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TITLE PAGE

TITLE: Managing Maternal and Child Health nurses undertaking family violence work in Australia: a qualitative study

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CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interest.

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ETHICS APPROVAL

The research has been approved by the La Trobe University Human Ethics Committee (Ethics approval number 22227) and the Department of Health and Human Services (HHSD/19/129427).

ABSTRACT

Aim: To explore the experience of nurse managers managing Maternal and Child Health nurses undertaking family violence work in Victoria, Australia.

Background: Health care practitioners' ability to address violence against women is strengthened by health service systems that include effective staff management and leadership (García-Moreno et al., 2015). Maternal and Child Health nurses work with women experiencing abuse; however, their support by the health system and their managers has not been examined.

Method: Semi-structured interviews with 12 nurse managers in 2019-2020 explored how they supervised and managed nurses. The data were analysed using Reflexive Thematic Analysis.

Results: We identified three themes - a) managing the service: being resourceful; b) supporting nurses' emotional safety; c) hitting the ground running: the demands on the manager.

Conclusion: Inadequate support for nurse managers undermines workplace well-being and role satisfaction, impacting the safety and supervision of nurses doing family violence work.

Implications for nursing management: An integrated family violence systems approach must include improved training and support for nurse managers to enable reflective practice and ensure effective support for nurses working with women experiencing abuse.

Keywords:

Nurse manager; family violence; Intimate Partner Violence, maternal and child health; Health Service Systems; Reflexive Thematic Analysis

BACKGROUND

Family violence

Intimate partner violence is the most common form of family violence in Australia (Australian Institute of Health and Welfare, 2019). Family violence may include emotional, physical or psychological harm and is a severe, preventable public health issue that has harmful effects on women's health and well-being (World Health Organization, 2013). Family violence often begins during pregnancy or in the first year of a child's life (García-Moreno et al., 2015; Hooker, Samaraweera, et al., 2016). It is one of the leading causes of death and injury for women of childbearing age (Breiding et al., 2014).

More than 1 million Australian children are affected by violence (Australian Institute of Health and Welfare, 2019), and these children are at higher risk for impaired cognitive development (Shonkoff et al., 2012) and poorer health and developmental outcomes (Gartland et al., 2021; Romano et al., 2019).

Health systems response to family violence

The broader health system has to respond effectively and can be the entry point to a network of supporting social and legal services (World Health Organization, 2017). In the integrated family violence system, managers play a critical role in primary and secondary prevention (Hooker et al., 2021). With organisational support, managers can lead the service response, mentoring and supervising health care providers (nurses), thus strengthening the health system's response to violence against women (World Health Organization, 2017).

In 2018, in Victoria, Australia, the introduction of a Multi-Agency Risk Assessment and Management (MARAM) Framework articulated a shared responsibility for assessing and managing family violence risk (Family Safety Victoria, 2018). Arising from the Victorian Royal Commission into Family Violence, the terms of reference included developing consistent systemic responses to family violence. It aimed to train all professionals across the continuum of service responses, covering all aspects of service delivery from early identification, screening, risk assessment and management, to safety planning, collaborative practice, stabilisation, and recovery (Family Safety Victoria, 2018).

Maternal and Child Health nurses play an essential role in supporting vulnerable families, often a consistent source of advice and support for new parents. (State of Victoria, 2016). The MARAM includes role-specific advice and training for Maternal and Child Health nurses in first-line responses in a Screening and Identification Training module (Family Safety Victoria, 2020).

Maternal and Child Health Service in Victoria, Australia

The Maternal and Child Health service comprises a free, universal primary health care service for families with children 0-6 years of age, an enhanced home visiting program that supports families with additional challenges, and a 24-hour Maternal and Child Health phone line. Jointly funded by Victorian state and local governments, the Maternal and Child Health service aims to improve young children's health and developmental outcomes (Department of Health and Human Services, 2019).

To practise in Victoria, Maternal and Child Health nurses must be registered in General Nursing and Midwifery and hold postgraduate qualifications in Child, Family and Community Health. Nurses work in centres located throughout local government areas. Most urban local government areas have created multi-centre hubs with nurses working together;

however, rural and remote nurses are more likely to work alone. Safety issues may arise for these isolated practitioners (Royal College of Nursing, 2016). The population size and subsequent nurse workloads vary significantly across the state, with births per year ranging from 26 to over 5000 in the largest local government areas (Adams et al., 2019). The nurse manager (sometimes known as the coordinator) is usually located within the council administrative offices, managing nurses remotely. Figure (1) illustrates the reporting relationships for the Maternal and Child Health nurse manager.

Enhanced Maternal and Child Health program

The Enhanced Maternal and Child Health program provides an outreach service for children, mothers, and families at risk of poor outcomes. The program was introduced in 2003 and was intended to focus on specific groups, including teenage mothers, rurally isolated families, Aboriginal and Torres Strait Islander and culturally linguistically diverse families (Department of Health and Human Services, 2019). A recent review of the program found that Enhanced Maternal and Child Health clients are complex, with multiple concurrent issues. More than 25% were referred with mental health issues, and more than 20% experienced family violence (Adams et al., 2019).

Over time, with very little clinical guidance or oversight, the Enhanced Maternal and Child Health program has evolved with local government areas offering service delivery models and service activities, often responding to local needs and resources (Adams et al., 2019). Some local government areas have a separate Enhanced Maternal and Child Health program, with nurses working exclusively with Enhanced Maternal and Child Health clients. Other services have integrated the program within the universal service, with all nurses carrying an Enhanced Maternal and Child Health caseload. In 2019, the Department introduced an Enhanced Maternal and Child Health Model of Care to provide standardized guidance and a consistent basis for program delivery across the state (Department of Health

and Human Services, 2019). At the time of this study, the Maternal and Child Health services were at different stages of adopting elements of the new program.

Purpose of the study

This study aimed to explore the experience of nurse managers supervising Maternal and Child Health nurses undertaking family violence work in diverse settings in Victoria, Australia.

METHODS

Design

This study is one element of a more extensive project exploring how the Enhanced Maternal and Child Health program supports women experiencing family violence. There are three parts to the study – (i) a state-wide service-mapping of the Enhanced Maternal and Child Health program (Adams et al., 2019); (ii) interviews with 25 nurses to explore how they support women experiencing family violence (Adams et al., 2021); and this third part of the study (iii) interviews with 12 nurse managers, to analyse how they support Maternal and Child Health nurses undertaking family violence work.

Sample/participants

Maternal and Child Health nurse managers in 79 local government areas in Victoria were emailed explaining the study and inviting them to participate. Fourteen responded, and we purposively selected 12 managers with diverse experiences and backgrounds (see Table 1). The two respondents who were not selected for interview were from local government areas with similar demography to other participants. All participants were female, as are most of the Maternal and Child Health nursing workforce.

Data collection

Semi-structured interviews were conducted by the first author, face-to-face in the managers' workplaces, over four months in 2019/20. Demographic information was collected, but the data analysis did not include participants' identities, with each participant given a pseudonym. The face-to-face interviews were recorded digitally and transcribed using NVivo Transcription (QSR International, 2020a). The first author checked the transcriptions to ensure fidelity to the recording before uploading them to NVivo for data analysis (QSR International, 2020b).

Data analysis

A detailed analysis of the interviews identified patterns of meaning, reported in a thematic form using elements of Reflective Thematic Analysis (Braun & Clarke, 2006, 2020). The first author conducted the interviews, so the content was already familiar on first coding (Braun and Clarke, 2012). Using NVivo to assist with coding and theme development (QSR International, 2020b), then summarised the data using a spreadsheet matrix, enabling a coherent report for sharing across the team (Braun & Clarke, 2012; Gale et al., 2013). The co-authors reviewed the transcripts, the NVivo codebook and the spreadsheet matrix, examined the data's interpretation, and assisted with identifying themes.

Rigour

The first author developed the interview guide with input from two research supervisors with qualitative interviewing experience. We piloted the interview guide and refined the questions' scope. A COREQ checklist has been provided (Tong et al., 2007).

Reflexivity

The first author is a researcher who has also been a Maternal and Child Health nurse and nurse manager. She used reflexive journaling to identify how her insider researcher's

experiences might bias or influence the research process and to allow consideration of how her professional and personal experiences might affect relationships with participants (Leslie & McAllister, 2002).

Ethical considerations

The research has been approved by the La Trobe University Human Ethics Committee (Ethics approval number 22227) and the Department of Health and Human Services (HHSD/19/129427).

The interviewer (first author) provided the nurse managers with resources and support should they experience any distress due to the interviews. Support services might have included the Nurse and Midwife phone support line, Employee Assistance Program, or referral to family violence support services if the nurse manager became distressed by discussing a personal experience of family violence. Another member of the research team, an experienced Maternal and Child Health nurse was available to take calls from participants to discuss their experience after the interview; however, this did not eventuate.

RESULTS

We interviewed 12 nurse managers working in various councils in Victoria, Australia, in urban, regional, and rural/remote locations (see Table 1). We categorized the managers' discussion of their work, focussing on how they supported family violence nursing practice. We identified the following themes – a) managing the service: being resourceful; b) supporting nurses' emotional safety; c) hitting the ground running; the demands on the manager.

Managing the service: being resourceful

When asked what their primary role as manager was, they responded to ensure the service ran smoothly. "There is an element of accountability, that we're funded for so many

hours. So, you know, making sure that we're not over-servicing. We stay within our scope to ensure that we service as many families as we can within those parameters." (Wendy). Many managers spoke of clinical governance, with quality improvement being a key part of their role, "doing audits, you know, following up with staff, regular portfolio visits to everybody, running PD (professional development) for the team (Bettina). Most managers spoke of needing to be "resourceful", particularly for nurses undertaking challenging work:

> Making sure they're safe, making sure they've got phones, making sure they've got easy parking, you know, parking permits, and, you know, things that help them get around in a safe and easy way. You know, they can communicate with the people they need to, that they've got good technology (Belinda). It's a lot of coordinating the where, why, and how. A lot of the background things that allow the nurses to actually get on and perform the role as effectively as they can when they're on the ground (Naomi).

Another manager spoke of the need to defend the program, "there's that need to justify and fight that battle and make the business case. And I suppose this is where I'm thinking of the manager's work is to provide that buffer between what the nurse is doing, which is poorly understood really (Belinda). Many of the managers reflected that within the Council bureaucracy, the scope of the nurse's work was underestimated - "they just weigh babies". Conversely, other services, such as Child Protection or Family Violence services, would overestimate the nurse's capacity to provide extensive, ongoing support and surveillance.

Managers also described their role as gatekeepers, maintaining the boundaries between services and protecting the nurses, where boundaries and responsibilities could be overstepped. This gatekeeper role was alluded to when discussing the relationship between maternal and child health, family violence services, and child protection services. When considering a service response, managers highlighted their responsibility to ensure effective communication with other service providers, including sharing information and joint

consultations. Many reflected that without effective service coordination, there was potential for overlap and duplication, or conversely for clients "to fall between the cracks".

Supporting nurses' emotional safety

According to most managers, ensuring the nurses' emotional safety was critical. The managers who had previously worked as Enhanced Maternal and Child Health nurses felt they brought a different insight to the nurse role. They were more likely to describe their role as "protective" and "managing burnout" – "I see my role is supporting them with their workloads, with their emotional load. How they're coping." (Bettina). Having been a worker, and really knowing what it feels like to be overwhelmed, the impact on you (Anna). "Without that experience, I probably wouldn't have understood the demands and just the daily world of enhanced" (Yvonne).

All the managers characterized the work of the nurses as challenging – "These are staff who are not just doing data entry. They are staff who are dealing with challenging conversations." (Anna). "They are doing really hard stuff, day in, day out. It's not just a two-weeker (2-week-old baby) coming in for a quick weigh and measure" (Naomi). Managers spoke of having to ensure the team had access to adequate clinical supervision. "I had to go out and argue for more money to expand the supervision (Sarah). "I want to be doing the right thing for them. I want them to stay well in their jobs. I guess I have a sense of responsibility" (Moira).

One manager reflected on their capacity to provide the level of support required by individual nurses when working with family violence clients.

> The comment that was made at the (family violence) training was that anytime a nurse felt uneasy or wasn't sitting well with a contact she'd had with the client, she should be able to speak to her supervisor about it. And I just thought, I don't know how I'd do

that with the number of staff I've got and the number who work off-site. And, you know, I just felt a little bit deflated. I just sat there thinking I cannot provide the level of support they're saying nurses need from their supervisor (Sarah).

Nearly all the managers said they would welcome training in clinical supervision. "That supports me to help a staff member debrief, reflect on her practice, problem solve. So, you know, find clarity about the work she's doing. I guess primarily to keep her safe" (Sarah). "I feel ill-prepared, mainly in the family violence context. So, if a crisis happens, being able to do a crisis debrief, I suppose, and the idea of holding space for nurses that are doing really, really hard work". (Bettina)

Almost none of the managers have funded access to clinical supervision, and a few managers spoke of funding it themselves, "I will just go out and do it myself, pay for it myself because I'm really conscious that my work is about supporting people, all the time" (Yvonne). Wendy also spoke of the emotional pressure of feeling isolated and unsupported, "I had a moment just in the last three or four weeks where I thought, oh, my gosh, I just feel so defeated". Other managers spoke of relying on informal networks and other sources of support; however, being geographically isolated for rural services made it hard to identify and maintain these supports.

Hitting the ground running; the demands on the manager

Generally, Maternal and Child Health nurse managers are Maternal and Child Health nurses appointed to the role because of their clinical expertise and experience. Many managers felt they initially lacked essential managerial skills and knowledge and were unprepared to transition to the position. Yvonne reflected on suddenly "being brought into the council world. Yes, that whole political, bureaucratic reporting can be a different world. And you're expected to hit the ground running and sort of know how to do management." Naomi also spoke of lacking "budget basics. team management, all of that policy".

The managers identified that medium-sized teams of between 15-20 nurses were challenging to manage, where the team is too small for more than one manager but too big for one manager alone. Many managers highlighted the issues with providing effective line management: "in some supervision structures, you do have daily contact with staff. Whereas with Maternal and Child Health nurses, they're isolated, independent practitioners. I don't want to micromanage, but you rely on them to flag when something is challenging, or if they are struggling" (Sally). Conversely, some managers felt they had to physically distance themselves from the team to have the headspace to fulfil their strategic and managerial responsibilities. "(Previously) my door would open into the waiting room. I was very much knee-deep in the operational stuff. So, I physically had to move myself". (Moira).

Most of the managers recognized the roles of line manager and clinical supervisor as distinct. However, they felt constantly pulled between managing a team of nurses and providing individual clinical support. Yvonne reflected that she felt she had the skills to support nurses emotionally but did not have the time, "if that was the only part of my job, you know, I think I would be fine". Another manager spoke of their heavy line management responsibility, with a direct report of over 25 nurses. "Every year when I have to do performance appraisals, and they (Human Resources) say they shouldn't take you too long because you shouldn't have more than five or six to do. And I have 25 to do" (Sally).

Managers spoke of working in isolation and often in the absence of organisational direction and articulated clinical governance. Yvonne reflected, "I wonder what other roles can exist in such an autonomous fashion with no oversight." Most managers felt this autonomy brought opportunities for innovation and role flexibility. However, they also reflected that working in isolation created stress and that their role was ill-defined.

The managers of the medium-sized teams felt the highest levels of role conflict, with responsibilities ranging from operational line manager, clinical lead, and clinical supervisor. Managers in larger local government areas were able to separate the elements of management and supervision by appointing a team leader with more frequent face-to-face contact with the team – "our council asked us to rename it to team leader. It's someone who doesn't have a client load in those appointed hours and is responsible for supporting the team (Bettina).

Many managers understood the critical role of clinical governance – "Looking at how does the service as a whole run, and deal with those clients experiencing vulnerability and how we are accountable, and our process is right. When we look at that risk that we hold because we do sit with a lot of risk in Maternal and Child Health." (Sally)

DISCUSSION

The results of this research align with other research describing the impact of management on the well-being of high emotional labour employees, such as Maternal and Child Health nurses supporting women and children experiencing abuse (Brunetto et al., 2014). The nurse manager role is increasingly complex, requiring high-level interprofessional communication and management skills (Henriksen, 2016) and nurturing nurses' psychological and organisational needs (O'Toole et al., 2021). Nurse managers strive to fulfil competing responsibilities and have multiple reporting relationships (see Figure 1).

Nurse managers in this study recognize their role in leading quality improvement, monitoring routine data and reflecting this to the team as key to achieving sustained nurse family violence practice, as recognized in other research (Hooker et al., 2021). Building the capacity and changing the attitudes and clinical practice of healthcare providers and their managers is a long-term endeavour requiring consistent investment (World Health Organization, 2017). Managers also identified the need to improve coordination and referrals

between health services and family violence and relevant community-based services, such as the police, in line with recommendations for improved service delivery (Dowrick et al., 2021; World Health Organization, 2017).

As noted in other research (Shirey et al., 2010), most nurse managers were appointed based on their clinical expertise but needed a more complex skill set beyond on-the-job training. The nurse managers in our study discussed being promoted without adequate management skills, consistent with other research (Wood et al., 2020). Most of the managers indicated they would have liked access to clinical supervision for themselves; however, only those who paid for their own had access regularly. Nurse managers often worked in isolation and created informal support networks of fellow professionals, valuing these professional connections. The managers spoke about peer support as a critical condition upon which effective advanced practice was based (Wood et al., 2020).

Our research highlighted the value to nurses having a supportive manager available to them for regular follow-up, mentoring and supervision (Hooker, Small, et al., 2016). Nurse managers have a role in motivating nurses to offer best-practice care. They can also help nurses address challenging clinical cases and improve their clinical and communication skills, ensuring ongoing training and supervision to avoid vicarious trauma and burnout (World Health Organization, 2017).

Many of the managers in our study identified that they were often unavailable when nurses needed them, being caught up in operational or managerial responsibilities. They also felt they lacked the training to support reflective practice and offer adequate clinical supervision. The managers also identified the need for regular, high-quality professional education in communication skills, supervision and support for staff undertaking heavy emotional work, in line with recommendations from other research (Adams et al., 2021;

Crombie et al., 2016). Training healthcare providers and their managers to respond to violence against women should be an ongoing process rather than a one-off event (Kalra et al., 2021).

Although the manager's role may vary depending on the size and nature of the teams (Adams et al., 2019), our research indicated common concerns for most managers. Clinical governance enables service delivery that is safe, effective, high quality, and continuously improving (Australian Commission on Safety and Quality in Health Care, 2017). Managers in this study have described the challenges of effectively managing large nurse teams while also supervising nurses individually.

Strengths and limitations

This study has been strengthened by interviewing 12 nurse managers with diverse experiences and backgrounds, from rural and urban local government areas, working in advantaged and disadvantaged areas, and migrant and refugee and Aboriginal and Torres Strait Islander clients.

The interviewer was known to many managers, which may have also introduced an element of social desirability bias.

IMPLICATIONS FOR NURSING MANAGEMENT

In this research, nurse managers have highlighted the lack of preparation for the nurse manager role, the structural impediments to support nurses doing challenging work, and the lack of ongoing support and education to develop communication and supervision skills, including critical incident debriefing. An integrated systems approach should include better training for managers and clinical resources and screening tools, organisational support, opportunities for clinical supervision, and reflective practice (Withiel et al., 2020; World

Health Organization, 2017). Opportunities for manager peer support should be identified, particularly for nurse managers working in isolation and newly appointed to the role.

We recommend regular training and updates for leadership teams and nurse managers to build their leadership role to support staff safety (Hooker et al., 2021). This recommendation is consistent with successful Maternal and Child Health family violence interventions (MOVE) (Taft et al., 2015) and recent recommendations for a family violence professional development plan for nurses and managers (Hooker et al., 2020). Sustained family violence practice change requires nurse managers who can lead strategies in an integrated family violence system. The MARAM (Family Safety Victoria, 2018) introduction has enabled nurses and their managers to contribute to a system-wide intervention to support women experiencing abuse.

Nurse managers need training in reflective practice, clinical supervision, effective data monitoring, enhanced service integration, and leadership training. Managers would benefit from specific training in effective support strategies for nurses doing challenging work and regular access to funded clinical supervision. Training for managers should aim to strengthen their ability to manage nurses' physical and emotional safety.

CONCLUSION

Our study has important implications for supporting Maternal and Child Health nurse managers. They are a dedicated workforce committed to the well-being of families. They play a crucial role in creating healthy work environments, maintaining the quality of care for families, and enhancing nurses' job satisfaction. They support nurses to meet their professional responsibilities and aspire to build a positive workplace culture and optimize care for families (Australian Commission on Safety and Quality in Health Care, 2017).

However, managers must attend to line management responsibilities, making them less available for clinical nursing support and supervision.

Inadequate support for nurse managers threatens workplace well-being and role satisfaction, jeopardizing the safe supervision of nurses doing family violence work. There is an urgent need to review nurse manager role descriptions to enable the multiple and conflicting demands on the manager to be considered.

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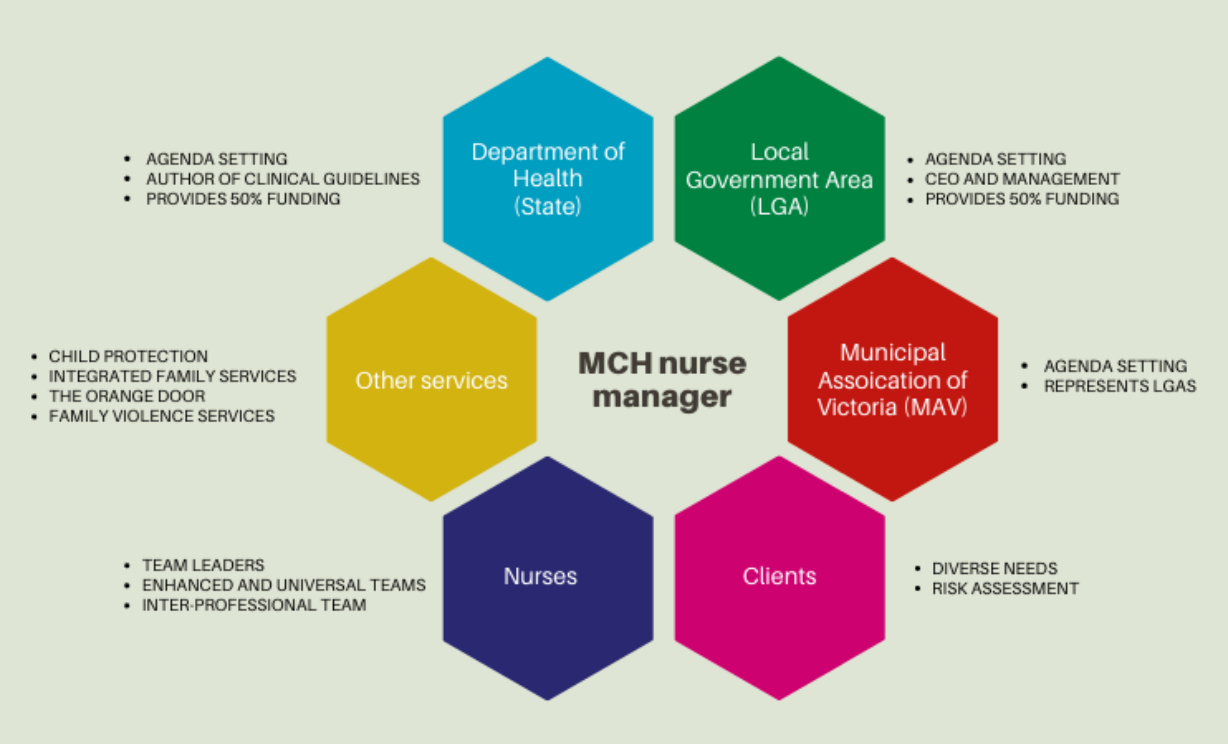

Figure 1 – Reporting and other relationships of the MCH nurse manager

Table 1. Details of participants and interviews

Characteristics	N
Number of nurse managers	12
Professional background • MCH nurse • MCH and EMCH nurse • Early childhood educator	 7 4 1
Local Government Area • Urban • Regional city • Rural/remote	 6 4 2
Length of interview • Range 35-95 minutes (mean 52 minutes)	