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A pedagogical framework for facilitating parents' learning in nurse-parent partnership

Abstract

Nursing work increasingly demands forms of expertise that complement specialist knowledge. In child and family nursing, this need arises when nurses work in partnership with parents of young children at risk. Partnership means working with parents in respectful, negotiated, and empowering ways. Existing partnership literature emphasises communicative and relational skills, but this paper focuses on nurses' capacities to facilitate parents' learning. Referring to data from home visiting, day-stay and specialist toddler clinic services in Sydney, a pedagogical framework is presented. Analysis shows how nurses notice aspects of children, parents, and parent-child interactions as a catalyst for building on parents' strengths, enhancing guided chance, or challenging unhelpful constructs. Prior research shows the latter can be a sticking point in partnership, but this paper reveals diverse ways in which challenges are folded into learning process that position parents as agents of positive change. Noticing is dependent on embodied and communicative expertise, conceptualised in terms of sensory and reported channels. The framework offers a new view of partnership as mind-expanding for the parent and specifies the nurse's role in facilitating this process.

Keywords

Parenting; child and family health; learning; nurse-parent relationships; parent education

Introduction

This paper conceptualises how nurses facilitate parents' learning in services for families with young

children. It presents a framework that emerged from a study of nurses working in partnership with parents of young children in Sydney, New South Wales (NSW), Australia. The pedagogic nature of partnership practices is highlighted, showing how nurses promote learning by changing parents' interpretations of and responses to situations, and their sense of what is possible.

Child and family nursing contributes significantly to helping families when children's development, health and emotional wellbeing are at risk. Such risks can involve premature, multiple or complicated births; child or parent disability or chronic illness; difficulty adjusting to parenthood; exhaustion, anxiety or depression; stressors relating to housing, social isolation and finance; parent/carer substance abuse; mental illness and feelings of helplessness; family violence; and child protection issues (NSW Health, 2010). These can undermine parents' capacity to provide appropriate care (Ermisch, 2008).

Early intervention is beneficial for preventing detrimental impacts of potential risks (Maggi, Irwin, Siddiqi, & Hertzman, 2010). This 'risk-focused prevention' paradigm (France & Utting, 2005, p. 78) frames the NSW policy for child and family health nursing, which provides 'prevention and early intervention' when risks are identified (NSW Health, 2010, p. 3). However, the issue is not just *when* to intervene, but *how*. If professionals simply give advice, parents can feel judged, disrespected, and unsupported in making their own decisions, meaning they are less likely to follow professional guidance (Eronen, Pincombe & Calabretto, 2010). Equally problematic are approaches where professionals 'fix' problems but fail build parents' capacity (Day, Ellis & Harris, 2015). Models of partnership between nurses and families have therefore been promoted, seeking to foster effective engagement, collaboration and empowerment (Smith, Swallow & Coyne, 2015). This is partnership at a professional-client level, rather than service or system levels (ACSHQ, 2014).

While not displacing nurses' caring and therapeutic roles, partnership work requires relational

expertise (Edwards, 2016), and a capacity ‘to promote parent expertise, wisdom and confidence’ (Rowe & Barnes, 2006, p. 124). The latter can be thought of as pedagogic expertise (Hopwood, 2017), which augments nursing knowledge and supports specialist work with parents (Hopwood, Day, & Edwards, 2016). While the intersection between partnership and learning is established in the literature, conceptual frameworks specifying the expertise involved and how it manifests in practice are lacking.

Literature on partnership and learning

Partnership implies a relational approach that supports power sharing, joint decision making, and client autonomy (Hook, 2006), building trust, listening to parent concerns, and valuing parents’ knowledge of their children (Smith et al., 2015). Example models include Family Systems Nursing (Östlund & Persson, 2014), the McGill Model of Nursing (Gottlieb & Gottlieb, 2007), and the Family Partnership Model (FPM) (Day et al., 2015). The FPM has been adopted in NSW (NSW Health, 2010) and is thus a specific exemplar of a broader agenda.

The FPM aims to enhance communication skills and understanding of the helping process (Day et al., 2015). The model promotes a staged helping process that relies on and contributes to the development of helper-parent relationships. The stages include negotiating goals, implementing strategies, and reviewing progress. FPM foregrounds skills such as active listening, and qualities such as an unconditional positive regard, authenticity, personal integrity, and empathy. Outcomes are conceived in terms of families becoming better able to identify and build on existing strengths, anticipate and cope with problems, access social support, and promote their children’s healthy development (Day et al., 2015).

Working in partnership is not just a question of implementing particular skills and procedures. It

requires 'living practice' in which practitioners remain alert and considered about how they enact partnership (Day, 2013). Gaps in knowledge remarked on over a decade ago (Glasby, Dickinson & Peck, 2006) remain: not enough is known about how partnership is accomplished in practice. This paper addresses the 'living practice' of partnership, conceptualising alertness, responsiveness, and sensitive use of expertise.

FPM training helps nurses focus on enabling change rather than solving problems for others (Keatinge, Fowler, & Briggs, 2008). However, this is not always straightforward in practice. Unclear roles and boundaries and entrenched professional practices to be among challenges to embedding partnership (Smith et al., 2015). Tendencies to revert to expert approaches, clawing back perceived loss of power and control, can be strong (Myors, Schmied & White, 2013). Organisational contexts may constrain partnership practice, with time pressure, lack of clinical supervision, and unmet needs for refresher courses noted as barriers (Myors et al., 2013). Issues around professional expertise in partnership echo wider evidence that practitioners may become unsure about their status as experts in particular domains (Glasby, 2016).

Despite these difficulties, studies continue to point to the value of partnership. Lam, Dawson and Fowler's (2017) review of studies of home visiting noted that working together with parents improves relationships and can increase a nurse's ability to assist parents. Diverse stakeholders in New Zealand viewed FPM as an effective way to help practitioners work more skilfully with parents (Wilson & Huntingdon, 2009), while McDonald, O'Byrne and Prichard (2015) found that the FPM provided a framework for shared decision-making and development of common understandings in Tasmania's Child and Family Centres.

However, McDonald et al. (2015) also highlighted how 'building genuine partnerships is hard work' (p. 25), especially given that the common need to challenge parents in order to move forward.

Nurses in the UK report being unsure about how to wield their specialist expertise, especially when challenging parents (Harris, Wood & Day, 2014), a finding echoed in Australia by Fowler, Lee, Dunston et al. (2012) and in the Netherlands by van Houte, Bradt, Vanderbroek et al. (2013). Challenging unhelpful constructs is a key feature of FPM and a crucial aspect of parents' learning if positive change is to be secured (Day et al., 2015).

An emerging body of research frames partnership practice in terms of learning. Fowler and Lee (2007) critiqued the idea of knowledge transfer, asserting the need to examine partnership in more complex, mind-expanding, ways. Fowler, Dunston, Lee, Rossiter, and McKenzie (2012) found that a home visiting service for mothers with depression required mothers and nurses to learn from each other in a process of reciprocal learning. An observational study of a residential service provided an account of living partnership practices that connects directly with questions of learning through cultural historical concepts such as scaffolding (Hopwood, 2016). This began the work of explaining how what professionals notice can be capitalised on for pedagogic purposes.

A different analysis from the same study took the notion of partnership as mind-expanding further. Using a cultural historical lens, it showed how ways forward were not simply picked from among existing possible solutions, but emerged as a result of collaborative knowledge work between professionals and parents (Hopwood et al., 2016; Hopwood, 2017). A subsequent study found that the focus of such joint work can be highly unstable (Clerke, Hopwood, Chavasse et al., 2017). This points to the need for ways to conceptualise pedagogic practices in partnership that are not based in a fixed learning trajectory, but capture how the process emerges responsively

Conceptual foundations of a pedagogic framework

A mind-expanding metaphor, rather than one of knowledge transfer, is used here to understand how nurses use their expertise to promote parents' learning in order to build their capacity and confidence. The framework focuses on pedagogic practices, i.e., what nurses do to facilitate parents' learning. Such practices can be hugely powerful:

Pedagogy as a social relationship is very close in. It gets right in there – in your brain, your body, your heart, in your sense of self, of the world, of others, and of possibilities and impossibilities in all those realms. (Ellsworth, 1997, p 6).

Partnership is thus understood as a form of interaction that can transform parents' sense of what they can do as parents. There are many ways of conceptualising pedagogy, including Freire's (2000) *Pedagogy of the Oppressed*, notable for its focus on empowerment. Without dismissing the relevance of other frames, we take a cultural-historical approach. This extends previous work and aligns with our purpose to capture how pedagogy emerges through unfolding practices.

Cultural historical theory (Vygotsky, 1978) conceives learning in terms of changing interpretations and actions: 'We transform the world through first interpreting and then acting on the basis of our interpretations' (Edwards, 2005, p. 173). Learning is not about knowledge being transferred directly from nurses, but about how parents develop their capacity to act as they expand ways to make sense of what happens in their lives and their possible responses to these occurrences. The mind-expanding metaphor is consistent with a view that partnership is not an outcome, but a 'point of departure that implies a joint search for meaning' (Roose, Roets, van Houte et al., 2013).

Stetsenko (2008) explains how such a stance regards human subjectivity, intersubjective exchange (i.e. social interaction), and material practice (i.e. actions we perform, bodily, with objects) as

dialectically related to one another. This means that pedagogy is not grasped by catching ideas floating between minds, but by examining what people do and say, in interaction.

A cultural historical approach regards learning and pedagogy as fundamentally social and dynamic processes (Hopwood, 2015). To understand how partnership functions pedagogically, we need to follow changes in how parents interpret and act in the world. Our framework does this at a high resolution, tracing subtle shifts that have important ramifications, transforming parents' sense of self and what is possible. The pedagogic role of the nurse is to make new interpretations and actions available to parents.

The following three steps constitute the conceptual backbone of the framework. When occurring together, they constitute a *pedagogy of noticing*.

1. The nurse notices something and draws attention to it (e.g., a child holding a parents' hand while crossing a road).
2. The nurse attaches significance to what has been noticed (e.g., hand holding is important because it helps keep children safe).
3. The nurse attributes agency to parents by linking to their own actions (e.g., commenting that a mother has done a fantastic job letting her children know when they need to hold hands).

The connection of noticing, significance and attribution was first suggested in relation to the aforementioned study of a residential service (Hopwood & Clerke, 2012). Subsequent analysis suggested the same three steps were mobilised in relation to three intentions: building on a family's existing strengths, enhancing the impact of change through new strategies, or challenge parents' unhelpful constructs (Hopwood, 2016). At this point the framework remained conceptually underdeveloped, and limited in its empirical basis to the residential setting. This was problematic, as the 24-hour nature of nurse-parent contact in residential services is unusual.

This paper expands and enriches this pedagogic framework, connecting it with data from more widespread services. It adds to prior work by categorising what is noticed and revealing two channels through which noticing is accomplished (sensory and reported). Responding to issues identified in recent research, it also specifies how these practices provide a means to challenge parents in an affirming and constructing way.

Our purpose is to explore how the framework opens up new ways of thinking about nurse-parent partnerships. Therefore, the discussion responds to the following questions: What does the pedagogies of noticing framework reveal about living partnership practices? What aspects of nurses' expertise does it highlight? How might it be helpful in resolving some of the difficulties documented in prior research in terms of implementing partnership in practice?

A summative findings section is presented to provide an empirical foundation for the subsequent discussion. The conceptual developments emerged out of analysis of new data, which shows the pedagogical processes to be widespread in diverse service settings, establishing the applicability of the framework. Quotations also offer authenticity, grounding discussion in reference to material practices and nurse-parent interactions, addressing Stetsenko's (2008) three linked aspects.

Data collection and analysis

Observation data was generated by shadowing professionals from home visiting, day-stay, and toddler clinics offering Parent Child Interaction Therapy (PCIT). Services from three Local Health Districts (LHDs) were involved. Typed field notes from 67 observations of entire appointments involving 19 nurses and 60 parents from 58 families were produced (the services involved asked that we not audio or video record in this phase of the study). Further details of each service and data

collection are presented in Table 1.

Place Table 1 here.

Observations were conducted by Hopwood and Clerke, both of whom had considerable experience in qualitative observation (see Clerke & Hopwood, 2014). Observations were unstructured, meaning observers noted down nurse-parent speech (as close to verbatim as possible), infants' actions and cries, and objects in use. The focus was on concrete description rather than looking for *a priori* concepts: the three pedagogic steps were not sought at the time of data collection.

Quantifications of observer consistency were not relevant, but the prior study and joint inspection of initial transcripts were sufficient to ensure observation captured operationally comparable data.

Frequency counts were treated as indicative of broader patterns, but not subject to statistical tests.

All participants gave written informed consent, and pseudonyms are used for participants and sites.

While all nurses had completed FPM training, none had received any training in relation to the three-step framework, nor were they told that this was being looked for. The study was presented as aiming to document living partnership practice.

MacQueen, McLellan, Kay and Milstein's (1998) approach to team-based coding was used to ensure consistency across authors in analysis. Each code was specified through: title, lay and technical definitions, criteria for coding/not coding, and an example. Initially, coding focused on the three steps and intentions identified previously (Hopwood, 2016). Constant comparison and iterative refinement of categories (Kolb, 2012) were used to expand the framework. Analysis of a subset of data was independently conducted by Hopwood and Nguyen and checked for inter-coder consistency based on percentages of codes in agreement. Discrepancies were discussed and resolved, and the data re-coded until 99% agreement was reached. Clerke reviewed the coding and

no further queries were identified. Hopwood and Nguyen coded additional data until all relevant data were covered. Further checks were conducted on random samples of coded data and no discrepancies were found. Data were coded independently in separate MAXqda software files, which were later merged.

Empirical Foundations

To establish an empirical foundation for the pedagogic framework and discussion that follows, key findings will now be presented.

Three-step pedagogies were widespread across different services

Three-step pedagogies were widespread in home visiting, day-stay, and specialist toddler clinics, and in all three Local Health Districts. They were evident in all 67 observed interactions. Table 2 shows the percentage of instances in which initial noticing was followed by explaining significance and asserting parents' agency, thereby completing the sequence.

Place Table 2 here.

Table 3 presents examples from all services and LHDs, showing how the steps may be accomplished in very short interactions. Table 3 also indicates further information about each example, referring to analytical distinctions that are discussed below.

Place Table 3 here.

Nurses noticed through sensory and reported channels

The residential service analysis (Hopwood, 2016) only depicted pedagogies of noticing based on things that were happening right at that moment. Once instances of the three steps were identified in the home visiting, day-stay and toddler clinic services, it became clear that these did not always have the same connection to live action. Nurses noticed features of what parents said about other times and places. The analysis thus identified two ‘channels’ of noticing: sensory and reported. Both were evident across services, and examples are provided in Table 3. The proportion of sensory and reported channels for each service is shown in Figure 1. There was variation between services in the relative proportion of each channel (discussed in the next section).

Place Figure 1 here.

Intentions underpinning pedagogies of noticing are broadly consistent across settings

Pedagogies of noticing reflect different intentions: to build on existing strengths, to enhance guided change, or challenge unhelpful constructs (see Hopwood, 2016). Each instance of the three-step process was coded according to these distinctions. No new intentions emerged – these categories were sufficient to capture varying intentions in other settings. Table 3 presents examples relating to feeding, soothing, reading cues, and settling. Figure 2 shows that all three were present in the different services and that the proportion of each intention was broadly similar across all settings. Pedagogies of noticing linked to enhancing change were the most common in all settings, while consistently least common was the challenging of unhelpful constructs.

Place Figure 2 here.

Nurses noticed aspects of children, parents, and parent-child interactions as a basis for pedagogies of noticing

Pedagogies of noticing respond to what comes up in practice, rather than reflecting a pre-defined

script. Thus an important development in the pedagogic framework involves focusing more on what is noticed. Table 4 specifies sub-categories of what is noticed in relation to children, parents, and parent-child interactions. Examples illustrating these foci are given below, in addition to those from Table 3 that are cross-referenced in Table 4.

Place Table 4 here.

In a day-stay at Grevillea, a nurse noticed a child toddling away, remarking:

She'll come back to you, you're that secure base for her. She's exploring the world now, but coming back to you. Actually the same is important in settling. It's kind of like a separation for her. She needs to know you are around.

Later, when they were settling the child, the focus was on the child's expression: "Listen, there's a wind-down, pause, she's calming herself". Nurses also noticed the absence of gestures where they might have been expected as when a child began to retain his dummy rather than spitting it out. Gestures were noticed both as single instances, repeat actions or changes in patterns. What nurses noticed in parents' beliefs about their capacity was often linked to a sense of inadequacy:

That sense of guilt or failure or wanting to fix it or whatever you want to call it, it's quite overwhelming. But at the same time, it's tapping into all the wonderful things you are doing, and there are some times when our babies are in such a frantic state that the only thing we can do is be with them. (home visiting, Samphire)

Nurses had varied bases for challenging parents' unhelpful constructs through pedagogies of noticing

Given that difficulties challenging parents without undermining partnership come up repeatedly in the literature, the pedagogic framework attends directly to this issue. Nurses challenged: parents' technical understandings of children and their development; parenting actions, responses and practices (with a specific set of relating to safety concerns); parents' understandings of themselves; their commitment to and understanding of self care; and their understandings of the change process.

The first category is based on specialist knowledge of children and their development. General principles or technical distinctions were invoked in connection to a particular child or situation, as with definitions of breastfeeding in Table 3, example 9 when the source of milk rather than means of its delivery was highlighted. Other challenges focused on parenting actions, (example 7, about not setting an alarm to wake the children), responses (example 8, about reading tired cues), and practices, especially those that raised safety concerns:

Nurse: I noticed a pillow under her head.

Mother: We've been doing that for a few months.

Nurse: I have to suggest this; she doesn't need it. It's a SIDS [Sudden Infant Death Syndrome] thing and a stepping-stone to climb out of bed (home visiting, Grevillea).

Parents' understandings of themselves as parents were also challenged, especially when they indicated feelings of guilt and self-blame, or saw themselves as failing, hopeless, or unable to bring about change. The prior example of the nurse at Samphire discussing parents' desires to 'fix it' and their feelings of guilt and failure illustrates this. Parents often struggled to look after their own physical and emotional needs, prioritising those of their children. Nurses challenged this, suggesting

that parents caring for themselves was important for providing the best care for their children:

Mother: My husband has a manual job ... so I want him to get his rest. I need to keep the family healthy.

Nurse: Yes that's really important, but you need your rest too. You could try some changes maybe on Friday and Saturday nights (day-stay, Banksia).

Nurses also confronted unrealistic expectations about how quickly changes might be achieved. After regressions, nurses normalised ups and downs, and challenged parents' convictions that, having been tried once, something would not work again:

Nurse: You can use one of your t-shirts, tied in a knot. [as a comforter]

Mother: That didn't help.

Nurse: These processes of change can get worse before it gets better, maybe two weeks, but you have to be consistent (day-stay, Grevillea).

Discussion

What follows is organised in relation to Figure 3, which presents all key features of the expanded pedagogical framework. The aforementioned questions guide the discussion: What does the pedagogies of noticing framework reveal about living partnership practices? What aspects of nurses' expertise does it highlight? How might it be helpful in resolving some of the difficulties documented in prior research in terms of implementing partnership in practice?

Place Figure 3 here.

The three-step practices and their association with three distinct intentions have now been documented in home visiting, day-stay and specialist PICT toddler clinics in addition to the residential service first studied (Hopwood, 2016). Table 2 shows that 85 per cent of instances where something was explicitly noticed by a nurse were followed up with the second and third steps of attributing significance and imbuing parents' agency. Participating nurses received no training in this approach nor indication that it was being looked for. The framework therefore captures an authentic feature of nursing practices that are a part of living partnership in such child and family health settings. While the discussion that follows refers to the contexts studied, it has potential value in elucidating partnership at the professional-client level more generally.

Addressing specific features of Figure 3, we look to the left of the Figure, where the potential sources of what might be noticed are represented. The framework points to how nurses can support parents' learning without following a pre-determined script that would pull practice back to an expert-led model. When the aim is to enact a responsive partnership (Day, 2013), the question arises: What are nurses responding to? Practices that expand and amplify the pool of actions, interactions, feelings and beliefs available as potential stimuli are crucial in delivering on the promise of effective partnership.

Greig, Gilmore, Patrick and Beech (2013) refer to 'arresting moments' when people are moved to change their way of talking and acting: through noticing something new about everyday situations, new possibilities become apparent. Figure 3 shows how such arresting moments may happen live during parents' encounters with nurses, but may also be grounded in things that happen at other times and places. This is significant, as nurses have limited direct contact with families (see Table 1), and this does not always coincide with the occurrence of concrete struggles such as night-waking, breastfeeding, toddler aggression, etc. Effective use of the reported channel can mitigate

difficulties associated with these temporalities (Myors et al., 2014). Sensory and reported channels are needed to make the most of what happens during the encounter, and to expand the pool of arresting moments that provide the catalyst for nurses' pedagogic work. Given the basis of pedagogies of noticing in what is happening *in situ* or in what parents offer up as of relevance to them, they offer a means to accomplish living partnership as a personalised form of practice (Glasby, 2016).

The emergence of events that have potential to be transformed into new possibilities for interpretation and action is not automatic. Figure 3 shows how the sensory and reported channels require distinctive forms of expertise. Using the reported channel, nurses solicit parents' detailed and relevant accounts of what has happened at other times and places. This requires expertise in asking questions, probing answers for concrete detail, and creating an atmosphere of trust and openness in what is often a difficult and sensitive process (Day et al., 2015). In this way, parents can be actively enrolled as 'bearers of the testimony of their own experience' (Taylor et al., 2009, p. 19), and partnership involves interaction based in a 'set of relational questions, interests and concerns' (Roose et al., 2013, p. 454).

The sensory channel requires nurses' bodily skills in listening and watching (Hopwood, 2016). need to remain alert in their enactment of partnership as a living practice (Day, 2013), and the pedagogic framework shows how such alertness involves embodied attuning and a capacity to shape spoken interaction. Use of both channels enables practitioners and parents to contribute their observations without the former taking over as an expert or alienating parents by imposing the agenda.

Figure 1 shows how the proportion of sensory and reported channels varied between the services studied. While the framework captures something common to diverse practice settings, it is thus also sensitive to context. It makes sense that the reported channel was used more in home visiting

than other settings, because home visits are relatively short (see Table 1) and much of the work involves discussing what has happened between visits. Day-stay visits are longer, producing live moments of settling or feeding, while the toddler service focuses primarily on parent-child interactions that happen during the visit. This highlights how living partnership is shaped by context. While models such as the FPM provide a useful, generalised account of the ‘ingredients’ of partnership, they do not show how it might vary in different services. The framework presented in Figure 3 does not specify expected or ideal proportions of sensory or reported channels, but signals these as relevant ways in which living partnership practices adapt to context.

The top right of Figure 3 lays out the three pedagogic steps. Eronen et al. (2010) mention the need for partnership practitioners to be skilful in promoting parent expertise, wisdom and confidence, while being non-judgemental and respecting parents. By following up what they notice with moves that make significance apparent and assert parents’ agency (either in relation to past accomplishments or the potential to bring about change in the future), nurses are doing precisely this. It is the trio of moves that addresses the dialectic of material practice, social interaction and changing sense of self (Stetsenko, 2008). All three steps contribute to expanding possible interpretations and actions.

Figure 3 depicts not only how nurses notice (sensory/reported channels), but what is noticed, further details of which are presented in Table 4. This concerns aspects of children (actions, gestures, expressions and their absence, states), parents (actions and beliefs), and parent-child interactions (interpretations of cues, parent assessments of interactions, qualities of interactions). Noticing and inferring significance of children’s actions, gestures, expressions and states relies on different specialist knowledge than does noticing relevant aspects of what parents do or believe about themselves. Different knowledge again underpins the capacity to notice what is salient in parent-child interactions. Alertness in living partnership (Day, 2013) relies on nurses’ ability to fluidly

navigate multiple knowledge terrains. This gets to the heart of nurses' capacity to act, since 'what we fail to notice is unlikely to have much influence upon our actions' (Mason, 2002, p. 29).

Three pedagogic intentions are indicated on the lower right of Figure 3. The ability to identify parenting capacity is crucial (Myors et al., 2014). Pedagogies of noticing framed by the intention to build on current strengths achieve this in a responsive way, but take the identification of capacity further. Capacity is noticed not as a generalised trait or quality, but in direct connection with concrete instances (live or reported) and Stetsenko's (2008) material practice. The second and third steps strengthen the partnership and transform this into a mind-expanding process, making new interpretations and responses available by rendering this noticed capacity explicit *and significant* to parents, and ensuring that the accomplishment is firmly placed in parents' hands. Capacity identified by nurses but overlooked or denied by parents has limited potential to contribute to positive change in families. The three-step process avoids this pitfall.

The second intention involves enhancing the impact of guided change, for example exploring possible strategies for settling children. Here, risks to partnership are strong: nurses' suggestions may be experienced as disconnected from parents' experiences and needs (Day, 2013), or parents may feel their skills are undervalued and that scope to make their own choices is being diminished (Eronen et al., 2010). The three-step framework offers a pathway through which interventions respond to live events or reported matters of concern to parents, the conclusion to which is always a matter of parents' agency. This does not guarantee that suggested interventions will be successful or acceptable, but it does ensure that they are framed in relation to concrete issues while maintaining a close connection to how parents make sense of the world and what they can do, as the possibilities for this expand.

The third intention, challenging unhelpful constructs, is noted in the literature as problematic:

professionals feel torn between being a bossy expert or leaving the challenge unspoken and thus failing to go beyond being nice (Fowler, Lee, Dunston et al., 2012; van Houte et al., 2013). The categories presented in Figure 3 show a range of terms upon which challenge can be presented. Generic partnership models acknowledge the need for challenge, but omit details of how this is accomplished in living partnership practice.

Positioning challenges within a pedagogic framework imbues them with a legitimate and actionable quality. They do not arise out of detached, generalised judgements, but are contextualised, justified through explicit articulations of significance, and framed in ways that emphasise parents' capacity to think or act differently, without casting them as to blame. As mentioned previously, challenges often involve disrupting parents' own beliefs of themselves as failures or incapable of bringing about change. This framework shows how professionals can challenge parents without undermining the principles of partnership, and points to the importance of the pedagogic expertise involved in doing so: noticing where challenge may be appropriate, and ensuring that when challenge is presented, it is accompanied with explanations of significance and affirmations of parents' agency.

Figure 2 shows that the proportion of each intention is relatively consistent: enhancing guided change is most common, followed by building on strengths and finally challenge. This suggests living partnership reflects the goal-directed nature of FPM and other models, and the need for early intervention services to progress by supporting parents through change. It also suggests that calls for such work to be strengths-based (Day et al., 2015; Myers et al., 2014) are both heeded and possible in living practice: building on current strengths accounted for between 20 and 30 per cent of all pedagogies of noticing (Figure 2). That challenge is rarest is consistent with a known sticking point for practitioners (Harris et al., 2014; van Houte et al., 2013). These findings may reflect a genuine living partnership in which strengths and supported change take precedence over direct challenge, the latter being reserved for moments when pedagogies based on the other intentions are

not available. Observational data are not conclusive in this regard; interviews could help understand why challenge is presented and when nurses retreat from doing so.

Conclusion

The framework presented here offers a valuable new way of thinking about practice issues rather than on asserting empirical claims and generalisations. It is now expanded, enriched, and shown to apply in diverse practice settings, couched in a cultural-historical theory of learning that focuses on changing interpretations and actions. It takes a mind-expanding view, in which nurses' role in partnership is not to find the 'right' solutions, but to work with parents to create new possibilities. In this way, parents' sense of self and what they are capable of shift together in an interactive process that is inherently connected to concrete parenting practices (recalling Stetsenko's (2008) dialectic). Pedagogies of noticing step right into the intimacy of family life, not just shifting what parents know, but how they make sense of their children, their interactions with their children, how they understand themselves as agents, capable of shaping their lives for the better. In this way, pedagogies of noticing have potential to live up to the powerful idea that the quote from Ellsworth (1997) above captures.

This study did not set out to map pedagogies of noticing, and while the observation methods produced operationally comparable data for our purpose, a more systematic approach would be needed to support statistical analyses. Tests of significant differences between services, geographic settings, or practitioners, would be useful. The framework could be used to design appropriate observation techniques and analytical categories for this purpose. Observation methods can describe patterns and variations but not fully explain why these arise. Interviews with practitioners, perhaps involving stimulated recall (using transcripts, audio or video recordings of practice if possible)

would add a valuable dimension to understanding why pedagogies of noticing emerge in the ways they do, especially in relation to issues concerning challenging parents.

The framework conceptualises on living partnership at the level of interaction between nurses and parents. It may be relevant to other interactions on this same plane: between nurses or other health professionals and patients, consumers and service users in a wide range of settings. This possibility – of living partnership as a mind-expanding process accomplished through pedagogies of noticing – is ripe for further exploration.

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Table 1 Details of services studied and data collected

Service	Duration of contact/program	Detail of each meeting	Target group	Focus of support	Observations	Participants
Home visiting	Either capped at three visits over 1-2 months, or more enduring contact (up to 1 year)	Nurse visits family home, visits last 1-2 hours	Parents of newborns to toddlers, where additional risk factors identified (tend to focus on younger infants)	Breastfeeding, sleep & settling, adjustment to parenting, perinatal mood disorders, toddler management	32	8 nurses 30 parents from 30 families (1 father seen alone)
Day-stay	Usually completed within 1-2 months, up to 3 sessions	Family visits dedicated centre, visits last whole day (up to 7 hours)	As with home visiting	Breastfeeding, sleep & settling, adjustment to parenting, perinatal mood disorders, toddler management	25	7 nurses 26 parents from 25 families (1 father attended with mother)
PCIT Toddler	12 week program of weekly visits, based on PCIT*	Initial admissions meeting followed by teaching session, then series of coaching sessions; visits last 1 hour	Parents with children aged between 15 months and 4 years in need of support	Conduct disorder, physical / verbal aggression, hyperactivity, sibling rivalry, anxiety / withdrawal, tantrums	10	4 nurses 4 parents from 3 families (1 father attended with mother)

* PCIT uses a play-based approach aiming to strengthen parent-child relationships, develop toddler management strategies, and promote positive behaviours (Hembree-Kigin & McNeil 1995; Eyberg et al 2001; CWIG 2013).

Table 2 Pedagogies of noticing by service

	Day stay	Home visiting	Toddler	Total
Instances of noticing	1056	530	268	1854
Percentage of instances followed up with significance being established	89	94	98	92
Percentage where attribution of parents' agency was accomplished	84	84	93	85
<i>Instances of complete pedagogies of noticing</i>	<i>883</i>	<i>444</i>	<i>249</i>	<i>1576</i>

Table 3 Examples of the pedagogic framework in practice

Example (M = Mother, N = Nurse)	Service / LHD	Noticing channel	Intention	What is noticed
1 N: I like the way you're feeding him upright, he can have more control over what comes out.	Day-stay / Samphire	Sensory	Building on current strengths	Parent-child interaction
2 M: I'm soothing her, taking her to listen to the tap running, whatever works! N: So you're finding what you can do to ease her stress levels.	Home visiting / Banksia	Reported	Building on current strengths	Parent-child interaction
3 M: One time I got upset so I gave him to my mum and he was fine N: You're very insightful, you can tell what he needs very well.	Day-stay / Samphire	Reported	Building on current strengths	Parent-child interaction
4 Baby starts to grizzle after a short period of 'tummy time' N: That's enough, we don't want her getting upset. We can leave it at that. Don't prolong it.	Home visiting / Banksia	Sensory	Enhancing impact of guided change	Child – gesture
5 M: I've got a play mat, but when I tried it before, by the time I got it out, she was asleep N: She's alert and content now, maybe we could give it a try	Home visiting / Banksia	Sensory	Enhancing impact of guided change	Child – state
6 M: He says 'stop talking', when you're trying to encourage him. N: It's good you've identified that, so you can put that back with a praise: 'I love talking with you, I love spending time with you, you're so much fun'.	PCIT Toddler / Grevillea	Reported	Enhancing impact of guided change	Parent-child interaction
7 M: I set the alarm to feed, but both boys are screaming N: I was thinking they will wake you. How would you feel if you let them wake you? They're putting on weight.	Home visiting / Samphire	Reported	Challenging unhelpful constructs	Parent – actions
8 M: I don't think he's that tired N: But he's been up since 5:30	Day-stay / Grevillea	Reported	Challenging constructs	Parent-child interaction
9 M: I don't breastfeed anymore [mother now expresses and uses a bottle]. N: You <i>are</i> breastfeeding. They are getting every benefit of your breast milk. You're giving them something no one else can, it's liquid gold, it's still your milk.	Home visiting / Samphire	Reported	Challenging unhelpful constructs	Parent – beliefs

Table 4 What was noticed as a catalyst for pedagogies of noticing

General	Specific focus	Example
Child	Actions (eg. crawling)	Below
	Gestures (eg. turning head away)	Table 3, example 4
	Facial expressions (eg. smiling)	Below
	Absence of gestures, actions, expressions	Below
	States (eg. tired, hungry, alert)	Table 3, example 5
Parent	Parenting actions	Table 3, example 7
	Parent beliefs about capacity	Table 3, example 9 and below
Parent-child interaction	Parent interpretation of child's cues	Table 3, examples 6 and 8
	Parent interpretation or assessment of the interaction	Table 3, examples 2 and 3
	Specific qualities of the interaction	Table 3, example 1