**Paper 3. The health visitor contribution to the parent/health visitor relationship.**

**Abstract:** This paper, the third in a series of five, presents selected data from a qualitative study undertaken to identify measureable indicators of the parent/health visitor [HV] relationship. This paper focuses on the HV contribution to that relationship. Data from both HVs and parents reveal the importance of the HVs qualities, characteristics and their relational skills. These are discussed with reference to existing literature and research. (64 words)

**Key words:** Qualities, Relational skills, Qualitative research, Measurement indicators

**Introduction**

This is the third paper in a series of five, about research to develop an instrument to measure parent/HV relationships. It reports findings regarding HVs’ contributions to those relationships in terms of qualities, characteristics and relational skills, and discusses them in the context of published literature. Bidmead et al, (2015) reviewed measures used in non-health visiting, helping relationships and argued for a specific parent/HV relationship measure. Measures in other professions were developed on well-founded theories of helping relationships, to inform the selection of measurement indicators, so qualitative research was undertaken to further understand and develop a theoretical framework of parent/HV relationships. Bidmead et al (2016) reported findings about the parents’ contribution to parent/HV relationships from that study.

**Methods**

This qualitative research aimed to identify observable indicators and a theoretical framework for the planned instrument. Striving for an objective tool may appear to reduce the phenomenon of the parent/HV relationship in a way that detracts from the deeper meaning of ‘relationship’. However, the measure is not the relationship itself, simply and indicator of it. The methods were detailed in Bidmead et al, [2016]. In brief, stimulated recall interviews were carried out separately with each of the six health visitors/parent dyads recruited in a multicultural, deprived, urban community [Table 1]. The interviews were analysed thematically using NVivo [QSR version 8]. The analysis was confirmed in discussion with one group of HVs [n=7] and one of parents [n=3].

Further analysis revealed rich data about the HV contribution [qualities, characteristics and relational skills] to the relationship with parents, reported below.

[Insert Table 1 here]

**Qualities and Characteristics**

Nine qualities and characteristics, described below, were identified by HVs and parents in this study. Table 2 summarises similarities and differences in emphasis and terminology between the two groups and in previous literature.

[Insert Table 2 about here.]

Parents valued HVs *technical knowledge*, recognising it as evidence-based. HVs too valued this knowledge as part of their professional role.

[HV4]…. She'd obviously been having some discussions with them [family] and often that is a topic [weaning] where clients have had input from family and friends but we're [HVs] able to bring more recent and up-to-date, research-based advice and so…… That’s an example of where I’d see health visiting being different because of that evidence-based knowledge.

Sound advice given by an experienced, knowledgeable HV, helped to build trust and strengthen the relationship.

*Empathy* also seemed central, although only one HV actually named it as an important quality. Others showed it whilst discussing and explaining parent’s concerns and difficulties, demonstrating it by their facial expressions and words they used. This was important in terms of identifying observable indicators.

Empathy involves ‘trying to understand’ (Davis et al, 2002), which may be particularly difficult if parents are from other cultures or their first language is not English. Whilst the effort of trying to understand may suffice for relationship building, this element was only identified in the HV data. Parents may have been unaware that HV’s struggled at times.

Parents greatly appreciated HV’s empathy, calling it ‘understanding’, and finding it a relief to talk because they felt understood.

HV *availability* by telephone was important to parents and HVs especially during relationship development when parents were less confident. Parents with questions particularly appreciated feeling comfortable enough to phone in so HVs had to be *approachable*.

[P4] She's gave me her phone number so I could speak to her if I've got any questions, I could phone her up and that, which is good because I do feel like I could actually phone her.

HVs felt they needed to be *honest* with parents about the organisational constraints affecting their relationships. One HV was careful to explain to parents that they would not see her at the clinic that they attended.

One Parent wanted a relationship with the HV where she could be ‘brutally honest [P1]’; that the HV was outside her normal circle of family and friends made this possible allowing her to explain when she disagreed with HV advice.

Parents seemed sensitive to the *genuineness* of HVs concern and appreciated that HVs seemed ‘genuinely interested’ in them and their babies.

*Respect* is complex (see Table 2) but for HVs and parents in this study it incorporated a *non-judgemental attitude, interest in the parent, politeness, praise, punctuality and flexibility of approach*.

A *non-judgemental attitude* differentiated HVs from friends and family enabling, parents to feel comfortable enough to express their needs. One parent reported that with her first child she had post-natal depression but she was unable to reveal it. With the second child the HV’s non-judgemental approach was crucial to obtaining the necessary support.

[P4] ….it’s important that you don't feel like you're being judged and that they're there to help you rather than them to criticise, which is really good.

HVs demonstrated respect when they were *interested* in parents and their families, not just the baby, helping raise parents’ self-esteem.

HVs respected parents for the struggles they had to face, their views and opinions. For example, when visiting a postnatally depressed, mother [P5] struggling with social isolation and visa problems, the HV expressed her admiration of her ability to care for her son so well.

Although parents did not speak about the HV respecting them, one parent spoke of the HV’s *politeness* as affecting her ability to be open. Where HVs failed to introduce themselves and there were punctuality difficulties, for example, there was potential for relationship break-down.

On the other hand, HVs demonstrated respect by being *reliable*, returning phone messages and doing what they said they would, aiming to build trusting relationships.

[HV 3] Any time she's made calls or left messages for me to contact her I've always followed things up; ….. whatever is necessary for her and see that through and that way, you know, shows reliability so then she knows that she can trust me. I think that if you let her down by not following on, that would have an effect on the relationship.

The HVs tried to be *flexible* about arrangements for home visiting, for the parents’ convenience. They used professional judgment about levels of support needed in spite of organisational constraints about the number of visits to deliver in an area of deprivation. They also demonstrated flexibility when advice giving, affirming parents’ decisions unless there might be adverse effects on the child.

When HVs *praised* parents for their child care, parents felt respected, building their confidence, feeling that the HV trusted them with their child.

HVs felt the ability to *trust* the parent was important to the relationship, which parents were also aware of.

[HV2] Well, I suppose, because I felt she was taking on board what I was saying I knew she would come back, I knew she wouldn't just drop out of the system so ‘cause that's another thing I'm always thinking about. Can I trust this person to come to the baby clinic and get the six weeks check done and the immunisations? So there's trusting in there.

HVs also spoke of distrusting some parents, particularly those with mental health or child protection issues. They realized that distrust could potentially damage their relationship, causing difficulties. For example, knowing that the HV distrusted her, one mother avoided her by attending different clinics and the father was aggressive towards the HV at home visits, making it very hard to continue to offer a service.

A *calm, gentle* approach seemed to relax parents enabling them to speak easily of their difficulties and unafraid to express their concerns.

[P1] And I don’t think anything would faze her and she’s just completely calm and that whole kind of personality just makes me think that it’s ok I can say anything. I think it’s her manner as well she’s really kind of gentle.

Parents identified *caring* as essential quality in the relationship.

[P6] She obviously takes good care of you and the situation you're in.

HVs caring for the parent and the parent’s whole situation might include other family members, and the amount of social support available through friendships or local community groups.

HVs demonstrated their care of parents, speaking about their *motivation to help* them in any way that they could, for example by listening to the parent’s story and showing they felt a need to provide solutions to difficult situations.

[HV1] I really wanted to do something for her to sort of sort this baby who was crying a lot …I wanted to help her in some way. I wanted to do something positive for her that she could go away with today that would help her through the next week.

Parents wanted HVs to be ‘*friendly*’ towards them.

[P4] I think it’s just that she's friendly as well which is nice like, cause you can get some people that come and they’re just doing their job and they’re not really there for any other reason .... But I feel that she was trying to make you feel better…

HVs, likewise, spoke about trying to make themselves ‘*approachable*’so parents would contact them if they needed help.

### Qualities and characteristics: Discussion

Many of the nine qualities or characteristics identified by HVs and parents as important to their relationships were found in the literature but some were not or appeared in novel guise in this study. The HVs’ calmness and gentleness were deemed important, as were their friendliness, sense of humour and trust in parents. Also, most literature about building trust in relationships refers to the client’s trust in the helper rather than the other way round. This study showed mutual trust in interactions when there were good relationships between HVs and parents.

A concept analysis of partnership working in health visiting (Bidmead and Cowley 2005) drew attention to the qualities of respect, genuineness, humility or acknowledgement of personal limitations, warmth, quiet enthusiasm, empathy, friendliness and approachability. Most of these were confirmed by this present study with the exception of humility and warmth.

HVs’ knowledge and experience were the overriding characteristics that parents highly valued (Russell and Drennan 2007). Confirming previous research findings, this knowledge was both experiential and professional (Collinson and Cowley, 1998; Plews et al, 2005) and parents felt it was unavailable to them elsewhere.

HVs’ respect for parents was demonstrated by being punctual, trying to arrange visits at the parent’s convenience, being polite, praising and encouraging parent decision-making. However, being non-judgemental was the essence of respecting parents as identified in previous research (Normandale, 2001; McIntosh and Shute, 2006). In a study of Canadian public health nurses, many mothers were ambivalent about receiving home visits, fearing being judged as failing or inadequate (Jack et al, 2005). Similarly, in the Oxford intensive home visiting study parents thought HVs were only there to check ‘you are keeping your kid properly fed’ (Kirkpatrick et al, 2007).

Support for parent decision-making was also a critical factor in demonstrating respect, reflecting previous research findings in building parental confidence through empowerment (McNaughton, 2000). Being respectful of parental autonomy and control needs, politeness, praising them and arranging visits according to parental convenience have been identified as being instrumental in gaining access to parents (Luker and Chalmers, 1990).

Reliability was an important factor in the development of parental trust (Jack et al 2005). The HVs demonstrated this by returning telephone calls, by being available should problems arise, by the HV’s flexibility to home visit when necessary, being non-judgemental, giving sound effective advice and continuity of contact. The importance of trust in a relationship has been explored in health visiting literature but there has been little written about HVs’ abilities to trust parents.

HVs’ abilities to trust parents and be friendly could possibly be coloured by their constructs and stereotypes when faced with a particular kind of parent. Previous experiences of encounters with teenage mothers, for example, may replay in their minds and unconsciously influence not only the relationship but also the service offer made (Chalmers, 1992). In this study HVs were aware of this possibility and endeavoured to avoid stereotypical approaches.

When parents experienced HVs as interested not only in babies but also in themselves, they reported feeling respected, important and their self-esteem grew. Kirkpatrick et al (2007) also found this led to the building of positive relationships.

Gentle, caring HVs enabled parents to speak freely. Pearson (1991) also found such an approach useful during the early months of parenting. As time progressed and mothers became more confident, then HVs withdrew. The majority of parents in this study were in early parenthood and had experienced the HV as caring. This caring approach was also found by Cowley (1991) as crucial to the ‘opening up’ of otherwise ‘closed’ conversations.

The HV needed to be honest and genuine in family interactions, demonstrating interest and caring, adopting a non-judgemental attitude, enabling parents to confide in her. Parents learnt to trust the HV and the relationship was enhanced where HVs could trust parents, although this may not always be possible. Their friendly approach and calmness, empathy and understanding were all qualities that parents greatly appreciated.

**Relational skills**

Helper qualities and characteristics can be demonstrated through a large set of relational skills, which have been described in the helping literature generally (Carkhuff, 2000; Davis and Day, 2010; Egan, 1998; Rogers, 1959). [Table 3]

[Insert Table 3 about here]

*Listening* was the most valued skill for both HVs and parents considered crucial for helping.

[HV1] It was the listening that was helping her and that maybe not advising her on every single thing that she was saying, I think, to let her continue to talk as long as she wanted to really.

 [P5] My partner he doesn't care to listen .... I told him, ‘he talks and I don't talk’ and he talks too much and I can't say everything that I want …….[but with HV] I can say what I want and she doesn't say what to do. She can listen and another person can't...

The ways in which HVs responded to parents demonstrated attentive listening and this was also confirmed in the parent group data.

For parents it was important for the relationship that HVs *remembered* who they were and may be linked to HVs being attentive.

[P1]…she seemed to kind of remember me and what I told her last week and she knew that I had seen a cranial osteopath .... She remembered some of the problems that we’d had with the feeding, …… and I think that’s a really kind of important attribute actually is that you can remember people’s stories because then, because I know health visitors must see so many people…….and they remembered you and that’s really good ….

HVs too considered this a crucial skill in maintaining their relationships with parents. They were keen to give parents a sense of continuity of care by remembering who they were even though they sometimes struggled. They tried to give parents the feeling that they were important individuals and the attention they received was unique to them.

Both HVs and parents identified some *skills of exploration*, although not the same ones. Parents spoke about HVs’ use of *‘open questions’* and *‘silence’.* HVs did not identify these basic skills but spoke of the skills of, *‘encouragement’, ‘following the parent’s lead’, ‘giving parents time’, ‘observation’* and *‘open body language’*

Parents identified *open questioning* as a key skill used by HV’s, enabling them to talk about their problems. They found it made them want to reveal more about themselves.

[P1] It’s her questioning; maybe it’s all the open-ended questions that makes me want to give a bit more than you would with other questions and stuff.

For another parent it was the *silence* between the questions that she found useful in helping her identify her concerns.

[P2] I suppose in some ways it's the silence between the questions and the asking if you're ok that you're then able to fill with your own concerns.

HVs were actively *encouraging* by being positive about what parents were doing, nodding and listening carefully.

[HV1] I hope that I was encouraging her to keep going if she wanted to.

HVs suggested that routine work might mean that the same information is repeated to parents without regard to their individual needs. They avoided this pitfall by *following the parent lead,* addressing issues they raised.

 [HV3] I was very aware of the fact that I do an eight-month check so often not to kind of give spiel about eight month but to do it in a systematic way and go along with the mother and baby and whatever she comes up with…..

HVs were cognisant of the time parents needed to tell their stories. Although this could be problematic they tried to organise work to *allow time* in clinic, or if necessary, make a home visit.

[HV 3] I don't interfere with what they're doing or try to rush her because ..., I feel, you know, it makes her nervous and erm whatever speed they do it in, not rush her, so I just chatted to the baby whilst she was doing that, rather than just in silence standing back waiting, which would make her even worse and more nervous….

HVs also *observed* what was happening during parent/child interaction and their own interactions with parents noticing body language, and particularly facial expression.

[HV1] She was explaining that very well and she likes that, I think, by the expression on her face, she does lighten up a little bit when she says that.

HVs were also aware of the way in which their *body language* conveyed information to the parents and children. They were aware that they needed to make eye contact with parents to indicate they were listening to them. Form filling at the new birth visit could detract from giving full attention at a time when HVs were trying to get to know them.

[HV grp. D] You don’t actually know your clients and it’s impossible to do a full assessment at that new birth visit because of the bureaucracy, you know the forms to fill in, the children’s centre form so you’re hardly making eye contact at times you know and erm…

Where the HV appeared on edge and not quite relaxed the parent was unable to build a relationship with her; the HV’s body language set the parent ill at ease and made her feel uncomfortable. Her *tone of voice* was also of particular importance.

[Parent Grp. C] …you want it to be confidential, to be friendly, if someone’s barking information at you or asking things in a pitying way because you look a bit distressed because you just had a baby you get a bit fed up.

HVs described how building relationships with parents over time allowed them to explore more sensitive issues such as domestic violence, which could not be covered at a first meeting. There were difficulties with this where work constraints meant they were unlikely to meet parents more than once.

 [HV grp. K]. I think sometimes that’s part of the problem with not being able to do offer the follow up because some of the things you see at one visit you want to address but you know a lot of the time you would try and address that later on down the line wouldn’t you? Because you cannot do it all in one visit and it’s not fair to the clients either ……

*Giving information* was one of the simplest ways in which HVs invited parents to change. Parents identified the importance of personalised advice to meet their individual needs as important in their relationships with HVs.

[P3] When he had the eczema, she was very specific about him she wasn't reading from a sheet, you know, none of your bog standard stuff, it was very specific to him and I had her attention and she followed it up.

When speaking with parents, especially when addressing something that might be seen as challenging, HVs tried to remain respectful of the parent’s choices.

[HV grp. N] If they have a problem and they’re doing something which isn’t too correct it’s how you address that without putting them down, you know it’s about going around and saying how can we do it this way or something. You know you approach it without undermining them.

### Relational skills: Discussion

In this study HVs demonstrated a range of relational skills helping them establish relationships with parents, explore their needs, and to change as necessary. They understood the value of allowing parents to tell their stories by listening closely to content and feelings that may have been expressed non-verbally. Active listening, where the HV hears what the parent says and responds to the meaning, content and feelings, helps parents feel valued and respected (Kirkpatrick *et al.* 2007). This facilitates parents’ exploration of their health needs as they see them, whilst also building relationships based on trust and respect. Moreover, it facilitates a deeper exploration of the parent’s world so there is more likelihood of developing a shared understanding of their problems, goals and aspirations. This study reflects the findings of other authors with regard to active listening (Cody, 1999; Bidmead et al, 2002; Bidmead and Cowley, 2005; Russell and Drennan, 2007).

The ability to ‘give parents time’ may be linked to how well HVs listen to parents. Giving time was important in building relationships in the Oxford intensive home visiting study (Kirkpatrick et al, 2007). The present study, found HVs could only give time, away from busy clinics, in the home environment. Often they gave parents more time than their organisations stipulated, because they felt their work and relationship would suffer if they did not; a strategy that has been found in other research (Condon, 2011).

When engaged in exploring the parent’s situation HVs tried to be led by the parent. The studies by Machen (1996) and Normandale (2001) revealed that parents find HVs most acceptable when they are most responsive to parent-determined need and are prepared to engage in relevant discussion. Pre-determined needs assessment, particularly using structured health assessment tools, have been found to be unhelpful (Mitcheson and Cowley, 2003).

Body language is an important element of any interaction and accounts for about 65% of communication (Pease, 1997). This is particularly true for communicating empathy (Caris-Verhallen et al, 2000). Body language was also identified as important by Jack et al (2005), whose study showed that public health nurses needed to nod in encouragement, smile, and give parents time thus beginning to create an atmosphere where both participants could be completely open with each other. In this study, HVs were aware of the communication of their own body language, especially when they felt their ability to make eye contact was compromised. However, during home visits they were able to focus their attention on the parent’s body language - particularly the facial expression - adding the information to their knowledge of how a parent might be feeling, echoing the findings of Zerwekh (1991).

Home visiting has the propensity to create the environment for difficult issues to be discussed, possibly leading to the identification of needs (McIntosh and Shute, 2006). However, even where the HV is a regular home visitor and relationships are positive, domestic violence may not be revealed (Peckover, 2003). Other difficult and sensitive issues may also go unaddressed because of lack of time and HVs inability to do more than one visit.

Giving advice and information without undermining the parent is a skill of challenging parents to change. HVs need to address infant care which is less than optimal, inevitably putting the relationship at risk as directive approaches are demonstrated to impact relationships negatively (Elkan et al, 2000; McIntosh and Shute, 2006). It is often the families who are most at risk with whom the HV has to make the greatest efforts at making a connection (Marcellus, 2005) and yet if the relationship is strong enough it can even survive a referral to social services (Kirkpatrick et al, 2007). In this study, HVs described avoiding ‘stereotyped advice’ (Kendall 1993) by tailoring information to specific family needs and avoided ‘unsolicited advice’ (Mitcheson and Cowley 2003) by listening carefully and following the parent’s agenda.

**Conclusion**

This study began before the HV Implementation Plan (DH2011) expanded the workforce. In the research sites HVs were under pressure to restrict the universal service to just one new birth visit, most often continuing to visit only those families in greatest need.

Positive relationships can be established when parent and HV qualities and skills combine to form the parent/HV relationship. Working with parents to address their perceived needs taking a non-directive approach appears to enhance relationships, helping parents build trust and confidence in HVs. However, this can only happen if HVs have sufficient time to devote to the, sometimes time-consuming, activity of building relationships with parents.

The aim of identifying observable, active constituents of parent/HV relationships was achieved, revealing indicators for the planned measures of parent/HV relationships. The in-depth analysis produced rich data covering HV and parent qualities and skills, also revealing the impact of organisational issues. Practitioners and parents both identified that these affected their abilities to use their relational qualities and skills effectively. These issues will be the focus of the next paper in this series. (4,200 words)

References

Bidmead C, Cowley S, Grocott P (2015) Investigating the parent/health visitor relationship: Can it be measured? *Journal of Health Visiting 3 (10) 548-558*

Bidmead C, Cowley S, Grocott P (2016) The parent contribution to the parent/HV relationship. *Journal of Health Visiting (in press)*

Bidmead C. & Cowley S. (2005) A concept analysis of partnership with clients. *Community Practitioner* **78**(6), 203-208

Bidmead C., Davis H. & Day C. (2002) Partnership working: what does it really mean? *Community Practitioner.75(7):256-9, 2002 Jul.(20 ref)*(7), 256-259

Bidmead C (2013) Appendix 1. Health Visitor / Parent Relationships: a qualitative analysis. In Cowley S et al. Why health visiting? A review of the literature about key health visitor interventions, process and outcomes for children and families. http://www.kcl.ac.uk/nursing/research/nnru/publications/Reports/Appendices-12-02-13.pdf

Caris-Verhallen W. M. C., Kerkstra A., Bensing J. M. & Grypdonck M. H. F. (2000) Effects of video interaction analysis training on nurse-patient communication in the care of the elderly. *Patient Education & Counseling* **39**(1), 91-103

Carkhuff R. (2000) *The Art of Helping*. 8th ed. Human Resource Development Press, Inc., Amherst, Massachusetts.

Chalmers K. I. (1992) Giving and receiving: An empirically derived theory on health visiting practice. *Journal of Advanced Nursing* **17**, 1317-1325

Cody A. (1999) Health visiting as therapy: a phenomenological perspective. *Journal of Advanced Nursing.* **29**(1), 119-127

Collinson S. & Cowley S. (1998) An exploratory study of demand for the health visiting services within a marketing framework. *Journal of Advanced Nursing* **28**(3), 499-507

Condon L. (2011) Do targeted child health promotion services meet the needs of the most disadvantaged? A qualitative study of the views of health visitors working in inner-city and urban areas in England. *Journal of Advanced Nursing* **67**(10), 2209-2219

Cowley S. (1991) A symbolic awareness context identified through a grounded theory study of health visiting. (How health visitors identify which approach to use within a particular situation). *Journal of Advanced Nursing*, p. Jun-656

Davis H. & Day C. (2010) *Working in Partnership: The Family Partnership Model* Pearson Education Ltd., London.

Davis H., Day C. & Bidmead C. (2002) *Working in Partnership with Parents: The Parent Adviser Model* The Psychological Corporation, London.

Department of Health (2011) *Health Visitor Implementation Plan: a call to action 2011-2015,* COI, London

Egan G. (1998) *The Skilled Helper: a Problem-Management Approach to Helping*. Book ed. Brookes/Cole Publishing Company 1998, London.

Elkan R., Kendrick D., Hewitt M., Robinson J. J. A., Tolley K., Blair M. & et al. (2000) The Effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. *Health Technology Assessment* **4**(13)

Jack S., DiCenso A. & Lohfeld L. (2005) A theory of maternal engagement with public health nurses and family visitors. *Journal of Advanced Nursing* **49**(2), 182-190

Kendall S. (1993) Do health visitors promote client participation? An analysis of the health visitor-client interaction. *Journal of Clinical Nursing* **2**, 103-109

Kirkpatrick S., Barlow J., Stewart-Brown S. & Davis H. (2007) Working in Partnership: User Perceptions of Intensive Home Visiting. *Child Abuse Review* **16**, 32-46

Luker K. A. & Chalmers K. I. (1990) Gaining access to clients: the case of health visiting. *Journal of Advanced Nursing* **15**(1), 74-82

Machen I. (1996) The relevance of health visitng policy to contemporary mothers. *Journal of Advanced Nursing* **Vol 24,** 350-356

Marcellus L. (2005) The ethics of relation: public health nurses and child protection clients. *Journal of Advanced Nursing* **51**(4), 414-420

McIntosh J. & Shute J. (2006) The process of health visiting and its contribution to parental support in the Starting Well demonstration project. *Health & Social Care in the Community* **15**(1), 77-85

McNaughton D. B. (2000) A Synthesis of Qualitative Home Visiting Research. *Public Health Nursing* **17**(6), 405-414

Mitcheson J. & Cowley S. (2003) Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool. *International Journal of Nursing Studies* **40**, 413-426

Normandale S. (2001) A study of mothers' perceptions of the health visiting role. *Community Practitioner* **74**(4), 146-150

Pearson P. (1991) Client's perceptions: the use of case studies in developing theory. *Journal of Advanced Nursing* **16**, 521-528

Pease A. (1997) *Body Language*. 3rd ed. Mackays of Chatham, Chatham, Kent.

Peckover S. (2003) 'I could have done with a little more help': an analysis of women's help-seeking from health visitors in the context of domestic violence. *Health and Social Care in the Community* **11**(3), 275-282

Plews C., Bryar R. & Closs J. (2005) Clients' perceptions of support received from health visitors during home visits. *Journal of Clinical Nursing* **14**(7), 789-797

Rogers C. (1959) A theory of therapy, personality and interpersonal relationships as developed in the client centered framework. In *Psychology: A Study of a Science* (Koch S., ed.) McGraw-Hill, New York, pp 184-256.

Russell S. & Drennan V. (2007) Mothers' views of the health visiting service in the UK: a web-based survey. *Community Practitioner* **80**(8), 22-26

Zerwekh J. V. (1991) Tales from public health nursing. True Detectives. *American Journal of Nursing* **91**(10), 30-36

|  |  |  |
| --- | --- | --- |
| HV1 | HV with over 20 years experience  | HV family partnership trained.  |
| P1 | First time mother with 3 week old breast feeding baby who wants to feed constantly |  |
| Location | Breast Feeding Cafe |  |
| Researcher notes | Articulate, professional woman very able to speak about her relationship with HV.  | HV took care of baby whilst interview took place |
| HV2 | HV with 15 years experience | Family partnership trained.  |
| P2 | Breast feeding first time older mother. Has had mastitis.  | Baby present during interview |
| Location | Home visit |  |
| Researcher notes | Articulate mother, former TV producer.  | Mother recruited HV to study. I  |
| HV3 | HV with over 20 years experience  | Family partnership trained. Practice teacher soon to retire |
| P3 | First time Irish mother married to an older man attending appointment with HV for 8 month developmental review. Baby has history of eczema.  | Baby present at interview |
| Location | Clinic room |  |
| Researcher notes | Interaction took place in clinic room but no other people were present  |  |
| HV4 | HV qualified 6 months  | Not family partnership trained. Experienced former paediatric nurse |
| P4 | Second time mother living in council block flat. Baby 6 weeks old [mixed race]. Follow up visit from new birth. Mother has previous history of post-natal depression. HV does Edinburgh post natal depression score. Feeding and weaning advice sought and given.  |  |
| Location | Home visit |  |
| Researcher notes | Needed to keep interview short as mother needed to collect her older son [9 years] from primary school.  | Baby present at interview |
| HV5 | HV with over 20 years experience | Family Partnership trained.  |
| P5 | 27 year old Lithuanian, first time, mother with 13 month old baby boy. Mother has post-natal depression and some difficulties with her partner relationship. HV does listening visit. |  |
| Location | Home visit |  |
| Researcher notes | Mother shy at first and not sure that she wanted to be videoed. She agreed when reassured about confidentiality. At interview did not want to see herself on the video. Happy to be interviewed without the reminder of the video. English not her first language but managed to express herself well with regard to relationship with HV. | Baby present at interview.  |
| HV6 | HV 2 years trained  | Not Family Partnership trained. An experienced paediatric nurse who had, prior to HV training, worked on local neonatal intensive care unit.  |
| P6 | Mixed race mother [European/ Caribean] attending the clinic her daughter’s 2.5 year developmental review with HV. Pre-term birth with respiratory problems. Mother also has health problems |  |
| Location | Clinic room |  |
| Researcher notes | Very articulate mother happy to talk about her relationship with HV.  | Child present at interview but played quietly.  |

### Table 1. Participants in Qualitative Study

|  |  |  |  |
| --- | --- | --- | --- |
| **Qualities and characteristics**  | **Prior definitions or descriptions**  | **Identified in current study** | **Identified by parents and/or health visitors?** |
| Technical knowledge  | Professional knowledge and expertise (Collinson and Cowley, 1998; Plews et al, 2005; Russell and Drennan 2007) | Professional knowledge, experience and evidence base | Knowledge and experience (both) |
| Empathy  | Involves ‘trying to understand’ (Davis et al 2002) | Identified by parents as HV ‘being understanding’ | Empathy and understanding (both)Trying to understand (HVs) |
| Availability, approachability |  | Availability, being approachable.  | Availability and approachability (both).  |
| Genuineness, honesty  |  | Honesty and genuineness – parents valued HV being ‘genuinely interested’ in whole family, not just baby | Genuineness, interest, honesty (both) |
| Respect  | Valuing of the other, thinking positively and constructively about them no matter their problems, background or present circumstances (Davis and Day 2010) | Being non-judgemental, polite, punctual, reliable and interested. Flexible approach (e.g. about arrangements to visit). Praise. | Respect – polite, punctual, praise (parents)Trust in parent, flexibility (HVs) |
| Trust | Reliability (Jack et al 2005) | Trust on both sides important; HVs’ trust in parent identified as central.  |  |
| Calm, gentle |  | HV being ‘calm and gentle’ was valued by parents | Parents |
| Caring | Quiet enthusiasm (Davis and Day 2010) may be similar to ‘caring with motivation to help.’ Explicit caring to open otherwise closed conversations (Cowley 1991) | Caring – making explicit caring for parent, wider family and community | Both |
| Friendliness | Humour as a means of negotiating sensitive topics (Warner 1984) | Being friendly. Sense of humour. | Friendliness (both)Sense of humour (HV) |

**Table 2 HV Qualities and Characteristics**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relational Skills**  | **Prior definitions or descriptions**  | **Identified in current study** | **Identified by parents and/or health visitors?** |
| Active Listening  | Attentive listening (Davis & Day 2010) comprises a skill set that lets the client know that they are listened to including summarising & reflecting back. (Rogers, 1959; Egan 1998; Carkhuff, 2000; Davis and Day, 2010.) | Listening and responding to meaning content and feelings of the parent’s story. | Both |
| Remembering  |  |  HVs wanted to remember parents to give them a sense of continuity of care. Parents wanted HVs to remember who they were and their stories | Both.  |
| Exploring: | Comprises a skill set that ‘helps clients tell their story’(Egan 1998) | * Open Questions
* Silence
* Encouragement
* Following

parental lead* Giving parents time
* Observation skills
* Body language
 | HVs identified all skills except silence.Parents identified open questions, silence that particularly helped them tell the HV their problems. |
| Challenging | Helping parents to change when necessary (Davis and Day 2010) | Giving advice and information tailored to need. Avoiding stereotypical advice. Avoiding giving unsolicited advice. | Parents |

**Table 3 HV Relational Skills**