



Exploring the Role of the Health Visitor and the Registered Nurse in the Health Visitor Team and the Health Visiting Service

Professional Briefing

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Contents

PAGE NO	
3	Introduction
5	Education preparation and practice
6	Standards of proficiency for SCPHN/health visitors and registered nurses
9	Activities that the registered nurse members of the health visitor team have the required knowledge and skill to deliver
11	Conclusion
11	Recommendations
12	References

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Introduction

The role and function of the health visitor has been the subject of much debate, especially in the last decade when strategies to implement grade mix and cut costs have led service providers to dictate that many essential health visitor activities be delegated to registered nurses. Unite the Union/CPHVA has received many enquiries from its members who are concerned about the way in which primary care trusts (PCTs) and now community provider services in the UK are employing registered nurses in place of health visitors. In these situations the registered nurse is expected to undertake health visitor activities without having the skill and knowledge required to do so. This thereby compromises public safety (Table 1).

Table 1: Examples in which registered nurses are employed in place of the health visitor

Example 1:

A PCT in England has recruited registered nurses to the health visitor service in an attempt to increase the number of health visitors. The PCT is proposing that these nurses complete a limited training programme in the hope that they will be able to undertake the health visitor role.

Issues arising from this action:

This will not enable the nurse to register on the Specialist Community Public Health Nurse (SCPHN) part of the Nursing and Midwifery Council (NMC) register with the annotation of health visitor. In explanation, registration on the different parts of the NMC register is subject to legal requirements which are in place to protect the public (regulation). Statute therefore requires people to meet the NMC requirements in order to achieve the combined SCPHN registration and health visitor annotation and hence the title health visitor.

Example 2:

A PCT in England has recruited registered nurses to the health visiting service and is instructing them to undertake first assessments/new birth assessments in place of the health visitor.

Issues arising from this action:

This assessment is extremely important because it is often the time when the mother first comes into contact with the health visitor, and as such forms the baseline for future assessments and the identification of need/issues of concern. It requires the practitioner to be able to identify the issues which may trigger future events and consider the impact that these and other contributory factors may have on the first few weeks of parenthood, on the child's life including issues relating to the family situation, and on the child's growth and development^{1,2}. This requires the practitioner to have and use advanced communication, analytical and judgement skills in order to elicit and process this information, which is often complex and sensitive, appropriately. Registered nurses are indeed able to collect information to build an assessment. However this skill is characterised by their ability to collect information relating to defined situations. They do not have the required level of knowledge and skill to consider the wider picture including the expected norms and deviations from the norm. Furthermore, they do not have the required knowledge and skill to collate this information in order to make sense of it and give it meaning in terms of the child in the context of the family and the community³.

Conversely, the health visitor assessment starts from the premise of the four principles of health visiting, namely, the search for health needs, the stimulation of an awareness of health needs, the influence on policies affecting health and the facilitation of health-enhancing activities⁴. In this way the health visitor is able to collect information which initially relates to a narrow and well-defined situation and continually add to it as the client shares more details in response to the health visitor-client relationship which develops over time².

This raises two important issues. Firstly, registered nurses who undertake activities which are clearly outside their level of competence are acting outside the NMC code and are thereby not acting in line with the principles of accountability⁵. In explanation, the lack of knowledge and skill means that they will not be able to justify the things that they do and the things that they do not do. The second issue relates to the delegation of the work to the registered nurse. The person delegating this work is accountable for the delegation and must therefore be able to explain the basis on which s/he has made the decision to delegate. In practice the person delegating will usually be the health visitor. However, if the decision to delegate the work has been made during the process of service redesign then it is the employing organisation which is delegating the work, as in this example, and not the health visitor. It is vital therefore that the health visitor as the leader of the skill mix team recognises this line of accountability and ensures that it is clearly documented in the policies and procedures for service delivery. In explanation, it is important to acknowledge that it is not admissible in law to say that you were told to delegate the work to the registered nurse by the line manager/employing organisation.

Example 3:

A PCT in England has employed registered nurses in the health visitor service and is instructing them to undertake new birth assessments/ first assessments for women who have had two or more babies and for those whom they do not consider to be vulnerable. The assumption in this situation is that the absence of vulnerability can be identified as a paper-based exercise, without seeing the client.

Issues arising from this action:

This raises the issue of accountability in terms of delegation and public safety as identified in example 2. Health visitors who delegate this work are accountable for the delegation and must be able to justify in a court of law the reasons why they have done it and the measures they have taken in order to keep the public, client, mother and baby safe. This will be extremely difficult to do in light of research which states that it is not possible to identify vulnerability in this way^{6,2}.

Example 4:

A PCT in England is employing registered nurses and is instructing them to undertake mental health assessments and listening visits for clients who are identified as experiencing post natal depression.

Issues arising from this action:

It is recognised that this activity requires a high level of communication and interpersonal skills, and emotional resilience. These skills are not part of the standards of proficiency for the registered nurse but are part of the standards of proficiency for the SCPHN/health visitor^{3,7}. Again this raises issues of accountability when identifying the actual and potential legal status of delegating this activity to the registered nurse (see example 2). In explanation, the person delegating this work is accountable for the delegation and must therefore be able to explain the basis on which s/he has made the decision. In practice the person delegating will usually be the health visitor. It is therefore important to acknowledge that it is not admissible in law as a health visitor to say that you were told to delegate the work to the registered nurse by the line manager/employing organisation.

The need to question this practice therefore remains a priority, as the number entering the health visitor profession continues to fall in response to a reduction in the availability of student places on health visitor education programmes, and the number leaving the profession continues to rise because of retirement, stress and disillusionment in relation to poor pay and career progression⁸. Indeed the need to increase the number of health visitors in the profession is a key pledge of the Department of Health within the recently launched Action on Health Visiting Programme⁹.

The role and function of the health visitor remains clearly observable in practice and in the literature^{10,11}. It is entrenched in public health with a key focus on accepting accountability and taking responsibility for tackling inequalities, social exclusion and promoting health of children, families and communities through early intervention and enduring preventive work^{12,13,14}. It is therefore essential that practitioners providing the health visitor service are capable of meeting this complex agenda.

A review of the standards of proficiency for SCPHN/health visitors clearly illustrates that they are key components of the education programmes leading to qualification and registration on the SCPHN part of the Nursing and Midwifery Council Register⁷. In contrast, however, a review of the standards of proficiency for the registered nurse illustrates that these features do not contribute to the programmes of education leading to registration on the nursing part of the NMC register³. Furthermore, the skill and knowledge base of the health visitor is clearly articulated within the public health skills career framework in which the health visitor is placed at levels 6 and 7¹⁵. This framework states that practitioners who operate at levels 6 and 7 have a high degree of autonomy, responsibility, skills and knowledge and are able to make high-level clinical decisions¹⁵. In explanation, health visitors are therefore capable, through their education preparation, expertise and practice experience, of making judgements and decisions in complex situations which are often based on limited information^{16,17}. This work has been described as the difficult things and health visitors are capable of taking responsibility for it because they have the required knowledge and skill to make professional decisions and judgements, and to deal with the emotional effort required. They also have the ability to see beyond that which is clearly visible and superficial^{4,10,11,14,17,18,19}. It is important to note that these skills are not included in the proficiencies for registered nurse education programmes and it is therefore not correct to assume that the registered nurse will have the required skill and knowledge base to undertake roles in which these are essential requirements^{3,7}.

Unite the Union/CPHVA acknowledges that registered nurses have a high level of knowledge and skill in line with their education and training, and are capable of using this knowledge and skill effectively when placed in the correct role. It also acknowledges that programme content is not universal but is related to the Higher Education Institute's (HEIs) interpretation of the standards. However, the consideration of

individual registered nurses ability in practice or the content of individual programmes is beyond the scope of this publication. This publication will:

- **Set the context of current health visitor practice, role, and function and education preparation.**
- **Compare and contrast the proficiencies on which the current preparatory programmes for health visitors and registered nurses are based.**
- **Outline a rationale for the activities that should and should not be delegated to the registered nurse when delivering a health visiting service.**
- **Outline a strategy for utilising the skills and knowledge of the registered nurse within the health visitor team/health visiting service.**

Throughout the document the term health visitor will be used to represent a practitioner who is registered on the NMC register as a Specialist Community Public Health Nurse with the annotation of health visitor.

Education preparation and practice

Currently practitioners wishing to follow a career pathway into health visiting must have already completed a nurse/midwifery education programme and be registered on part one or two of the NMC register. They undertake a 52-week SCPHN programme which enables them to develop a robust grounding in public health policy and practice, evidence-based practice and discipline-specific instruction and register on the third part of the NMC register with the annotation of health visitor. All education programmes are delivered by higher education institutions at a minimum of degree level (Level 6) with many being offered and undertaken at master's level (Level 7)²⁰. The educational underpinnings of these programmes therefore enable the qualified practitioner to be analytical, critical, assertive and innovative in the planning and delivery of care and service. Health visitors are therefore prepared to assess risk in a wide range of complex situations, and to deal with conflicting priorities and ambiguous situations⁷.

Conversely the current pre-registration nurse education programme enables the student to follow one of four branches, namely adult, children, mental health or learning disabilities nursing³. On successful completion of the programme the student will register on part one of the NMC register and the branch is denoted by annotation. It is important to acknowledge that the standards of proficiency are the same for all branches, but the practice experience will be different. This means that first level registrants will have met the same standards of proficiency. The programmes are delivered at diploma level (level 5) or degree (level 6) and they prepare the student to manage care delivery in specific, defined situations^{3,20}.

The two programmes thereby have a very different focus and ultimately set out to achieve different outcomes. The SCPHN programme prepares health visitors to work autonomously to manage preventive, public health focused care in primary/community settings, which are complex, diverse and multi-faceted. The registered nurse programme prepares nurses to deal with situations which are more focused and defined. Current programmes continue to enable registered nurses to react to patient need in secondary/tertiary care settings with varying levels of experience in primary care. Furthermore, members of the current health visitor workforce have a high degree of professional knowledge by virtue of their education achievement and work experience¹⁰. Many may also have specialist knowledge relating to specific areas of client need, for example domestic violence and post natal depression, as well as experience of working as a nurse or midwife in primary and/or secondary and/or tertiary health care. This promotes their ability to develop effective, enduring relationships with people from many different client groups including the child, the young person, the parent, the carer, community groups and voluntary agencies. A key feature of the health visitor's contribution to these relationships is her/his ability to negotiate and motivate clients in her/his care, to navigate highly complex and often ambiguous situations in clients' lives and to reassure them of her/his ability to take appropriate action¹⁰. It also enables the health visitor to operate effectively in multi-professional and/or interagency settings within the statutory and voluntary/ third sectors in order to co-ordinate service provision and public health promotion for the client group, and to plan the development and delivery of specialist services⁷. In contrast, the current preparatory programme for the registered nurse enables her/him to deliver nursing care to individuals and to collaborate with members of the health and social care team. These two professional roles therefore have very clear and distinct directions for care delivery. The health visitor is able to identify the wider issues impacting on the client, family and/or community and is able to draw on a plethora of skills and knowledge to take appropriate action towards resolution. In contrast, the focus of the registered nurse's intervention is one-dimensional, often focusing on the individual in isolation. This is illustrated in the next section which considers the standards of proficiency for these professional roles.

Standards of proficiency for SCPHN/health visitors and registered nurses

Review of the standards of proficiency suggests that they are similar in only two key areas of practice (Table 2).

Table 2: Comparison of the SCPHN (health visitor) and registered nurse standards of proficiency^{3,7}

Registered Nurse ³	Health visitor ⁷
Registered nurses are prepared to be able to “systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observation and measurement” (p28). Health Promotion: “Consult with patients, clients and groups to identify their need and desire for health promotion advice” (p28).	Health visitors are prepared to be able to “ collect and structure data and information on the health and wellbeing and related needs of a defined population” (p10). Health promotion: “Communicate with individuals, groups and communities about promoting their health and well being” (p11).

In explanation, this suggests that on completion of the relevant education programme both groups of practitioners will be able to collect health-related data. Furthermore, both programmes will enable the practitioner to communicate with individuals and groups about health promotion. However, if the standards are seen as the blueprint for the ability to act then it could be suggested that the registered nurse is not able to deliver health promotion. In reality this will depend to a great extent on the way in which the Higher Education Institution (HEI) has designed the health promotion elements of the programme. Some programmes, for example have facilitated and assessed the registered nurse’s ability to do this, but currently this may not a feature of all programmes.

Both programmes are thereby operating at different stages in the health promotion cycle and the resultant outcomes will therefore be different (Table 3). For example, one of the key health promotion objectives for children is to increase the initiation and continuation of breastfeeding²¹. This objective therefore forms a major component of the work plan for the health visiting service. However, both groups of practitioners will approach this objective in very different ways because of the knowledge and skills that they have (Table 3).

Table 3: Health promotion: Promoting breastfeeding

Registered Nurse	SCPHN (health visitor)
The registered nurse collects data about the number of mothers who choose to breastfeed their baby from the information collected by the health visitor during the first visit and recorded in the personal child health record (PCHR). S/he identifies that mothers aged 15-24 years are keen to start breastfeeding as soon as their baby is born. The registered nurse uses this information to design health promotion displays in key locations which will attract the attention of women in this age group. This will be used to inform women in this age group who are pregnant/planning pregnancy/parenthood about the advantages of breastfeeding and how to access advice and support to enable them to breastfeed their baby. The ultimate aim is to provide all women in this age group with the information that they need to help them make the decisions about the method of feeding their baby. This will also aim to increase the number of people starting to breastfeed and deciding to continue to breastfeed because they know at an early stage how to access support and advice.	Health visitors collect information about the number of mothers who choose to breastfeed their baby and identify that mothers aged 15-24 years are keen to start breastfeeding as soon as their baby is born. The health visitor uses this information to identify the key discussion points that must be included in their conversations with this group of women to enable them to make an informed choice to breastfeed their baby and access the relevant support and advice to continue doing so. The health visitor will design her/his health promotion intervention based on individual needs of the mother which are addressed at the first contact and reviewed on an ongoing basis at subsequent contacts and s/he shares this information with the registered nurses to enable them to design the health promotion display ¹⁰ . In explanation, the messages are ultimately the same but the delivery is different for each mother. This enables the health visitor to increase the number of people who choose to start breastfeeding as well as those who choose to continue to breastfeed their baby ²² .

In summary, therefore, both practitioners have very important and distinct roles in the promotion of breastfeeding within this target population. They both have the same information to deliver but are able to use it in different ways in order to meet the needs of the maximum number of women in relation to breastfeeding. **In explanation**, the health visitor and the registered nurse are both able to share information about breastfeeding with pregnant women and new mothers. However, health visitors have a depth of knowledge about breastfeeding which enables them to engage women in discussion and decision-making. They also understand health promotion theory which allows them to develop appropriate/effective interventions.

Further analysis of the standards of proficiency highlights that the skill and knowledge base of the health visitor and the registered nurse differs in three key areas of practice, namely relationships, public health and management (Table 4).

Table 4: Differences between the SCPHN/health visitor and the registered nurse standards of proficiency

Registered Nurse ³	Health visitor ⁷
Relationships	
Nurses are prepared to develop relationships with clients at times of illness which enables them to meet the client’s identified nursing needs. These relationships are driven by the illness trajectory and are therefore time-limited. “maintain and where appropriate disengage from professional caring relationships that focus on meeting the patient’s or client’s needs within professional therapeutic boundaries” (p27)	Health visitors are prepared to establish, develop and maintain relationships with clients over time. Initiation of these relationships often occurs in the absence of identified need/problem and must therefore be developed on an individual case-by-case basis. “develop and sustain relationships with groups and individuals with the aim of improving health and social well being” (p10)
Public Health	
Registered nurses are prepared to enhance health and social wellbeing through health promotion. “consult with patients, clients and groups to identify their need and desire for health promotion advice” (p28) “provide relevant and current health information to patients, clients and groups in a form which facilitates their understanding and acknowledges choice/individual preference” (p28)	Health visitors are prepared to identify public health priorities, influence, plan, and lead and deliver all aspects of public health policy and practice. “analyse, interpret and communicate data and information on the health and wellbeing and related need of a defined population” (p10) “undertake screening of individuals and populations and respond appropriately to findings” (p10) “communicate with individuals, groups and communities about promoting their health and wellbeing” (p11) “raise awareness about health and social wellbeing and related factors, services and resources” (p11) “raise awareness about the actions that groups and individuals can take to improve their health and social wellbeing” (p11) “work with others to protect the public’s health and wellbeing from specific risks” (p11) “work with others to plan, implement and evaluate programmes and projects to improve health and wellbeing” (p11) “work in partnership with others to prevent the occurrence of needs and risks related to health and wellbeing” (p12)

Continued on page 8

Public Health (Continued)	
	<p>“identify and evaluate service provision and support networks for individuals, families and groups in the local area or setting” (p11)</p> <p>“appraise policies and recommend changes to improve health and wellbeing” (p11)</p> <p>“interpret and apply health and safety legislation and approved codes of practice with regards for the environment, wellbeing and protection of those who work with the wider community” (p11)</p> <p>“contribute to policy development” (p11)</p> <p>“Influence policies affecting health” (p11)</p> <p>“work in partnership with others to prevent the occurrence of needs and risks related to health and wellbeing” (p12)</p> <p>“work in partnership with others to protect the public’s health and wellbeing from specific risks” (p12)</p> <p>“apply leadership skills and management projects to improve health and wellbeing” (p12)</p> <p>“plan, deliver and evaluate programmes to improve the health and wellbeing of individuals and groups” (p12)</p>
Management	
<p>Registered nurses are prepared to be able to manage explicit and defined situations when delivering nursing care.</p> <p>“manage the complexities arising from ethical and legal dilemmas” (p26)</p>	<p>Health visitors are prepared to manage ambiguous and ill-defined situations.</p> <p>“prevent, identify and minimise risk of interpersonal abuse or violence, safeguarding children and other vulnerable people, initiating the management of cases involving actual or potential abuse or violence where needed” (p12)</p> <p>“identify individuals, families and groups who are at risk and in need of further support” (p10)</p>

This summary clearly identifies that the health visitor is capable of embracing the full spectrum of public health policy and practice, relationship development, and management. In contrast, the preparation of the registered nurse allows her/him to focus on more defined components of care. These differences can be illustrated in terms of the service delivery and/or practice activity required by the Healthy Child Programme to support parenting in the first few months of a child’s life (Table 5). It therefore forms a key objective of the work plan for the health visitor team/health visiting service which means that all team members must contribute to its achievement^{21,23}. However, the way in which they will be able to act following achievement of the standards of proficiency is illustrated in Table 5.

Table 5: Delivering the Healthy Child Programme: Supporting parenting

Registered Nurse	SCPHN (health visitor)
<p>The registered nurse collects information about the number of newly delivered mothers who attend the local hospital’s accident and emergency department more than three times in one month because they fear that their baby is unwell. The nurse talks to a few of these mothers and finds out that they feel scared and ill-prepared for being a mother, they spend a lot of time on their own and do not know how to deal with their baby when s/he cries non-stop for long periods of time.</p> <p>The registered nurse has very little experience and knowledge about children/child development and does not really know why babies cry for long periods of time. However, s/he feels that s/he must give the mothers some information about how to make this situation better and how to reduce the need to attend the accident and emergency department on such a regular basis. S/he gives the mothers a leaflet and a website address which provides information about what to do when the baby is crying.</p> <p>The registered nurse is surprised when she collects the same data three months later and sees that the same group of women are still attending the accident and emergency department.</p>	<p>The health visitor is aware that there are an increasing number of newly delivered mothers who attend the local hospital’s accident and emergency department more than three times in one month because they fear that their baby is unwell.</p> <p>The health visitor knows that the community profile illustrates that the level of unemployment is higher than the national average, the level of education attainment for mothers is GCSE/‘O’ levels and the average age at conception is 20 years. The education preparation that the health visitor has undertaken means that s/he is aware that these features increase the mother’s risk of post natal depression and that mental health issues increase the incidence of mothers identifying physical symptoms as illness in their child. However, s/he is working in an organisation that does not provide primary care led services for people with mental health issues. Despite this, the data that s/he has collected leads her/him to think that these services are really important and that many issues that s/he is dealing with on a daily basis could be avoided if these services were provided e.g. the increasing attendance at the accident and emergency department²⁴.</p> <p>S/he collects data to help her/him to illustrate these findings to the commissioners and requests an opportunity to present the information at the commissioners’ next meeting. In preparation for the meeting s/he also collates information about the services that are already available in the community and the agencies that s/he currently engages with to assist women in these situations to access treatment and support. S/he also collates information about the benefits and shortfalls of these services and the benefits that primary care led mental health services would provide in terms of objective and subjective data. Furthermore, s/he could also develop a proposal which outlines the opportunity cost of not providing a primary care led mental health service for mothers in terms of the services that the health visitor service will not be able to provide because of insufficient resources.</p>

Activities that the registered nurse members of the health visitor team have the required knowledge and skill to deliver

The summary in Table 5 illustrates the way in which practitioners from these two professional groups are able to deliver the Healthy Child Programme. It is clear that both professional groups have different skills and knowledge following achievement of the standards of proficiency^{3,7}. It is essential therefore that these are taken into consideration when designing the role and function of the registered nurse in the health visitor team/health visiting service and when delegating activities that must be undertaken within this role.

In summary, therefore, the registered nurse on completion of the registered nurse education programme is able to contribute to the work of the health visitor team/health visiting service in relation to the following three key components:

- Managing explicit and defined situations
- Providing relevant and current health information
- Identifying the need and desire for health promotion advice

Some examples of the particular activities that the registered nurse may undertake within the health visitor team/health visiting service in relation to these components are provided in Table 6.

Table 6: Activities that the registered nurse members of the health visitor team have the required knowledge and skill to deliver

<p>Activity Accident prevention is an important component of the universal service which is offered by the health visiting service to children and families. It is integral to the work relating to child health and wellbeing with a specific emphasis on child development. The service offered must be proactive and reactive, and have both an individual and group focus in relation to need that has been identified^{21,23}.</p>
<p>Registered nurse role and function Example: Managing explicit and defined situations The registered nurse will collect and collate data relating to accidents experienced by children within the caseload population. S/he works with the health visitor, who is able to incorporate the 'soft data' that s/he has in relation to the local living conditions and community issues in order to identify areas of need in relation to accident prevention, for example the problems arising from overcrowded living conditions which are characterised by a lack of space in which children can play safely inside and outside the home. The health visitor and the registered nurse could work together proactively to decide on priority work areas in relation to accident prevention for the caseload population. The registered nurse can then put in place the health promotion strategies that are required. This may be a matter of designing and displaying information in specific environments, for example in the child health clinic, community or children's centre, that people can read when attending for other reasons. The registered nurse is also able to work with the mother/parent to encourage her/his use of accident prevention services, for example the local accident prevention loan scheme in order to facilitate her/his access to the required equipment. Following this activity/intervention, the registered nurse could collect and collate information to identify the number of people/families from the caseload population who use the accident prevention loan scheme and the number of accidents reported over a defined period of time. This will help her/him to identify if there is a relationship between the use of the loan scheme and the occurrence of accidents in that population group. For example, if the data suggest that the people who use the loan scheme experience fewer accidents then this will help the registered nurse and the health visitor team to prioritise activities which will encourage the use of the loan scheme by the caseload population.</p>
<p>Activity The delivery of the childhood immunisation programme is an important component of the universal service offered to children and families by the health visiting service. Its public health focus is very clearly on illness prevention, health protection and promotion. It is possible to divide the delivery of this service into work which focuses on the preparation of people to enable them to make informed decisions about accepting/declining the programme and the execution of the programme to facilitate administration of the correct immunisation, at the correct time, to the correct child^{21,23}.</p>
<p>Registered nurse role and function Example: Providing relevant and current health information The registered nurse can administer the immunisation and care for the child and parent during and immediately following administration. For example, s/he is able to take measures to reduce the risk of anaphylaxis and can advise the parent/carer about the identification and treatment of immunisation-related pyrexia. S/he is also able to collect data about the immunisation administered, the person receiving it, and the number of immunisations delivered to specific age groups of children over a particular timeframe. S/he is also able to consider the information in relation to the children within the caseload population and identify those who have not received the required immunisations in relation to the UK schedule. The registered nurse can contact the mother/parent/carer to identify the reasons why s/he has not accessed the immunisation programme for her/his child. The registered nurse can collate this information, identify issues that prevent uptake of the UK immunisation schedule within the caseload population, inform the health visitor team and make recommendations for resolution in order to increase future uptake within the caseload population.</p>

Activity

The promotion of healthy eating behaviour is an important component of the universal service offered to children and families by the health visitor service. The public health focus of the health visitor service means that this area of work must be designed and delivered in ways that meet the needs of those living in poverty as well as those living in situations of wealth. The literature states that messages which are understood and accepted by adults in families are more likely to be passed on to their children through the lifecycle. It is therefore important that strategies are in place to encourage adults to engage with health promotion messages throughout their child's life^{21,23}.

Registered nurse role and function

Example: Identifying the need and desire for health promotion advice

The registered nurse can provide information which is displayed in locations that are frequently used by mothers/parents/carers about the content and format of a healthy diet and the specific food groups to include in daily meals. S/he is also able to provide information about ways in which people can maintain a healthy weight.

The registered nurse is also able to facilitate group work activities for people to help them to develop skills and confidence in healthy eating. For example cooking and food preparation, making food choices, promoting activity and exercise, eating on a restricted budget.

S/he can help the group members to work together, learn from each other and identify ongoing health promotion requirements by providing information and continuity of contact over time.

Conclusion

This document has used the NMC standards of proficiency to outline the specific skill and knowledge base that the SCPHN/health visitor and the registered nurse will gain during their respective education programmes^{3,7}. It has also illustrated the importance of utilising the skill and knowledge base appropriately to ensure that registered nurses are contributing effectively and efficiently to the health visitor team /health visiting service and are thereby helping to secure the health, wellbeing and safety of children and families within the caseload population.

Recommendations

It is clear that practitioners are faced with dilemmas in practice when seeking to design and resource a service which historically suffers from insufficient resources. However, it is essential that the following factors are retained when designing the health visiting service in order to ensure public safety and the delivery of a service which effectively and efficiently meets client needs.

1. Registered nurses must not be expected to undertake work for which they do not have the required competence (skills and knowledge). **In explanation**, the action of promoting work practices outside the required competence inhibits the ability of the employing organisation to maintain public safety and is clearly in breach of the 'Code'⁵.
2. The role and function of the registered nurse within the health visitor team/health visiting service must be clearly defined in terms of the potential and actual contribution and anticipated outcomes that s/he is able to make to the delivery of the Universal Health Visiting Service, the Healthy Child Programme, and the Strategy for Children and Young People's Health^{21,23}.
3. Professional leaders and team managers must acknowledge the potential and actual contribution that the registered nurse will make to the delivery of the Universal Health Visiting Service and use this information to support the design of skill mix rather than the implementation of grade mix within the health visitor team.

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