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## The nursing history of Ngala since 1890: An early parenting organisation in Western Australia

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# The nursing history of Ngala since 1890: an early parenting organisation in Western Australia

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## Abstract

**Background:** This study was the first phase of a larger study which explored the past, present and future of nursing in early parenting services in Australia.

**Aim:** The aim of this paper is to describe the history of nursing within an early parenting service in Western Australia (WA).

**Methods:** Triangulation of multiple data sources was used to summarise the nursing role over 120 years. The history was discovered through a document analysis of archives, including oral histories, organisational documents, focus groups, nurses' diaries and interviews with nurses.

**Findings:** The nursing role and context is described over three time periods: 1890–1960; 1960–1990 and 1990–2010. Nursing during the 20th century was influenced by societal and policy changes, but the essence of nursing remained the same with a focus on providing support and education to parents during pregnancy and caring for their babies and young children. Nursing within early parenting up to the 1980s was reasonably static until the move from hospital-based training to the university sector, which

was the turning point of change to a new era of professionalisation and ultimately working within an interdisciplinary team.

**Conclusion:** This description of nursing history within one early parenting service has provided insight into this specialist area of nursing.

## Introduction

Ngala is a not-for-profit, early parenting organisation within Western Australia (WA) and has for over a century advocated for and supported families with young children. Early parenting services (EPS) are designed to support families, build parenting capacity, enhance parent–child relationships, and strengthen a family's connection with supports within their community. Parents often contact an early parenting service because they need some assistance with issues to do with their children's sleep, nutrition, behaviour or parental adjustment and/or distress in the early years of life, particularly the first two years. This assistance varies from receiving information and education, meeting other parents in a group context, through to more specialised support such as counselling or therapeutic group work for the enhancement of a parent–child relationship. Ngala has a long history of employing nurses to deliver early parenting and child health support and education programs. Today Ngala is a provider of parenting and early childhood services, delivering a range of universal, targeted and specialist services such as a parenting line, group sessions, parenting education workshops, residential and day services, individual consultations and community development.

The investigation and description of nursing history was undertaken in phase one of a larger nursing study (Bennett 2013).

## Purpose

The aim of this study was to describe the nursing role within the context of history at Ngala since its inception over 120 years ago.

## Background

The importance of the larger study was to understand the origins of nursing at one early parenting service, to place the overall study in the context of the current and future role of nursing within like Australian services. Early parenting services around Australia evolved with many similarities. Ngala is one of the oldest of these services. Most services commenced in the early part of the 20th century as a result of the child welfare movement originating

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in Europe and New Zealand. Due to high child mortality, this generated the need for experts to provide public health interventions such as parental education provided by nurses.

Little has been documented in WA about how history and the role of nurses within EPS have evolved over more than a century. However, there is documented history of other specialities and contexts in the nursing literature. Many anecdotes from nurses exist in the current nursing workforce within EPS and there are limited publications available explaining the role of the early parenting (EP) nurse in WA over 120 years.

For this first phase of the larger study, a culmination of multiple sources of data were brought together to describe the nursing role over time which is a valuable historical resource for the future. Ngala is fortunate to have maintained a plethora of historical documents archived at the Batty Library, in Perth. This data provided a rich, extensive document analysis of nursing history and the role. The researcher sought consent from Ngala CEO and Executive to undertake the study. Ethics approval was received from the University of Notre Dame Australia (Ref # 010154F).

## Methods

Data triangulation in the first phase of the study involved the use of different data collection methods for the collection and interpretation of data to gain a more accurate representation of reality, thereby enhancing the rigour of the research (Williamson 2005). Figure 1 summarises the various methods used.

The data (archived documents, recorded oral histories) was collated into time periods and the themes were described. The next set of data (interviews, focus groups, reflective diaries, management documents) were then collated and a thematic analysis of the current role was undertaken. These findings were discussed with two past leaders to verify the findings. The current role was identified through nurses' diaries, interviews and focus groups. Questions were asked such as, "What was unique to the role within the context of the interdisciplinary team?" and "What had changed for nurses over time?" The coding and themes were categorised and managed (reviewed and refined) in NVivo. Braun and Clarke's six-phase framework of thematic analysis was used to guide the process of analysis and recording (Braun & Clarke 2006).

## Results

### 1890 to 1940s

Ngala commenced as The House of Mercy, which was established in 1890 during a time of turmoil in the history of WA; with the 1890s Gold Rush to the eastern goldfields, resulting in increased immigration and infectious diseases. Hospital governance commenced with the passing of the first *Hospitals Act* of 1894 in Parliament, which brought in regulations related to hospitals and boards of governance (Hobbs 1980).

A matron was engaged to run the Home. She was not a certified midwife, so a doctor was called in during births (Jull; Lang 1980). It was not until much later (1911) that midwives were called in to assist. Young women were admitted during their confinement, up to the child being six to nine months, if required (Lang 1980). The first note of a "probationer nurse" being employed was in 1907

(Mattinson 1970). An Infants Home in connection with the House of Mercy was opened in 1904, which employed untrained nursing staff for the purpose of caring for the children. The purpose of the Home was to care for children "for a small fee, after their mothers had obtained situations and left the House of Mercy, as the boarding out system had in so many cases meant death of the children". These children were often "malnourished, sick and/or convalescing" (Lukin 1904). Volunteer women would come in to assist with the running of the home (Lukin 1905).

Excerpts from the matron's diaries 1894–1904 gave examples of young women or babies having infectious disease such as typhoid fever. The doctor visited each day. Women and babies often died in the home due to infection or neglect. Volunteer women would come in to assist with the running of the home. A report on the Infants Home in 1905, stated:

*The Matron reported the death of two babies Harold Edward and Billie Nottle on Jan 28th. They both died of consumption of the bowels although something possible had been done to save them both by the Doctor and Nurses. An Assistant nurse had to be engaged early in the month as all the children were ill and there was no help available from the House of Mercy (Lukin 1905).*

The establishment of a maternity hospital was in planning by key community members in Perth, including the matrons of the Perth Hospital, House of Mercy and Children's Hospital (opened in 1909, see Piercey 2006), as well as eminent doctors and high-profile community members, including the clergy. A committee was established in view of the debate at the time about whether the hospital should service both "married and single women". It was noted by Reverend Kench in 1909 that with "the good work being done by the House of Mercy amongst single women, we should be conferring with the principals of that Home in regard to the proposed maternity hospital" (Hobbs 1980).

Annual reports from the House of Mercy from 1911 to 1914 highlight the matron's position on the Midwifery Board of WA and the difficulty in being able to recruit 'probationer nurses' (1911). The report in 1912 alludes to the potential amalgamation of the House of Mercy with the proposed maternity hospital. This was not agreed to by the committee (1913) and highlights the cases that were admitted each year, and the services of the matron.

Infant mortality attracted much public attention in WA during the first two decades of the 20th century. This period saw a far greater incidence of infant death in WA than in any other state in Australia, predominantly attributable to the Gold Rush. Death mostly occurred in younger infants, with the major causes being congenital debility, digestive illness such as diarrhoea, and respiratory problems such as influenza and whooping cough. Government strategies at this time were to "educate the mother in better methods of infant care as well as her basic household tasks" (Davis 1983). The First World War commenced in 1915 and the King Edward Memorial Hospital (KEMH) opened in 1916 (Hobbs 1980). Also in 1916, the House of Mercy changed its name to Alexandra Home for Women (Lang 1980). During 1916, a Child Welfare Conference was organised by the Women's Service Guild in Perth to:

*... consider in view of the present world crisis, the necessity for studying the best methods of awakening and of training the*

Figure 1: Triangulation of data collection

Method data collection	Type of triangulation	Method of analysis	Purpose
Archived documents (nursing notes, meeting minutes, photos, media images, organisational documents, correspondence, diaries and reports)	Researcher and data	Analysis of texts — notations of nursing tasks/activities, social context and purpose of document	To examine, categorise and tabulate information from documents
Recorded oral histories (n4)	Researcher and data	Analysed transcriptions, analysed for codes and themes	To understand context of nursing 1940s–80s
Interviews with nurses and allied professionals (n10)	Researcher and data	Recorded, transcribed, analysed for codes and themes	To investigate nurses current role within the context of an interdisciplinary team
Interview with two leaders: Matron 1959–1980 CEO 1989–2011 (n2)	Researcher and data	Recorded, transcribed, analysed for codes and themes	To investigate historical contexts at Ngala with two leaders from 1959–2011
Ngala document management system	Researcher and data	Analysis of texts — notations of nursing activities, policies & procedures, position descriptions & competencies; social context and purpose of document	To examine, categorise and tabulate information from documents
Nurses reflective diaries (n8)	Researcher and data	Analysed for codes and themes	To undertake reflexivity to capture thoughts, ideas, clarifications, observations and reflections of their role
Focus groups with nurses (3)	Researcher and data	Recorded, transcribed, analysed for codes and themes	To investigate nurses current role within the context of an interdisciplinary team
Focus group with allied professionals (1)	Researcher and data	Recorded, transcribed, analysed for codes and themes	To investigate nurses current role within the context of an interdisciplinary team

*capacities of the child; to create a deeper interest in the moral question of child welfare, and to discuss the importance of child psychology and relation to social progress (Davis 1988).*

The Alexandra Home for Women name change came at a time of shifting attitudes towards unmarried mothers and their babies (Lang 1980). Nursing during this era was becoming increasingly professionalised, with advocacy at higher levels of nursing. The training of nurses became more regular, and regulations were introduced for the registration and training of nurses and midwives. The First World War and Depression and then the Second World War were features during this period, as was the escalation of the infant welfare movement. Infant health centres were established from 1922 to assist in the movement to reduce infant morbidity and mortality, to teach mothers about health and hygiene and to promote breastfeeding (Hobbs 1980).

The Infant Health Association (IHA) was established in 1922 with societal interest in the welfare and lowering of the death rate of young children (Davis 1988). An article in the WA newspaper entitled 'Save the Babies' alluded to maternal ignorance, with the

need to educate and increase the community and Government's awareness of their responsibility for children (Davis 1988). The first Infant Health Clinic was opened in 1922 (Hobbs 1980) and by 1925 there were 10 centres (O'Hara 1988). The IHA worked closely with and sought advice from the medical profession, and Dr Roberta Jull was a strong advocate and link to gain cooperation from the medical profession, who at that time saw themselves as instructing the role of nurses in the health care of women and children (Davis 1983). Davis, in her study, found a letter written to doctors and nurses from the IHA. A medical advisory committee of the IHA in 1923 provided advice and instruction to midwives and nurses:

*The nurses are instructed that they are not to treat sick babies, but are to refer all cases of illness among the infants under their care to a medical practitioner and to aid the mother in carrying out his instructions. Under no circumstances are they to recommend any particular doctor (Davis 1983).*

The medical profession regarded their specialist training and knowledge as vital in ensuring the health of the mother and baby.

## 1940s to 1980

During the 1940s, the Ngala Committee planned the introduction of a training centre for mothercraft nurses, and they also embarked on an expansion of the facilities. The Nurses Board approved the curriculum and registration for mothercraft training to occur and:

*... in June 1949 there were 15 trainees in residence for a period of 15 months training under the direction of Matron Ulrich, Dr Edwards, Dr Cook, and a staff of three nursing Sisters and a Mothercraft Nurse (Lang 1980).*

Meerwald (1995) stated in her oral history interview:

*A Sister Hack came ... she was a wonderful woman. She taught us a lot, not only in caring for children but accepting of people and knowledge of people. She had guided us through and it was really very well done. She had a natural instinct to explain because you get, you know, for us country girls and most of us were country girls, incestuous children and that. I mean we'd heard ALL the stories you know, and everything about that, but she helped us understand how these things could occur, how to love the children — we loved the children anyway, it was only people that had them we didn't like (Meerwald 1995).*

She said that the course initially taught the basics of caring for a baby, including hygiene, bathing, clothing, safety, play, feeding, breastfeeding, engorged breasts, infectious diseases and caring for children. The nurses spent time in pre-schools and various kindergartens and she stated that "My mothercraft training provided a good basic education that was built on in further nursing certificates" (Meerwald 1995).

The years from 1949 to 1959 marked the attainment of unity within nursing, adjustment to changes in the pattern of nursing care and nursing education and the formation of the College of Nursing Australia in 1951 (Hobbs 1980). During the 1950s and 1960s, there was a considerable increase in the population and a drop in mortality rates. This rapid growth also generated economic development and growth in health facilities (Piercey 2006). During this period, nursing training was still heavily influenced by an army style of education and a shortage of nurses generally. There was a movement during the 1960s to build a new curriculum for nurses that was more relevant to the time (Piercey 2006). There was also a move towards improved nursing pay and conditions (Hobbs 1980).

Two nursing oral histories (Ellis 1995; Meerwald 1995) describe the period of nursing from the 1950s (prior to the transition of Alexandra Home to Ngala) until the transition period into the 1980s, including the key role of the nurse. The sisters in training and the mothercraft nurse roles interfaced, as they often both worked together with the children. One of the key roles of the nurse was as a "substitute mother", and routines for children had to be established, such as for feeding, bathing, dressing, sleeping, walking, playing, cooking, preparing food, checking or supervising, toileting, cleaning, settling of children and making up of milk feeds (Figure 2). The following quotations explain this role:

*Nurses undertook all activities that were related to the daily chores of looking after children. We did things that anybody else would do with their children (Ellis 1995).*

*We were to care for any child whose mother was unable to care for it, whether she was ill or ... while they went on holidays sometimes, or she might have been in hospital or the child could have been for adoption or fostering or for any reason whatsoever that the mother couldn't care for the child (Ellis 1995).*

*The nurses were fantastic ... they would often come down when they were off duty and in the evenings, and often feed their babies (Ellis 1995).*

*They were to create a homely environment and 'look on as a home not an institution'; Treat children as individuals, and buy gifts for children and necessities like shoes and nice clothes (Ellis 1995).*

*Everybody was encouraged to have a baby or toddler that they loved ... we had permission from Matron to take children out on outings when we were off duty ... and sometimes for weekends (Ellis 1995).*

*You'd go into the milk room and that was ... and you'd cook the children's meals and you'd do the special diets for the babies as well as the milk bottles. The main kitchen would cater for the older children — 2–3 year olds (Meerwald 1995).*

*All feeds were worked out for babies in those days on the calorie intake — how many calories they needed for pound of body weight a day and all the feeds were worked out on that. You'd have a chart for each baby and when you'd finished your shift you'd have to check that the other nurses had all their calorie charts and that baby had had sufficient nourishment for the day. If it wasn't you'd see that it was increased the next day or if the child was still hungry you'd have to work out another diet for the baby. That was the nurse's job. Then the matron or the charge sister would come and check it over (Meerwald 1995).*

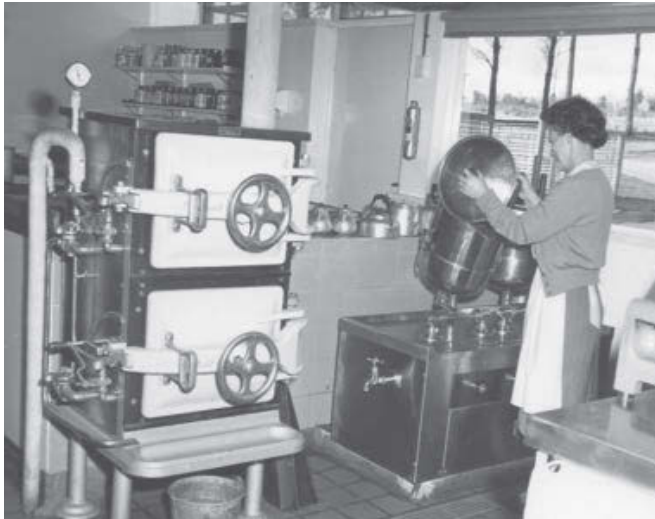
The other parts of the role are as follows;

- Caring for sick child/mother;
- Caring for disability/special needs;
- Coordination of care;
- Health assessments;
- Doing mothercraft;
- Protecting children and advocacy;
- Giving psychosocial support; and
- Training and supervision.

Ngala promoted both training for mothercraft nurses and the child health course in 1958. Without a training program registered nurses had to go to the 'East' [Eastern states of Australia] to train for the 'Infant Health Certificate'. The shortage of nurses was identified in this brochure as well as the benefits of a WA-based training school (Figure 3).

In 1959, Alexandra Home was transferred to new premises and became Ngala Mothercraft Home and Training Centre, undertaking the training and registration of mothercraft nurses and the infant

Figure 2: Photos of nursing activities 1960s–1970s



health certificate for general and midwifery nurses (Hobbs 1980; see Figure 4).

The 1960s also saw the introduction of television; change in the metric system and currency; introduction of the contraceptive pill; the introduction of disposable equipment and a central sterile supply department at major hospitals; the introduction of a manometer and stethoscope for measuring blood pressure; and allied health disciplines. During this time, consideration was also given by the Commissioner of Public Health to the introduction of health visitors using infant health sisters in implementing this, together with those giving domiciliary care under the Silver Chain service. Nurses were not willing to participate in such an initiative, as it required extra specialised training not available in WA (Hobbs 1980).

For nursing in the 1970s, the expanding role of the community nurse was evidenced by the change of name from 'infant health' to 'maternal and child health'. In 1974, the WA School of Nursing was formed next to Royal Perth Hospital. The building opened in 1975 and the commencement of the first Bachelor of Applied Science (Nursing) at Western Australia Institute of Technology (WAIT) began in February of that same year (Hobbs 1980).

A large part of the registered nurse's role was to teach and to oversee all the activities related to the care of children. An interview with Matron Grant (Grant 2013) validated the above description of the nursing role during this time. She reiterated the importance of nursing education and the professionalisation of nursing and was a strong advocate to the move to tertiary education. She stated that the nursing roles are exemplified by three key elements; that is, caring, education and a holistic approach to working with families (Grant 2013).

As noted previously, the 1970s were a decade of planning and change for nursing, with the gradual move of training into the



Figure 3: Promotional brochure for Ngala (Ngala 1958)



tertiary sector. The broader influence internationally of the Alma Ata Primary Health Care Conference in 1978 was the beginning of change for health promotion into the 1980s (State Government of Victoria 2012). This had a major impact on nursing and the gradual move away from the medical model over the following two decades.

**1980s to current role**

The 1980s was a turbulent period for Ngala. During this decade, societal changes brought new perspectives on residential care, broader definitions of family and less critical views of single parenting, combined with the challenge to the organisation to shift its focus from mothers and children in isolation to the nature and functioning of children in the context of family.

Firstly, the Booth Report (Booth 1980) recommended a new way forward and the introduction of social work services to the organisation. Secondly, as a not-for-profit organisation experiencing financial difficulties, the Committee undertook a functional review in 1984. Thirdly, the Department for Community Services undertook a significant review during 1985–1986 in which they examined the finances and residential services of Ngala. Finally, the child health course was transferred to the Western Australian Institute of Technology (WAIT), and mothercraft nurse training at Ngala ceased. At a national level, the traditional mothercraft training was also being replaced by TAFE courses that

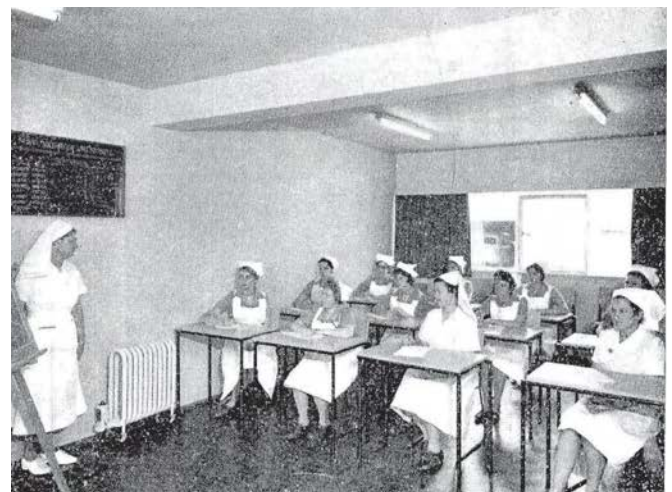


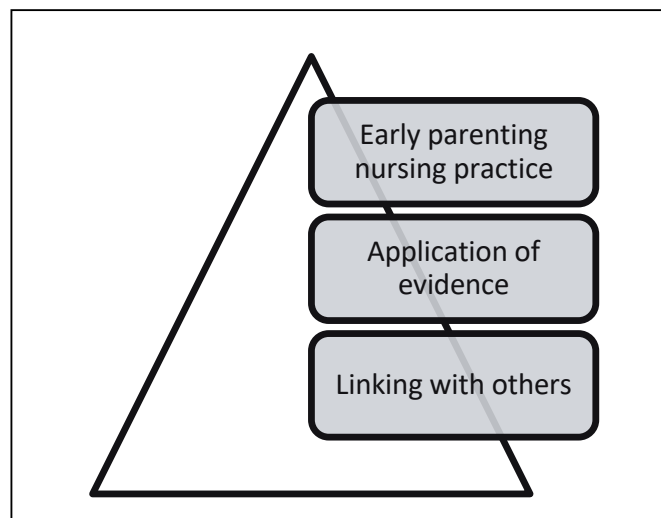
Figure 4: Deputy matron lecturing RNs in child health (Ngala 1963)

qualified students for a child care certificate. At this time, there was also evidence that employment opportunities for mothercraft nurses were decreasing and that enrolled nurses were taking their place (Department for Community Services 1986).

The Booth Report also recommended the reduction in residential care for children as it was no longer regarded as best practice. Instead, a move to family support programs was recommended.



Figure 5: Overall nursing role in EPS



Additionally, the report recommended the employment of a nurse educator and a change from a medical advisory to a professional advisory committee that incorporated less medical dominance and included social welfare. Booth also raised the issue of the nursing role being enmeshed with the medical model and communication styles being prescriptive rather than consultative (Booth 1980). The DCS Report (Department for Community Services 1986) reinforced the importance of Ngala's child health role, but recommended the closure of the residential unit and a shift to a community-based model of care.

During this time, the training for the mothercraft nursing certificate ceased and a new Board of Management was formed, creating more uncertainty for Ngala. Part of the change occurring for Ngala (from the culture of an institution) came with the demolition of the old building and its replacement with a family-friendly complex in 1995.

Throughout the 1990s, there were many quality reviews that kept the organisation moving forward while trying to keep the focus on the reason for Ngala's existence. The CEO was interested in asking questions about the quality of practice and impact on families. Nurses found it difficult during this decade because the effect of nursing having moved into the tertiary sector had yet to take effect at Ngala, as there was no critical mass of nurses with a degree to make changes (Walter 2013).

The organisation began reaching out into the community with various programs to support and educate families with young children. Parent and professional education programs were also scheduled (Ngala 2000; Ngala 2002), and community development programs were initiated to expand the outreach of the organisation (Walter & Dawson 2001). The development of systems was a priority, and was an ongoing challenge due to resources.

The focus on being in the new millennium in 2000 was a timely opportunity for Ngala to commence a quality review of how its residential and more intensive services were operating together. The focus was on interdisciplinary and family-focused change and continuity of care (Ngala 2000). Some of the changes being planned were a one care plan for use by all disciplines, joint meetings, shared leadership and joint training. The evidence used at the time was *Documenting the Nursing Process* (Hacker Chana

1992) and *The Patient-driven Interdisciplinary Care Plan* (Gage 1994).

The most substantial change experienced by nurses in the 2000s was the move away from the 'expert approach' by nurses to partnership approaches with families and the introduction of a strength-based, solution-focused way of working.

Nurses were asked through focus groups, interviews and written journals to discuss their role within the context of an interdisciplinary team. Their responses generated three categories (Figure 5):

1. Early parenting nursing practice;
2. Application of evidence; and
3. Linking with others.

Under each of these three categories were various themes. The role was described as very broad and over time these experienced practitioners developed very comprehensive skills, as follows:

#### **Early parenting nursing practice**

Category one included two sub-categories of *Building connection and relationship*; and *Coordination and planning*. The first one encompassed health assessment, advocacy, promoting health, parent-craft and child development. The category of coordination and planning contained anticipatory guidance, individual consultation and group facilitation.

#### **Application of evidence**

Category two was seen by nurses as important and integral to their work and contained four sub-categories. These were *Professional development, Information management, Reflection and Evaluation, and Research application*.

#### **Linking with others**

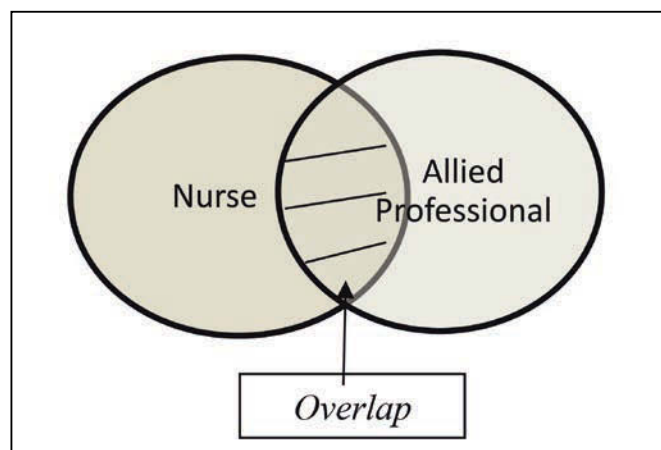
Category three involved nurses linking clients back out to the community via referral, or to a range of resources available locally or via the internet. Nurses network and link internally and externally to the organisation. The support for team, colleagues and students was also a large part of their role. The sub-categories were identified as *team connection, mentoring colleagues, preceptoring students and referral*.

The uniqueness of the nursing role was described consistently, with both nurses and allied professionals through their conversations in the focus groups and interviews. They discussed an interprofessional overlap that develops when working with children, parents, families and communities. Figure 6 demonstrates the interface with an overlap segment.

A nurse summed up this interface by saying "you are working alongside each other and you are sharing by 'osmosis'".

In summarising the perceptions of the nursing role, the uniqueness was outlined under the everyday practicalities of working with parents in their parenting role. This included parent-craft and child development, health promotion, health assessment, holism and the coordination of care.

Figure 6: The nursing role within an interdisciplinary team



## Discussion

A summary of the nursing role evolved over 120 years and during this time reflected influences from a range of factors and changes that have made nursing in EPS what it is today. Ngala was first established in 1890 as the House of Mercy to assist young single women giving birth without the support of family and under difficult social circumstances. Nurses were employed at the turn of the 20th century, prior to which midwives would come to the house and assist with the births. From 1904, other infants were cared for at the House of Mercy and, over time, Ngala became one of the key places in Perth, WA, for the institutional care of children and the adoption of children, up until the 1980s. Nurses also cared for young pregnant women, and from the 1990s, for parents, with the shift to a family focus.

Nursing was the predominant discipline employed at Ngala up until the 1980s. In addition, the medical profession had visiting rights since inception and this continued until the 1990s, at which point a paid general practitioner commenced. Visiting social workers to Ngala were mentioned in the documents from the Department of Welfare from the 1950s, but were never employed until the 1980s.

The nursing role was strongly influenced by the army and the first part of the 1900s with the two World Wars. Many of the tasks described by nurses were aspects of 'women's work' around the home and the role of a mother in looking after a child. Nursing at Ngala was consistent with the context of what was occurring in WA and nationally, as many nurses went east to train in infant welfare nursing up until 1959, when the course was introduced at Ngala. The regulation of nursing began in WA with the introduction of Parliament in 1890 and the *Hospitals Act* in 1894. Regulation appeared more informal initially, with the formal title of 'nurse' being used and the wearing of a uniform symbolic of being a nurse. The traditions of nursing were a part of the early child welfare movement and often a precursor or simultaneous development to the setting up of infant welfare clinics. Many such clinics were supported very strongly by community advocates and volunteers (mostly women) and women's or church organisations.

The education and training of infant welfare nurses commenced in the 1920s in Australia and the first Australian degree in nurse education was established in 1975 (Piercey 2006). The

professionalisation of nursing through the tertiary sector had major implications for nursing, affecting nursing at Ngala over time. The effect was not fully realised until the 1990s, by which time more nurses had undertaken the bridging degree from the hospital-based certificate. The professionalisation of nursing affected how nurses approached their work. The rise of formalised professionalism created developments of theoretical frameworks, the introduction of the nursing process, legal parameters, professional boundaries and ethics. Many of the symbols that designated nurses such as hats, badges, uniforms and terminology (such as the word 'sister' or 'matron') disappeared gradually during the 1970s and 1980s.

In terms of community nurses specifically, the World Health Organization (WHO) defined community nurses as identifying the community's broad health needs and involving the community in development projects related to health and welfare (World Health Organization 1974). In Australia, community nursing has encapsulated a range of care contexts, providing health promotion, community development, health education and disease prevention within a framework that recognises the broad social, economic and environmental determinants of health (World Health Organization 1978). Over time, societal changes to family structures and the introduction of technology started to change the nature of work in EPS, and the international impact of The Ottawa Charter and the influence of primary health care during the 1980s saw a shift away from the medical model to community health models of care. This continues to be important in nurses' practice today.

This study demonstrated that through nurses working closely with an interdisciplinary team there is a clear ability to articulate the unique role of the nurse, despite there being a sharing of skills or 'osmosis' of knowledge and skills in collaborative practice. Nurses also maintain a strong sense of boundaries and professional identity. Brown *et al.* (2000) discuss blurred roles and permeable boundaries when different disciplines work within mental health services. Some see this as role erosion and a threat, while others see it as an opportunity. Brown *et al.* (2000) purport that "boundaries between professions are actively encouraged by the experience of interdisciplinary modes of working" (Brown *et al.* 2000). These also emphasise the benefits for all team members, saying that "a less precious approach to disciplinary boundaries needs to be explained and a culture that facilitates flexibility needs to be promoted" (Brown *et al.* 2000).

Working within a team does challenge the limits of what one can and cannot legitimately be required to do. In a study by Wuest (1998), she encourages nurses to attend to one's own professional "voice", which then allows workers to "limit the number and extent of caring demands as well as to draw on self-knowledge to order their caring". It is suggested that the "clearness of a nurse's professional identity" is linked with his or her personal growth, ability to progress and determination to enrich his or her knowledge and skills (Harmer 2010). The important attributes required for interprofessional collaboration identified by Miers and Pollard (2009) included communications skills, interpersonal relationship skills, teamwork skills, knowledge of roles, respect and tolerance, experience and personal maturity, and being able to inspire trust and work across professional boundaries.

When role theory was developed during the early part of the 20th century (Jackson 1998), there were strong correlations with the nursing role, given the societal context and that nursing evolved with strong influence from the army. Nursing was also strongly dominated by the medical model and task-driven until the move to the tertiary sector, which began to create a stronger voice for nursing. Nursing in EPS had influential medical advocates alongside volunteer advocates, and hence differed from the hospital context. Nurses in child health centres and EPS were very strong and autonomous women with a strong identity and role expectation. This was identified in the present cohort of nurses by the allied professionals in phase one of this study, and it can be suggested that this is consistent with nursing being the largest health discipline in Australia (Duckett 2005) and the public perception on the role of the nurse in society (McKenna & Keeney 2004).

## Conclusion

The rich history of nursing at Ngala over 120 years gives a greater understanding of how nursing has evolved and changed and how nurses continue to contribute to the health and wellbeing of families in the early parenting context. The respect held by the public for nurses has been well documented in the public domain. The uniqueness of the nursing role in EPS when working closely with other disciplines has been identified and will assist nurses to articulate their role with other disciplines in a team environment.

## Contributorship

EB was the primary author and S and CB had a role in editing the manuscript and supervision of doctoral research. All authors had substantial contribution to the revision and final approval of this manuscript.

## Ethical approval

Approval for the research project was given by Ngala.

The University of Notre Dame Australia ethics approval: HREC #010154F.

## Competing interests

Nil.

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