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'Everything's adaptable': A qualitative study of how nurses make decisions in sustained home-visiting care with mothers and children experiencing adversity

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Abstract

Aims: To explore nurse decision-making processes in the delivery of sustained home-visiting care for mothers of young children who are experiencing adversity.

Design: Qualitative descriptive research design using focus group interviews.

Methods: Thirty-two home-visiting nurses participated in four focus group interviews exploring their decision-making in the care they provide to families. The data were analysed using a reflexive thematic analysis approach.

Results: Four steps of a recurring stepwise decision-making process were identified: (1) information gathering; (2) exploring; (3) implementing; (4) checking. The facilitators and barriers to effective decision-making processes were also identified and included elements relating to good relationship skills, a good attitude, high quality training and mentoring and resources.

Conclusion: The findings indicate that a recurring stepwise process of decision-making requires both analytical and intuitive approaches. The intuition required by home-visiting nurses is to sense unvoiced client needs and identify the right time and way to intervene. The nurses were engaged in adapting the care in response to the client's unique needs while ensuring the fidelity of the programme scope and standards. We recommend creating an enabling working environment with cross-disciplinary team members and having well-developed structures, particularly the feedback systems such as clinical supervision and case reviews. Enhanced skills to establish trusting relationships with clients can help home-visiting nurses make effective decisions with mothers and families, particularly in the face of significant risk.

Impact: This study explored nurse decision-making processes in the context of sustained home-visiting care, which has been largely unexplored in the research literature. Understanding the effective decision-making processes, particularly when nurses customize or individualize the care in response to the client's unique needs, assists with the development of strategies for precision home-visiting care. The

identification of facilitators and barriers informs approaches designed to support nurses in effective decision-making.

KEYWORDS
child health, decision-making, home-visiting, maternal health, newborn health, precision home visiting, qualitative study, reflexive thematic analysis

1 | INTRODUCTION

Sustained nurse home-visiting is a service delivery mechanism that has been used to provide prevention and intervention services in which mothers, caregivers and children receive structured support for health and well-being within their home environment over an extended period of months or years (Howard & Brooks-Gunn, 2009; Kemp et al., 2011; Molloy et al., 2021). The effectiveness of sustained home-visiting interventions has been investigated in previous studies, and overall, this form of support and service delivery has been found to improve maternal and child health and development outcomes, especially for mothers and families at risk (Avellar & Supplee, 2013; Molloy et al., 2021; Peacock et al., 2013; Sweet & Appelbaum, 2004). However, there is very little research that gives focus to effective care processes and practices in the delivery of sustained home-visiting (Goldfeld et al., 2018; Kemp et al., 2019; McNaughton, 2004). Understanding how home-visiting nurses make decisions about the care provided, particularly as this relates to the customization and tailoring of care to individual family needs, is critically important to developing strategies that support effective care responsive to clients' unique needs. This paper aimed to explore the decision-making processes of nurses providing sustained home-visiting care to mothers and children with significant risk factors in the delivery of the Maternal and Early Childhood Sustained Home-visiting (MECSH) programme in Australia.

2 | BACKGROUND

The MECSH programme is a structured programme of sustained home-visiting developed and trialled in Australia and being delivered across the world. It was designed to address health inequities by providing intensive professional support for maternal and child health, well-being and child development in families who are at significant risk of poor outcomes (Kemp et al., 2011, 2017). The services are delivered by registered nurses with postgraduate qualifications in child and family health nursing. The programme commences in pregnancy and continues until the child reaches 10 years old. Previous research has shown MECSH-based programmes to be effective, reporting significant improvements in maternal parenting confidence and knowledge, improved parenting experience, positive child health and development outcomes and creating positive home environments to support child development and parent–child interactions (Goldfeld et al., 2018, 2019; Kemp et al., 2011, 2018).

In order to provide effective and client-centred care for mothers and families, the MECSH programme encourages home-visiting nurses to adapt and customize the care and interventions purposefully based on the mother's needs and circumstances (Kemp, 2016). While programme adaptation is critical to providing bespoke and meaningful family care, there is always a risk that adaptation of an evidence-based programme will produce unanticipated outcomes or have a negative effect. A previous study (Kanda et al., 2022b) found that home-visiting nurses were actively engaged in ensuring the care they provided had high fidelity to the programme in terms of scheduled content but also engaged in adaptation and customization of the care based on maternal risks. Furthermore, mothers who were provided with customized care in response to their risks had a higher level of satisfaction with the care provided and a sense of enablement (Kanda et al., 2022a). It is clear that well-trained nurses have high levels of competency in creating variations of care whilst remaining true to the core elements of an evidence-based programme. However, there is little research examining how the care customization, or purposeful variations, occurred and the processes that underpinned this decision-making in the delivery of home-visiting services.

Decision-making is an integral part of nursing practice (Lauri & Salanterä, 2002; Tanner, 2006). It is vital to the delivery of effective care in a wide range of challenging contexts (Standing, 2010). It is a complex process that encompasses a series of steps, including observations of a client's situation, the evaluation of client data and the assessment of actions that could be taken to achieve desired outcomes (Lauri & Salanterä, 1998). Tanner (2006) stated that decision-making includes forming conclusions about a client's status, needs and preferences to determine a method for meeting client needs, including assessing the client response.

Previous research regarding decision-making in the clinical setting has identified a variety of decision-making processes and factors, including nursing experience, organizational culture, education, understanding of client status, situation awareness and autonomy (Jasper & Rosser, 2013; Nibbelink & Brewer, 2018). Hagbaghery et al. (2004) identified five main factors in effective nursing decision-making: feeling competent, being self-confident, organizational structure, nursing education and being supported. Den Hertog and Niessen (2019, 2021) found in their qualitative studies that excellent nurses consciously invest time in discovering patient preferences using a set of implicit and intuitive communication tools to guide their professional care while adhering to evidence-based practice. These tools appear to be part of the nurses' practical wisdom. Benner and Tanner (1987) reported that expert nurses use intuition in their decision-making. Research

literature supports that nurses value intuition in their nursing practice and that it improves with experience, informs their decisions and leads them to take action within the caring relationship (Rew & Barrow Jr, 2007). Another study (Kozlowski et al., 2017) concluded that clinicians, including nurses, experienced emotions that can and do affect decision-making, and both emotion and cognition are engaged in decision-making.

Decision-making can vary significantly based on the nursing practice setting (Tummers et al., 2002). In the home-visiting care setting, a practitioner normally visits the client's home by her/himself to provide care over the continuous course of intervention. Thus, the impact of nurse decision-making can be direct and immediate. However, the processes involved in their decisions about the delivery of home-visiting care have not been explored. The authors have previously conducted a small unpublished study to identify MECSH programme home-visiting nurses' decision-making approach using the questionnaire designed based on the Nurse Decision-Making Instrument by Lauri and Salanterä (2002). The results demonstrated that of 13 home-visiting nurses who completed the questionnaire, five were assessed as employing an analytically oriented approach (score < 68) and eight were assessed as employing both analytical and intuitive approaches (score 68–78). There was no nurse assessed as intuitively oriented (score > 78). Further exploring nurses' decision-making in home-visiting care could contribute to our understanding of the mechanisms that support 'precision home visiting', that is client-centred care practices (Haroz et al., 2019; Home Visiting Applied Research Collaborative, 2017).

3 | THE STUDY

3.1 | Aims

This study aimed to explore nurse decision-making processes in the delivery of home-visiting care for mothers of infants (aged 0–2 years) and their families experiencing adversity. The following key research questions guided the study:

(i) What are the decision-making processes of home-visiting nurses for each of the three phases of a visit: pre-visit, during the visit and post-visit?
(ii) What are the facilitators that support effective decision-making in the provision of home-visiting care?
(iii) What are the barriers that inhibit effective decision-making in the provision of home-visiting care?
(iv) What factors are perceived by nurses to be most important in their decisions to adapt and customize care and intervention?

3.2 | Design and participants

The study used a qualitative descriptive research design. This design is relevant to capture individuals' experiences, perceptions and insights in a particular setting under investigation (Bradshaw et al., 2017; Liamputtong, 2018). We chose the qualitative descriptive design as the most appropriate approach as this study intended to explore nurse decision-making processes and practices where there was little related research. Eligible participants were recruited from a pool of Child and Family Health nurses who were trained in the MECSH programme and delivering home-visiting care in a Local Health District in New South Wales, Australia. There were two participants who had not yet delivered the programme as a result of COVID restrictions. However, because they were trained and part of the MECSH implementation teams, they were included in the focus group interviews. Purposive sampling was used to recruit the nurses. A total of 56 nurses were invited by email to participate in the study. A total of 32 nurses from three different sites participated in the focus group interviews.

3.3 | Data collection

Data were collected using focus group interviews. We chose focus group interviews rather than individual interviews as they can create a natural conversational setting for storytelling and allow participants to talk with each other in natural practical discourse about their experiences and practices relating to decision-making in home-visiting care (Tanner et al., 1993; Thomas, 2006). Four focus group interviews were conducted in April and May 2022. Two of these focus groups were conducted face-to-face at local health premises. Two focus groups were virtual using the Zoom application due to COVID-19 restrictions. The first and last authors moderated the interviews for one group, the first author for two groups and the second author for one group. A semi-structured interview format with eight guiding questions was developed by the authors and used to guide the discussion. Key questions are listed below.

- How do you plan the care for a mother before visiting the home?
- What facilitates your effective decision-making in the provision of care for a mother?
- What barriers interrupt your effective decision-making in the provision of care for a mother?
- Can you think of a time when you have had to change the way you would normally do things with a mother/a family to better meet their individual needs?

Each focus group interview had different numbers of participants: 5, 7, 9 and 11, depending on the size of the MECSH team. It took between 45 and 75 min and was audio-recorded for the purpose of transcription. In addition to focus group discussions, a short survey was completed by each participant to collect demographic data, including their nursing educational background and work experience.

3.4 | Ethical considerations

Ethics approval was obtained from the South Western Sydney Local Health District Research and Ethics Committee (2021/ETH11840).

All procedures were in accordance with the ethical standards of the institutional and national research committees and with the 1964 Helsinki Declaration and its later amendments or comparable ethics standards. Written informed consent was obtained in writing prior to the data collection.

3.5 | Data analysis

The audio recordings from the focus group interviews were transcribed by the Zoom and Otter applications at first. Then, all transcriptions were checked manually for accuracy and entered into NVivo 20 for analysis (QSR International, 2022). Reflexive thematic analysis was undertaken. This approach allows patterns and meanings to be captured from qualitative data, which are important to understanding the experiences of participants (Braun & Clarke, 2006). We followed the six-phase approach outlined by Braun and Clarke (2006). The approach includes: (1) familiarization with the data, (2) generating codes, (3) constructing themes, (4) reviewing themes, (5) defining and naming themes and (6) producing the report. Our analysis was inductive. The data from the short demographic questionnaire were entered into Microsoft Excel for descriptive analysis.

3.6 | Rigour

Each transcription was initially analysed by the first author, and initial codes were identified. The remaining members of the authorship team then reviewed the transcripts. Similar codes were merged by the first and second authors. Then, three authors had a face-to-face meeting to discuss the codes and reach consensus on the key themes as a means of validating the accuracy of the interpretations to improve the rigour of this study.

3.7 | Reporting method

We have adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

4 | FINDINGS

4.1 | Participant characteristics

The demographic characteristics of the participants are described in Table 1. All participants were female nurses with tertiary training in child and family health nursing (CFHN). The participants' average length of nursing experience was 23 years, and their average length of time working within the MECSH programme was 2 years.

TABLE 1 Participant characteristics and experience ($n = 32$).

Characteristics	n	%
Age		
20–29	4	13
30–39	12	38
40–49	3	9
50–59	7	22
60–69	6	19
Core nursing training		
Hospital	7	22
University	18	56
Both hospital and university	7	22
Child and family health nursing training		
Certificate	27	84
Diploma	4	13
Master's degree	1	3

Experience	Mean	SD	Min	Max
Nursing experience (years)	23	13	4	46
Experience as Child and Family Health nurse (years)	10	9	0[a]	30
MECSH experience (years)	2	1	0	4
Number of families the nurses have ever provided with MECSH programme	12	13	0	50
Number of current families being provided with MECSH nurses	4	4	0	12

[a]One of the participants was completing training as a Child and Family Health Nurse.

4.2 | Reflexive thematic analysis

4.2.1 | Decision-making process in the provision of home-visiting care

We identified a recurring stepwise decision-making process, which consists of four key themes identified from the focus group data, as described in Figure 1.

Gathering information

Nurses described the first step in the decision-making process as gathering data and information about mothers and families. Several nurses described investing time and care in gathering information about the mother's and family's characteristics and status as critical information to understanding the family context. The information that was seen as being most important to establishing family

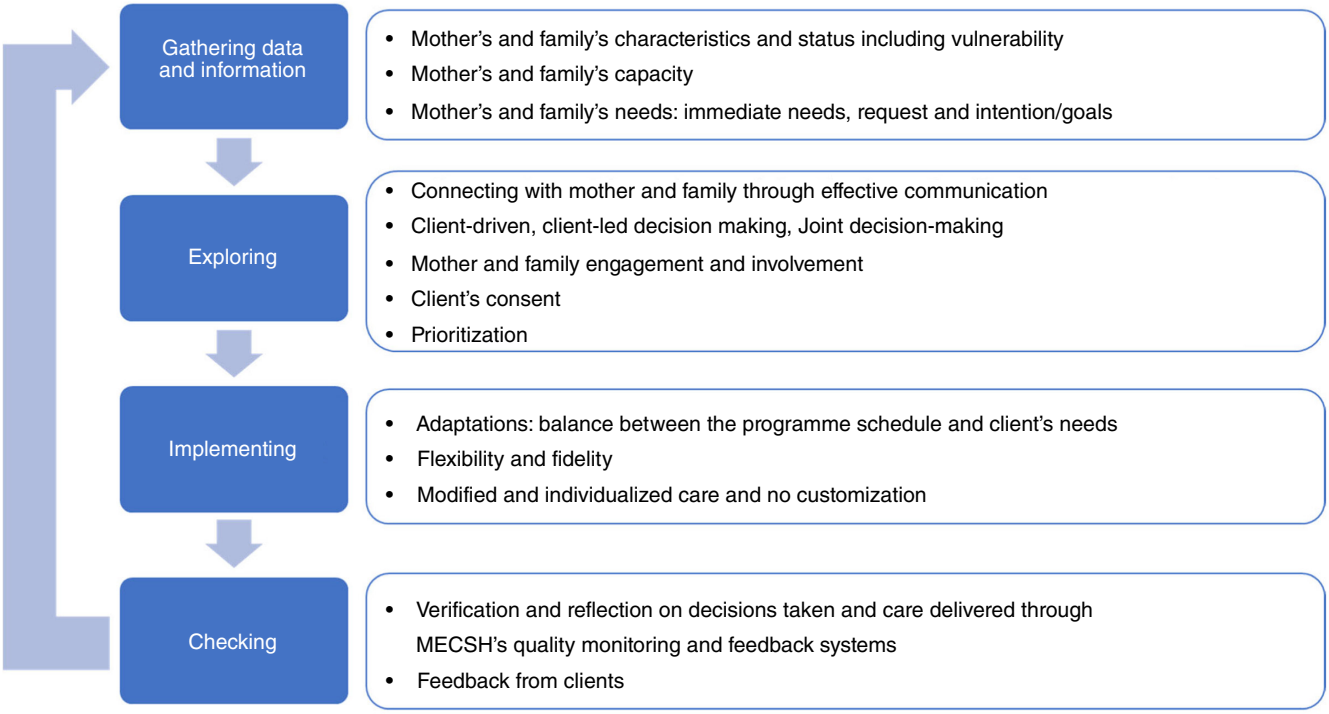

FIGURE 1 Recurring stepwise decision-making process.

context included: the mother's and baby's age, cultural and linguistic background, educational status, health history, health status, social and health risk factors, partner relationship, mother's and family's capacity, particularly their ability to understand and absorb new knowledge; mother's and family's needs, including immediate needs, requests, mother's intention and goals and mother's schedule.

Prior to the first home visit, as much information as possible was sought from available notes and records to be prepared for the provision of care and intervention according to the client's individual context. According to one of the nurses, different types and sources of information were located and assessed prior to the first visit to get her ready with basic knowledge of the family:

> I think the first time, we're going through basically all of the notes available. So, that would be the hospital notes and any previous mental health, and drugs and alcohol issues. You're basically looking through everything to make sure that you've got that picture as well as what information they've provided us with. We'd like to make sure that we know the basics of that family, so that we can pack up the toolbox, I guess. That'd be what we'll be doing first.
>
> (FG1)

The participating nurses highlighted mother and family capacity as this relates to access to social, health, financial and education resources as the most important information to understand in subsequent visits. The nurses carefully observed how much new information and advice the mother and family can take in and learn at each visit, and their capacity to respond based on individual and environmental factors. They described seeking to fully understand the different constraints and resources that were present for a mother and family, and where there were the best opportunities to move forward and build on positive momentum. The nurses emphasized the importance of ensuring that they did not put pressure on families to introduce more changes than would be possible at one time: "I suppose you have to consider the capacity of the families as well. To what you would do and how much you would do at each visit. Like, there is the schedule. But, you know, sometimes the family's capacity is limited. So, you would break that up over a few visits" (FG2).

Exploring

The second step in the process is exploring the best ways of providing care and intervention for each individual family. In this process, nurses described applying their experience and commitment to a client-driven and client-led approach, joint decision-making, supporting the client's decision-making and prioritization in partnership with the mother: "It's client-driven. And essentially, I mean, there's obviously a basis in the structure" (FG3). The nurses described needing to bring to bear their own training, experience and peer mentoring as the foundation for making informed judgements:

> It's particular to the individual family needs, but we draw on everything from expertise, professional, you know, our experience, our training, and discussion with the team. You can read notes and have a bit of putting our heads together before you go out or come

> back, and then debrief and plan from there. So, I think it's a combination of everything.
>
> (FG2)

Some nurses said that, with all of the many different sources of information influencing professional decision-making, the client's priorities and intentions can sometimes be overlooked, which is problematic and equates to missed opportunity:

> I think it's about intention because we have intention. But what's the client's intention – that's missing. But that should be one of the questions we ask, what do you look at goals and what they want. Sometimes they don't even know what their goals are.
>
> (FG2)

In this 'exploring' process, nurses stated that supporting the active engagement with mothers, babies and families was critically important: "We're constantly checking them the whole time and constantly making sure that the mum's still engaged" (FG4). Nurses described actively working to involve mothers and their families in decision-making, particularly during care planning, by asking them what they wanted to get from the programme. In addition, father and family involvement in planning and decision-making was also addressed. It was suggested by the participants that father involvement needs to be more strongly emphasized during home visits.

Implementing

Exploration was followed by implementation. It was evident in all focus groups that the nurses individualized or customized care delivery according to their perceptions of clients' needs, capacity, educational background and the condition of the mother, baby and family on the visit day: "I think everything's adaptable. But it depends on the individual family as to how you're going to go about it. What might be challenging for one family, it could be really easy for another" (FG1). Meanwhile, the nurses described being engaged in ensuring the fidelity of the programme scope, schedule and content were preserved, balancing this with programme adaptation based on the client's needs:

> It's all individualised and differently according to their needs. .... and that's also following the schedule of the MECSH program as well. So, there's, it just depends on where we're up to in it as to what needs to be done at a particular time, and it's not just, it's not straightforward.
>
> (FG3)

While implementing the care and intervention, nurses considered the scope of the programme and professional scope of Child and Family Health Nursing more broadly as key foundational knowledge to which they referred to prioritize care and inform their decision-making. Nurses focused on improving the client's confidence and enablement. They employed an attachment lens to support mothers in their parenting, relationship building and in establishing positive communication and interactions between the mother and baby. A nurse shared the importance of the scope of work in care decision-making:

> Looking at what's prioritised, because obviously, it has to be client-led, but not driven the whole time either. Because otherwise, you could just go off on a tangent and be doing stuff that's not even your job. So, it's always coming back and sort of sticking with the scope as well.
>
> (FG1)

Checking

After implementing individualized care and interventions, home-visiting nurses checked back in with families to determine if their actions and approaches were perceived as impactful and satisfied client perceptions of their own needs. Across all the focus groups, MECSH's built-in structured quality monitoring and feedback systems were utilized for checking the effectiveness of their care and interventions. These systems included case review, clinical supervision and the programme's regular feedback systems, such as its online dashboard, which provides timely feedback on mother's satisfaction and other key indicators. The nurses felt supported by these systems. They valued multidisciplinary discussions and conversations, opportunities for reflective learning and team/peer support: "Case review, peer review and clinical supervision. Those are the big ones, where you can have multidisciplinary conversations" (FG4). The nurses utilized these opportunities to seek validation of the decisions they had made about how to support particular families: "... because it is a very important part of getting that (clinical supervision), ... getting those eyes from outside to confirm how you're feeling to validate it and to come up with a solution" (FG2).

The MECSH online dashboard was highly appreciated as a form of important feedback as it provides information about client satisfaction with care and their sense of enablement: "We get the feedback from the PSQ (Patient Satisfaction Questionnaire) and PEI (Patient Enablement Index) through the dashboard. It's always great to know what's the feedback from the questionnaire" (FG2). This information was seen as providing concrete evidence of whether or not their approach was well-received and impactful. The participating nurses did, however, suggest room for improvement, requesting more regular and real-time feedback from clients through the dashboard to enable them to improve their practice further.

Feedback on the impact of their practices also came directly from clients: "When we've completed the session, I just say I hope that's been helpful in some capacity. And they'll give me some ideas of what they've been supported" (FG1). However, some nurses felt hesitant to ask for feedback directly from their clients: "We can probably ask (mothers and family), but not. Because there're patient

satisfaction tools that we use. Because we're already getting so much feedback from our MECSH clients. We tend not to go ask them for more" (FG4).

The findings indicated that home-visiting nurses applied a variety of decision-making strategies, reflecting different domains of knowledge, expertise, experience, observation, communication and the nature of their relationship with the family in practice. Most of them considered that everything is adaptable in the delivery of care based on age, educational background and the need to achieve high quality of care. Meanwhile, they kept in mind the need to go back to the scope of the programme when considering whether or not to adapt and customize an element of the care.

4.2.2 | Facilitators and barriers for effective decision-making in the provision of home-visiting care

We identified four elements that can facilitate effective nurse decision-making in the provision of home-visiting care through reflexive thematic analysis. They included: (1) good relationship skills; (2) a good attitude, (3) high quality training and mentoring; (4) resources.

Good relationship skills

Good skills to establish trusting relationships and equal partnerships were described as an essential facilitator for effective decision-making: "We establish that trust relationship, and then we can potentially move on" (FG2). A nurse shared her experience that once trust is assured between nurse and client, "clients opened the door to a whole range of issues that you kind of thought maybe were there" (FG2). The participating nurses positioned trusting relationships with clients at the heart of home-visiting. For example, one participant described the importance of carefully listening to the client: "Even though they might disclose something that's really tough for them, we can acknowledge them and just stick with that. And, you know, just that listening can be really effective for them" (FG1).

Several participants described the negative effects of the COVID-19 pandemic on establishing relationships with clients. They could not physically visit homes and had to provide the services via telehealth due to restrictions. A nurse stated, "We had to work a lot harder to maintain the relationship. … we had to push so much effort to keep those families engaged" (FG1).

A good attitude

Participants identified a variety of nurse characteristics and attitudes that influenced their decision-making in home-visiting care, including nurse confidence, emotions present within the nurse such as frustration or fear, open-mindedness and coming to the first home visit without preconceptions, personality, strength of knowledge and expertise and professional experience. Some nurses shared that they had developed listening skills and learnt the importance of honesty and openness through their home visit practices.

> "I think it's also important that each visit, having a bit of an open mind."
>
> (FG2)

Nurses endeavoured to balance their personal and professional attitudes. A nurse indicated that that balance enabled them to position themselves as partners working towards a common goal:

> "Like just being honest, when you don't know something, and just actually going out, let's figure that out together. And let me go back and find, and I'll figure it out, and we'll get back to you. And then that breaks down that professionalism and me being professional, you being a parent or whatever. And it's actually we're in it together. And we're working together about it. I think that breaks down barriers. So, it makes you think they see you as a more humane person."
>
> (FG2)

High quality training and mentoring

Participants stated the importance and usefulness of training, particularly in-service education, and mentoring for effective decision-making in the provision of care. They described the training and mentoring programmes of MECSH, the Family Partnership Model (Davis et al., 2002) and the Child and Family Health Nursing as helpful: "Customisation (of care) is part of MECSH. That was in the core training. People all run with that"
(FG2). Nurses highly valued the continuous in-service education programme. One of the participants gave an example of effective education programme through mentorship to build confidence:

> "Good education program when you first start Child and Family Health. And then good support throughout usually provides an allocated mentor as well that you can go through up to that three months, supernumerary (probational) period. So, I think by the time you're on your own doing visits, that makes confidence."
>
> (FG3)

Resources

Participants identified a variety of resources that were useful and essential to home-visiting care and practices. They included: resources in the forms of documents, tools and manuals; resources to support the engagement of culturally and linguistically diverse (CALD) families such as translation services and translated materials; resources in the form of access to a broad range of cross-disciplinary professionals, including social workers, allied health workers, nutritionists and perinatal and infant mental health nurses; resources in the form of workforce, including sufficient staff for reasonable word loads.

Participants valued the resources developed by the programme such as leaflets, videos and tools: "I use a goal setting tool which can

help the mum set some goals to work out what we are actually going to do with the program, and what we are going to work on" (FG2). However, some nurses spoke of the need to produce more materials that were translated into a range of different languages in response to the increasing number of mothers from culturally and linguistically diverse backgrounds.

At all locations, nurses felt valued and appreciated the support from cross-disciplinary professional support, particularly social workers. For example, one of the participant nurses shared the important role of social workers:

> We need that social worker's support. It's imperative because there's things that are not up to us, that shouldn't be up to us to provide resources, referrals, as well as everything else that we have to do. You know, it's core essential that we have that support. And just to debrief as well, to have a second set of eyes going into our house because we all see things from different perspectives and catch different things. So, it's imperative.
>
> (FG2)

The focus group data also uncovered the impact of the human resources and working environment on nurses' decision-making. This included issues relating to: achieving a balance between home-visiting and other work; staffing and team capacity; workload; cost. At the majority of centres, nurses observed that demand for sustained home-visiting services had increased. However, most centres faced critical staff shortages, particularly during and following the COVID-19 pandemic.

> We are currently extremely short-staffed. So that, we actually try and schedule our clients into visits when needed, like that's sometimes a barrier to us, because we don't have enough hours in the day to do that.
>
> (FG1)

The findings reveal facilitators and barriers to effective decision-making in the delivery of sustained home-visiting care. Participants expressed the importance of good relationship skills and attitude, such as deep listening skills, honesty and openness. In addition, high quality training and mentoring and resources can support and facilitate effective decision-making. Particularly, in-service training and the mentoring programmes of the MECSH model and the Family Partnership Model were highly valued by home-visiting nurses.

5 | DISCUSSION

This study explored nurse decision-making approaches and processes in home-visiting care. The findings contribute to the existing body of research on nurse decision-making by giving focus on to the home-visiting context, which has been largely unexplored (Goldfeld et al., 2018; McNaughton, 2004).

The results demonstrated the importance of engaging with both analytical and intuitive decision-making processes when working with families at risk of low levels of engagement and poor outcomes. It has been reported in previous studies conducted in clinical settings (Den Hertog & Niessen, 2019), particularly in critical care (Andersson et al., 2006), that nurses used intuition, in other words, a 'sixth sense' or 'gut feeling' in their treatment decision-making. Nurses within community and home-visiting contexts may not be under the same kind of pressure to act quickly based on their 'gut'. Home-visiting nurses are working with their clients in the context of a long-term relationship, and there is generally time to apply a more analytical approach, drawing on the available information and investing in communicating with their clients to understand the impact of the care they are providing. The intuition required by home-visiting nurses is not about critical care for timely decisions in diagnosis or identification of deterioration in a client's condition (Andersson et al., 2006). The intuition required of home-visiting nurses is more about sensing unvoiced maternal needs, supporting ongoing family engagement and knowing when and how to share more information and challenge the family to make changes, and when to slow down and give families time to absorb new information without moving on too quickly.

The findings reveal that home-visiting nurses applied a variety of decision-making strategies, reflecting different domains of knowledge, expertise, experience, observation, communication and the nature of their relationship with the family. Participants reported that the personal contexts of both clients and nurses, such as age, educational background and needs, influenced their decisions in care. Particularly prior to and at the initial stage of the home-visiting programme, nurses work to gather all the necessary information relating to client characteristics and to analyse the needs and preferences of individual clients. Client capacity was assessed to customize and adapt care content and strategy. While the early stages of engagement are critical to this process, it is an ongoing one, with nurses learning more and more about the capacity and needs of the family over time. This is consistent with previous research, which highlights the importance of knowing the client and family to appropriate clinical decision-making (Den Hertog & Niessen, 2019; Higuchi et al., 2002; Stajduhar et al., 2011).

Effective decision-making processes are essential to facilitating effective outcomes. This study identified a recurring stepwise decision-making process consisting of four steps: gathering information; exploring; implementing; checking. The participant nurses described decision-making processes as ideally being client-driven, client-led and jointly made with clients. In practice, nurses' ability to support client-led decision-making depended on the level of established trust and the strength of the nurse–client relationship. It also relied on the characteristics of the nurse, such as a willingness to share 'power' in decision-making with the family, or professional humility. These findings support previous studies from clients' perspectives (Byrd, 1998; DeMay, 2003; Landy et al., 2012), which reported that clients highly valued the intimate and comfortable relationship with home-visiting nurses. A prior qualitative study of the MECSH programme found that mothers reported a close relationship with

the nurses, referring to nurses as a friend, sister, or second mother who always supports them (Zapart et al., 2016). Both emotion and cognition are engaged in decision-making (Kozlowski et al., 2017). Previous studies suggest an important association between nurses' Emotional Intelligence (EI) and their skills in nurturing relationships (Kooker et al., 2007; Shanta & Gargiulo, 2014). EI is the foundation for the development of desirable characteristics such as caring and empathy (Mayer & Cobb, 2000), which are essential to home-visiting nurses establishing strong and trusting relationships with clients.

Study participants pointed out that father involvement might be an area for improvement. Family engagement beyond direct engagement with the mother remains a challenge for most sustained home-visiting programmes (Duggan et al., 2013; Kemp et al., 2019). However, this is critically important as it intersects with client-centred care (Australian Commission on Safety and Quality in Health Care, 2011) grounded in trust, respect and positive relationships between families and practitioners (Chauhan et al., 2021; Mathie et al., 2018). Understanding family diversity in culture, values and belief is critically important as they inform decisions made about the child and family (National Center on Parent Family and Community Engagement, 2020).

The participating nurses constantly emphasized that, when thinking about whether or not to adapt an element of the programme, it was important to go back and check if the proposed variation was within the scope of the programme. Similarly, a previous study demonstrated that nurse decision-making depends on the professional scope of care and practice (Gillespie & Peterson, 2009). Effective decision-making requires multi-dimensional knowledge, including professional expertise and knowledge of the specific aspects of the client's situation. The scope of the programme and standards of care guide nurses in their decision-making to provide safe and high-quality care (Gillespie & Peterson, 2009). Understanding the scope of home-visiting nurses' practice in the programme is vital as it outlines the parameters and boundaries within which nurses practice (International Council of Nurses, 2010).

The findings from this qualitative study reaffirm the ways in which home-visiting nurses make decisions based on their understanding of the rich contexts of the lives of their clients. Nurses closely observed the families they worked with and analysed the most critical needs of the clients to decide how and when interventions should be delivered (Kanda et al., 2022b). Meanwhile, the nurses were engaged in ensuring the fidelity of the programme schedule and content and addressing the balance between the fidelity of the programme and adaptation based on the client's needs.

5.1 | Limitations and strengths

There are limitations to this study that should be considered when interpreting the findings. First, this study was conducted with home-visiting nurses working within the MECSH programme in a New South Wales health authority. Therefore, findings may not fully represent home-visiting care and practice across Australia or other countries. Second, the conduct of this study within one geographic area meant that the number of participants was relatively small, reflecting the size of the MECSH Child and Family Health nursing team working within this area. Third, the data were collected through focus group interviews in which the nurses were describing their views and experiences in the presence of their peers. Thus, the environment might have affected whether the participating nurses could be completely transparent about their perceptions and experiences. Despite these limitations, this study was worthwhile as it captured and documented home-visiting nurses' decision-making approaches and processes, which were unknown in previous literature.

5.2 | Implications for practice

First, it is important to create an enabling working environment with cross-disciplinary team members, such as social care practitioners and allied health workers. The important roles of social care practitioners were particularly emphasized in the focus group interviews as vital to supporting holistic care. Social care practitioners were able to provide additional instrumental and psychosocial support for families and assist nurses and families to leverage community resources (Kemp et al., 2019). In the MECSH model, there is supposed to be at least one full-time social care practitioner employed to work with each team of child and family health nurses. Nurses and social care practitioners were encouraged to work together guided by a strengths-based approach and joint goal setting based on the Family Partnership Model (Davis et al., 2002). However, the focus group interviews revealed that several teams experienced an absence and/or shortage of social workers during and after the COVID-19 pandemic. Re-establishing these integrated cross-disciplinary teams was a priority and essential to good practice in home-visiting contexts.

Second, the data presented in this paper reinforces the importance of well-structured programmes fully equipped with a rigorous and well-developed manual, training, resources and monitoring and feedback systems that support effective nurse decision-making. A high-quality programme provides structure, clear direction and scope for the programme, which guides high quality implementation. As several nurses emphasized, particularly well-structured quality monitoring and feedback systems, such as those developed and utilized within the MECSH programme (Kemp et al., 2019), are critically important. High quality programmes and materials also facilitate nurse confidence, ultimately resulting in better client outcomes.

Third, the findings emphasize the importance of relationship and communication skills to support the establishment of trusting relationships throughout the recurring stepwise decision-making process. A previous study identified the competencies for delivering sustained home-visiting care, which included advanced skills in relationship and attitudinal competency for working 'with' families (Kemp et al., 2005). A well-established nurse–client relationship is a precursor for positive changes in parental behaviour and maternal and child health (Hebbeler & Gerlach-Downie, 2002; McNaughton, 2000). Thus, the provision of opportunities for nurses to develop strong communication skills is critical to effective decision-making and high quality care.

5.3 | Future research

We acknowledge that the research only took place with nurses. It is important for further research into understanding clients' experiences with decision-making in their own care, how they are engaged in this process and whether or not they feel acknowledged as decision-makers and experts in their own lives. Another area for future research is to explore possible additional ways to support nurses in making decisions in care more precisely in response to their unique needs and contexts. Decision-making requires cognitive analytical skills and the intuition of nurses to integrate all the information received and observations made as a whole and decide the optimal intervention. The first step may be to seek to identify the effective care processes, including the frequency, length and precision of the care content for mothers and families with specific contexts, such as significant risks for their health and development. After obtaining such evidence, there may be the potential to utilize digital technology supports to integrate all the information and data, such as individual risks and unique characteristics, and precisely customize and individualize care.

6 | CONCLUSION

This study explored nurse decision-making processes in the delivery of home-visiting care and identified facilitators and barriers to effective decision-making. The findings indicate that the recurring stepwise decision-making process requires both analytical and intuitive approaches. The intuition needed for the sustained home-visiting context is to be able to sense when there are unvoiced client risks and needs and identify the right time to intervene or slow down the pace of intervention. The nurses were engaged in adapting the care they provided in response to clients' unique needs while ensuring the fidelity of the programme scope and standards. They described applying their commitment to a client-led and joint decision-making approach.

The themes identified in this study may contribute to the development of strategies to support nurses in effective decision-making. An enabling working environment with multidisciplinary team members, such as social care practitioners and allied health workers, can facilitate a holistic approach to decision-making. The study highlighted the importance of well-structured programmes, which are fully equipped with a manual, training, resources and monitoring and feedback systems to facilitate nurses' effective decision-making. In addition, the provision of opportunities for nurses to further develop their skills to establish trusting relationships is encouraged to be made for home-visiting nurses.

AUTHOR CONTRIBUTIONS

Kie Kanda, Stacy Blythe, Rebekah Grace, Emma Elcombe, Kim Rodgers and Lynn Kemp made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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