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Health visiting assessment—unpacking critical attributes in health visitor needs assessment practice: A case study

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Abstract

Background: Assessment of family health need is a central feature of health visiting practice in which a range of skills, knowledge and judgements are used. These assessments are pivotal in uncovering need, safeguarding children and in determining levels of health intervention to be offered to children and their families by the health visiting service in the UK.
Objectives: The central focus of this paper is to outline the critical attributes of the basic principles that underpin health visiting assessment practice that emerged as part of a case study enquiry.
Design: A case study design informed by a constructivist methodology was used to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support.
Settings: The main study was conducted in three community Trust case sites in England, UK, with pilot work being undertaken in a fourth site.
Methods and participants: Fifteen health visitors participated in the main study and data were collected during 56 observed home visits to families receiving extra health visiting support. Separate in-depth interviews were conducted with the health visitors, pre- and post-home contacts, while 53 client interviews also took place.
Results/conclusions: The analysis suggests that there are certain fundamental elements associated with the majority of health visitor assessments and these have been termed assessment principles. These characteristics are integral to, and provide the basis upon which health visitors' assessments are conducted and professional judgement is formed. They reflect the basic principles of health visiting assessment practice, which exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of assessment processes.

Keywords: Professional judgement; Needs assessment; Health visiting; Assessment principles; Constructivist enquiry

What is already known about the topic?

- Accurate assessment of family health need is a core health visiting skill, requiring considerable knowledge and expertise.
- Health visitor assessments are of crucial importance in uncovering need, safeguarding children and in

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determining levels of health intervention to be offered to children and their families.
- Research was needed to examine health visiting assessment practices in the real-life setting and incorporate client and health visitor views of need which can differ.

What this paper adds

- It addresses a gap in the literature and unpacks some of the underpinning features of health visiting needs assessment practice.
- A unique case study approach, interviewing health visitors both pre- and post-observed home visits and by seeking the client perspective.
- Detail about seven fundamental elements, termed assessment principles, that are integral to, and provide the basis upon which health visitors' assessments are conducted and professional judgement is formed.

1. Introduction

It is widely acknowledged that assessment of family health need is a central feature of health visiting practice (NMC, 2002). These assessments are crucial in identifying children and families in need and in determining the nature and level of intervention to be offered to families by the health visiting service. This paper will outline the critical attributes of the basic principles that underpin health visiting assessment practice which emerged from a case study enquiry conducted to examine health visitors' professional judgements and use of formal guidelines for identifying families in need.

The paper begins by examining the background literature on needs assessment practice, before providing an overview of the case study research design. Data analysis offered several insights into how health visitors make health needs assessments and results suggest that assessment is a complex, interactive and serial activity. This paper outlines seven principles that emerged through data analysis, these features appear central to health visiting assessment practice and continuously appeared within the data. These characteristics appear inherent to the nature of assessment. They are integral to, and provide the basis upon which health visitors' assessments are conducted and professional judgement is formed. Another paper (under review by IJNS) moves on to explore in more detail the intricacies of health visiting assessment processes.

2. Background literature

Since its inception in the UK in the middle of the 19th century, health visiting's roots have been firmly embedded in public health work (Cowley and Appleton, 2000; Brocklehurst, 2004). A health visitor is a registered nurse who has undertaken a further post-registration specialist practitioner qualification, focussing specifically on child and family health promotion, public health issues and disease prevention. Currently, the majority of health visitors work in the community employed by a range of primary care organisations. All pre-school aged children and their families are allocated to a health visiting caseload for purposes of health promotion and preventive care; with other groups being included depending on local policy. Central to the role is a focus on the identification and assessment of health need and when the service is properly resourced, health visitors are extremely well placed to identify children's needs and recognise parenting and other family difficulties (Home Office, 1998). Professional practice requires health visitors to accurately assess health and social need, accept responsibility for professional judgement and be accountable for their professional actions (NMC, 2002).

An initial review of the literature revealed that although the health visiting literature has many references to the term professional judgement there is little evidence of the topic having received a detailed analysis. There is a paucity of health visiting research in this area, with only a limited number of studies investigating how health visitors identify and make assessments of children and family health needs. Indeed it was only in 1993 that Chalmers (1993, p. 144) noted that no empirical evidence existed "*which provides clarification of how health visitors conceptualise needs and the actual practice strategies used to search out needs.*" This was surprising in view of the fact that since the implementation of the NHS and Community Care Act (1990) there has been considerable interest surrounding the impact of needs assessment in health care policy and practice. Since the early 1990s, research in this area in health visiting has focussed broadly on 'needs assessment' (Chalmers, 1993; Cowley et al., 1995, 2000a, b; Carney et al., 1996), or assessment of family 'vulnerability' (Appleton, 1995, 1999; Williams, 1997; Newland and Cowley, 2003; Brocklehurst et al., 2004).

However, existing empirical research is beginning to build up an emerging picture of the complexity of health visiting assessment practices. For example, while Primary Care Trusts as employers of health visitors have been keen to promote the development and use of vulnerability assessment tools, clinical practice guidelines and other assessment protocols early research has revealed health visitors relying mainly on professional judgement when assessing the needs of children and families (Appleton, 1993). A national survey found that while 63% of NHS Trusts had developed some guidance to assist health visitors in their assessments of vulnerable families, this guidance is largely subjective and not evidence based (Appleton, 1997, 2000).

Furthermore, in a study exploring methods of assessment of need for health visiting, in two contrasting areas of a city in West Scotland, Carney et al. (1996) found health visitors identifying different types of health needs depending on the area in which they worked. In the deprived areas health visitors used social and economic factors in their rationale to visit clients and they did this more frequently than colleagues working in more affluent areas. The researchers also recommended that the Health Board's visiting protocol (reflecting minimum standards of service provision) should not "be used as a basis for assessing need on a population basis" (Carney et al., 1996, p. 76).

These early studies raised questions about the extent to which such structured assessment guidelines should and do direct health visitors' in making needs assessments. More recently, when structured health needs assessment tools have been examined, researchers have recommended that they are neither effective in identifying health needs nor acceptable to practitioners, or their clients (Cowley and Houston, 2003; Houston and Cowley, 2003; Mitcheson and Cowley 2003). A problem with rigid adherence to needs assessment tools is that vulnerable families could be missed and preventive work not undertaken.

In terms of the process of needs assessment, one of the first British studies to examine how health visitors undertake family assessments was conducted by Wheeler (1989). Using a phenomenological approach she investigated how a small sample of 5 health visitors and 5 social workers perceived their work in child protection. Wheeler's (1989, 1992) findings suggested that both professional groups use a similar assessment process, incorporating intuition, personal standards and life experiences, assessments of interpersonal relationships between family members and physical factors of the home/environment.

Chalmers (1993) in a grounded theory study also explored the processes involved in how health visitors search out and stimulate clients' awareness of health needs. Through interviews with 45 experienced health visitors she discovered participants reporting a complex range of processes in identifying clients' needs. Chalmers (1993, p. 160) found that health visitors offered clients different levels of input depending on two factors: the practitioner's assessment of clients' "worthiness for [the] service" and secondly, how clients responded to the health visitors offers of support. For example, clients responding in a positive manner were more likely to receive extra input from the health visitors. An interesting feature of the study was that these health visitors appeared to be functioning according to their own practice agendas (Chalmers, 1993).

Although interesting, a weakness of these early studies is that they can be criticised for relying largely on health visitors' perceptions of their practice rather than focussing on an analysis of observed practice and also for neglecting the client perspective in the study of needs assessment. In a theoretical discussion paper Bryans and McIntosh (1996), examined decision making in community nursing practice using the stages of decision making outlined by Carroll and Johnson (1990). The seven stages included "recognition, formulation, alternative generation, information search, judgement or choice, action and feedback" (Bryans and McIntosh, 1996, p. 25) and the paper discusses the relevance of each of these stages to community nursing assessment, practice and research. The authors particularly emphasised the importance of the preliminary and predicisonal stages of decision making 'problem recognition and formulation' involving "exploration and classification of the situation by the decision maker" (Bryans and McIntosh, 1996, p. 25). This stage is often ignored in decision making models, yet Bryans and McIntosh (1996) regard this as an integral part of community nurse decision making.

Bryans and McIntosh (1996) were also critical of systematic approaches to nursing care which imply that all nurses will assess client needs in the same way. In addition, these authors highlight the importance of considering the practice context when examining decision making in community nursing practice and emphasised the unstructured nature of many of the problems facing community nurses. They, as did Cowley et al. (1995) describe the ongoing and continuous nature of much community nursing assessment, which Bryans and McIntosh (1996) state is equivalent to Barrows and Feltovich's (1987, p. 86) view of doctor's reasoning which involves "a temporal unfolding of information". These authors argue that it is extremely important to take this fact into account when designing studies to examine decision making in community nursing.

In a large ENB funded study, Bergen et al. (1996a, b) investigated the educational requirements of community nurses with regard to needs assessment, in an attempt to identify models of good clinical practice. These researchers conducted focus group discussions and a multiple case study where 32 recently qualified health visitors and district nurses were observed during a practice shift and were interviewed about their health needs assessments. The data revealed that when assessing health needs practitioners often faced difficult situations and ethical dilemmas relating to differing perceptions and priorities. Bergen et al. (1996a, p. 239) suggested that as a result community nurses need to develop both "a deeply ethical and practical wisdom (*phronesis*; Carr, 1995)", the ability to incorporate theoretical perspectives into everyday thinking (*praxis*; Carr, 1995) and to integrate finely judged decisions into practice." These researchers pointed out that community practitioners need to develop "high-level skills" to be able to deal with complex needs assessments in a range of situations: and that education should focus on

developing a practitioner's ability to make sound professional judgements. Cowley's (1995) findings also outlined the considerable knowledge levels required of health visitors to deal with the complexity and ambiguity of the practice context. More recently, Bryans (2003) conducted a study to describe the knowledge used by health visitors at home visits. This study also revealed the breadth and range of knowledge used by health visitors "incorporating both factual elements and the know how to recognise and address psychosocial needs constructively and sensitively"(Bryans, 2003, p. viii).

Given the importance of taking into account contextual factors and the consumer view in the study of professional judgement and needs assessment, recent studies have attempted to incorporate these elements in study designs. However, although Bryan's study examined the health visitor/client encounter in both simulated and real life contexts (Bryans, 2003, 2004, 2005), it did not incorporate the consumer perspective and while Cowley and Houston (2003) did seek client views, their study centred on health visitors' use of a structured health needs assessment tool. This doctoral study sought to address the gap in the literature and to unpack the detail of health visiting assessment processes by observing health visitors in their real life working practice. This study adopted a unique approach, interviewing health visitors both pre and post observed home visits and by seeking the client perspective.

3. Study aim and objectives

A case study design (Stake, 1995; Appleton, 2002) informed by a constructivist methodology (Guba and Lincoln, 1989) was used to examine health visitors' professional judgements and use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support. While aspects of the study findings have already been reported (Appleton and Cowley, 2003, 2004), this paper will focus on a different study objective: To observe and examine how health visitors make assessments in their day-to-day professional practice. This paper will scrutinise the basic principles that underpin health visiting assessment practices and will endeavour to unravel these critical attributes.

4. Study methods

To develop knowledge about this important, but neglected area of practice, it was deemed crucial to study health visitors at work with clients in their own social contexts, which is a central feature of the constructivist approach. The study was conducted in three community Trust sites where different guidelines were issued to health visitors to assist in the identification of families in need. This strategy was adopted to examine professional judgement and to investigate the impact of differing guidelines on health visiting practice. Fifteen health visitors participated in the main study and data were collected during 56 observed home visits to families receiving extra health visiting support (i.e. additional input to the core health promotion programme).

4.1. Case sites

Case study sites were identified through a national survey which had explored the extent to which guidelines were in existence in England to assist health visitors in identifying children and families in need. Access permission was sought from the Senior Nurse of each Trust and following Local Research Ethics Committee approval, pilot work was undertaken in a fourth site. The case study design facilitated the integration of multiple sources of data (Table 1). By integrating different methods it was hoped to explore the various elements of professional judgement to provide detailed explanations of this phenomenon. By combining several data gathering techniques a richer, deeper and more comprehensive understanding can be achieved, as the strengths and limitations of the different methods are counterbalanced to add rigour, breadth and depth (Denzin and Lincoln, 2003).

4.2. Data collection

A purposive sample of five health visitors from each Trust were recruited to participate and an initial in-depth interview was conducted with each to explore their conceptualisations about professional judgement and assessment processes. These practitioners were then accompanied on home visits to families receiving an increased level of health visiting input, to observe and record the interaction between health visitor and client[s], to examine the assessment process taking place. Data were collected during 56 observed home contacts. Following these visits separate in-depth interviews were conducted with clients and health visitors. The main focus of the health visitor interview was to explore the practitioner's professional judgement in identifying health needs and offering families increased health visiting intervention. While client interviews centred on the client's perspective of the home visits and the perceived impact of extra health visiting. Over 12 months, 53 client interviews took place, in either the client's home or that of a friend or relative.

4.3. Data analysis

Data organisation began with each recorded home visit and all the tape-recorded interviews being fully

Table 1
Data sources

Initial Interview with health visitor (sometimes with first post-visit interview)	Background interview with HV, general issues explored around their conceptualisation of professional judgement, assessment processes and families requiring increased support.
Pre-home visit interview with health visitor (field notes)	Informal discussion with HV prior to home visit to elicit background information about the family and visit objectives. These notes have been combined with the transcription of the HV interview conducted post-home visit.
Field notes on observation schedule	Re-typed after each visit, additional field notes recorded following home visit. Contains context observations and notes on significant actions/events during the observed visit.
Tape-recording of observed home visit	Transcription of tape-recorded home visit. Combined with observation field notes.
Tape-recording of health visitor interview post-visit	Transcription of interview focusing on observed home visit. These data have been combined with notes made during the informal interview with the health visitor prior to each home visit.
Tape-recording of client interview post-visit	Transcription of client interview.
Research diary	A log of daily contacts with the research sites, consisting of research thoughts, reflections and insights about, for example, access issues.

transcribed to typed format and anonymised. Observation field notes were retyped and where possible were analysed jointly with the data from the audio-recordings. Data analysis was informed by contructivism, incorporating an inductive and data-driven approach. The analysis incorporated the multiple phases of data immersion, unitising, categorising and pattern searching (Lincoln and Guba, 1985) using QSR.N4 software. During the analytical process coding was constantly compared and refined so that where links and relationships were identified codes were either merged together, or hierarchies developed with a main category and series of subcategories. Codes and categories were continually challenged and revised as analytical processes progressed. Process elements were tracked both within and across data sets, comparisons were reviewed and many questions asked of the data. So for example, if a health visitor was observed to question a client about other family members, did she recognise this as part of her assessment strategy and did the client make any comments about this. Was this a strategy that she adopted across the four visits or not?

5. Findings

5.1. Assessment principles

The analysis suggested that assessment is a complex, interactive and serial activity and the data offered several insights into how health visitors make health needs assessments. There appear to be certain fundamental elements associated with the majority of health visitor assessments and these have been termed assessment principles. These characteristics are inherent to the nature of assessment. They reflect the basic principles of health visiting assessment practice which exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of assessment processes. The term is used to illustrate the fact that the seven areas are guiding 'principles', rather than research theory and that these critical attributes must be in place for needs assessment practice.

The seven assessment principles are illustrated in Fig. 1, which illustrates their integrative nature and synthesis. These features are central to health visiting assessment and continually appeared within the data. Indeed some of these attributes have been identified in earlier research work (Wheeler, 1989; Appleton, 1993; Bergen et al., 1996a; Cowley et al. 2000a). It is also worth pointing out that the principles and their attributes are not all of the same order, with 'Difficult to articulate' and 'Influenced by personal values and life experiences' being about the health visitor, whereas 'Holistic', 'Multifactorial' and the 'Ongoing nature of assessment' are about health visiting practice. 'Prioritisation' appears to be dependant on organisational influences, while the potential for clients to have unmet needs centres on the client experience.

5.2. Holistic assessment

The data reinforced that health visitors' assessments are holistic in nature, involving a focus on the whole situation, not a single problem or issue, as Bergen et al. (1996a) also found. The process of making a professional assessment appears to involve a series of judgements rather than a single or isolated judgement (Appleton and Cowley, 2003). It is a complex and skilled process and encompasses the co-ordination of

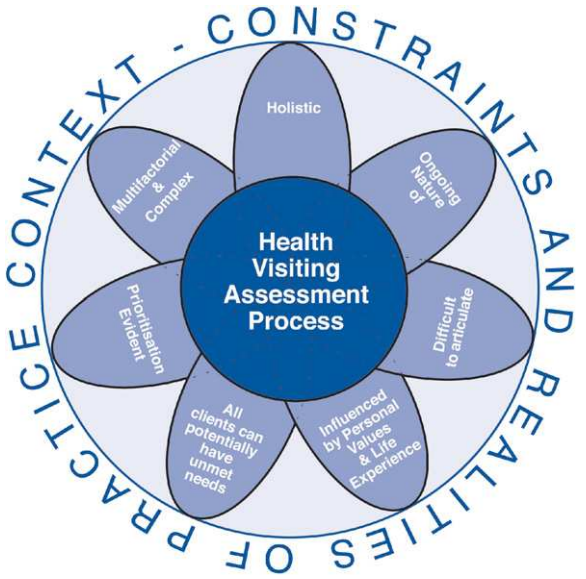

Fig. 1. Health visiting assessment: Essential principles.

assessment data from a variety of sources. Without exception during the 56 observed visits, health visitor assessments never focused on a single health need, instead multiple needs were addressed and a holistic approach adopted. As one health visitor summarised, its "the whole scene" (HV 3.49), "it's a hundred little things" (HV 3.49). Even when a home contact initially appeared to have a single central focus, health visitors did not limit their assessment to the single issue.

It was evident that many of the health visitors did not confine their health visiting work to the under fives and their parents. Many viewed their role as a 'family visitor' and as such would not restrict their practice to work with pre-school children. It was interesting to find that the primary focus of many visits was not a child but an adult (Table 2). Some might argue that as practitioners involved in the safeguarding of children, this might indicate professionals "loosing sight of the child" (Ayre, 1998, p. 33). However, a recurrent theme raised by the health visitors was their intent on recognising and addressing parents' needs, 'working through the parents' in order to fully promote a child's health and well-being. They described how parental problems are often closely intertwined with the child(ren)'s health and developmental needs and therefore cannot be ignored.

A common thread throughout the observed home visits was the need to provide emotional support to women. One health visitor when describing the extra support that she was offering a young mother who was feeling particularly isolated on a new housing estate, stated: "*she needed that nurturing for herself at that time*" (HV 2.38.1). This health visitor went on to describe how, from the children's point of view her support to mother

Table 2
The central focus of the visit

Area	Mother		Child(ren)	Parent(s) and child(ren) family focus	
Site A	1.15.1[a]	1.39.2	1.25.2	1.15.3[a]	1.82.2[b]
	1.15.2	1.39.3		1.25.3	1.82.3
	1.15.4	1.39.5		1.39.4	
	1.25.1	1.70.4		1.70.1	
	1.25.4[a]	1.82.1[a]		1.70.2[a]	
	1.39.1	1.82.4		1.70.3	
Site B	2.06.2[a]	2.77.2	2.20.2	2.06.1[a]	2.77.1[b]
	2.06.3	2.77.3	2.20.3[b]	2.06.4	
	2.38.1	2.91.1	2.38.3	2.20.1[a]	
	2.38.2[a]	2.91.2[a]	2.91.4[b]	2.20.4[b]	
	2.38.4			2.91.3[a]	
Site C	3.07.4[a]		3.07.2	3.07.1[a]	3.49.4
	3.53.1[a]		3.71.2[b]	3.07.3[b]	3.53.3
	3.53.2[a]		3.71.4	3.49.1	3.71.1
	3.53.4[a]			3.49.2[b]	3.71.3
				3.49.3[a]	
Total	25		8	23	

Codes: numbering system. First digit = case site, digits 2 and 3 = HV and digit 4 = visit number; e.g. 1.15.1 = site 1, HV 15 and accompanied visit number 1.

[a]Living as a single parent family.

[b]Father/boyfriend present for the duration of the visit.

was an "… *early intervention preventative measure*" (HV 2.38.1). She was concerned about the potential for the children to be neglected or to be deprived emotionally, as the mother became more short tempered, shouting at the children and less likely to control her actions. In this family situation, health visiting interventions centred on helping the mother to recognise her own needs, while boosting her confidence levels and own self-esteem and making her feel important as an individual person.

The notion of the holistic assessment also became evident during home visits, where observation data revealed that some health visitors attempted to make a logical assessment of each family member in turn, through a combination of discussion, observation and/or physical assessment. This compartmentalising of assessment was often a feature of very 'busy' visits, where several family members and sometimes other individuals were present.

This health visitor recounts how with one family there have always been three strands to her assessment:

> There'll be I suppose like three threads there really and that's how it's been every time I've visited you know. … even like this morning you know there's the three components there. There's the baby and there's [Mum] and it's usually started off with [Mum]. Then we went to the you know talking about the baby and the diarrhoea, we talked about [9 year old] and [13

year old] and whatever, so there's always those sort of three sort of strands to every visit then and that can make it quite complicated …(HV 1.82.1)

Bryans (2003, p. 126) has also described this strategy as an "interweaving" of issues.

5.3. Assessment is a complex and multifactorial process

A probable consequence of health visitors' assessments rarely focussing on a single issue, is the multifactorial and often complex nature of assessment. Health visitors talked about the fact that it was "*often a combination of factors*" (HV 1.82) which influenced a judgement to offer a family extra intervention. Thus assessment appears to incorporate a multiple perspective with a practitioner registering and considering several factors apparently simultaneously. As this health visitor describes:

> I looked at the baby's motor development, was he weight bearing what he doing with his arms and his legs, basically, is he doing what he should be doing, erm I looked at, is his speech and language development appropriate for his age, vision and hearing what was he doing, and his social behaviour so it was really an overall assessment of whether the baby had reached milestones for his age … I also assessed by observation and what the mother was saying, her relationship with the baby, was she relating with the baby, whether the baby was being stimulated … I tried to assess her mental state, her physical state, in terms of is she getting sleep, is she eating.(HV 1.25.4)

This extract illustrates the multi-factorial nature of the health visitor's assessment which involves a range of skills and knowledge, yet it is worth noting that there is little research evidence detailing the nature of these processes. Indeed the skills required for such an assessment are often overlooked. A further feature of the complexity is that a lot of assessment activity is actually invisible to clients, as practitioners conduct assessment in such a sophisticated and integrative way. As one mother commented on her son's 18/12 developmental assessment:

> I thought she was just going to come and chat, to see if there were any problems. I didn't realise she was going to weigh him, measure him and use all the toys to see his sort of motor development, because she does that very cleverly you know, you don't realise what she's doing and she's observing things that you take for granted.(C 2.77.2)

5.4. Ongoing nature of assessment

The health visitors in this study regarded assessment of family health need as an on-going process, with assessment taking place at each client contact, as Bergen et al. (1996a) have previously found. This was further reinforced by the observation data gathered during the 56 home visits which illustrated that in many cases health visitors assessments were not complete, but required ongoing review (Table 3). Some health visitors distinguished between a first assessment "*where you're looking at lots of different … areas*" (HV2.06.3, p. 206) and subsequent ongoing assessment where a lot of information is already known and assessment begins to focus on a specific need or needs. Health visitors continually stressed the on-going nature of assessment:

> If you make the assessment and you think that you need to go back, then every time you go back you're reassessing the situation …(HV 1.82, p. 231)

The serial nature of the assessment process was particularly emphasised in those cases where health visitors find an initial assessment difficult or where practitioners are unsure about the outcome of their assessment. For example, if a client displays what the health visitor perceives to be inappropriate behaviour a re-assessment may be necessary to confirm this view. One health visitor described how if she is unsure about something she would visit the client again, "*because sometimes it takes two visits to actually get clear in your mind that somebody is more stressed than they would normally be …*" (HV 1.39, p. 166), she went on to say:

> … they may not need more support but if I haven't got it clear in my mind where they're coming from and what they understand and how they're going to be, then I will go back sooner(HV 1.39, p. 688)

The need for reassessment appeared to be one consequence of the uncertainty of many family situations, particularly more complex families. Some health visitors described how "*it can be very dangerous*" (HV 1.15, p. 245) to rely on an assessment made during a single contact. Many stressed the importance of having the time to build up a relationship with a client in order to make an accurate assessment, arguing that perceptions of people change as you become more familiar with them and get to know them better. Time is required for the health visitor to reassess family situations and to enable clients to tell their story. Ideally:

> You go in to build up a relationship so that they can take up the services that are offered"(HV 1.25.2)

However, health visitors continually described situations where they are constrained by a lack of time because of the demands of large caseloads or staff

Table 3
On-going nature of the assessment process

	Assessment process apparently complete		Assessment process apparently incomplete		Follow-up arranged—planned contact		Follow-up arranged—telephone contact[a]	Follow-up implied. No contact planned	No follow-up arranged
Area A									
First contact with client/family	—		—		—		—	—	—
First contact for new need	1.39.4		1.82.3		—		—	1.82.3	1.39.4
Subsequent contact	1.15.4	1.70.4	1.15.1	1.39.1	1.15.1	1.39.3	1.25.3	1.15.3	1.15.4[b]
	1.70.1	1.82.4	1.15.2	1.39.2	1.15.2	1.39.5	1.25.4		1.70.1
			1.15.3	1.39.3	1.25.1	1.70.2	1.70.3		1.70.4[b]
			1.25.1	1.39.5	1.25.2	1.82.2	1.82.1		
			1.25.2	1.70.2	1.39.1		1.82.4		
			1.25.3	1.82.1	1.39.2				
			1.25.4	1.82.2					
Area B									
First contact with client/family	—		—		—		—	—	—
First contact for new need	2.20.1		—		2.20.1		—	—	2.20.4
	2.20.4								
Subsequent contact	2.06.2		2.06.1	2.38.4	2.06.1	2.38.2	2.38.1	2.20.3	2.06.2[b]
	2.38.1		2.06.3	2.77.1	2.06.3	2.38.3	2.77.3	2.77.1	2.77.2
	2.77.2		2.06.4	2.77.3	2.06.4	2.38.4	2.91.1		2.91.3
	2.91.1		2.20.3	2.91.2	2.20.2	2.91.4	2.91.2		
			2.38.2	2.91.3					
			2.38.3	2.91.4					
Area C									
First contact with client/family	3.71.4		—		—		—	—	3.71.4[b]
First contact for new need	—		3.71.3[c]		3.71.3[c]		—	—	—
Subsequent contact	3.07.3[d]	3.53.3	3.07.1	3.53.2	3.07.1	3.71.1	3.07.4	3.53.1	3.07.3[d]
	3.07.4	3.53.4	3.07.2	3.71.1	3.07.2	3.71.2		3.53.2	3.49.1[d]
	3.49.1[d]	3.71.4	3.49.4[b]	3.71.2	3.49.2			3.53.4	3.49.3
	3.49.3		3.53.1		3.49.4[b]				3.53.3

Numbering system. First digit = case site, Digits 2 and 3 = HV and digit 4 = visit number; e.g. 2.38.2 = site 2, HV 38 and accompanied visit number 2.

[a]This includes a phone contact to give information to client, contact by phone to review progress of needs or a phone call to arrange a subsequent home visit.

[b]In these cases, the health visitor encouraged the client to make contact if needs arose and wished to address these.

[c]Follow-up with another member of the health visiting team.

[d]Transferring client to another health visitor.

shortages. As such in reality they often have to make an immediate assessment of a family's health needs, because of the one-off nature of many client visits:

> … it's like a lot of people, you have to get to know them and yet you've got to make an assessment on that first visit because you need to look to see whether there is anything particularly outstanding that needs following up, but I think you've got to keep an open mind and allow for the fact that people need to get to know you. They're not all going to be very open and that to a stranger, which is what you are.(HV 3.53, pp. 211–212)

This point was also substantiated by client data, with clients reinforcing the view that they needed to get to know their health visitor and build up a relationship before feeling able to talk openly about their family's health needs. This was particularly evident during one observed visit when a mother disclosed to the health visitor that as a child, a neighbour had sexually abused her. In a separate interview she said:

> … you've got to build up the confidence as well. I mean I know they're all trained and everything but erm I wouldn't have told a complete stranger what I said today, you know.(C 1.39.3)

Connected with the issues of relationship building and trust is the fact that sometimes clients are just not ready to acknowledge and open up discussion about their needs, however apparent to the health visitor. Part of the skill of health visiting is about holding back even when a practitioner may have some concerns and waiting until the client is ready to make a disclosure. This seems to be about getting the timing right and may involve an element of risk taking. The importance of reassessment was also evident when health visitors reviewed the outcome of earlier interventions with clients and reassessed previously agreed action plans.

5.5. Difficult for health visitors to articulate how they make an assessment

During post-visit interviews it was sometimes quite difficult for health visitors to articulate the process of making an assessment of a client needing extra support. A few expressed hating this part of the interview, as they are seldom required to make such everyday practice performances verbally explicit and rarely reflect on the minutiae of the process. Many suggested that some aspects of the process are undoubtedly automatic and as such they probably do things without recognising they are doing it:

> you do cover things without realising it and you do it so automatically.(HV 2.77)

This health visitor described the tacit nature of this type of knowledge:

> … I think most people in doing any form of assessment they just do it, they don't think about it. And I think back to Schön in one of his books … and he's saying that you know professionals do things and you change, you amend, you evaluate as you go because as a professional you, you know … instinctively if you like …(HV 1.25.3, p. 256)

Despite the difficulties associated with describing and putting into words assessment processes, many practitioners stressed the importance of health visitors being able to clearly articulate how they make their professional assessments. This seems crucially important in justifying the health visiting role in light of recent policy and the increasing focus on evidence-based practice. One health visitor commented:

> I think we need to be more vocal about what we're doing, about how we're assessing, what we're looking for, what we're looking at, and how we're actually prioritising. I mean, here, I said before that we visit on assessed need, but even we struggle with, well what do we do when we're assessing.(HV 3.71, pp. 70–71).

There is an implicit assumption that health visitor training and education will prepare practitioners to be able to undertake needs assessments competently, although recent reports have raised serious questions about the basic content of some course curricula, with some failing to address assessment of need and not all reflecting professional practice standards (Clark et al., 2000; Cowley et al., 2000b). Despite the increasing complexity of health visiting practice and the current policy emphasis on public health, course content has been pared to a minimum and the situation continues to deteriorate. In this study, participants' education and training on needs assessment did vary and the data provided little acknowledgement of the continuing professional development needs of practitioners around needs assessment practice.

5.6. The assessment process is influenced by a practitioner's personal values

Previous research has suggested that when a health visitor makes a professional judgement, s/he is influenced by personal values and life experiences (Wheeler, 1989; Appleton, 1993) and this was a view held by many in this study. It seems likely that health visitors will also be influenced by their personality, by cultural beliefs and attitudes as they draw on personal knowledge and prior experience in shaping their professional assessments.

Health visitors describe the need to recognise that client standards may differ from their own, that people obviously live in very different ways and that there is a need to be sensitive to this fact. Health visitors were also aware of the potential dangers of making early judgements about clients. Where possible, health visitors gather background information on a client or family before making a first assessment, although many were aware of the potential dangers of being overly influenced by this type of background information. Indeed one practitioner, HV 3.89, stressed the potential danger of building up a picture about a client before meeting them that could be wrong. This health visitor describes how she avoids reading family notes until after she has completed a transfer-in visit assessment to avoid being influenced by other's judgements. Health visitor 2.06 suggests that when working with clients she makes a judgement about the clients she is visiting and alters her behaviour and approach accordingly. Indeed, this ability to work at the client's level did appear to be highly valued by her clients:

> You know you don't have to speak to her on a different level from what you're on you know you don't have to speak to her as if she's a more upper class person, I don't know how else to say it, or a lower class or you know you can speak to her how you feel …(C 2.06.2, p. 137)

5.7. All clients can potentially have unmet needs

There was a consensus of opinion amongst the health visitors that any client or family could potentially have unmet health and/or social needs. Health visiting starts from the premise that all families can potentially have need for increased support and/or referral to other services.

While the challenges of parenting are apparently recognised at Government policy level (Home Office, 1998; DfES, 2003, 2004), a theme tentatively running through the health visitor interviews was that Trust management cannot afford to acknowledge that families who are apparently 'normal' may also have needs. ('Normal' in the sense that the family does not come from an 'obviously' deprived background and has no obvious child protection risk factors). It seems that an expectation exists that these families should not have needs and if they do, that they should be able to sort them out, with little or no professional support. This view was reinforced by a presence in all study sites of limited core programmes, which impede preventive work and an emphasis on extra health visiting, only for the so-called 'problem families'. However, the difficulties faced by some of the parents participating in the study highlights the need for continued support to any family in need. As one client and her mother described:

> C: This is my sixth child and I've, I'm still like a nervous mother all over again. It's even worse as you get older. The more children you have it's not as easy, it's not easy as people say it is. It's not though, is it mum? It gets harder.
> GMa: No you see more things you know than what you did when you were younger.
> C: Yeah. It's harder as you get older and there's more children you have, it is harder, there's more worry involved in it … It's a lot of rot when people turn round and say, ''oh you've had children you'll be alright, you know what to do'', no you don't!'' (C 3.53.4, pp. 288–295)

5.8. Prioritisation

Needs assessment processes were integral to the prioritisation process used by health visitors, in conjunction with other influencing factors. Firstly, in terms of the wider social policy arena, Department of Health policy initially guides and determines local Trust agendas and the focus of health visiting work. This brief is likely to intensify with an increasing emphasis on the implementation of government driven health and social care quality standards, such as the UK National Service Framework for Children, Young People and Maternity Services (DfES and DH, 2004). Organisational service specifications and requirements for health visiting work then determine the client groups whose needs are to be addressed by the health visiting service. Across all three study sites such service specifications result in health visitors prioritising families whose needs are to be assessed. This prioritisation appears to encompass two elements. Firstly, service specifications require health visitors to give high priority for assessment to new birth visits, transfer in visits, developmental checks—as one health visitor described ''*the routine stuff*'' (HV 3.71, p. 16) as well as child protection work. At this level, prioritisation for assessment reflects a general response to service requirements rather than client need:

> The things that we have to do because of policies are you know the new birth visits the transfers in, they have to be a priority, and the developmental checks. They have to be a priority to get them in at the right time …(HV 2.06, p. 207).

Health visitors 1.82 and 1.25 described how as well as new birth visits and families transferring in to the area, ''*the high intervention families*'' needing increased support have to take a priority on their caseloads.

A second priority for health visitor assessment is those clients requesting increased support, with prioritisation taking place as a response to client expressed need. A recurrent view was that any client requesting help would take priority for assessment. In the following, extract HV 1.39 describes how she would prioritise any client asking for assistance and if necessary would cancel visits to try and see the client the same day:

> I mean if a mum called me and said she needed me to go that day then I would look at my diary to see what else I had booked in and if it was things I felt I could cancel—visits I felt I could cancel I would do so.(HV1.39, p. 698)

The fact that health visitors give priority for assessment to clients expressing needs and/or asking for help, was supported by the views of several of the clients in the study (see Table 4, evidence of health visitors' responding to clients requests for contact).

At a third level, prioritisation takes place once an assessment has been made in the fact that health visitors' prioritise which clients/families they are going to offer extra support to. Thus, the outcome of the health visitor assessment leads to a prioritisation of which client/families will be offered extra support, as well as the nature and extent of that support. However, there was general agreement amongst the majority of the health visitors that demand for the service often outstrips available resources and lack of time was a major factor in determining priorities of need. Several clients also recognised the increasing demands being placed on the health visiting service.

Table 4
Health visitor response to client request for contact

Client	Client encouraged by HV to make contact	HV responds to a client request for a contact	Client would contact HV with needs
1.15.1	Yes	HV sees at home or clinic or accompanies to hospital appts	Yes—phones HV for help
1.15.2	Observed	Visits when client rings with a concern/chases up referrals	Yes contacts HV and 24 h service
1.15.3			
1.15.4	Yes and observed	HV responds to any needs client raises in clinic	Yes speaks to HV in clinic
1.25.3	Client not interviewed	Client not interviewed	Client not interviewed
1.25.2		Yes	Yes phones HV
1.25.3	Observed	Yes	Yes phones HV
1.25.4	Client interview not taped	Client interview not taped	Client interview not taped
1.39.1	Yes	Rings HV in tears and HV visits. Took to hospital when in labour	
1.39.2	Yes and to contact 24 h service	Yes	Yes would contact HV or 24 h service
1.39.3	Yes	HV always returns client's call if not there	Yes contacts HV and night on-call service
1.39.4	Yes	HV will visit same day client calls her[a]	Yes does phone HV and on-call service
1.39.5		Yes HV goes round immediately[a]	Yes often phones HV
1.70.1	Yes		
1.70.2	Observed	Yes HV pushed for social services to visit family	
1.70.3			
1.70.4	Observed		
1.82.1	Observed client not interviewed	Client not interviewed.	Client not interviewed
1.82.2		Yes HV calls client if not in office, will go round ASAP[a]	Yes
1.82.3	Yes	Yes makes appt. to see client. Pushes forward a referral	Yes does phone for help/advice
1.82.4	Observed	Yes will visit when client calls her	Yes does phone HV or accesses in clinic
2.06.1	Yes and observed	Visited daily outside her area—when client desperate	Yes phones HV with any problems
2.06.2	Observed	Yes	Yes has phoned HV re child care issues
2.06.3	Yes	Yes rings client later same day if not in office	Yes knows she can contact HV anytime
2.06.4	Yes and observed	Yes	Yes for advice re children but not self
2.20.1		Clients walk in see HV in surgery. Took to hospital in labour	Yes phones or goes to see her in clinic
2.20.2			Yes does, but not always happy with advice
2.20.3		Yes came out to see client when she called her	Yes
2.20.4		Gets back ASAP to their messages report father and mother	Both parents have contacted/been to see HV
2.38.1	Yes	Yes she visits client at home	Yes HV always there when mum needs her
2.38.2	Yes		Yes
2.38.3			Yes
2.38.4	Yes	Responded to client's message and came out same day	Yes and to contact 24 h service too

Table 4 (*continued*)

Client	Client encouraged by HV to make contact	HV responds to a client request for a contact	Client would contact HV with needs
2.77.1			Yes
2.77.2	Yes		Yes, she does phone HV
2.77.3		HV comes out if mum asks her to. Saturday am clinic set up	Yes will phone her or go to see her
2.91.1		HV will go round if needed	Yes phones HV or will call and see her
2.91.2			Yes would call or go to see HV
2.91.3		Checked on family when mum in hospital. Gets prescriptions	Yes does phone HV
2.91.4		Yes had visited twice in a day	Yes does phone HV
3.07.1	Observed		Yes
3.07.2			
3.07.3	Observed		
3.07.4	Observed	Yes	Yes does phone HV
3.49.1			Yes
3.49.2	Yes	Yes	Yes rings HV or goes to see her at clinic
3.49.3			Yes does phone HV
3.49.4	Observed. Client not interviewed	Client not interviewed	Client not interviewed
3.53.1	Yes	Yes HV will come out to see client	Yes
3.53.2	Observed. Yes HV home phone no. given	Yes HV will come out same day or next morning	Yes does phone HV
3.53.3		Comes out to see client or sees in clinic. Brought her nappies	A helping hand at the end of the phone
3.53.4	Observed	HV will come out to see her if client needs her to	Yes will contact HV
3.71.1			Would go straight to HV with any concerns
3.71.2		Yes comes out if client asks to see her	Yes phones HV
3.71.3	Observed	*	Yes would contact HV
3.71.4	Observed	HV came out to see client today for sleep problems. *	Yes

[a]Accompanied visit—in response to client request for contact.

6. Conclusion

This paper began by highlighting the dearth of evidence about the processes employed by health visitors in assessing family health and social need. As part of an examination of health visiting professional judgement, this study sought to investigate how this group of professionals make needs assessments in their daily practice. The detailed constructions resulting from the enquiry contribute to the theoretical knowledge base of health visiting by providing empirical evidence about the key factors underpinning health visitor needs assessment practice.

This paper has outlined the seven fundamental principles that emerged through data analysis, these features appear central to health visiting assessment and continually appeared within the data. These characteristics are integral to, and provide the basis upon which health visitors' assessments are conducted and professional judgement is formed. The assessment principles and their attributes reflect the basic principles of health visiting assessment practice that exist despite the constraints and realities of the practice context and can be differentiated from the activity centred methods of the assessment process. Some principles, such as the on-going nature of health visiting assessment, its general complexity and the influence of personal values and experiences are already well documented in the literature. However, other elements, such as the clear evidence of prioritisation and the potential for any client/family to have unmet health or social needs are more new.

By integrating data from health visitor and client interviews combined with observations/recordings of health visitors' interactions with clients, the components

of needs assessment have been scrutinised and new insights uncovered about the detailed elements of this process. The case study approach adopted in this study has been extremely productive as a means of unpacking the various elements of health visiting assessment. It is important that these components have been laid out for public scrutiny, rendering simple complex processes and providing insights into health visitors' practical 'know-how' (Schön, 1987).

A further strength of the study's design was the opportunity it afforded to observe health visitors in their real life working contexts. An apparent advantage of accompanying the same health visitor on a number of home visits was to reduce the impact of observer effect on health visitor practice. By accompanying practitioners on several visits it appeared that practitioners soon became accustomed to the researcher's presence. It also presented an opportunity to discover that some health visitors adopted different approaches with different clients, as Cowley (1991) and Bryans (1998) have previously indicated.

However, a limitation of the design which resulted from observing only one health visitor interaction contact with each client, meant that it was not possible to consider how a health visitor's assessment practice and interventions might alter over a period of time with the same client or family. Neither was it possible to determine whether or not the client perspective would change as Pearson (1991) has previously identified and some clients alluded to in their experiences of different health visitors. This would be an extremely interesting area to explore further to examine the long term impact of health visitor assessment practices and interventions.

It must also be remembered that in the main study the researcher has followed the conventions of a constructivist enquiry to explore the concept of health visitor professional judgement; hence the study findings represent one interpretation of the health visitors' constructions and experiences of professional judgement. The study findings are exclusive to the particular contexts under study and as such there was no intention to seek statistical generalisation which would be inappropriate in case study research. However, the authors' hope that the descriptive interpretation resulting from the study, through vicarious experience, will be meaningful to health visitors working in other similar contexts. The trustworthiness of the study is displayed through the rigorous and systematic approaches adopted during data collection and analysis and their critique and transparency throughout the thesis. Having the opportunity to present papers at national conferences further clarified the researcher's thinking as data analysis and writing up progressed.

In attempting to unravel some of the complexity of health visiting assessment processes, this paper has offered a conceptualisation of the seven assessment principles.

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