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Ready for Practice: What child and family health nurses say about education

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Ready for Practice: what child and family health nurses say about education
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Author Contribution
VS, CF, SK – conception and design of the study
VS, CF, KP, SK – acquisition of data
CF, VS, KP, SK, CR – data analysis and interpretation
CF – drafted the article
VS, KP, SK, CR – critically reviewed article and approved final version for submission
ABSTRACT

Background
Australia has a well-established universal child and family health service predominately staffed by specialist/qualified child and family health nurses. Two common and interrelated concerns are the need for nurses to be ready for practice after completing a nursing education program and the means to ensure ongoing nursing competence.

Objective
To investigate the readiness of CFH nurses to practise after qualification and their continuing engagement with learning.

Design
The study used an interpretive descriptive approach.

Setting
This paper presents data from four questions from a larger survey of child and family health nurses across Australia.

Participants
1098 child and family health nurses responded to the survey.

Method
Qualitative survey responses from the four education questions were analysed using inductive thematic content analysis.

Results
Five significant themes were identified: hands-on experience (student clinical practice/placement); drawing on prior experience; learning on the job; learning (learning over time); and barriers to learning.

Conclusion
This paper provides insights into nurses’ readiness for practice at the completion of a postgraduate child and family health nursing qualification and their maintenance of competence and specialist knowledge. It highlights: the need for clinical placement to be retained and enhanced; the significant contribution of more experienced child and family health nurses mentoring newly graduated child and family health nurses; the need for minimum education standards; the importance of reviewing education courses in relation to graduates’ readiness for child and family health nursing practice; the importance of supporting ongoing professional development; and the removal of barriers to accessing education opportunities.

Keywords
Child health nurses; Clinical education; Continuing education; Professional development;

**INTRODUCTION**

Australia has a well-established universal child and family health service predominately staffed by specialist child and family health (CFH) nurses (Grant, 2013; Schmied, Fowler, et al., 2014; Schmied et al., 2010). In some Australian states they are called Maternal and Child Health nurses (M&CHN). These nurses are registered nurses with additional qualifications in CFH nursing. The international nurse equivalents are health visitors in the United Kingdom (Cowley, Cann, Dowling, & Weir, 2007); child health nurses in Sweden (Fägerskiöld & Ek, 2003); and public health nurses in Canada (Canadian Public Health Association, 2010).

Two common and interrelated concerns for the nursing profession are the need for nurses to be ready for practice at the completion of an education program (Haddad, Moxham, & Broadbent, 2013; Wolff, Regan, Pesut, & Black, 2010) and the means to ensure ongoing nursing competence (Ross, Barr, & Stevens, 2013). Knowledge and skills requirements are particularly amplified when nurses are employed in positions that are professionally and geographically isolated, as occurs in many community health services in Australia. The second issue is the continuing professional development to ensure ongoing competence and contemporary clinical practice when nurses have been employed for many years (Ross et al., 2013).

This paper draws on data from the Child Health: Researching Universal Service (CHoRUS) study. The CHoRUS study used a three-phased mixed method approach to investigate the feasibility of implementing a national approach to the provision of universal health services to children and families. This paper focuses on CFH nurses’ readiness for practice and their continuing engagement with learning.

**BACKGROUND**

Enhancing the health of infants and young children has become a high priority for governments (Woodhead, 2006). This commitment is partly due to population health programs that led to identification and early intervention to reduce child risks, improve educational outcomes and reduce adult health issues such as heart disease, diabetes and obesity (Center on the Developing Child at Harvard University, 2010).

Nurses have been and remain one of the key professionals to focus on child health and parenting. In Australia, as elsewhere, the promotion of child health and illness prevention is seen as crucial during infancy and early childhood (Oberklaid, 2013). Achieving positive outcomes for young children and families requires CFH nurses to have extensive knowledge and skills, including but not limited to: child health surveillance, assessment and early intervention; growth and development; infant and family nutrition; family support; perinatal and
infant physical and mental health; health promotion and education (Nursing and Midwifery Office, 2011). Most Australian health jurisdictions require nurses to have an additional qualification in CFH nursing to ensure this knowledge (Kruske & Grant, 2012).

In Australia, CFH qualifications range from post-registration hospital-based certificates to masters degrees. Currently, all CFH nursing postgraduate qualifications require tertiary-level study. Yet, there is marked variation between CFH nursing qualifications in Australia: course length ranges from 12 months part-time (graduate certificate) to two years (graduate diploma or masters qualification), and clinical placement requirements vary from 40 to 320 hours (Kruske & Grant, 2012). This situation is likely to continue as there are no national requirements or provision for specialist nursing registration in Australia (Kruske & Grant, 2012), leaving the development of CFH nursing curriculum and its implementation unregulated. Thus health service employers are left to determine the acceptability of the CFH nursing qualification, resulting in employment of some nurses without CFH nursing qualifications (Grant, 2013).

The past decade has seen a significant shift from the promotion of an expert model of CFH nursing to a partnership approach for working with families and their young children, emphasising the co-production of knowledge (Fowler, Lee, Dunston, Chiarella, & Rossiter, 2012). CFH nurses have been required to upgrade their knowledge and skills in many areas to meet the demands of contemporary clinical practice such as child health, parental and infant mental health, and early brain development (Nursing and Midwifery Office, 2011). Incorporating additional content and ways of working within an already crowded CFH nursing curriculum is difficult, especially if administrators do not support increased course duration. This over-crowding is not unique to CFH nursing courses but is being experienced by most nursing courses (Dalley, Candela, & Benzel-Lindley, 2008). Further challenges are limited availability of clinical placements that enable appropriate and authentic learning experiences to facilitate student readiness for beginning practice (Fowler, Wu, & Lam, 2014; Smith, Corso, & Cobb, 2010). This scarcity can compromise the quality of the clinical placement (Hall, 2006) while placing additional pressure on CFH nurses to continually mentor or supervise students.

A minimum standard for continuing professional development requires nurses to take responsibility for their ongoing learning and nursing competence in order to maintain their registration status (Nursing and Midwifery Board of Australia, 2010). Work has commenced at a national and state level to develop standards to clearly guide CFH nurses, managers and educators in the minimum competency levels expected of CFH nurses (Grant, 2013; Guest E et al., 2012; Guest et al., 2012; Nursing and Midwifery Office, 2011). There is little published information on how the current CFH nursing workforce perceives their preparation for practice or ongoing education needs.

**METHOD**

**Aim**
This study used survey data to investigate CFH nurses’ views on their readiness to practise after qualification and about their continuing engagement with learning.

Design

The research was guided by an interpretive descriptive approach (Thorne, 2008). This approach acknowledges that human experience is context-bound, while accepting that there are shared realities (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004). It does not prescribe a circumscribed sequence of steps that must be followed (Thorne, 2008); rather it enables the exploration and description of experience (Lasiuk, Comeau, & Newburn-Cook, 2013; Thorne et al., 2004).

This paper uses qualitative data from a survey developed for the CHoRUS study (Schmied, Fowler, et al., 2014). The survey was designed to examine the views of CFH nurses across Australia on wide-ranging issues identified in focus group data collected in phase one of the study (Schmied, Homer, et al., 2014) and an extensive literature review (Schmied et al., 2008) and review of national and State policies. This was the first Australia-wide survey of nurses working in CFH and it included questions about education and practice-readiness from a large sample of Australian CFH nurses. A survey approach enables the collection of a range of data of a large number of participants that enables a snapshot at a given time (Kelley, Clark, Brown, & Sitza, 2003). Each survey item was reviewed for content validity by expert CFH nurses and other health professional members of the research team.

Participants

Overall 1098 CFH nurses responded to the survey, from all Australian States and Territories. This represents 25.3% of all Australian Registered Nurses working in CFH (Australian Institute of Health and Welfare, 2012).

Data Collection

Surveys were distributed to CFH nurses across Australia via their professional association (Maternal Child and Family Health Nurses Australia), either electronically via a web link to a dedicated CHoRUS study page or via hard copy distributed at a national conference in 2011. The survey was available from May to October 2011. Online questionnaires entered data directly onto Qualtrix; data from questionnaires returned in hard copy were entered manually into Excel (Schmied, Fowler, et al., 2014).

This paper uses data from four education questions in the CHoRUS survey (see below). The response rate for the responses to open-ended questions, varied in number (see Table 1).

[Insert Table 1: Questions]
Ethics

Ethics approval for the study was obtained from the Human Research Ethics Committees of the University of Western Sydney and the participating State and Territory Health Departments. Prior to and during the distribution of the survey the professional association was involved in dissemination of information about the survey. The questionnaire form provided written information about the study and participant completion was taken as consent. The survey did not request identification from the participants, resulting in the data being de-identified at entry. If participants did enter responses that could result in identification these were de-identified during the coding process.

Data analysis

Consistent with an interpretive descriptive approach, this paper uses an inductive thematic content analysis to analyse the qualitative responses. Data from Qualtrix were transported to Excel. In keeping with the inductive approach, the responses to the four questions were amalgamated, rather than being analysed separately under each question. The transcripts of the qualitative responses were read and re-read before final coding occurred. The first author completed the first round of coding and condensed meaning units and themes; the next three researchers confirmed these findings (Graneheim & Lundman, 2004).

The first reading generated open coding; notes and headings were written beside the text (Elo & Kyngäs, 2008). The data were read and re-read to enable classification into categories and then themes (Elo & Kyngäs, 2008; Graneheim & Lundman, 2004). The identification of recurring patterns guided the final coding (Elo & Kyngäs, 2008). Each quote is identified and then condensed into a meaning unit and finally into an overall theme. Table 2 illustrates this process.

[Insert Table 2: Thematic content analysis coding method]

FINDINGS

A total of 1098 registered nurses with additional qualifications in CFH nursing responded to the survey. Respondents had a mean age of 51.2 years (range 23–75) and 99.5% were female. The majority worked in urban areas (82.8%). The State with the highest response rate was Victoria (N=455, being 39.1% of Victorian nurses working in CFH).

Many of the nurses had additional qualifications in midwifery, children's nursing, mental health nursing, management and education. In terms of their highest qualification, the most common was a postgraduate diploma (38.5%), followed by a Master’s degree or higher (17.6%), postgraduate certificate (16.2%), undergraduate degree or diploma (14.8%) or a post-registration certificate (9.6%). The remaining 3.3% listed a variety of other educational qualifications,
including those in areas other than nursing or the fact that they were currently studying towards a higher qualification.

The nurses worked in settings ranging from universal CFH service provision (59.2%), secondary level services (13.1%), residential units (1.8%) or a combination of CFH clinical services (2.7%). Other respondents were nurse practitioners, clinical nurse consultants, or academics. The length of time the nurses worked in CFH services ranged from less than 5 years (18.6%) to more than 20 years (26.4%).

Survey data provided insights into the readiness for practice at the completion of a postgraduate CFH nursing qualification and the ongoing maintenance of competence and specialist knowledge. Five significant themes were identified within the data as follows.

**Hands-on experience (student clinical practice/placement)**

Respondents identified that experience gained through clinical placement during the CFH nursing course was a crucial course component and highly valued in enabling the nurses’ learning. Many nurses supported this view in their comments.

All information about child family health was appropriate – but hands-on exposure to practice was most important to gain confidence in actually doing the job. (CFHN58)

Clinical placement was the greatest preparation for my role. (CFHN238)

Onsite experience was the best experience for my knowledge. (CFHN459)

The opportunity to have ‘real life’ experience of CFH nursing enabled the nurses to be exposed as students to the complexity of families, the difficulties parents experience and the strategies parents found most useful.

The practical–seeing what mothers and babies did–sleeping, feeding and problems, what helped and what didn’t. (CFHN789)

The prac time at a child health clinic, learning about the complexities of families and learning how to assess and provide support with these, learning about community support organizations, learning basic knowledge and skills like developmental milestones of 0-4 year olds. (CFHN790)

Many nurses clearly identified the importance of integrating theory into practice. They acknowledged the balance between integrating knowledge first through such things as case studies and then having an opportunity to practise these new skills during clinical placement:
The practical married well with the theory plus as part of the course we had a 3 month autonomous practice period which was invaluable. (CFHN96)

Clinical practice observation and placement, case studies discussed and pulled apart on campus, counselling and communication unit ... (CFHN279)

The emphasis on evidence-based practice during my tertiary studies was particularly useful when applying same to clinical practice. (CFHN7)

The nurses’ comments revealed a connection between theoretical learning, clinical placement experience and their learning to become CFH nurses.

**Drawing on prior experience and knowledge**

Many respondents had other postgraduate qualifications or experience as midwives, paediatric nurses, educators or mental health nurses. They explained the contribution of pre-existing knowledge and skills to their expertise or ability to work as qualified but novice CFH nurses:

Enhanced analytical and decision-making skills through clinical practice and examination of research specific to working with normal and complex families thereby further developing skills and knowledge gained through nursing and midwifery education and experiences. (CFHN366)

General nursing plus other qualifications eg: midwifery and paediatrics then M&CH; building upon nursing expertise. (CFHN403)

Having a good knowledge of paediatrics has prepared me for this role. (CFHN430)

Some nurses identified that, as they engaged in the full spectrum of CFH nursing, the importance of midwifery qualifications diminished.

For initial contact with family in the early weeks being a trained Midwife is immeasurably valuable but of course down the track as the families and children grow older and community is important, the Grad Dip in Child, Family and Community Health provides much of the basis for nurse practice. (CFHN394)

A small proportion of the nurses highlighted the importance of their experience as mothers. In the following quote, the nurse foregrounded her experience as a mother, but then tries to minimise the importance of her maternal status:

My practical experience of having 3 children! (Not that this makes me any better than MCHN with no children). (CFHN555)

**Learning on the job**
Some of the CFH nurses expressed dissatisfaction with their CFH nursing course and felt most of their learning occurred once they commenced work as a qualified CFH nurse and through other programs they have completed:

Definitely learnt on the job, found the course very academic and not hugely relevant. Have done better courses since such as family partnership training which have been much more helpful in dealing with parents and their problems. (CFHN192)

For some nurses learning on the job was significant. Some highlighted that the courses did not always adequately prepare them for practice.

The course gave me a broad over-view, but the clinical practice over the years has continually enhanced my practice. (CFHN774)

For these two nurses, learning on the job was facilitated by having support and mentoring from their colleagues to assist them overcome any knowledge or skills deficits.

"The real world" in an inner city low socio economic area with a large percentage of non English speaking families of diverse and varied belief and customs - but having very experienced preceptors /fieldwork supervisors helped to overcome this short fall. (CFHN812)

Great Child Health staff who banded together to support each other & share information freely. (CFHN409)

**Never stop learning (learning over time)**

Most CFH nurses work in community settings providing universal services for families and young children. This milieu is often unpredictable with changing family, professional and community demands. The nurses recognise the need to continue to learn after gaining their CFH nursing qualification – both formally and informally - to meet these changing demands over time:

The course that I completed was comprehensive, but also made me aware that it was the beginning of my learning. (CFHN846)

Since the course - the education provided or sought built on the foundation which kept CFH competency current. Having the foundation meant it could be built on. (CFHN863)

Regular updates. Things change & it is vital to keep building on knowledge. Anything related to substance abuse, [parents’] own childhood effects on abilities to parent etc. (CFHN120)
The following quote illustrates the importance of having the skills to find information and translate research and knowledge into practice to ensure currency.

My course prepared me to work with families, follow cultural trends, emerging evidence and integrate research as it emerged to ensure that my practice is always current. It's been a learning path. (CFHN551)

Some acknowledged that any course has limitations and that personal and professional responsibility are necessary to continue to learn. This nurse also alludes to the importance of preparing nurses with skills in accessing and translating information.

I've always gone and learned what I need. No course can fully ground you in what evidence emerges. The best thing a course can do is advocate a student to continue to learn, adapt and incorporate knowledge. (CFHN551)

Other nurses made statements about the professional development opportunities they had experienced through their careers:

No, the education has never ceased, 36 years of the most amazing professional development opportunities. (CFHN69)

The training in 1973 touched on the complexity of family functioning and the implication this has on children. However, ongoing training over the years keeps me informed. (CFHN460)

Many nurses highlighted the value and quality of the ongoing education their CFH service provided, as well as the informal and self-directed learning that occurred:

With community change I feel that our service has kept up with good inservice training and my own self-education. (CFHN475)

Ongoing information sharing with other service providers, working alongside co-workers to observe variations in practice. (CFHN801)

**Barriers to learning**

Developing and maintaining confidence and competence as a CFH nurse could be an ongoing challenge. Nurses raised numerous concerns about the lack of support for ongoing learning activities and opportunities.

The role of child health nurse is becoming increasingly complex and the clients are often medium–high risk. Professional development is often not available in areas that is needed; ie refugee issues. The delivery of a 'child health' updating for staff who have been in practice for a long time, but don't have the skills for current practice. (CFHN219)
Time, we are not always replaced when undertaking education. This can create a dilemma regarding weighing up providing a service to a family or undertaking training. Usually client care wins out. (CFHN264)

In Australia, many rural nurses face travelling huge distances to access professional education. This can be an impediment:

Most education in Perth 350km away & I have 3 children and a FIFO [fly-in fly-out] husband. (CFHN270)

Working in isolated areas sometimes we are unable to attend conferences because of distance. (CFHN315)

Tyranny of distance = exorbitant travel/accommodation costs. (CFHN280)

These distances often result in increased physical and financial costs for the nurses and their organisations.

DISCUSSION

The findings of this qualitative descriptive study highlight several important issues for further consideration, including: the need for clinical placement to be retained and enhanced; the significant contribution of more experienced CFH nurses as mentors; the need for some CFH education courses to be reviewed to ensure they achieve an outcome of graduate readiness for practice; the importance of supporting ongoing professional development; and the removal of barriers to accessing education opportunities.

"Hands-on" experience through participation in clinical placement was highly valued by the nurses during the postgraduate CFH nursing course. Clinical placements were highlighted as a significant and practical aid to developing readiness for clinical practice. Many nurses indicated that clinical placement yielded a more realistic understanding of the complexity of CFH nursing. They stated that these placements enabled theoretical knowledge to be translated into practice and provided different learning opportunities. The importance of the supervising nurse sharing information and providing comprehensive support and guidance is frequently highlighted during clinical placement and when commencing as a graduate nurse (Emanuel & Pryce-Miller, 2013).

Increasing clinical placement length does not always enhance readiness for practice. Unfortunately clinical placements vary in terms of the experiences and learning that is achieved (Emanuel & Pryce-Miller, 2013). Educators and managers remain concerned about the consistency, quality and access to key nursing competency experiences and the ensuing learning (Kruske & Grant, 2012). Being responsible for students during clinical placement can be challenging for some clinical nurses. It creates additional stress through having
to answer questions, share knowledge and expose their clinical practice to scrutiny by students and educators. It has been argued that clinical settings need to develop a more educationally sensitive culture (Haddad et al., 2013; Levett-Jones & FitzGerald, 2005).

Many CFH nurses had already gained other specialist nursing qualifications and experiences and used these in their daily practice. Even with these existing professional backgrounds they identified that having a skilled and knowledgeable mentor was valuable in taking on the CFH nurse role. Unfortunately the level and quality of nursing mentorship continues to be variable (Emanuel & Pryce-Miller, 2013; Teatheredge, 2010). The realities of their new employment can be overwhelming for some; working autonomously, feeling professionally isolated and a lack of professional support were all mentioned by respondents.

While there were many positive comments, some nurses criticised the CFH course they had completed. These concerns were often about not being prepared to work independently, that the course was very academic and not hugely relevant for the work of a CFH nurse. These concerns confirm the findings of Kruske and Grant (2012) arguing for a more consistent national approach to the provision of CFH nursing qualifications with minimal educational content. An important starting point to address these concerns will be the development and acceptance of national CFH nursing standards (Grant, 2013).

As clinical demands increase and curriculum become more crowded, educators must become innovative (Dalley et al., 2008) to ensure appropriate content. Currently, there are marked variations in Australian CFH nursing curricula. Kruske and Grant (2012) suggest that some courses provide inadequate preparation for CFH nursing practice in some core skills. In many instances, educators need to work more collaboratively with clinical nurses to identify minimal education and competency standards required by the profession. Reduced reliance on teacher-centred curriculum is necessary (Dalley et al., 2008) to ensure the needs of contemporary CFH nursing. Some Australian states have developed professional frameworks to define and guide CFH nursing practice (Nursing and Midwifery Office, 2011). However, minimal education requirements at a national level are urgently needed (Kruske & Grant, 2012).

Many nurses identified the importance of continuing professional development, and described the types of education they had participated in since completing their CFH nursing program. Several nurses reported significant barriers that to access to professional development programs. Some workplaces had limited access to and range of computer-based learning programs, as well as a lack of encouragement to use internet communication modes such as Skype and Facebook. However, there is a potential need for more CFH nursing practice focused content.

There were limitations to this study, in particular the significant variation between participants’ level of highest qualification and the length of time since they had completed their CFH nursing qualification. The majority of the
participants were from urban areas and there was an over-representation from one state. As this survey was distributed via the CFH nursing professional associations and at their bi-annual conference it is likely that the participants were the more professionally engaged nurses. Future surveys may attract a larger and more varied sample from other states if distribution occurs through the nurses’ workplace.

The data were drawn from a much larger survey without a major focus on education attitudes, learning or requirements. Ideally, future research should explore more specifically: the need and content for a national CFH nursing education curriculum; effective education methods to increase access to continuing professional development, especially for nurses living in rural and isolated areas; and inclusion of skills and knowledge to facilitate CFH nurses’ collaborative work with other professionals (D’Amour & Oandasan, 2005).

**CONCLUSION**

Given their health and wellness focus, CFH nurses play a crucial role in enabling physical and emotional health of infants, young children and their families. As with all areas of nursing, CFH nursing has become extremely complex and requires a commitment to maintain nursing knowledge and skills (Spencer, 2006) and to ensure safe nursing practice (Gebble, 2013).

Many CFH nurses who responded to this questionnaire demonstrated this commitment to ongoing learning. Substantial numbers of nurses referred to the crucial importance of never stopping their learning and continuing engagement with professional development opportunities and ongoing self-education. This was reinforced by the recognition that their CFH nurse qualification provided a foundation but that continued learning and assistance to access continuing education were equally necessary. Participants identified that organisational support for learning assistance was crucial to reducing the financial and distance barriers that many nurses experienced.

**References**


Nursing and Midwifery Board of Australia. (2010). Continuing professional development and registration standards. Canberra: Nursing and Midwifery Board of Australia.


Table 1: Education Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Number of Written Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8. Which specific aspects of your Child and Family Health Nursing course do you feel most prepared you for your role?</td>
<td>862</td>
</tr>
<tr>
<td>Q9. Are there aspects of your role for which you were poorly prepared by your education in Child and Family Health Nursing?</td>
<td>816</td>
</tr>
<tr>
<td>Q10. What types of professional development or educational activity do you consider would assist you with your role?</td>
<td>723</td>
</tr>
<tr>
<td>Q11. Are there any barriers which prevent you undertaking professional development?</td>
<td>481</td>
</tr>
</tbody>
</table>
Table 2: Thematic content analysis coding method

<table>
<thead>
<tr>
<th>Participant response</th>
<th>Condensed meaning unit</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>All information about child family health was appropriate - but hands-on exposure to practice was most important to gain confidence in actually doing the job. (CFHN58)</td>
<td>Enabling the nurses’ to gain confidence</td>
<td>Hands-on experience (clinical practice/placement)</td>
</tr>
<tr>
<td>The practical - seeing what mothers and babies did sleeping, feeding and problems what helped and what didn’t. (CFHN789)</td>
<td>‘Real life’ experience</td>
<td></td>
</tr>
<tr>
<td>Having a good knowledge of paediatrics has prepared me for this role. (CFHN430)</td>
<td>Pre-existing knowledge</td>
<td>Drawing on prior experience and knowledge</td>
</tr>
<tr>
<td>My practical experience of having 3 children! (Not that this makes me any better than MCHN with no children). (CFHN555)</td>
<td>Maternal status</td>
<td></td>
</tr>
<tr>
<td>The course gave me a broad overview, but the clinical practice over the years has continually enhanced my practice. (CFHN774)</td>
<td>Course not adequate preparation</td>
<td>Learning on the job</td>
</tr>
<tr>
<td>The course that I completed was comprehensive, but also made me aware that it was the beginning of my learning. (CFHN846)</td>
<td>Continue to learn</td>
<td>Never stop learning</td>
</tr>
<tr>
<td>My course prepared me to work with families, follow cultural trends, emerging evidence and integrate research as it emerged to ensure that my practice is always current. It’s been a learning path. (CFHN551)</td>
<td>Skills to continue to learn</td>
<td></td>
</tr>
<tr>
<td>Most education in Perth 350km away &amp; I have 3 children and a FIFO [fly-in fly-out] husband. (CFHN270)</td>
<td>Distance</td>
<td>Barriers to Learning</td>
</tr>
</tbody>
</table>
HIGHLIGHTS

- Clinical placements and on-the-job experience are critical components of CFH learning
- CFH courses vary in the capacity to equip graduates to be job ready
- CFH nurses are thirsty for opportunities for continuing education to accommodate the complexity of their role