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Developing and Implementing a Family Health Assessment

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Summary of project

This short report outlines a project which aimed to develop a standardised approach to the assessment of family health needs. The Family Health Assessment (FHA) was developed by a group of health visitors using evidence from a variety of sources. The approach supports the active involvement of clients in the assessment of health needs as recommended by the Health Visitor Practice Development Resource Pack (Department of Health, 2001).

Background

Health visitors work with families to promote health. Many health visitors spend a lot of time working with families who have the greatest health needs, supporting and working with parents to help them cope with the stresses of parenting and other life events (Appleton, 1996; Department of Health, 2001). Searching out health needs and stimulating clients' awareness of health needs are two key principles of health visiting practice (Chalmers, 1993). Such practice is supportive of the health visitor's role as defined by the Government in the following publications: Saving Lives: *Our Healthier Nation* (Department of Health, 1999) and *Making a Difference* (Department of Health, 1999).

Currently there is no standardised approach by which health visitors identify those families who are at greatest risk of developing poor physical, psychological and/or social health. In recognition of the demand for health visitors to be explicit about the way in which they target their services, and the increased emphasis on evidence based practice, this project aimed to develop and implement a valid and reliable family health assessment to identify those families with the greatest health needs.

The Family Health Assessment (FHA)

Using evidence collected from a variety of sources, factors that contribute to the health of a family in either a positive or negative way were identified and clustered into categories. Discussions were then held, involving group members, academics, researchers and clients, to determine how these categories could be turned into sensitive and non-threatening questions relating to family health. These questions developed into what became known as 'trigger questions' and, collectively, as the Family Health Assessment (FHA).

The FHA was designed with the intention that the health visitor and client should discuss it together, each question providing an opportunity for the client to consider a different aspect of their lives that may affect the health of themselves or their family members. It was anticipated that health visitors would follow up clients' responses to the questions where appropriate, using their knowledge of the factors that contribute to family health needs, and the issues around responding to cues and gaining entry as identified in the work of Luker and Chalmers (1990) and Chalmers (1993).

In addition to the questions, a Family Health Assessment Summary was developed. Underlying the development of this summary was the desire to:

- focus on the positive aspects of a family's situation as well as those which may be detrimental to health
- recognise the role of social support in promoting health
- provide a method for summarising the family

situation with the client which could be used to develop appropriate packages of care and which could easily be reviewed with the client.

When using the summary, the client is asked to rate themselves on a scale of 0 – 10 for “stress” and “support”. These terms reflect the concept of vulnerability that suggests that it depends on an individual’s/family’s ability to cope with stress, and the support that is available to them (Appleton 1994).

Piloting the FHA

The FHA was piloted between June and August 2000 with a total of 20 families. Ethical approval was gained. Whilst only a small scale pilot, a variety of methods were employed to test the validity of the FHA. A theoretical sampling approach was used, whereby families from the caseloads of the health visitors involved in the designing of the FHA were approached to ensure that the sample would include families with a variety of ‘stresses’ and levels of ‘support’.

Having gained consent, the project worker visited the family and discussed and completed the FHA with the main caregiver. Two other validated assessments, which focus on aspects of life covered by the FHA, were also completed. (Warwick Child Health and Morbidity Profile; MOS Social Support Scale.) The clients were asked to give their views and ideas about the FHA and the assessment process.

Criterion-related validity was measured by comparing the findings from the FHA with those of the other validated assessments, and also comparing the clients’ responses to the trigger questions with the validated assessments and their ratings for stress and support.

As the sample size was small, statistical testing was not felt to be appropriate. However, the pilot study found that there was a high level of agreement between the responses to the trigger questions, the ratings for ‘stress’ and ‘support’ and the comments and scores from the two validated assessments. There was a high degree of acceptability for the FHA and the assessment process amongst the sample group. No negative comments were recorded. A few adjustments were made to the FHA in response to comments from clients.

Because of the small sample size, it was not possible to formally test the reliability of the FHA as part of the project. Many of the methods that could be used, such as, split-half technique, require larger sample sizes, or depend on testing large batteries of questions. Internal consistency however, could be considered by comparing the responses to trigger questions with the responses to the FHA Summary, and a structured assessment format was used to reduce user-bias.

Implementing the FHA in practice

Limitations of the theoretical sampling and small sample size used in the pilot study were recognised. To address these, a number of health visitors agreed to use the FHA in practice over a period of several weeks to find out how a larger number of clients, who had not been specifically selected, responded to this new approach. Initially this process involved the group of health visitors who had developed the FHA, but later included health visitors working in several neighbouring localities who had expressed an interest in the project. Feedback was obtained from more than 30 health visitors. This included their experiences of using the FHA, together with comments from clients and their ideas about the further development of the assessment.

All the health visitors who were involved in this phase of the project initially appeared enthusiastic about the new approach to assessing family health. However, their plans to use the FHA in practice were not always realised when they got back to the workplace. Some reported feeling unhappy about introducing a new way of working at a time when they felt under pressure from the day-to-day burden of their caseloads. Others tried using the FHA and then gave reasons why it didn’t work for them, often relating to situations when the client and health visitor appeared to have different views about the health needs of the family. As a consequence, the FHA was rejected by some of these health visitors and they continued with, or returned to, their usual ways of practising. There were others, however, who had used the FHA many times and were positive about their experiences. These health visitors were able to offer case scenarios that illustrated how it had enabled them to work with clients to:

- identify health needs
- prioritise health needs
- develop appropriate packages of care
- measure the outcome of interventions
- identify public health issues
- provide evidence to support the development of services

Personal reflections on the development and implementation of the FHA

This section is written in the first person as it contains the personal reflections of the project leader. This process

was stimulated by the mixed response of the health visitors to the implementation of the FHA and has raised many questions concerning the development of healthcare practice.

When taking on the role of project leader, I was given a specific project outline. That was to develop a valid and reliable assessment that health visitors could use in practice to identify those families with the greatest health needs. I now recognise that this outline was based on several assumptions. Some of these assumptions and other key thoughts/ dilemmas that have emerged from the reflective process will be discussed briefly below.

A standardised approach versus the use of professional judgement alone

This project assumes that using an assessment is better than the approaches that were currently being used in practice to identify health needs. This raises many questions for which I feel there are no definite answers. How should health visitors identify those families with the greatest health needs? We cannot recommend the use of invalid checklists or risk indices as this could lead to the unethical labelling of families. But why shouldn't health visitors use professional judgement alone? It could be argued that this is subjective, makes it difficult to standardise decision-making and doesn't ensure the active involvement of clients in the process. Appleton (1994) reports that health visitors find it difficult to articulate their thoughts around vulnerability. Could an assessment such as the FHA inform and support health visitors' professional judgement and enable them to articulate what their clinical decisions are based upon, whilst actively encouraging the involvement of clients?

Validity and reliability

The project outline assumed it was possible to develop a valid and reliable assessment. It may be possible to measure the validity and reliability of an assessment if you develop a large battery of closed-ended questions that can be tested on large quantities of people. However, I would suggest that such an approach is in conflict with the nature of health visiting practice, which I see as being based on the development of relationships with individuals and families. Appleton's work (1994) highlights that some family situations may be complex and that it is important to consider the "complex interaction of factors rather than a simple sum of factors". This would suggest that an assessment that is essentially qualitative in nature is needed. Yet such approach makes validity and reliability more difficult to measure. This presented the dilemma of trying to use a process to develop an assessment that was seen as 'rigorous' whilst recognising that the assessment may get used in a variety of ways as health visitors and clients responded to individual needs and circumstances. In the end, I feel that we tried to achieve the middle ground by developing the FHA with reference to issues of validity and reliability as far as possible within the limits of the project and the values that we felt were important to ensure that the FHA could be used sensitively and flexibly to meet the needs of clients.

Approaches to practice development

When reflecting on my role as project leader, I now recognise that I largely adopted a 'technical' approach to practice development (Manley and McCormack, 2003). This is generally a top-down approach based on the assumption that, once practitioners have the evidence, their practice will change. The focus is on the **outcome** rather than the **process.** Although I did recognise the need to involve others in the process of developing the FHA, I did not have the knowledge and skills to involve the health visitors in a way that would enable them to reflect on and develop their practice to achieve sustainable change.

This might have been achieved by adopting an emancipatory approach to practice development (Manley and McCormack 2003) in which the development of staff is a deliberate purpose. Successful implementation of the FHA might have been achieved if the health visitors had been facilitated through a process that enabled them to:

- establish the purpose of assessing family health
- identify the values and beliefs that underpin this purpose
- critically reflect on their current practice to determine if it was consistent with their values and beliefs
- be supported in developing new ways of working

Challenges to professional practice

The Department of Health (2001) states: "Working in partnership with a family to assess needs challenges aspects of professional practice and requires a high level of communication skills" (Department of Health, 2001, p.21). The apparent reluctance of some health visitors to use the FHA in practice led me to consider whether this reluctance was related to these challenges and if so, in what ways.

Lancaster (1999) suggests that resistance to change may develop if practitioners perceive that their 'role and power' maybe altered. In this way, perhaps some health visitors may feel threatened by an approach that actively encourages the involvement of clients in the assessment

of health needs. Suggestions of this were made by some health visitors who said they felt their professional judgement was being threatened, and others who felt uncertain when the client's perception of their health needs differed from their own assessment of the situation.

Such situations may feel 'threatening' if there is a lack of understanding as to what actively involving clients entails. Whilst terms such as 'participation' and 'partnership' are commonly used, there is often a lack of clarity about what such concepts mean (Cahill 1996). Although the health visitors said that they wanted to develop an assessment that could be shared with the clients, as a group we did not take any time to explore how adopting such an approach would affect our practice. This now seems very naive and it has led me to consider whether our failure to do this shows a lack of understanding, and question how far, as practitioners, we espouse the values of client involvement rather than working towards making them a reality. On reflection, I believe that health visitors need to be given an opportunity to explore how actively involving clients in searching for health needs and the planning of care will affect their role. They need to be clear and feel confident about the skills that are required to facilitate such a process, and be supported in order that they can reflect on and develop these ways of working.

Conclusion

This short report has attempted to address two outcomes from the project. Firstly, the development and implementation of a FHA (using evidence from practice) which appears to have value for families and health visiting practice. Secondly, it provides personal refection on the implications of the work and the complexity of practice change and development. In part, this raises questions not just for health visitors but for all practitioners wishing to engage in the development of practice or wanting to implement a change.

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Further Reading

A copy of the original full report can be obtained from the website: http//www.fons.org/projects/hvtool.htm

Sanders, K. (2004) Developing and Implementing a Family Health Assessment: From Project Worker to Practice Developer. In: McCormack, B., Manley, K. and Garbett, R. *Practice Development in Nursing.* London: Blackwell Science Ltd. (Available February 2004)

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