstrate professional integrity. The only way they can manage these barriers and reduce their own anxiety about leaving 'unfinished work' is to stay behind after work hours or take it home. They do not see any alternative and feel that the organization had unwritten expectations of time in relation to child protection work. Unreasonable demands are being carried by nurses as personal failure which contributes to burnout. This comment is validated by Waterworth (2003) that

management of time incorporates important performance standards RNZPS, 2009).

Documenting and/or reporting suspicion of child abuse and/or neglect was regarded as a high priority. This was stated by the nurses as being a difficult process. Documenting subjectiveness was so difficult that one nurse stated 'I need help with this' [PN 3]. Documentation called upon many nursing skills. The literature supports the impact of time having negative effects on the quality of decision making and report writing (Brush & Daly, 2000; Hunt & Joslyn, 2000). The importance nurses placed on taking time to reflect on their uncertainty before writing in client notes was significant. They worried that they would not get their documentation 'water tight'. They worried that gaps in their documentation could be called upon later in court and be used to question their professional judgment in either reporting or not reporting suspected child abuse and/or neglect.   Working within a socio-environmental approach to primary health care Well Child/Tamariki Ora nursing, documentation should reflect a holistic assessment in which crucial judgments' should be made on the collective signs, symptoms, risk and resilient factors observed or suspected. Each characteristic should not be viewed in isolation but rather time should be taken to consider each as part of the holistic approach to assessment (Lewin & Herron, 2007).

Nurses in this study all voiced concerns that were directly linked to balancing their days work with contract obligations, professional responsibilities of legal, moral, and ethical practice and the uncertainties they faced in practice situations. Of note here is that nurses referred to contract obligations rather than recognising the work they do is around caseload management and delivering a universal service. The nurses felt the emphasis was placed more on the organisations target obligations than the delivery of a universal service. The balancing act between all components of their role consumed more time and energy and in turn created stressful complexities each with undesirable outcomes for the nurses. Stress and moral distress presents in disturbances of bodily functions for example, feelings of helplessness, anger, tiredness,

sleeplessness, exhaustion, gastrointestinal disturbances (Taylor & Barling, 2004; Patronis-Jones, 2007). These are some of the effects nurses experienced in this study. These stresses can lead onto burnout in nurses. Nurses then felt powerless and vulnerable (Edwards & Hercelinsky, 2006; Gustafsson, Norberb & Stradberg, 2008). Nurses in this study talked about the demands of the job, including being politically driven by targets and the demands of the Well Child/Tamariki Ora Schedule (2010) as the largest contributor to feeling drained and exhausted at the end of the day. Two nurses frequently considered resigning, but their passion to be involved with children/tamariki and families/whanau in Well Child/Tamariki Ora nursing, over rode this nagging thought. Reduced job satisfaction and intention to leave appears to be related to burnout from continual stressful situations (Patronis-Jones, 2007; Skovholt, 2001; Taylor & Barling, 2004).

Intuitive feelings or gut feelings as described by the participants dominated this study. All the participants used the term 'gut feelings' however none were readily able to describe it. One nurse described it as a feeling that came after processing prior information. She questioned herself later on how she thought the conversation went with the client, how open they were with her and how direct was she with them [PN 4]. Although not verbalised by the nurse, this was a self reflective process that enabled a 'weighing up' of the information she had, and thinking about the environment she had gathered it from. Other nurses described it as feeling uncomfortable, worried, and a feeling that something wasn't right. Still another nurse said it was 'her feeling'. This was also explained as a feeling that had been experienced many times previously and she had come to trust it and use it as a means for making decisions.

The literature is divided over the use of gut feelings, intuition or tacit knowledge. Zinn (2008) and Ling & Luker (2000) support the idea that gut feelings set off alarm bells or act as a silent alarm for nurses and it awakens their senses to probe further for additional information from clients. Nurses in this study identified with alarm bells that lead them to 'dig deeper' needing to find out more; that something 'was not right'. Zinn reports that intuition can compliment rational considerations that help reduce and manage uncertainty

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when making decisions to report. Welsh and Lyons (2001) state that health professionals should not base decisions on intuition alone, but intuition should be valued as part of the decision making process. No nurses in this study made decisions to report based on their gut or intuitive feelings alone. Some of the nurses felt that in preference to talking with their Clinical Leader that talking with a colleague was of more help. Nurses felt that their colleagues were closer to the reality of child protection work out in the field every day than their Clinical Leader was. Talking to another nurse working at the grass roots appeared to provide nurses with the feeling of being more understanding as to how they were feeling about making the difficult decision to report. Clinical Leaders were seen perhaps more for their ability to support the nurse in making a decision to report. Participants conveyed the importance of not making decisions in isolation that making contact with their Clinical Leader was important and policy directed this before any report was sent to CYF.

Previous exposure to risk factors that contribute to child protection issues, be it personal or practice experiences could be a precursor to experiencing 'gut feelings' (Welsh & Lyons, 2001). One nurse in this study described her naivety in identifying risks that more experienced staff identified more readily. She felt that the naivety she brought to child protection work was a major barrier to identifying potential or actual risks and highlighted for this nurse the increased risk she had placed herself and the child in because of her inability to see some of the signs. This nurse's previous life experiences had not included exposure to drugs and abuse so she was unprepared for working with these issues. This indicates the importance of regular ongoing education about the psychosocial aspects of working with diverse families. Benner's (2001) novice to expert framework indicates that nurses are at different stages in their journey to knowledge acquisition. However experience alone does not provide all that is required to make professional judgment decisions. Education and experience combine to build knowledge in all areas of the decision making processes. The complexities facing Plunket Nurses in making decisions to report suspected child/tamariki abuse and/or abuse cannot be underestimated.

Nurses in this study talked about having a Plunket child protection policy to keep them safe in making decisions, however, they were often caught needing to think on the spot. For example one nurse [PN 4] explained that at one of her visits she asked the family violence question and the client got up and walked away from the room and did not answer her. This situation left the nurse feeling 'so what do I do now'? The nurse was at that moment left in 'no mans land' feeling very uncomfortable and wondering how she was going to respond to the clients reaction. Should she as the nurse ignore it, or should she ask again? The nurse also did not wish to assume that there is family violence in the clients' life, but the reaction of the client led her to believe there may have been.

Human life is relational, complex and changeable. Because of this there is no way a nurse can know for certain which is the best way to proceed or know for certain what is really going on for people (Hartrick-Doane, 2005).

> Competent, skilful practice does not rest on certainty but rather on inquiry-safe practice is grounded in a continual process of questioning how best to proceed with particular families in particular situations. (Hartrick-Doane, p. 197)

This practice is known as the inquiring facilitator rather than the expert 'fixer'. Hartrick-Doane suggests rather than nurses taking a "professionally distant stance and treating people as objects we are observing…it means involving oneself as a compassionate stranger" (p. 197). Seeing families in the context of their culture, and social and economic circumstances goes beyond thinking purely about policy. It is suggested that this be considered when educating nurses around the Manitoba Risk Scale and policy. It is further suggested that nurses share their unique scenarios within their practice with their team to provide exchange of ideas, support and learning opportunities.

Another nurse commented that

> *'If we just purely went on policy I'd be reporting every second person I saw!' [PN 1].*

This nurse indicated she used her professional judgement combined with policy before making a decision to report suspected child abuse and/or neglect in uncertainty. Reporting purely on the Manitoba Risk Scale (RNZPS, 2008) was felt to be underrating the ability of the Plunket Nurse to use professional judgement that included assessing the family's relationship with the Plunket Nurse and their resilience and risk factors. Where it was quite clearly obvious that risk factors were evident, nurses did not hesitate to report, but were more hesitant when they only suspected abuse and/or neglectful situations.

Levels of confidence in making decisions to report, were evident in this study. Where gaps in knowledge or experience in identifying risk factors exist, nurses were less likely to report. This is identified in other studies as a significant factor associated with confidence levels (Feng & Levine, 2005; Nayda, 2002). The greatest predictor of reporting tendency is found in nurses with confidence in self. Confidence is related to peoples' self-efficacy which is defined as the personal belief in one's abilities to inspire motivate and to perform work confidently (Manoijovich, (2005). Where self-efficacy is enhanced it has been shown to improve professional practice behaviours (Manoijovich). Overall, self-efficacy concerns the confidence in people's capacity to perform tasks they believe will produce desired outcomes. Accordingly this would suggest that nurses need a level of self confidence to make decisions to report in uncertainty. It seems logical to suggest here that nurses require a level of self confidence to enable them to make reporting decisions, to what level could be the topic of further research.

As I reflect back on this discussion I made notes in my research journal.

This journey has extended my personal learning about the complexities nurses face around making decisions in uncertain child protection situations. It has made me stop and think for long periods about each staff member who reports to me. I now find myself assessing their confidence levels and wonder how I would 'score' them. My thoughts also have ventured off and thought about the links between confidence levels, professional judgement decisions and the content of policy. Perhaps there

is still some work to be done in this area with staff to increase self efficacy

levels.

Conclusion

From this discussion it becomes obvious that there are many over lapping complexities and tensions for Plunket Nurses working in the area of suspecting child abuse and/or neglect.   This work finds nurses engaged in difficult multifaceted decision making situations.   Decisions must be made within the bounds of government and nursing legislation and organisational policy, including the rights of the child. This includes ethics, professional judgment, documentation and reporting obligations. The final chapter will bring this study to a conclusion with an outline of recommendations and the limitation of this study.

CHAPTER SIX

Conclusion and Recommendations

Introduction

The goal of this hermeneutic phenomenological study was to bring meaning to what it is like for Plunket Nurses to make decisions to report suspected child abuse and/or neglect in uncertainty. The Heideggerian (1927/1962) philosophy was the foundation for the methodology. van Manen's (1990) framework guided the data interpretation steps to end with rich in-depth data obtained. A research journal was kept to bring awareness of meaning and personal growth from this journey.

This study highlights the difficulties Plunket Nurses face in the complexities of making decisions to report. Each participant brought their individual professional and ethical dilemmas along with their practice experiences. The nurses described perspectives of what it is like 'being' in the world of child protection work. Their personal and valued experiences have taken me on a journey looking through the phenomenological lenses to uncover insightful information. This chapter concludes the study and offers recommendations specifically for The Royal New Zealand Plunket Society but may also be found useful to other organisations that have nurses working in the area of child protection.

The significance of the study was to reduce the gaps in the current literature where little research has been undertaken that explores how those who are required to assess risk actually do so. This study contributes to future Plunket Policy development where assessing risks of the unborn child needs to be considered and included. Outcomes of this study contribute to supporting nurses in their decision making. Therefore, this research adds to the limited research previously undertaken in this area, especially in the New Zealand context.

Primarily, the recommendations relate to the implementation of further Plunket Nurse Education around suspected child/tamariki abuse and/or neglect to enhance current skills and confidence levels in practice. The study limitations are explicated and the gaps between research and nursing practice with suggestions for future research are presented.

Summary of this study

This hermeneutic phenomenological study has captured the individual experiences of six Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertainty. Using van Manen's framework to analyse the data the findings represent the complexities the decision making process presents. The challenges facing nurses are many. They include locating the elusive client, building nurse client relationships, identifying suspected child abuse and/or neglect, making decisions to report in uncertainty, working within cultural diversity, balancing time and caseloads and documenting subjective or intuitive feelings. Further to this, nurses felt uncomfortable when trusting nurse-client relationships had been built, only to 'stab the client in the back' when it became necessary to report abuse or neglectful situations.

Nurses found child protection work stressful with varying levels of stress experienced from feeling like one was 'carrying a heavy load' through to bodily function disturbances and thinking frequently about leaving the job. Self confidence or lack of it, appeared to be linked to the level of experience and knowledge a nurse had with child protection work. What nurses did report as being of most benefit were conversations with other colleagues when faced with difficult decisions and they tended to access a colleague before approaching their Clinical Leader, feeling that their colleague was 'closer' to the grass roots of the work.

What nurses identified as needing to improve their reporting decisions was regular ongoing education that included up to date research findings, case discussions, working in a culturally diverse society and skills in documenting intuitive feelings in such a way that protected their professional integrity when facing scrutiny in court appearances or interviews with police. Nurses also wanted recognition that acknowledged the out of hours work undertaken to

complete documentation. A time of reflection before documenting suspected abuse and/or neglect was felt necessary to truly reflect subjective information.

Recommendations - Future research opportunities

Nurses in this study outlined increasing demands on their time and energy. What is seen as ideal and what they could manage as a nurse appeared, at times, to be at odds. The literature did not provide any insight into this aspect of nurses' work. This could be an area of potential research.

Rodriguez (2002) in his New Zealand study, recommended investigation into the influencing factors on professionals' decisions to report or not.   This includes whether more comprehensive training would improve accuracy and reporting behaviour and is suggested here as another research avenue. As identified in this and other international studies, nurses want further education about documenting their intuitive awareness that is professional, accurate and 'safe', and acceptable in a court of law. Participatory Action Research working with nurses around this difficult area could be a useful approach to developing further skills and knowledge.

The dilemmas for nurses who try to engage or do engage with unwilling families are missing from the New Zealand/international nursing literature. This is seen as another opportunity for future research, one ideally suited to research within the population of Plunket Nurses and important to increase access for these potentially more 'at risk' families/whanau.

Recommendations for Plunket Nurse Education

The literature confirmed what Plunket Nurses voiced as their needs in assisting them in making legal, ethical, moral, and professionally safe practice decisions. This includes regular education around child abuse that includes practice scenarios, reflection on real case situations, and practice sessions on documenting intuitive feelings. Also regular professional/peer supervision and on-going support from line managers was requested. It is suggested that some self development work could be useful in terms of managing ambiguity, and not taking responsibility for issues that are agency, managerial or interagency issues.

What is less clear in the literature is what Plunket Nurses identified as their needs to successfully carry out this work. Plunket Nurses want knowledge about tacit or intuitive feelings and how to document this type of subjective information. Education around court appearances was also requested. What would be expected of them, and how does the court system work. Nurses did not wish to learn on the day should they ever need to attend. Another issue was how they can make their documentation 'water tight' so they could feel confident of their documentation when subjected to lawful scrutiny. They want credible documentation rather than to jeopardise their professional integrity in courts of law.

Plunket Nurses identified the need for consistent feedback from CYF following reporting suspected child abuse and/or neglect. Clarification of section 5.2.2., with nurses around the Interagency Protocol document (RNZPS & CYF, 2009b) regarding CYF commitment to Plunket following nurses reporting child abuse and/or neglect is indicated. Consideration of how Plunket can further strengthen its relationship with CYF at a local level to enhance feedback from them on their reporting could improve outcomes for families/whanau is suggested. Nurses felt this would greatly assist them in planning on-going nursing care for both child/tamariki and family/whanau and reassured them about their safety in returning to the clients' home.

Although nurses are required to have culturally 'safe' practice (RNSPS, 2009) it appears from this study that as cultural diversity expands in New Zealand, nurses are experiencing a knowledge gap in cultural competence. This suggests future educational opportunities in aspects of clinical practice within cultural diversity and exploring the power relations within each as suggested by Ramsden (2002).

Plunket Nurses self identified the need for additional and regular education and support in identifying suspected child abuse and/or neglect. The literature also suggests nurses lack of knowledge concerning what the risk factors or 'red flags' are (Adams, 2005; Barton, 2000; Lazenbatt & Freeman, 2006; Paavilainen & Tarkka, 2003). This is knowledge that is fundamental to child protection work. One response might be to consider having a nurse within teams as the

dedicated 'resource' or 'expert' in the field of child abuse and neglect. It is suggested that this nurse be supported to undertake the Child Protection Studies Certificate and perhaps the Advanced Certificate. Holders of this certificate have a comprehensive knowledge about a wide range of issues and influences that affect children and what puts them at risk. It provides training in how to access the most effective resources in supporting families. Participants will also develop a thorough understanding of the basic issues involved in child/tamariki protection and child/tamariki advocacy. This course is run by the Child Protection Studies Trust based in Hamilton. The Certificate is New Zealand Qualification Authority recognised. This could be a valuable educational opportunity for a nurse with a particular interest in child protection and in return be an additional support to other team members.

Using Heidegger's three modes of engagement (Heidegger, 1927/1962) with staff at an education day and providing scenarios of abuse and neglect could provide a useful reflection framework for nurses. The framework may assist nurses to understand in context their Ready-to-Hand and Unready-to-Hand experiences in a different way, rather than place blame or guilt on their shoulders for making or not, decisions to report.

Recommendations for Policy

Although the literature reviewed was specifically around child abuse and/or neglect, during the course of my participation in the local Police Family Violence Investigation Report Meeting (PolFVIR) there are increasing numbers of pregnant woman subjected to violence. These cases are 'red flagged' by the local midwife representative at the Police meeting, for follow up with the Lead Maternity Carer for that client. Research indicates where abuse is subjected to pregnant women it is likely to also occur after the baby is born (Charles & Perreura, 2007). Plunket Nurses must consider the 'risks' to the unborn child in families where abuse is suspected or is a reality. Knowledge around the 'risks' for the unborn child should be considered in future Plunket Nurse education. Risks and reporting that take into account the unborn child is missing from Plunket Policy and this is something to consider when reviewing this policy.

The development of a Memorandum of Understanding with the College of Midwives and the Royal New Zealand Plunket Society is put forward here as a consideration to enhance information sharing. Significant information that supports Plunket Nurses in being fully aware of a family's situation is imperative when midwives have prior knowledge of actual or suspected child protection issues. The participants spoke of the lack of significant information around risk factors identified by midwives when referring to Plunket. This could improve health outcomes for infants and other family/whanau members through earlier intervention when risks are known from the first contact with a Plunket Nurse. This study having described and presented meaning and understanding of lived experiences may provide essential reading for nurses entering into the primary health care setting where families/whanau with children/tamariki are the predominant clients.

Limitations to the study

This study has been limited by time, scale and my inexperience as a researcher and in using phenomenology as a methodology. It was expected however that working alongside an experienced research supervisor would ensure the trustworthiness of the methodology and the findings.

Only staff identifying as European or New Zealand European came forward to participate. No Maori or Pacific voices are heard. This may be because few Plunket Nurses identify as Pacific or Maori and may not have been employed in the areas where this study was undertaken. This study looked at nurses' experiences making decisions to report suspected child abuse and/or neglect in general and not specifically to any one cultural group. However, culture difference was identified as a complicating factor for nurses. This could be an avenue for further research.

Weaver and Olson (2006) state that due to an infinite number of interpretations for a given phenomenon that this is a limitation and generalisation is not possible. The small sample size of six participants, although adequate in this qualitative phenomenological study, does not claim to be representative of nurses' experiences across cultures, and communities,

both rural and urban throughout New Zealand. The results cannot be taken to represent all Plunket Nurses experiences. Generalisation was not the purpose of this small exploratory research. A larger scale study using mixed methods could extend this research to discover if the experiences reported by this group of nurses, is shared more widely.

The significance was to capture data from one small sample of Plunket Nurses. However, the results of this study may inform Community Health Nursing research, education and practice regarding how Plunket Nurses experience, describe, define and identify child abuse and neglect and the decisions they make in uncertainty. This study can also add to readers' understanding of the phenomena under study. It is only when we bring the voices of nurses' practice to family/whanau nursing knowledge through the continual nursing journey that knowledge contributes to the responsiveness of nurses (Hartrick-Doane & Varcoe, 2005). This can only be achieved through continual research, listening and recording nurse experiences to build and progress nursing knowledge for all.

Conclusion

Participants in this study where clear about their understanding of reporting responsibilities where physical abuse was obvious. There was less evidence of this around suspected physical or emotional abuse or neglect. 'Grey' areas and gut feelings were more problematic in reaching any conclusion to report, often resulting in a more 'wait and see' approach. Documenting gut feelings and intuition was also problematic as nurses struggled with both fear of 'getting it wrong' and thinking about the right language to use to describe subjective experiences. This study adds to the suspected child abuse and/or neglect literature and highlights the need for regular on-going education to support nurses' professional judgment and intuitive knowledge when making decisions to report in uncertain situations. It is imperative that Plunket Nurses have an in-depth knowledge in all areas to assist them in making decisions to report suspected child abuse and/or neglect in a more confident and competent way for the best outcomes for children/tamariki in New Zealand/Aotearoa.

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Job Description

Clinical Leader

REPORTS TO	Area Manager
STAFF REPORTING	Plunket Nurses Community Karitane Plunket Kaiawhina
BUDGET AUTHORITY	Financial Delegation as approved by the Chief Executive in the delegations policy
FUNCTIONAL RELATIONSHIPS	**Internal** Clinical Advisors Education team Maori Health team Volunteer Services Leaders Plunket Volunteers National Office staff Administration staff Area Society **External** PHO's IWI Other local well child health providers Primary Health Care Nursing Groups External Agencies as appropriate
PRIMARY PURPOSE	To provide clinical leadership for the area care delivery staff, by supporting, guiding, directing, monitoring and evaluating clinical practice in order to meet standards and targets outlined in the Well-Child Framework and contractual requirements and the area business plan. Fully participate in the area operations manager team, setting the direction, communicating and monitoring progress in each team
KEY TASKS:	**LEADERSHIP** To work collaboratively with other Clinical Leader(s) and Operations Manager to develop an area leadership team which will effectively manage area services within the negotiated resource allocation. To actively contribute to the Area planning team To enhance Plunket's reputation through articulate and authoritative representation of Plunket perspectives on child health to other agencies, the media and to staff. To work with the Operations Manager on change management processes that may be associated with best practice, contract and

service delivery alterations.
Contribute to policy development and review within the organization as required

BUSINESS MANAGEMENT
1) Relationship Management
- To manage the Clinical team consisting of direct reports
- Build and maintain sound working relationships with community service providers.
- To build and maintain sound working relationships with local Iwi and volunteers

2) Agreement on Area Business Plan
- To contribute to the development and implementation of the annual plan for the Operating Group which supports and contributes to the overall business plan of the Society.

3) Business Planning
- To actively participates in the Area Operations team and support the Operations Manager and VSL to achieve the area business plan.
- To ensure daily contact rates are met

4) Financial Performance
- To operate within the Area budget.
- To effectively plan and use resources allocated

5) Monitoring Trends
- To provide timely, accurate and relevant reports on clinical issues.
- To utilize Plunket data (such as PCIS, Payroll and any other data and information) to assist in service delivery

6) Quality Service and Delivery
- To continually review the coordination of service delivery
- To be responsible for the quality of Plunket service. To contribute to quality improvement processes (such as Te Wana) and activities to meet requirements and meet client expectations.
- To actively participates in the development and review of policies and procedures where required

7) Management
- Leads and manages clinical practice of care delivery team.
- To guide and supports clinical staff to meet their objectives.
- To recruit, select and orientate clinical staff
- To plan, coordinate and evaluate orientation programmes. To conduct annual performance appraisals for direct reports as per Plunket's policy
- To develop the potential of care deliver staff and identify and develop successors
- To support health, wellbeing and safety of staff
- To support staff participation in professional development

	• to support staff participate in peer supervision • To ensure clinical practice complies with relevant legislation. Standards and policies • Interprets the well child framework in clinical terms with area staff • Applies population health knowledge to service delivery **8) Professional Development** • To increase own clinical and organizational knowledge • To maintain requirements of professional nursing practice to comply with Nursing Council requirements • To ensure an annual performance appraisal is completed by manager **9) Commitment to te tiriti o waitangi** • Establish and maintain positive working relationships, networks and partnerships with tangata whenua, existing and potential client groups, relevant agencies, iwi authorities, community groups, other health professionals and paraprofessionals as required • Performance goals and professional development plans reflect a commitment to te tiriti o waitangi
PROFESSIONAL EXPERIENCE / QUALIFICATIONS	• Registered Nurse with post graduate nursing or health qualification (or is currently working towards) • Current NZ Nursing Council Annual Practicing Certificate. • Extensive knowledge of community, health promotion, primary health care, population health and well child health nursing
CORE COMPETENCIES	**Personal Attributes** • *Cognitive ability* – a balance of conceptual and analytical thinking. The ability to manage complex situations and ambiguity and to do so with speed • *Emotional Intelligence* – awareness of one's own feelings and behaviors; their impact on others; ability to accurately assess other peoples response and emotions; ability to manage one's own emotions and to incorporate own and others emotions and feelings in to the decision making process • *Honesty and Integrity* – demonstrates high integrity, honesty and openness in all interactions and activities • *Client focused* – demonstrates a commitment to working with people to make a difference **Core Leadership Competencies** • *Teamwork* – includes building effective teams and building potential and talent • *Future focused* – includes strategic thinking, decision making, business acumen and flexibility • *Integrity and ethics* – includes open communication and respect and integrity • *Leadership and innovation* – includes innovation and creativity, leadership and emotional intelligence • *Client/stakeholder focused* – includes client/customer orientation, action and results orientation and relationship

	management/marketing
	• ***Cultural awareness*** – includes cultural development (internal) and cultural awareness (internal and external)
	Professional and Technical Knowledge Is recognized by peers as an expert in the Clinical Leadership area and is sought by colleagues to assist in this field; willingly shares knowledge and expertise with others; both formally and informally; contributes effectively to the Clinical Leader team and the Area Operating Team
	Computer Skills The successful candidates will be able to demonstrate a level of understanding and computer literacy in: Excel, Word and emails. Plunket uses Group wise.
	Travel Prepared to travel throughout New Zealand and stay away for up to 3 nights, occasionally.
	Drivers License It is essential that the successful applicant has a current valid drivers license and is willing and able to drive a manual Plunket car.

Signed off by:
Lynn McKenzie, General Manager Human Resources May 2005

APPENDIX TWO

Participant Information Sheet

DATE………………….

You are invited to participate as a participant in this research study which will be conducted outside of your work time. The title of this study is:

"The experiences of Plunket Nurses making decisions to report suspected child abuse and/or neglect in uncertainty New Zealand".

This is a Master's study and is being supervised by Sallie Greenwood Senior Post Graduate Nursing Lecturer and Research Supervisor at Waikato Institute of Technology. Sallie is also a PhD Candidate at Auckland University. Sallie is contactable by phone on (07) 834 8800 extension 8461 during office hours Monday to Friday and will be pleased to discuss any questions you may have about participating in this study or at any stage during this study.

The aim of this study is to gain an understanding in how Plunket Nurses form and make decisions in their role, working with families around child abuse and neglect and reporting this. The study will focus on situations where nurses have found making a decision to report a difficult one due to ambiguity/uncertainty/complex situations. It maybe that a nurse has decided not to report as a result of the ambiguity/uncertainty/complex situation. There is little research in New Zealand into the practice of how Primary Health Care Nurses reach decisions in their practice, and in what context these decisions are made. This research aims to answer these questions and gain a deeper understanding into the issues that are involved in the decision making process and providing an analysis of 'risk' assessment and decision making to report to the Statutory Authority by Plunket Nurses in New Zealand. This is not about your practice being under scrutiny.

This research is being conducted in order to identify and understand current Plunket Nurse practice issues and then to inform Plunket how we might enhance support for Plunket Nurses in clinical practice.

Inclusion Criteria: Plunket Nurses with two or more years experience post Plunket Nurse training who have had experience in reporting suspected or actual child abuse and/or neglect where there has been ambiguity/uncertainty/complex situations in deciding to report. This also includes those Plunket Nurses who fulfill this criterion but for whatever reason have decided not to report.

Exclusion Criteria: Participants must not have worked with or had the researcher as their line manager.

Your participation in this study will involve an interview with the researcher of approximately one to one and a half hours at a venue comfortable for the participant. The interview will be a discussion on the way decisions are developed in practice. All information will be confidential and all identifying information about you will be changed to protect your anonymity including the final report that will be published. You have the right to withdraw from the study or withdraw any information you have provided, for up to two weeks (fourteen days) after the interview date. The interview will be audio recorded, then transcribed by the researcher. Written notes will also be taken.

The researcher will meet with you in person at a date convenient to the participant to verify the meaning of the data following transcribing and analysis.

All interview data will be stored in a locked cabinet only accessible by the researcher. All electronic data will be password protected. At the end of the research you may choose to have your audio tape/transcript returned to you or destroyed by the researcher by way of a professional destruction service. Please complete the questions below to indicate your choice.

1.   Returned to the participant via courier pouch   YES or NO
2.   Destroyed by the researcher   YES or NO

If your answer was YES to question one please complete details below:

Name:

Postal Address:

City:

Phone Number:

Post Code:

Should a participant reveal any practice that is not in keeping with the legal responsibilities and competencies of a Registered Nurse/Plunket Nurse, the researcher has a legal, ethical and moral responsibility to address this with the participant.

Should a participant become distressed during or following the interview, support will be offered by way of the Employment Assistance Programme (EAP) free of charge. Professional peer supervision, clinical leader or clinical advisor support will also be offered until distress is resolved. Debriefing following the interview will also be offered to all participants, and the participant will have the choice of whom they would prefer to debrief with.

A summary of the results can be requested by the participant and this can be send to you on completion of the published results of the research.

This research has been reviewed and approved by the Royal New Zealand Plunket Society (Inc.), and Waikato Institute of Technology Ethics Committees.

You can contact me at the email address below within two weeks of the date at the top of this information sheet and I can then register your interest in taking part in this research and arrange an interview convenient for you outside of your working hours and at a venue comfortable for you. You can contact me on (07) 348 4466 or 021 1292975 or via email at gordonandlynn@xtra.co.nz

Yours faithfully

Lynn Carter

Clinical Leader

Lakes Area Plunket

RCpN., BN., Graduate Diploma, Post Graduate Diploma (Nursing)

Masters in Nursing Candidate, Waikato Institute of Technology

APPENDIX THREE

Participants Consent Form

(Date)

Lynn Carter

Royal New Zealand Plunket Society

Lakes Area

PO Box 2271

ROTORUA 3040

Email: gordonandlynn@xtra.co.nz

Title of Research Study:

"The Experiences of Plunket Nurses Making Decisions to Report Suspected Child Abuse and/or Neglect in uncertainty in New Zealand".

I have read and understood the description of the above-named research study in the information sheet, and had an opportunity to have all my questions answered to my satisfaction.

On this basis, I agree to participate as a participant in the study, and consent to publication of the results of the study with the understanding that anonymity will be preserved. Any discussion and/or documentation between you the participant and the researcher will be keep confidential at all times. Although the study will identify Plunket Nurses as those interviewed, participants will not be able to be identified in any way including from which area they work in.

I understand that all written data will be coded and locked in a file only accessible to the researcher and electronic data will be coded and password protected.

Results of this study will add to the current body of nursing knowledge in the area of child protection work and may be used to enhance practice development and policy.

I also understand that my withdraw from the study can occur for up to two weeks (fourteen days) following the interview date.

I understand should I reveal any practice that is not in keeping with the legal responsibilities and competencies of a Registered Nurses/Plunket Nurse, the researcher has a legal, ethical and moral responsibility to address this with the participant.

I understand that the audio tape and transcript of my interview can be returned to me after the research is published and after any legal holding period or destroyed by the researcher by answering the questions below. Please circle, which applies.

1. Return audio tape and transcript to participant via courier pouch   YES / NO
2. Audio tape/transcript destroyed by researcher via professional destruction service   YES / NO

NAME (please print):……………………………………….

Signature:……………………………………………………

Date of consent:…………………………………………….

Date of Interview:……………………………………………

Email address:……………………………………………….

Contact Phone Number:……………………………………..

(Copy to participant)

APENDIX FOUR

Wintec
WAIKATO INSTITUTE OF TECHNOLOGY
Te Kuratini o Waikato

Waikato Institute of Technology
Private Bag 3036
Waikato Mail Centre
Hamilton 3240
New Zealand

Telephone +64 7 834 8800
Fax +64 7 858 0245
Freephone 0800 2 Wintec (0800 2 946 832)
Email info@wintec.ac.nz
Website www.wintec.ac.nz

e-mail research @wintec.ac.nz

Telephone 07 834 8800 Extn 8460
Fax 07 834 8884

20 March 2009

Lynn Carter
Clinical Nurse Leader
Lakes Area
Royal NZ Plunket Society (Inc.)
Rotorua

Dear Lynn

HUMAN ETHICS RESEARCH APPLICATION
The Experiences of Plunket Nurses making decisions to report suspected or actual child abuse and/or neglect in New Zealand

Thank you for your application which was considered at the Human Ethics in Research committee meeting held on 19 March 2009. I advise ethics approval for your project was granted subject to the following provisos:

- Questionnaires – needs to be renamed 'Interview Guide'.
- Name of the Wintec Supervisor needs to be provided.
- Sighting of ethical approval from the Plunket Society
- Under Question 3.0 remove the three key definitions

Please send an amended electronic copy of your application form and the ethical approval from the Plunket Society and then I can issue you final approval.

The Human Ethics Committee wishes you every success with this project.

Kind Regards

Pamela Tait
pp Hon Katherine O'Regan QSO JP
Chairperson
Wintec Human Ethics in Research Committee

c.c. Katherine O'Regan
Research Leader or HOS

HAMILTON | THAMES | TE KUITI | OTOROHANGA

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APPENDIX FIVE

Royal New Zealand Plunket Society (Inc.)

Ms Lynn Carter
Lakes Area Plunket Office
P O Box 2271
Rotorua 3040

9 May 2009

Dear Ms Carter

The Experiences of Plunket Nurses Making Decisions to Report Actual or Suspected Child Abuse and/or Neglect in New Zealand

Many thanks for the additional information you have provided and for the manner in which you have responded to the seven queries raised in my letter to you, when I indicated that you had provisional approval from the Plunket Ethics Committee.

I am pleased to say that you have satisfactorily responded to each of these points, and you now have final approval to proceed.

On behalf of the Plunket Ethics Committee, I wish you well with your project.

Yours sincerely

PP

D Gareth Jones
Chair, Plunket Ethics Committee

APPENDIX SIX

Interview Guide

The following is the proposed opening interview question that participants will be asked.

When answering questions please ensure client confidentiality by not using any client names, you must use pseudonyms and or non-identifying family information.
"Thinking about everyday practice, that is, practice that is not out of the ordinary, please describe to me in as much detail as you can, about your thoughts, feelings, sensations, experiences and the processes you use when you are with a client where you suspect their child/ren are being abused or neglected".

"Describe to me how it feels for you when you think a child is being abused and/or neglected"

Other questions that will guide the researcher will include asking the participant to:

Think about an experience where the situation has been unclear/ambiguous/uncertain/complex, from your own perspective in regard to suspecting child abuse or neglect:

"Describe an example of an assessment of a child 'at risk'. How did you assess that risk?
What did you do with that assessment?"

"Describe to me your experience of how you make a decision to report suspected child abuse".

"If you had a situation where you decided not to report, can you please tell me about this experience and why you choose not to report".

A final question will ask:

"Is there anything else that you would like to share about your experiences of doing child protection work as a Plunket nurse?"

APPENDIX SEVEN

Participant Demographics Form

(This information remains confidential between participant and researcher. It will be used in the general description of the demographics within the research report, but you will not be able to be identified in any way).

Name of Participant: Assigned code (Researcher use only):

How many years have you worked as a Registered Nurse: (Please exclude any long absences over 6 months).

Please state if you mostly work in a high or low deprivation area or general mixture across all deprivations.

Total length of Service with Plunket:

Please describe previous nursing experience and qualifications:

The ethnicity(s) you identify with:

1.   I agree to being contacted later to discuss further aspects of the research '*Experiences of   Plunket Nurses in Making Decisions   to   Report Suspected Child Abuse and/or Neglect in New Zealand'.*   ***YES / NO***

    I can be contacted on (Phone):

    Email:

2.   I would like to receive an executive summary of the research on completion of the written report being returned to the researcher. (This is not expected until late 2010).   ***YES/ NO***

    Please send the summary to the following address:

Signed:………………………………………………………………….

Dated:……………………………………………………………….

Researcher:…………………………………………………………...

Dated:………………………………………………………………

APPENDIX EIGHT

MANITOBA RISK ASSESSMENT MODEL

The Manitoba Risk Assessment Model gives a list of risk factors for child abuse and neglect. Number 1 is the highest level of risk; number 2 the second highest and so on. Where there are multiple risk factors present, the risk to the child increases proportionally.

MANITOBA RISK ASSESSMENT MODEL

1. History of previous abuse or neglect or suspected abuse or neglect
2. Domestic violence
3. Parent indifferent or intolerant of child or report child as particularly troublesome
4. Severe social stress
5. Severe isolation and lack of support
6. Parents abused as children
7. Alcohol and drug use
8. Mental illness including post natal depression
9. Young parents – under 20
10. Frequent changes of address – more than two over last twelve months
11. At risk family actively avoids contact with health care providers or family Support agencies