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The evidence base for individual patient and client assessment by community nurses*

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There is wide recognition that patient and client assessment by community nurses is central to the provision of high quality care. It is also acknowledged that assessment in the home setting is a complex process requiring a wide range of knowledge and skills. This article identifies two distinct approaches to assessment that have emerged in different contexts around the world. These approaches comprise the formal, structured questionnaire-based assessment that has been developed particularly in response to the requirement to determine service eligibility and the informal, conversation-based assessment that draws on nursing concepts and theories. The article briefly traces the professional and policy influences that have shaped the development of these two approaches before turning to a critical analysis of selected empirical work that has examined their effectiveness. Research undertaken on the structured form of assessment has focused largely on issues of reliability. While the majority of studies indicate that this form of assessment is reliable in identifying patient need, some research highlights its failure to take account of patient and client perspectives. This raises questions about the appropriateness of the nursing interventions that are planned in response to a structured assessment. Less research attention has been devoted to exploring the conversation-based approach to assessment, but this body of work has drawn attention to the potential for practitioners to adopt a controlling influence over the assessment process. Reference is made to research in which the author has collaborated that illuminates the way in which two styles of conversation-based assessment impact differently on patients and clients. The article concludes by identifying the need for further research and argues that a key focus should be the ways in which assessment contributes to care planning and patient outcomes.

Key words: assessment tools; client assessment; patient assessment

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Introduction

This article analyses and critiques the evidence base for individual patient and client assessment by district nurses and health visitors. These two groups have been selected because they play a key role in assessing the health care needs of people living at home. The article focuses on two distinct approaches to assessment and will first of all explore their development in light of both professional and political or organizational influences. The article goes on to outline the principles or theories that underpin the two approaches before examining the evidence for their effectiveness. Finally, the article will discuss the implications for community health nursing. While it is recognized that the concept of 'need' is socially constructed and that there is considerable debate about its

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contested nature, it is not the intention here to enter into that discussion (Cowley *et al*., 1995; Parry-Jones and Soulsby, 2001).

The importance of individual patient and client assessment is widely acknowledged (Cowley *et al*., 1996; Vernon *et al*., 2000). A key UK policy document stated that 'assessment' is the 'cornerstone of good quality care' (Department of Health, 1989). Community nursing assessments are no exception and include gaining information about and an understanding of the physical, psychological, social, family, cultural, economic, and environmental factors that impinge on individuals' well being. This information and understanding must then be integrated with a recognition of patient and carer preferences and a knowledge of local policies and service provision. This complex process is required in order to achieve what Nolan and Caldock (1996) have argued are the three components of assessment namely analysing information, determining care or support needs and relating these to options for intervention or referral. In short, assessment in the home setting is multi-faceted, context dependent and requires a reconciliation of possibly competing priorities. Given its complexity, it is not surprising that there are different approaches to assessment. A quotation from a district nursing textbook published in the UK in 1955 aptly illustrates two recognizable approaches: 'A certain amount of questioning is inevitable at a first visit but, whenever possible, information should be obtained gradually and in conversation rather than by the catechism method' (Merry and Irven, 1955, p. 74).

This comprises the author's only statement on assessment and it is safe to assume that it was based on experiential professional knowledge rather than research-based evidence. The use of the term 'catechism' is unusual as this refers to a system of religious instruction using formal fixed questions. As the two distinct approaches to patient assessment were not clarified, students were left to infer that careful 'conversational' pacing of questions was in some way more productive than reliance on a more formal approach to gathering information. On the basis of Merry and Irven's statement it can be concluded that assessment practice during the 1950s varied considerably. As far as assessment approaches today are concerned, the international literature demonstrates that these two broad models are still used and that a substantial body of empirical work supports the modern equivalent of the 'catechism' approach. It is instructive to examine why and on what basis each of these approaches has been endorsed either by the professions or by the policy community.

Professional influences on assessment practice

Professional influences on community nursing assessment practice include expert educational texts and a wide range of community nursing textbooks that are published globally and that provide a rich source of conceptual and theoretical guidance on assessment (Freeman and Heinrich, 1981; Martinson and Widmer, 1989; Turton and Orr, 1993; Armentrout, 1998; Twinn *et al*., 1998; Clemen-Stone *et al*., 2002; Sines *et al*., 2005). The majority of these texts advocate a comprehensive but reflexive form of questioning that may explicitly or implicitly draw on nursing theory or nursing models (Clemen-Stone *et al*., 2002). There is recognition of a number of key elements in assessment. Some examples include:

> the ability to observe and analyse specific body system functioning, recognize and interpret abnormal findings
> (Lillibridge and Wilson, 1999)

> the role of the nurse patient relationship and the building of trust in facilitating disclosure of concerns, needs and problems
> (Martinson and Widmer, 1989; Clemen-Stone *et al*., 2002)

> the need to take account of patient/client preferences and choice
> (Turton and Orr, 1993)

> the impact of environment and individual circumstances
> (Freeman and Heinrich, 1981; Turton and Orr, 1993; Clemen-Stone *et al*., 2002)

> the significance of the family structure and family roles
> (Armentrout, 1998)

> acknowledging that too many questions may appear intrusive
> (Martinson and Widmer, 1989; Clemen-Stone *et al*., 2002)

> the value of theoretical frameworks that support assessment, for example systems theory, developmental and life-course theory, interactional and communication theory and ecological theory
>
> (Clemen-Stone *et al*., 2002)

Given the complexity of such a process it is not surprising that conceptual frameworks designed to encapsulate and clarify the constituents of assessment have been developed. It is also not surprising that tools in the form of guidelines and protocols have been formulated to assist both students and practitioners to achieve comprehensive assessments. These are of course formalized to a greater or lesser extent within nursing documentation which plays an important role in nurse-to-nurse or nurse-to-agency communication.

It could be argued that frameworks and/or guidelines and any documentation designed to reflect the principles embodied within them, act as a codification of knowledge and theory which provides a cognitive map to support practice. In supporting practice, however, they are not intended to act as a formulaic substitute for the use of communication skills. Indeed many authors expressly recommend that such frameworks and guidelines should not detract from the nurse's reflexive approach to patients and clients and that records are completed away from the home setting so as not to interfere with the nurse's ability to carry out a holistic assessment (Martinson and Widmer, 1998; Clemen-Stone *et al*., 2002).

A related issue is the potential influence on assessment of the nursing diagnosis movement and the use of databases such as the Minimum Data Set (MDS) (Goossen *et al*., 1998; Schumacher and Marren, 2004; www.nanda.org). Of course neither the MDS nor the nursing diagnosis movement focus directly on assessment. But in spite of the fact that new nursing diagnoses are under continual review and now include wellness categories as well as problem categories, the emphasis on problem identification and very detailed documentation requires critical appraisal, particularly in the context of community nursing. The emphasis on problems may serve to divert attention away from the analysis of the causal connections between patient problems, circumstances, individual capabilities, motivations and environment. It is arguably the ability to critically appraise these connections that is fundamental to decision making. Therefore an over-emphasis on problem identification may, inadvertently, compromise community nursing assessment practice (Lützen and Tishelman, 1996). In summary then it appears that professional influences on assessment practice emphasize a number of underpinning principles; assessment requires to be broad based and patient centred, while at the same time there should be recognition that its very complexity demands a codification of its constituent parts in order to promote holism and consistency. This may therefore present community nurses with a cognitive and interactional challenge as they seek to conduct a reflexive patient-centred assessment while at the same time sustaining an awareness of all the possible issues that may need to be discussed.

Political influences on assessment practice

Health care systems around the developed world are all confronting challenges in terms of cost containment, effectiveness and efficiency. Governments' responses to these challenges have a greater or lesser impact on most aspects of professional practice and assessment of the individual patient and client is no exception. It has been argued that political influence over assessment practice first arose in the USA, where in the 1970s and 1980s, the federal government identified and tackled what was seen as unacceptable increases in costs of long term residential care and uncoordinated services (Stalker and Campbell, 2002). The government's response was to introduce care management with a process of assessment of individual need as its essential foundation. The concept of care management was adopted enthusiastically in the UK where Challis and colleagues undertook a series of projects to adapt and test its application in the field of social care in England (Davies and Challis, 1986; Challis *et al*., 1997). Their pilot schemes demonstrated that the system could readily support older people to live at home. The UK government subsequently incorporated care management principles into a key policy document, Care in the Community (Department of Health, 1989) and subsequently into the Community Care Act of 1990 with responsibility being conferred onto social work/services departments. As a consequence, community nurses had to adapt to a change in their level of control over the

assessment process in those situations where patients experienced both health and social care needs (Parry-Jones and Soulsby, 2001). Over the last two years policy influence over the assessment process has continued in the form of the single shared assessment undertaken by either district nurses or social workers with older patients and clients (Torkington *et al*., 2004).

In other parts of the world political and/or organizational control over community nursing assessments can be identified. For example, in the Netherlands Kerkstra and Beemster (1994) reported that there was pressure from health insurance companies for a more structured and objective assessment method for home care. In the USA community nurses are required by various care agencies to complete forms during the assessment process (Armentrout, 1998). In Japan, Shimanouchi and her colleagues undertook work on the creation and testing of an assessment schedule for home visits to patients in order to meet the requirements of a new insurance system (Shimanouchi *et al*., 2001).

The requirement to undertake assessment for service eligibility purposes is thus a feature of community nursing across a number of countries. It is a testimony to government and agency efforts to contain costs, to be accountable for costs and to prioritize service delivery (Parry-Jones and Soulsby, 2001). It has the potential to have a significant impact on the nature of assessment because it requires the use of detailed and highly structured documentation, usually completed during the course of a single visit. This policy or organizationally driven approach is clearly in complete contrast to the professional approach described above and its underlying principles reflect tensions that are familiar to practitioners. For example in the UK, there is an acknowledgement that assessments should be flexible and take account of the individual and their carer's wishes (Department of Health, 1989). However policy intent is that actions taken as a result of an assessment must be determined by the stated objectives and priorities of the local authority (Social Services Inspectorate, 1991). This gives expression to a feature of professional practice with which community nurses are all too familiar. They have always had to reconcile the competing demands of limited resources, patients' and clients' needs and patient and carer preferences, a 'rationing' dilemma clearly spelled out by others (Lewis *et al*., 1995; Wells, 1995; Richards, 2000; Parry-Jones and Soulsby, 2001; Worth, 2001). A key question is how is this process of reconciliation best achieved? Can it be accomplished effectively through the 'catechism' or structured approach to assessment, or by the conversation approach to assessment? Is there evidence to support either of these approaches given the challenges that have been outlined above?

This paper will now focus on evidence derived from empirically based work on assessment, but does not discount the professional arguments for the models of assessment mentioned earlier. As Kendall (1997) and Rycroft-Malone *et al*. (2004) have argued, it is legitimate to draw on a number of sources as evidence for the appropriateness and effectiveness of specific nursing practices.

The evidence base for assessment practice – structured approaches

The structured approach to patient assessment, based on a set of fixed questions, consists of three broad types, generic, specific and targeted. The generic structured approach comprises questions covering a range of physical, psychological, social, and financial issues. The purpose of such an approach is to provide a profile of the current health and illness status of the patient/client as a basis for deciding which services should be provided. It has been associated extensively with the requirement to establish eligibility for services (Slater and McCormack, 2005). The second type of questionnaire-based assessment focuses on a specific problem area such as nutrition, cognitive functioning, risk of pressure sore or depression. Here the purpose is to identify whether a specific problem or health need exists and to assess its severity in order to provide an appropriate intervention. The third type of tool is for the purpose of targeting a service.

Empirical work supporting a generic structured approach to assessment

There is a considerable body of evidence relating to the effectiveness of the generic structured approach to assessment, albeit not all focused on community nursing. For example Challis has long championed this approach to assessment as a basis for care management of elderly people (Challis

et al., 1997). Latterly considerable effort has been devoted to the testing of the MDS which is being developed under the auspices of the ICN (www.icn.ch/matters_i-NMDS_print.htm). Empirical work in this field has been undertaken in Europe and the USA and the benefits of using this tool include not only the assessment of need but also the development of outcome-oriented measures of quality of care (Hawes *et al*., 1995). The MDS used by Hawes *et al*. (1995) with nursing home residents, focused on function but also included resident preferences and normal routines. While the MDS was shown to demonstrate excellent reliability except for the identification of delirium, there was no reported attempt to identify resident responses to the assessment. In further work designed to explore the effects of implementing the MDS, Hawes *et al*. reported that care plans and documentation were more comprehensive (Hawes *et al*., 1997). This finding has been echoed in work carried out in Sweden and the Netherlands where specific mention was made of improved assessment of need (Hansebo *et al*., 1999; Achterberg *et al*., 2001). The benefits of using structured tools have also been demonstrated in Japan in community nursing (Shimanouchi *et al*., 2001). Shimanouchi *et al*. developed an assessment schedule explicitly for eligibility purposes. They demonstrated that an extensive list of questions could be delivered by community nurses in 30–40 min. In their conclusion they state that the assessment sheet covered all the areas that would be regarded as necessary for assessing the needs of home care clients and for developing a care plan. Given that the schedule was adopted by the Ministry of Health it is safe to conclude that it was effective in meeting its purpose from an organizational perspective.

More recently, in the UK, following the publication of the National Service Framework for Older People for England and Wales (Department of Health, 2001), and the Scottish Executive Health Department's Our National Health: a plan for action, a plan for change (SEHD, 2001a; 2001b), the focus has turned to developing single shared assessment by health and social care professionals in the community. The aims of single shared assessment are to ensure that the older person is a key player in the assessment process, that professionals can deliver 'person-centred' care that is appropriate and effective and that the assessment process is rendered more efficient and effective (www.doh.gov.uk/scg/sap). Prolific guidance on the process of single shared assessment and on the use of assessment tools and scales has been provided (Department of Health, 2002, 2004; SEHD, 2001b).

Understandably there is as yet scant empirical work exploring the impact of single shared assessment although some investigators have undertaken preliminary pilot work (Miller *et al*., 2004; Dickinson *et al*., 2005). Some key issues regarding professional use of single shared assessment have been identified and include assessing only areas of need that are relevant to the assessing practitioner's professional practice, difficulty asking questions that are uncomfortable, notably about mental health, occasional lack of trust in assessments undertaken by other professionals and a feeling by some that form filling is too reductionist an approach to assessment (Dickinson *et al*., 2005). These findings are echoed in other work undertaken with both professionals and users which identified benefits as well as challenges in the use of single shared assessment (Christiansen and Roberts, 2005). Clearly this fundamental change in the nature of assessment requires further development and scrutiny.

As the selective review of empirical work has shown, its key focus has been investigation of the reliability of the assessment forms and there is a relative lack of research exploring effectiveness from the perspective of the patient or client. However there is some evidence that the impact of structured tools on users can be equivocal or negative (Callan *et al*., 1995; Cowley *et al*., 1996; Cowley and Houston, 2003). Richards (2000) undertook an ethnographic study of elderly people being assessed for community care. The assessments were accomplished using a relatively short assessment form that provided a 'systematic investigation of activities of daily living, health and well being, support networks and home equipment' (Richards, 2000, p. 42). Study findings showed that the structure of the assessment form precluded gaining an insight into the older person's perspective, failed to capture some of the complexities of individuals' domestic situations and involved some unnecessary questions. Richards also reports that practitioners had difficulty 'managing a process that, instead of enabling them to develop an understanding of the elderly person's needs, could obstruct or distort their view' (Richards, 2000, p. 46).

A study conducted by Mitcheson and Cowley (2003) is also critical of the impact on practice of using a structured assessment tool. They used audio recordings of assessment visits undertaken by health visitors in two areas. Findings showed that on the whole the assessments did not facilitate client participation, there was a predominance of the health visitor as questioner, there were long sequences of unsolicited information giving by health visitors, failure to follow up cues and the interactions overall demonstrated an asymmetry of participation and an interactional style that acted as a barrier to client empowerment and full identification of needs. While this study of interactions was based on a small sample, the findings echo the above-mentioned empirical work.

Empirical work supporting a specific structured approach to assessment

The specific structured assessment form addresses health needs in areas such as nutritional status, mental state, cognitive functioning, pressure sore risk and pain experience. All of these have direct relevance in community nursing and meta-analyses and reviews provide an overview of the effectiveness of such tools in some key areas. For example Green and Watson's (2005) comprehensive review of nutritional assessment tools highlighted the serious problems of under-nutrition and malnutrition among older people in Sweden, Canada and the UK. From a total sample of 71 different tools they studied 35 and while they do not claim that their review was exhaustive and did not constitute a meta-analysis, they report that few of the tools that they reviewed have undergone rigorous testing and that none of the publications reported on the effect on nutritional care of using a tool.

Similar criticisms were made in an investigation of fall risk assessment tools (Myers and Nikoletti, 2003) and potential dangers of assessment tools for the identification of child abuse by health visitors were highlighted by Browne (1995). Defloor and Grypdonck (2005) compared the Braden and Norton pressure sore risk assessment scales with nurses' clinical judgement and found the effectiveness of both scales to be poor although the use of the scales was a better alternative to reliance on clinical judgement alone.

By contrast, as Kendall (1999) has shown, the Edinburgh Post-Natal Depression scale has been found to provide a valid means by which health visitors in the UK and their counterparts in other parts of the world have assessed women at risk. However while the scale has been demonstrated as a useful aid to practice, it has been acknowledged that it is not culturally sensitive.

The range of specific structured tools of potential value to community nurses is enormous and cannot be fully appraised in this article. What is clear from the empirical work described is that scrutiny and testing involves sustained commitment and considerable skills in critical appraisal. If community nurses are to be assisted in developing expert practice in assessing specific health needs in detail they will need more managerial support to undertake such work.

Empirical work supporting a structured approach to assessment for targeting

The process of assessment for the purposes of targeting appears to be a feature more in health visiting than the other community nursing specialities. This has resulted from challenges to the universal nature of the health visiting service. Identifying vulnerable families provides a good example of the challenges that practitioners face and Appleton (1999) has reported on a key study that exemplifies this. She undertook an investigation of the use of guidelines provided to health visitors to assist in the identification of vulnerable families in the community trusts in England. Her findings showed that 63 per cent of trusts issued such guidelines but when critically analysed it was clear that many contained subjective criteria and there was sparse evidence of attempts to establish validity and reliability.

To summarize the evidence for and against the structured approach to assessment it is apparent that a considerable amount of effort is required for the development, testing and evaluation of structured tools. It is important to acknowledge that there are significant challenges associated with undertaking rigorous testing and that it may be difficult to secure funding for such investigations, particularly where organizations and agencies demand swift solutions in their efforts to establish eligibility or the targeting of services. From an agency perspective such tools may be effective in determining eligibility, may lead to better documentation and provide a basis for auditing the quality of care. However in some

areas the tools have not undergone any form of rigorous testing, there still remain weaknesses in terms of reliability and validity. Schedules designed to assess health and care needs of older people and young mothers can fail to take account of their perspectives and result in practitioner dominance of the interaction. Some attempts are being made to address these weaknesses, but very recent work suggests that there are still significant challenges associated with reconciling a structured approach to assessment with the aspiration to ensure genuine patient and client involvement in the process (Houston and Cowley, 2002; Dickinson *et al*., 2005). Given the policy drive in the UK for single shared assessment and the continuing emphasis on the value of structured tools, is there countervailing evidence of the effectiveness or otherwise of the 'conversational' approach to assessment?

The evidence base for the conversational approach to assessment

Until the single shared assessment became mandatory, the conversation model of assessment was widely used in community nursing (Bryans, 1998; Worth, 1999; Kennedy, 2004; Young, 2003). Each of these Scottish based studies exemplifies in different ways the complexity and challenges of assessment. However as Mitcheson and Cowley (2003) have argued, research in the health visiting field over a period of 20 years has demonstrated a number of negative aspects of assessments that use the conversation model. Work by Abbott and Sapsford (1990), Foster and Mayall (1990), Heritage and Sefi (1992) and Kendall (1993) all demonstrate that practitioners can exert a negative controlling influence on the assessment encounter which results in clients ignoring advice. Other work, however, has shown that the conversation approach to assessment can have either a positive or a negative impact on patients and clients, depending on the way in which the community nurse manages the assessment encounter (Bryans, 2000; 2003).

Both of the studies conducted by Bryans used an innovative method of simulation, interview and observation to examine assessment practice (Bryans and McIntosh, 2000). The merit of the approach is that by creating credible and typical cases for simulated assessment, it was possible to identify differences in professional practice by maintaining a consistent set of assessment challenges in the form of patient and client problems. Following detailed analysis of audio-taped assessments and associated interviews, two discernible forms of practitioner interaction were identified: 'patient focused' and 'nurse agenda-led'. In the patient focused approach practitioners adopted an open and reflexive style of conversation, attending carefully to, and following up, cues and statements made by patients/clients. In contrast, the nurse agenda-led approach comprised a structured approach to questioning, as though using a mental checklist. In this approach the practitioners' agenda appeared to dominate, cues were not consistently pursued and patient and client statements not always acknowledged. The majority of study participants were consistent in their use of one or other approaches, but a small minority adopted a blend of both approaches. The significance of these two approaches is that the patient-focused approach was more effective in eliciting information relevant to practitioner interventions. This strongly endorses the professional writings referred to at the beginning of this article that a conversation model that adopts a patient focus is likely to provide a basis for sound judgement and decision making.

Additional confirmation that open questions can promote more effective disclosure of perceived need is demonstrated in empirical work carried out in a nursing home setting (Levy-Storms *et al*., 2002). Three different interview methods designed to assess need were compared. The differences in question design ranged from structured to open-ended. Findings showed that the open-ended approach to the assessment was more effective in providing information necessary for person-centred care.

Discussion

This examination of evidence relating to the two approaches to patient/client assessment provides health and social care professionals working in community settings with a number of challenges. While a structured form of assessment undoubtedly provides agencies and organizations with a speedy assessment of eligibility, some of the tools appear to restrict the breadth of information that practitioners can gather, including patient/clients' views about their concerns, needs, capabilities, and preferences. In much of the empirical work there is

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a focus on the ability of the tool to produce consistent results, rather than its ability to capture needs as perceived by the assessed individual. There is little or no evidence relating to the way in which assessment tools are used to decide on care options, whether these are judged to be appropriate by those receiving the services and whether and how priorities are set. In addition, while more recently those supporting and testing structured approaches to assessment engage to some extent with the principles underpinning the professional writing referred to at the beginning of this article, there remains an emphasis on reliability and meeting criteria set out in policy documents (Slater and McCormack, 2005). This is testimony to the difficulty in achieving true integration between the structured and the person-centred approach to assessment.

It is acknowledged that the policy intent for the single shared assessment process is that it should be person-centred and include user and carer views. The scope of information that requires to be gathered is considerable (Department of Health, 2002; SEHD 2001b). It is too early to judge whether the stated potential of this form of assessment will yield improved identification of need and a degree of involvement that is acceptable to patients and clients. There remains a concern that in the time consuming process of data gathering, the connections and links between the many different data domains may not be drawn out by the assessing nurse. In other words there is a risk that 'need' will remain objectified as a list of problems rather than being understood in context. However this would only hold true if the assessing practitioner adheres rigidly to the assessment tool and does not seek explanatory connections from his/her patient client. There is little empirical evidence of the way in which practitioners use assessment tools in practice and whether they depart from the agenda set by the tools. As Mitcheson and Cowley (2003) have argued, we have no evidence that confirms that a structured assessment tool can yield a more patient or client centred approach in the hands of a practitioner who decides to amplify the information being sought in the assessment encounter.

Despite the volume of empirical work in the field of assessment, there are still important questions to address regarding the appropriateness and effectiveness of structured assessment tools. While policy imperatives promoting their use are ubiquitous, the case for the conversation approach to assessment should not be dismissed. As this article has shown, there is promising evidence that highlights the merits of this approach but it is not universally applied and it has not been tested to identify whether it is appropriate for eligibility purposes. Moreover, as with structured tools, there is as yet insufficient evidence on how these assessments provide a basis for decision-making and whether the subsequent interventions are judged to be appropriate by those receiving care and support. As Dickinson *et al*. (2005, p. 24) have stated there is a lack of evidence as to which 'construction of information' is more 'accurate or useful'.

Therefore there remain key challenges in relation to ensuring the quality of assessment practice. In order that the cognitive and interactional skills associated with expert assessment practice are not undermined it is important to ensure that students and practitioners have opportunities to develop a truly patient/client centred approach that draws on, but is not dominated by their theoretical and practice based knowledge. This, as has been noted, is a complex skill and requires focused attention. In addressing this challenge, Bryans is in the final stages of producing a multi-media learning package that integrates her scenario-based research findings with relevant theory. Several groups of community nursing students have evaluated it positively.

Secondly more research that explores both approaches is needed in order to identify which is the most effective in terms of the outcome for patients/clients. This will present both methodological and funding challenges. Research designed to address such questions would have to be longitudinal and encompass triangulation techniques in order to achieve robustness and transferability. It would be ethically complex owing to its focus on practitioners, patients, clients, carers and possibly agency members. As part of such research there is also a case for focusing on the way in which practitioners and managers reconcile identified needs with the resources at their disposal and the impact that ensuing decisions have on patient/client outcomes. There is scant discussion or research in this area and there is a need for evidence to demonstrate practitioners' capacity to take account of cost-effectiveness and the criteria both formal and informal that they use to operationalise it. This is particularly important in a political climate in which managerial and organizational control can, at times, impose processes that can circumscribe and restrict practice.

As stated in the introduction to this article, assessment is universally regarded as the cornerstone of good quality care. Therefore there is justification for it to be subject to ongoing research, accorded a key place in the education of community nursing students and central to the professional development of practitioners. Only by maintaining this critical scrutiny will there be guarantees that patients and clients get the type and level of assessment that they deserve.

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