



**Professional Briefing:**

# The New Birth Visit

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*Throughout this document the term new birth visit will be used to refer to the first contact with the client (mother) after the birth of the baby.*

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*The Community Practitioners' and Health Visitors' Association (CPHVA) is a professional section of Unite Health Sector which has about 100,000 members working in the health sector. Unite/CPHVA is the third largest professional nursing union and is the only union which has public health at its heart. Unite/CPHVA is the UK professional body that represents registered nurses, nursery nurses and health visitors who work in a primary or community health setting.*

*The sector is itself part of the Unite trade union with 2 million members nationwide. Unite was formed by an amalgamation of Amicus and the Transport and General Workers' Union in May 2007.*

## Introduction

Welcome to this series of professional briefings designed to help practitioners in practice achieve and maintain evidence based, quality practice. This briefing is designed to be a source of reference and should be used to enable you to begin your enquiry. It is the start rather than the endpoint of your enquiry so you will need to access further sources of information depending on the specific information that you require. Unite/CPHVA hopes that you will use the information to:

- Raise the profile of the health visitor/visiting service as the service with the required knowledge and skills to undertake this assessment visit safely and competently
- Raise the profile and importance of the new birth visit when seeking to engage and develop ongoing relationships with clients (mothers and families)
- Help you to influence and contribute to the thinking of managers /commissioners when they are seeking to make decisions about changing service design and delivery options.

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## The new birth visit

This is a significant component of the work undertaken by all health visitors and has been throughout the service's history. It is often the first point of contact with the mother, child and the family, despite assurances to the contrary within the Child Health Promotion Programme, which highlights the importance of establishing contact antenatally.<sup>1</sup> This is especially the case where service design and limited resources have resulted in the disbandment of any contact with women by the health visiting service during pregnancy. Other influences also act to reduce the potential for contact in the antenatal period including the increasing mobility of people, dependence on temporary housing, and the increase in the number of women choosing to continue working until late into their pregnancy (36/37 weeks' gestation).

Research relating to the new birth visit was conducted in the mid to late 1980s within the field of health visiting in the United Kingdom and within the field of public health nursing in Europe and the US. Many of the issues raised are still important in current health care provision, and indeed have been prioritised in recent literature and health policy documents.<sup>1, 2</sup> For example, the provision of needs led services and the development of partnership working between the client and the practitioner and between practitioners who work across professional boundaries.<sup>1,2,3,4</sup>

The requirement to contact the mother following the birth of the baby dates back to the 1946 National Health Service Act.<sup>5</sup> Subsequent interpretation of the Act has meant that this contact results in a home visit, by the health visitor (home visitor/welfare), which takes place between 10-14 days following the birth.<sup>6</sup> This time scale is considered to be ideal because it is the time at which care and direct involvement can be transferred from the midwifery service. However, in this era of evidence-based practice, it must be acknowledged that continuing to undertake this assessment at this stage is not supported by research evidence, nor is there evidence to show that this time scale is appropriate. However, it is also important to note that there is no research to revoke this timescale as the ideal time for this assessment.

Many primary care organisations in the UK are currently reviewing and changing the way in which they deliver this service. The key issues that are under review are the timing of the visit and the professional who undertakes the visit.<sup>1</sup> Anecdotal evidence suggests that some organisations are suggesting that the new birth home visit is undertaken by the community staff nurse rather than the health visitor. Unite/CPHVA is concerned by the potential impact of this decision on the health and well-being of children and families. Since decisions to delegate the new birth visit to a community staff nurse is usually made in situations where families are deemed to be 'low risk' or where the contact is considered to be 'routine'. These labels are attributed based on a variety of disparate sources of information for example, information relating to the mother's obstetric, medical and general history, and information relating to contact with other services, for example, social services. Although there is no doubt that this information is relevant to the assessment of family need, research states that it is of extremely limited value when used in isolation of other important information. Furthermore, research has also proven that the tools used to make these

decisions are inaccurate when used in isolation of a robust and holistic assessment.<sup>7</sup> Research has also shown that it is not possible or safe to label a client contact as routine until it has been completed.<sup>8</sup> Thus, any decision made, which is based on limited information is thereby placing the client (mother, child, family) at risk of not receiving the correct level of intervention. It is also placing the practitioner at risk of breaching the Nursing & Midwifery Council's Code for Professional Conduct because s/he is not able to justify the rationale for her/his actions and non actions if s/he is making a decision based on inadequate information.<sup>9</sup>

A review of the literature relating to the new birth visit suggests that it concentrates heavily on the timing of the visit at the expense of giving attention to the skills and knowledge requirements of the professional completing the visit, the rationale for the visit and the content and the outcome of the visit.<sup>5,10</sup> However, these factors deserve equal consideration because they contribute to the success and effectiveness of the visit.

The literature states the new birth visit has three key functions. Firstly, it is an important time at which to develop a relationship with the mother and the family. It is also the time when an assessment of the baby's growth and development and the family situation is started. These key functions will be explored further in the following section.

## Functions of the new birth visit:

- i. Relationship development
- ii. Assessing the baby's growth and development
- iii. Assessing the family situation in order to make a decision about the most appropriate care requirements, for example, core, targeted or intense service intervention.<sup>1</sup>

### i. Relationship development

Research demonstrates that the foundations of an effective relationship between the mother and the health visitor, if not established in the antenatal period, are laid during the new birth visit, and continue to develop over time. This facilitates the development of partnership working, client empowerment and trust.<sup>11,12,13</sup> Furthermore, these foundations are strengthened if the health visitor uses the time during the new birth visit to try and 'get to know' the mother, and share information about the health visiting service and how to use it.<sup>12,13,14</sup> The importance of these features is illustrated in the Peckover study,<sup>15</sup> which demonstrates that mothers who had a good relationship with their 'named' health visitor chose to disclose domestic violence, and that this disclosure did not happen in situations where they did not have a good relationship. Similarly, Chalmers<sup>16</sup> proposes that there are three important phases of relationship development and progression through each of the phases in turn enables the health visitor to feel confident that the client would, and could, access the service when needed. This knowledge enables the health visitor to confidently reduce the level of monitoring/surveillance provided for families<sup>16,17</sup> (See table 1 below).

<b>Phase</b>	<b>Action</b>
The entry phase	In which the health visitor is allowed to enter into the physical and emotional family environment. This is an important feature of the new birth visit because in situations where the health visitor is allowed into the physical environment only, the ability to fulfil the objectives of the new birth visit is severely restricted.
The health promotion phase may order	In which the health visitor is able to discuss strategies for health promotion that are relevant to the mother and the family. This need to be focused on the child initially in to encourage the mother to accept the advice.
The termination phase	In which the health visitor outlines the content and outcome of the visit and agrees an action plan with the mother. This should contain the details of how to contact the health visitor and reasons why people may want to contact her/him.

Source<sup>16,17</sup>

## ii. Assessing the baby's growth and development

The new birth visit allows the health visitor to see and examine the baby.<sup>16, 18</sup> This is the part of the contact which is most valued by mothers.<sup>18</sup>

## iii. Assessing the family situation in order to make a decision about the most appropriate care requirements for example, core, targeted or intense service intervention

Health visitors gather information during the new birth visit that informs their decisions and judgements about the content of the care plan, and the care delivery programme and helps them to establish the urgency with which the service must respond to the client's needs.<sup>16,17</sup> In practice, many consultations are complicated and it is imperative that the information that is collected is collated. This means that it is possible to identify what the information means to the mother, baby and the family in the context of their lives and the situation in which they are living.<sup>8,17</sup>

## Purpose of the new birth visit

The health visitor must collect, analyse, and critique the following categories of information during the new birth visit to ensure that s/he is able to maintain the health, well-being and safety of the mother, baby and family:

- i. The mother's health and well-being
- ii. The pregnancy, labour and delivery
- iii. Health care provided to the baby, including the date of the newborn screening test, the weight and condition at birth, any known health problems, feeding type and pattern, and progress since birth
- iv. Public health status of the family for example, the quality of the parental relationship, the presence of health challenges such as poor diet, obesity, smoking and drug use.

This will ensure that the health visitor is able to offer the mother, baby and family the service, which will meet the needs that s/he has identified.

## Line of accountability

Anecdotal evidence states that health visitors working in some primary care organisations are being instructed to delegate the new birth visit to the community staff nurse members of the team. This delegation is expected when clients are considered to be 'low risk' or not vulnerable. In these situations the health visitor is expected to make a decision about the forthcoming visit in terms of the anticipated outcome. For example, a visit to a mother who has given birth to her second child may be considered low risk and meet the criteria for delegation. Other criteria for delegation may include the fact that there has been no known contact with social services, and that there are no known concerns in relation to the mother's obstetric, medical or general history. However, research states that decisions and judgements made using these criteria may result in practice which is outside of the Nursing & Midwifery Council's Code of Professional Conduct, and is unsafe and poor quality because each situation is different.<sup>9</sup> For example, the partner/father of the baby may be a different person, there may be different people living in the household since the birth of the first baby and social circumstances may be different since the birth of the first baby. The health visitor service may not be aware of these changes because there may not have been any contact in the years preceding the birth of the second baby. It is imperative that due regard is given to the line of accountability in these situations. For example, accountability remains with the person delegating.<sup>9</sup> It is her/his responsibility to ensure that the person to whom s/he is delegating has the required knowledge and skills to undertake the task competently.<sup>9</sup> Furthermore, the health visitor must be able to justify her/his actions and non actions in order to meet the requirements of accountability which are laid down in the Nursing & Midwifery Council's Code of Professional Conduct and s/he will not be able to do this in the absence of all the relevant information.

## Comparison of the skills and knowledge provided during preparatory education programmes for nursing and specialist community public health nursing (health visiting)

Nurses and specialist community public health nurses (health visitors) complete very different programmes of education and thereby achieve different skills and knowledge on successful completion of their respective education programmes.<sup>19,20</sup> The following section will compare some of the skills and knowledge that the nurse and the specialist community public health nurse (health visitor) will gain during their respective education programmes and be expected to illustrate at registration with the Nursing & Midwifery Council. Specific proficiencies pertinent to delivering the new birth visit have been selected to illustrate the way in which the two disciplines may approach this area of practice (See table 2 overleaf). The comparison is provided here as a way in which to enable the reader to objectively consider the rationale for the decisions that s/he makes about delegating work to other members of the team.

## Competency: Fitness for Purpose and Practice

Competency is the term used by the Nursing & Midwifery Council to describe the knowledge, skills and judgement that a practitioner has to enable her/him to practice safely and effectively.<sup>9</sup> Employers have a responsibility to ensure that the practitioners they employ have the skills to undertake the work that they are employed to do. Furthermore, employers also have a responsibility to recognise and reinforce good practice and performance.<sup>9</sup> This will influence the decisions that are made about service delivery.

The following proficiencies are selected from the Standards of Proficiency for Pre-registration Nursing Education and the Standards of Proficiency for Specialist Community Public Health Nurses.<sup>19,20</sup> These documents outline the national requirements for registration of nurses and specialist community public health nurses with the Nursing & Midwifery Council.<sup>19,20</sup>

**Table 2: Standards of proficiency for registered nurses & specialist community public health nurses (health visitors)**

Competencies at registration		
Specialist community public health nurses/ health visitors	Registered nurse	Correlation ✓
Domain		
Search for health needs	Care delivery	
Collect and structure data and information on the health and well-being and related needs of a defined population.	Systematically collect data regarding the health and functional status of individuals, clients and communities through appropriate interaction, observation and measurement.	
Analyse, interpret and communicate data and information on the health and well-being and related needs of a defined population.	Seek specialist/expert advice as appropriate.	
Develop & sustain relationships with groups and individuals with the aim of improving health and social well-being.	Utilise a range of effective and appropriate communication and engagement skills.	
Identify individuals, families and groups who are at risk and in need of further support.		
Undertake screening of individuals and populations and respond appropriately to findings.	Provide support and education in the development and/or maintenance of independent living skills.	
	Develop and document a care plan to achieve optimal health, habitation and rehabilitation based on assessment and current nursing knowledge.	
	Identify expected outcomes, including a time frame for achievement and/or review in consultation with patients, clients, their carers, family and friends and with members of the health and social care team.	
	Contribute to the application of a range of interventions which support and optimise the health and well-being of patients and clients.	
	Analyse and revise expected outcomes, nursing intervention and priorities in accordance with changes in the individual's condition, needs or circumstances.	
	Demonstrate the ability to transfer skills and knowledge to a variety of circumstances and settings.	
	Recognise the need for adaptation and adapt nursing practice to meet varying and unpredictable circumstances.	
	Ensure that practice does not compromise the nurse's duty of care to individuals or the safety of the public.	
Stimulation of awareness of health needs		
Develop, sustain and evaluate collaborative work.		
Communicate with individuals, groups and communities about promoting their health and well-being.	Consult with patients, clients and groups to identify their need and desire for health promotion advice.	
Raise awareness about the actions that groups and individuals can take to improve their health and social well-being.	Identify and respond to patients' and clients' continuing learning and care needs.	
Develop capacity and confidence of individuals and groups (including families and communities), to influence and use available services, information and skills, acting as an advocate where appropriate.	Identify, collect and evaluate information to justify the effective utilisation of resources to achieve planned outcomes of nursing care.	
Work with others to protect the public health and well-being from specific risks.	Establish priorities for care based on individual or group needs.	
Influence on policies affecting health		
Work with others to plan, implement and evaluate programmes and projects to improve health and well-being.	Analyse and interpret data accurately to inform nursing care and take appropriate action.	
Identify and evaluate service provision and support networks for individuals, families and groups in the local area or setting.	Provide relevant and current health information to patients, clients and groups in a form which facilitates their understanding and acknowledges choice and individual preference.	

Develop, implement, evaluate and improve practice on the basis of research, evidence and evaluation.		
Facilitation of health-enhancing activities	Care management	
Work in partnership with others to prevent the occurrence of risks related to health and well-being.	Use appropriate risk assessment tools to identify actual and potential risks.	
Work in partnership with others to protect the public's health and well-being from specific risks.	Communicate safety concerns to a relevant authority.	
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.		
Plan, deliver and evaluate programmes to improve the health and well-being of individuals and groups.	Participate with members of the health and social care team in decision making concerning patients and clients.	
	Review and evaluate care with members of the health and social care team and others.	
	Maintain one's own accountability and responsibility when delegating aspects of care to others.	
	Demonstrate the ability to co-ordinate the delivery of nursing and health care.	
	Literacy: interpret and present information in a comprehensible manner.	
	Problem-solving: demonstrate sound clinical decision-making which can be justified even when made on the basis of limited information.	

Source<sup>19,20</sup>

Consideration of these proficiencies illustrates that nurses and specialist community public health nurses (health visitors) are educated to undertake similar areas of practice. However, further analysis of the proficiencies clearly illustrates that the depth of activity undertaken by each discipline is very different. For example, people on both programmes gain skills and knowledge which helps them to engage with clients about health promotion.

#### Stimulation of awareness of health needs

***"Communicate with individuals, groups and communities about promoting their health and well-being" (Specialist community public health nurses/health visitors)<sup>19</sup>.***

#### Care delivery

***"Consult with patients, clients and groups to identify their need and desire for health promotion advice" (Registered nurses)<sup>20</sup>***

These examples clearly illustrates that health visitors are able to undertake health promotion activities in order to advance client health and well-being. However, nurses are prepared to offer health promotion advice. Both activities are important; however, professionals undertaking the new birth visit need to be able to actively advance client health and well-being rather than merely offer advice about how to do so. This is especially important in situations where clients are only seen on one occasion.

These two documents clearly illustrate that the education programmes provide a different focus for each discipline. The registered nurse is prepared to undertake specific tasks, for example:

***"Collect data"***

***"Use a range of communication and engagement skills"***

***"Identify and respond to patients"***

***"Use appropriate risk assessment tools"<sup>20</sup>***

This means that a community staff nurse undertaking a new birth visit will adopt a task-orientated approach based on the provision of specific instructions because this is the focus of the education programme that s/he has completed in order to become a registered nurse. Many organisations have tried to accommodate this by providing specific written instructions detailing a list of actions that must be completed and information that must be collected during the new birth visit. However, the community staff nurse may experience difficulties and may not be able to complete the task safely if information which is not on the check list comes to light during the new birth visit. For example, this situation may arise when the client is unwell, or when family circumstances and living arrangements have changed and someone is present in the home during the visit that is not known to the service. The community staff nurse will not be able to analyse this information or identify what it means because the education programme has not prepared them to do this.

Conversely, the proficiencies within the specialist community public health nurse (health visitor) programme prepare the health visitor to undertake a range of activities in order to achieve the outcome, for example,

***“Develop and sustain relationships”***

***“Collect and structure data”***

***“Undertake screening of individuals and populations and respond appropriately to findings”***

***“Work in partnership with others to protect the public’s health and well-being from specific risks”<sup>19</sup>***

This means that the health visitor is able to approach the new birth visit in a holistic way which allows her/him to collect central, peripheral and previously unknown information in order to complete a comprehensive assessment. This enables the health visitor not only to collect the information but also to identify what it means in terms of the client (mother, baby, family) in the context in which they are currently living. The health visitor is also able to interpret the information in order to make a decision about the service to offer. S/he is thereby able to make a judgement about when the situation must be reassessed in order to ensure that the client receives a level of service which best meets their health and well-being requirements.

**Case scenario:** A new birth visit to a mother who has just had her second baby and has no known/recorded obstetric, medical or social history which might lead to concerns about risk or vulnerability. This scenario is likely to meet the requirements for delegation of the new birth visit to the community staff nurse. However, once the visit is complete more information is collected which significantly changes the assessment of need for example:

The mother divorced the first child’s father 18 months ago and has been with her current partner for just under a year. This is an unplanned pregnancy. Her partner has recently moved into the family home because he has been made redundant. The mother is the higher wage earner but has taken maternity leave to care for the baby. The relationship with her partner is fragile and they have been arguing a lot since he moved into the family home. The baby was born via a normal delivery and weighs 2.5kg at 38 week’s gestation. Mum has decided to breastfeed because she was not able to do so following the birth of her first child.

**Significant information**

- Fragile relationship
- Change in family dynamics and composition of the household
- Difficult financial situation
- Baby’s weight is low in relation to the gestational age
- Potential difficulty with breastfeeding.

**Analysis (establishing meaning)**

- Potential for relationship break down which may impact on the first child as well as the new baby
- Problems associated with dependence on financial benefits and limited income
- Potential problems arising from the weight of the baby and not knowing why mum was not able to breastfeed her first baby.

This example illustrates the problems that may arise when a judgement is made purely on the basis of information that is known and recorded. The fact that a woman has had a baby already does not necessarily mean that they can be considered ‘low risk’ because family situations and social circumstances may change. Furthermore, it also illustrates the fact that a new birth visit does not merely require the person completing it to collect information. Rather, it requires the person to complete an assessment which involves collecting information, analysing it to establish meaning and prioritising the different components in order to develop a care/action plan to meet the client’s actual and potential health and social care needs.

**Standards for Practice**

The following section presents the proficiencies which most closely relate to the new birth visit and are used here to illustrate the way in which the health visitor has the knowledge and skills to undertake this area of practice competently. Findings from research and literature are also presented to illustrate the way in which the knowledge and skills linked to these proficiencies are used by health visitors in practice.

**Search for health needs<sup>19</sup>**

***“Develop and sustain relationships with groups and individuals with the aim of improving health and social well being”<sup>19</sup>***

Peckover suggests that clients who have a good relationship with their ‘named’ health visitor chose to disclose domestic violence. This disclosure did not happen in situations where the relationship was not established and developed.<sup>15</sup>

The presence of an effective relationship facilitates client empowerment, which encourages clients to work in partnership with the health visiting service during service delivery.<sup>12,13,21</sup>

Research suggests that the relationship is developed when the health visitor actively listens to the mother, normalises the events, does not panic about what the mother is saying and acts in a friendly way while still retaining the required client-practitioner professional boundary.<sup>11</sup>

An effective relationship with the client also enables the health visitor to feel confident about when to terminate the contact.<sup>16,17,22</sup>

The knowledge and skills required to develop a relationship with another person are different from those required to communicate with another person. Hence, the registered nurse, following completion of the education programme is able to communicate with clients and

***“Utilise a range of effective and appropriate communication and engagement skills”<sup>20</sup>***

However, in order to complete the new birth visit competently and completely, research has shown that it is important to do more than communicate with the client.<sup>15,16,17</sup> Rather, it is imperative that the practitioner develops a relationship and maintains it over time.

Moreover, the proficiencies suggest that there are several activities involved in searching for health needs. For example, the focus may be on the individual, groups of individuals or data. Activities relating to these components may be undertaken in isolation or collectively. Again, the proficiencies illustrate that the nurse and SCPHN are able to undertake this area of practice at different levels. For example, the nurse is able to:

***“Use appropriate risk assessment tools to identify actual and potential risks”<sup>20</sup>***

This illustrates that nurses are able to identify risk when using specifically designed risk assessment tools. However, the health visitor is able to adopt a multi-focused approach to searching for health needs as illustrated by the proficiencies gained during the specialist community public health nurse education programme. For example:

***“Undertake screening of individuals and populations and respond appropriately to findings”<sup>19</sup>***

***“Collect and structure data and information on the health and well-being and related needs of a defined population”<sup>19</sup>***

Health visitors have been recognised as the lead professional for the delivery of public health focused child health promotion interventions.<sup>1</sup>

Hall & Elliman also state that it is not possible to provide effective, quality services to children and families if they are based purely on a protocol-driven process.<sup>23</sup>

It is difficult and inappropriate to anticipate the outcome of the new birth visit in advance of its completion.<sup>7</sup> Hence; it is not possible to diagnose the mother and baby as ‘normal’ before the health visitor has made the assessment even if the mother is having a second/ subsequent baby.<sup>7</sup>

## Conclusion

The new birth visit is a significant contact with the mother, baby and the family. It is the time at which information about the mother, child and family must be collected, collated and the content analysed in order to plan immediate and long term actions to meet actual and potential health and social care needs. Research and current health policy state that it is imperative that this important contact is undertaken by a practitioner who has the necessary educational preparation and expertise to complete it safely and competently.<sup>1,16,17</sup> This is a position which Unite/CPHVA is strongly committed to. The research and literature clearly illustrate that this person is the specialist community public health nurse (health visitor). This document has outlined the rationale for this decision by providing:

- An analysis of the characteristics of the education programmes which lead to qualification as a registered nurse and those which lead to qualification as a specialist community public health nurse (health visitor)
- An analysis of the essential features of the new birth visit
- An analysis of the rationale for achieving the essential features during the new birth visit
- A review of the research and literature that illustrates the way in which the essential features of the new birth visit can be met and the outcomes that can be achieved.

Health visitors in practice must take care to ensure that they are able to justify the actions and the non actions that they take in practice in order to work within the Nursing & Midwifery Council's Code of Professional Conduct and thereby be accountable to the profession, the employing organisation, the regulator and their colleagues.<sup>9</sup>

It is anticipated that the information within this document will provide health visitors in practice with the necessary building blocks to develop a response to calls from managers and commissioners to delegate the 'normal' new birth visit to community staff nurse members of the health visitor team.

## Recommendations

1. The health visitor must work within the realms of the Nursing & Midwifery Council's Code of Professional Conduct and is accountable for the tasks that s/he delegates to junior members of the team irrespective of the instructions which s/he receives from managers/commissioners. For this reason the health visitor must be able to justify the actions and the non actions that s/he takes in practice. It is not sufficient defence to state that the task was delegated in line with the organisation's instructions.<sup>9</sup>
2. Health visitors and community staff nurses must have a clear understanding of their skills and knowledge and be able to articulate this to managers and commissioners in order to help them understand the tasks that can and can not be delegated when providing evidence based, safe and quality services to clients during the new birth visit.
3. Community staff nurses must work within the realms of the Nursing & Midwifery Council's Code of Professional Conduct and must therefore understand and clearly articulate the ways in which they are working in a responsible and accountable way within the health visitor team. Therefore they must be able to justify the rationale for taking on the new birth visit in terms of the skills and knowledge they have, and are able to use, in practice. It is not sufficient defence to state that the task was accepted in line with the organisation's instructions.<sup>9</sup>
4. Health visitors must take steps to be actively involved in the discussions about service design and delivery especially where this impacts on their professional accountability and the regulatory status of the profession. It is not sufficient to merely choose not to engage with unfavourable organisational and operational change that is taking place.
5. Service reviews and operational changes must be based on evidence from research and the literature in order to ensure that service provision is safe and appropriate for the client group.
6. Service development projects which assert that the new birth visit can be classified as 'normal' in advance of it taking place are incorrect, inappropriate and unsafe, and should not be part of current evidence based practice.
7. The new birth visit is an important contact for mothers, children and families following the birth of a baby and the needs presented during the visit may be different each time it takes place. Therefore new birth visits to mothers who have had a second and subsequent baby should not be classified as 'normal' until the visit has been completed.
8. The label of 'normal' can not be allocated to the new birth visit for a client (mother, child, family) who has had more than one baby in the absence of further essential information. Hence the label of 'normal' should not be allocated to visits in the absence of other essential information.
9. The new birth visit is the time at which information is collected, collated and analysed in order to make a decision about the service to provide, and the timescale for provision. Managers and commissioners must be helped to identify the complex nature of the information collected at this time and the need to obtain this information in order to successfully meet the health and social care needs of the client.
10. Health visitors must take steps to actively engage with the research and literature in order to keep up-to-date with developments in relation to the new birth visit. Hence this professional briefing should be used as a starting point and not the only source of evidence to support engagement with managers and commissioners.

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