Oifig an Stiúrthóra Seirbhísí Altranais & Cnáimhseachais | Office of the Nursing and Midwifery Services Director

National Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service

Policy ☐ Procedure ☒ Protocol ☐ Guideline ☐ Clinical Guideline ☐

DOCUMENT GOVERNANCE [1]	
Document Owner (post holder title):	National Practice Development Coordinator for Public Health Nursing Service, ONMSD
Document Owner name:	Sinéad Lawlor
Document Owner email contact: *(Generic email addresses only for the Repository)*	nursing.services@hse.ie
Document Commissioner(s): (Name and post holder title):	Grainne Ryan, National Lead for Public Health Nursing Service
Document Approver(s): (Name and post holder title):	T. J. Dunford, Head of Operations Primary Care
Lead responsibility for national implementation:	Grainne Ryan, National Lead for Public Health Nursing Service
Lead responsibility for national monitoring and audit:	Grainne Ryan, National Lead for Public Health Nursing Service
Development Group Name:	Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service Procedure Development Group
Development Group Chairperson:	Sinéad Lawlor
Additional headings can be inserted as required	

DOCUMENT MANAGEMENT [2]			
Date effective from:		12/08/2024	
Date set for next review:		12/08/2027	
Your Reference No: *(if applicable)*		PCPHN09	
Current version no:	0	**Archived version no:**	
Note: HSE National 3PGs should be formally reviewed every 3 years, unless new legislative/regulatory or emerging issues/research/technology/audit etc. dictates sooner.			

[1] Records the senior management roles involved in the governance and development of the document.
[2] Records the control information about the document.

VERSION CONTROL UPDATE [3]			
Version No.	**Date reviewed**	**Section numbers changed**	**Approved by**
		(Insert additional lines as required)	
Document management notes: *For example: If title of the HSE national document has been changed since the last version*			

PUBLICATION INFORMATION [4]

Title:

Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service

Topic:

Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service

National Group:

Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service Procedure Development Group

Short summary:

The purpose of this procedure is to provide guidance to all Registered Public Health Nurses/Registered Midwives (RPHNs/RMs) in the Public Health Nursing Service on the management of non-engagement with child health and development assessments and reviews as part of the National Healthy Childhood Programme.

Description:

To minimise the potential risk to a child's health, safety and welfare through identifying issues early (prevention) and to facilitate early intervention to influence positive outcomes (HSE, 2015). To recognise and respond if there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected. To promote standardisation in the provision of the child health and development assessment and review contacts as part of the National Healthy Childhood Programme by the Public Health Nursing Service. To provide guidance to RPHNs/RMs on the procedures to be followed when managing non-engagement with PHN child health and development assessments and reviews as part of the National Healthy Childhood Programme.

[3] Records details when a document is reviewed, even if no changes are made.

[4] Records the document information required for publication on the HSE National Central Repository.

Contents

1.0 Planning

1.1. Purpose

To provide guidance to all Registered Public Health Nurses/Registered Midwives (RPHNs/RMs) in the Public Health Nursing Service on the management of non-engagement with child health and development assessments and reviews as part of the National Healthy Childhood Programme (NHCP).

1.2. Scope

1.2.1. Target users

This procedure applies to all RPHNs/RMs in the Public Health Nursing Service delivering the child health and development assessments and review contacts as part of the NHCP. This procedure must always be used in conjunction with professional clinical judgement.

1.2.2. Target population

- This procedure applies to all children who are seen by the Public Health Nursing Service as part of the NHCP.
- This procedure does not apply to children who are referred to the Public Health Nursing Service for clinical nursing.
- This procedure does not apply to nurses working in specialist services or to their client caseload e.g. specialist palliative care, continence service.

1.3 Objectives

- To promote standardisation in the provision of the child assessment contacts as part of the NHCP by the Public Health Nursing Service.
- To provide guidance to RPHNs/RMs on the procedures to be followed when managing non-engagement with PHN child health and development assessments and reviews as part of the NHCP.
- To recognise and respond if there are reasonable grounds for concern (See Section 12.2) that a child may have been, is being, or is at risk of being abused or neglected.

1.4 Outcomes

- Every child has the opportunity to avail of the full NHCP programme from the Public Health Nursing Service.

- To assist effective and efficient management of NHCP programme in the PHN service.

1.5 Disclosure of interests

None

All signed declaration of interest forms are retained by the National Practice Development Coordinator for Public Health Nursing on behalf of Office of the Nursing and Midwifery Service Directorate (ONMSD).

1.6 Rationale / alignment with HSE national priorities

This document supports the PHN service in providing services in line with the National Service Plan of the HSE and the National Healthy Childhood Programme.

1.7 Supporting evidence

Relevant Legislation & PPPGs;

Government of Ireland (2015) Children First Act. www.irishstatutebook.ie
Government of Ireland (2011) Nurses and Midwives Act. www.irishstatutebook.ie
Government of Ireland (1970) Health Care Act. www.irishstatutebook.ie
Government of Ireland (1949) S.I. No. 128/1949 - Health (Duties of Officers) Order, https://www.irishstatutebook.ie/eli/1949/si/128/made/en/print
Government of Ireland (1947) Health Act. www.irishstatutebook.ie
Health Information and Quality Authority (2012) National Standards for Safer Better Healthcare.
Health Information and Quality Authority (2015) Guidance for Providers of Health and Social Care Services: Communicating in Plain English.
https://www.Tusla.ie/services/family-community-support/prevention-partnership-and-family-support-programme/meitheal-national-practice-model/
Health Services Executive (2020a) The National Healthy Childhood Programme Child Health Assessment Manual for Registered Public Health Nurses
Health Services Executive (2019a) Child Protection and Welfare Policy
Health Services Executive (2019b) Data Protection Policy
Health Service Executive (HSE) (2020b) Incident Management Framework
Nursing and Midwifery Board of Ireland (2021) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives
Nursing and Midwifery Board of Ireland (2015a) Recording Clinical Practice Professional Guidance

Nursing and Midwifery Board of Ireland (2015b) Scope of Nursing and Midwifery Practice Framework
Health Services Executive (2011) Standards and Recommended Practices for Healthcare Records Management
Health Service Executive (2021a) Procedure for Managing the Safe Transfer of Child Health Records in the Public Health Nursing Service
Health Service Executive (2021b) Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service
Health Services Executive (2022a) National Consent Policy, HSE National Office for Human Rights and Equality Policy
Health Service Executive (2022b) Guideline on Maternal Postnatal Care in the Public Health Nursing Service.

2.0 Methodology

2.1. Key question this National procedure will answer

What is the procedure to be followed for the management of non-engagement with child health and development assessments and reviews in the Public Health Nursing Service?

2.2. Evidence search

A review of the relevant literature was undertaken for the period from 2010 to date. Based on the key questions defined above a literature search strategy was developed. The main database used was CINAHL (Cumulative Index to Nursing and Allied Health). A search was performed using the following search terms “was not brought”, “non-attendance”, “missed appointment”, “Ineffective Visit”, “No Access Visit”, “Opt-out”, “Refusal of Service”, “Child Health”, “Universal Screening”, “Primary Care” using AND and OR Boolean combinations to source articles of relevance. Only English language publications and articles published after 2010 were included. A further search was performed by a HSE librarian to ensure all relevant national and international guidelines and published papers were captured. Samples of local and national procedures and guidelines were sourced and reviewed. In addition, search of relevant websites in Ireland and the United Kingdom was undertaken. The following websites were accessed to identify publications and guidelines that related to the subject area; Nursing Midwifery Board of Ireland; Health Information Quality Authority, Ireland; Health Service Executive, Ireland and the NICE guidelines website UK. All relevant articles were reviewed by members of the procedure development team.

2.3. Method of screening and evidence appraisal

Each member of the development group took the literature generated that was felt to be valid and appraised it. Although some of the articles were not directly related they were useful in the formulation of definitions required or background information. Other government publications that related to out-patient appointment attendance, in an Irish context, were deemed relevant and reviewed by the group.

Recommendations were formulated through discussion within the development group and working group of the National Group of Practice Development Co-ordinators to develop a structured procedure. A draft of the procedure was developed. Feedback was sought on the consultation draft from key stakeholder groups, DPHNs, INMO, National Healthy Childhood Program, TUSLA, National Data Protection Officer and HSE Children First National Office. The development group reviewed all feedback received and a final draft of the procedure was prepared. The final draft of the procedure was submitted to the National Quality Improvement Governance Group PHN Service for recommendation for approval to HSE National Community Operations and National Healthy Childhood Programme.

The PHN service offers a community-based service and as such is generally the first service to see the infant in the home environment and plays a critical role in linking with all related child services. The universal nature of the National Healthy Childhood Programme facilitates equal access for all children. The RPHN is the only professional in the community who is mandated to offer defined universal services to infants and children as underpinned in legislation. Non-engagement with health services can be a sign of neglect and frequent non-attendance at appointments may trigger a safeguarding concern. Providing clear procedures for RPHNs/RMs to follow when a child is not brought for child health and development assessment appointments should lead to consideration of the consequences for the child of the missed appointment (Appleton et al. 2016). Missed appointments may lead to late diagnosis, delayed treatment and monitoring; potentially negatively impacting a child's health outcomes. A service focused on safe care and support is actively and continuously looking for ways in which it can be more reliable and areas in which it can improve the quality of its service delivery (HIQA, 2021).

Unfortunately, it is known that missed appointments are often a feature in serious case reviews. In the literature reviewed, missed appointments or visits include ones that are missed/late/cancelled/failed to attend/did not attend (DNA)/was not brought (WNB)/no-shows/no access visit/inaccessible visit and are used to describe when children are not brought to their planned appointment or there is no access at the home. All have the same result: an unseen child. Missed attendance at appointments can be divided into occasionally missed, due to an unavoidable issue, or serially missed, usually in cases where there is house instability, social issues, mental health and financial instability (Rahman et al. 2020). Evidence demonstrates that missed appointments and lack of follow up, are often detailed in serious or fatal cases of child maltreatment (Powell and

Appleton, 2012). Children First National Guidance for the Protection and Welfare of Children (2017) list factors that should be considered as part of being alert to the possibility that a child may be at risk of suffering abuse. These include: poor motivation or willingness of parents/guardians to engage, non-attendance at appointments, lack of insight or understanding of how the child is being affected, lack of understanding about what needs to happen to bring about change, avoidance of contact and reluctance to work with services, inability or unwillingness to comply with agreed plans. All reasonable concerns should be brought to the attention of Tusla.

Furthermore, the Office for Standards in Education, Children's Services and Skills in the UK (Ofsted) (2011) report a way in which parents prevented agencies from seeing children was through missed appointments for children. NICE Guidelines on when to suspect maltreatment in under 18s, in relation to attendance at medical services, state that healthcare professionals should consider child maltreatment if there is an unusual pattern of presentation to and contact with healthcare providers (NICE, 2017). RPHNs are a vital part of the child and family public health workforce who have unparalleled opportunities to make a major contribution to safeguarding and child protection (Hanafin, 2013). Children are more likely to be vulnerable if they are not brought to health care appointments, so follow-up is always required. A recommendation of the Roscommon Report (Gibbons, 2010) is that all personnel be alert to parents and carers who consistently try to divert attention away from the primary concern with the well-being of the children. There may also be a need to communicate with other services to seek further information about the child and family (Powell & Appleton, 2012).

Moving our language from the idea that a child ‘did not attend’ (DNA) an appointment to ‘was not brought’ (WNB) allows us to shift the focus to the child by being more child-centred and reflects the idea that children do not have the means to attend without a parent. It is important to document the WNB, and make a record of action taken and outcomes. Public health nurses should liaise with their manager or safeguarding/child protection lead if they have concerns about a child or young person’s health or well-being. Arai et al. (2015) state that guidelines would be more useful if they make distinction between different categories of unseen child and not conflate different categories ie. DNA with refusal of service – difference between families who decline all services and those that are selective. Guidelines need to be accessible and used and it is suggested that evidence-informed guidelines that are developed nationally but tailored to specific services might be helpful for providers and users alike (Arai et al. 2015). Missed appointments can be an indicator of a family vulnerability, equally it can be an indicator that services are difficult for families to access or seen as unnecessary (Powell & Appleton, 2012).

Adverse childhood experiences (ACEs) are potentially traumatic events including exposure to violence; emotional, physical, or sexual abuse; neglect; divorce; parental substance abuse, mental health problems or death; and social

discrimination (Miccoli et al. 2022). ACEs can cause lifelong medical and social suffering including premature death. Higher ACEs scores were also associated with more missed well child visits by 2 years of age (Miccoli et al. 2022). Similarly, Koball et al. (2021) found that children with any reported ACEs were more likely to not attend appointments and to use emergency services than children with no ACEs. Also of interest to PHN teams is the knowledge that high ACEs exposure in parents can translate to intergenerational trauma in their children, however it is also encouraging to know that there is potential to mitigate this effect through safe and nurturing environments that can be promoted through positive social supports. Trauma informed care, that acknowledges parental exposure to ACEs, aims to encourage self-empowerment among parents, increase family resilience and reduce the risk for future childhood trauma (Ballard et al. 2019).

Trauma-informed is defined as a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma that emphasizes physical, psychological and emotional safety for both providers and survivors to rebuild a sense of control and empowerment. Central tenets of trauma-informed care are empowerment, voice and choice (Chapman et al. 2022). SAMHSA (2014) identify six key principles of trauma informed practice:

1. Safety (physical and emotional); throughout the organisation, staff and the people they serve feel physically and psychologically safe.

2. Trust; Organisational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

3. Peer support and mutual self-help; are integral to the service delivery approach and are understood as a key component for building trust, establishing safety, and empowerment.

4. Collaboration; There is a balance of power between staff and clients and among staff from clinical to non-clinical disciplines. The organisation recognises that everyone has a role to play in a trauma-informed approach.

5. Empowerment & Choice; throughout the organisation and among the clients served, individuals' strengths are recognised, built on, and validated and new skills developed as necessary. The organisation recognises that every person's experience is unique and requires a client driven individualised approach. This includes a belief in the ability of individuals, organisations, and communities to heal and promote recovery from trauma. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

6. Cultural Competence; The organisation actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography), offers gender responsive services, utilises the healing value of traditional cultural and/or religious connections, and recognises and addresses historical trauma. (SAMSHA, 2014, p.9-12).

A trauma informed approach assists parents in reflecting on how a traumatic personal history affects their current life circumstances and possibly their children's future outcomes (Ballard et al. 2019). In line with principal 2: Safety and Wellbeing, of the Draft Overarching National Standards for the Care and Support of Children using Health and Social Care Services (HIQA, 2021), when appointments are arranged for a child it is done in a way that suits the family and is respectful to their needs and circumstances. Where a child needs care and support from more than one service, it is important that services work with each other and with the child and their family to provide integrated care and support. This helps to ensure that children's health, safety, and wellbeing are promoted and they are supported to reach their potential. Systems and structures to support collaborative working and communication between services are needed to ensure that children get the care and support they need and do not fall between services (HIQA, 2021).

Reasons given as barriers to primary care appointment attendance include, miscommunication or not being notified about an appointment, forgetfulness, work/competing priorities, transport, patient/staff relationships (has potential to both promote and deter appointment attendance) and appointment booking systems (Chapman et al. 2022). Trauma-informed care and continuity of care have a role in improving patient-provider relationships and thereby improved non-attendance rates in patients with history of ACEs. Personal reminders of appointments may reduce non-attendance rates and they align with trauma-informed practices of strengthening communication and relationships.

There is a dearth of literature in an Irish context related to missed appointments in primary care. However it has been reported in Ireland that one in six patients did not attend (DNA) hospital outpatient appointments in 2015, costing the HSE over €20 million and compounding the waiting list problem (DOH, 2019a). Analysing the reasons for DNAs suggests interventions or changes that may help. It may be possible to increase attendance with better communication (e.g. more effective appointment letters, the use of reminders) and by reducing barriers to attendance (e.g. addressing transport problems). Text message reminders were found to be as effective as phone call reminders at reducing missed appointments in primary care (Perron et al. 2013). DNAs may also be reduced by providing patients with a choice of appointment times or by providing an easy means for rescheduling or cancellation (DOH, 2019b). Reducing non-attendance may significantly equate to reducing waste in the system (HSE, 2016). Unfilled appointments limit the clinician's ability to provide efficient care (Chapman et al. 2022). Through implementing strategies, such as trauma-informed practices, the aim is to overcome barriers to attendance.

2.4. Resource implications

- Briefing sessions on the procedure to DPHNs and ADPHNs via Webex to support the roll out of the procedure will be required.

- Communication with the Child Health Programme Development officers in the NHCP to ensure awareness and promotion of this procedure.
- Communication with the Higher Education Institutes responsible for student PHN education will occur to ensure awareness of this procedure.
- Local induction programmes for new nurses commencing employment will include briefing on all 3PGs approved for use within the PHN Service, including instruction on use of the electronic policy portal where in use and signposting to the PHN page of the HSE website www.hse.ie/phn

2.5. Attach any copyright or permissions sought

No copyright or permissions are required in relation to this document.

3.0 Procedure

3.1 Context and background information

National Healthy Childhood Programme (NHCP) PHN Child Health and Development Assessments

The National Healthy Childhood Programme is the universal programme of clinical care that is available to all children. The clinical programme is mandated for in the Health Acts (Government of Ireland; 1947,1970). The primary purpose of the NHCP programme in the PHN service provides for systematic, evidence-based assessments of all children up to 50 months of age which includes 5 core assessments. It is providing health information; supporting vaccine and screening programmes through answering questions, reminding, advocating; linking families to reliable and evidence based health information resources; raising awareness of some local supports that might be relevant to families, signposting to services/GPs as needed; and then the onward referrals or repeat visits where clinically indicated. This is also underpinned by legislation governing the rights of the child (UNCRC, 1989, 2010). The Public Health Nursing (PHN) Service is mandated to make available without charge a universal child health programme (as per the Health Act 1970/section 66). Each PHN facilitated child health and development assessment should take place within the recommended timeframe for the scheduled assessment date (National Healthy Childhood Programme Child Health Assessment Manual for Registered Public Health Nurses 2020b).

This procedure provides guidance to the Public Health Nursing Service in the management of non-engagement with PHN child health and development assessments and reviews. Non-engagement with PHN child health and development assessments and reviews may occur when parents do not bring their child (previously known as did not attend/DNA), have cause for multiple cancellations, or move with no forwarding address (previously known as

unknown address).

The Registered Public Health Nurse (RPHN) and Registered Midwife (RM) should be aware of risk and protective factors for child health and wellbeing. This procedure should be read in conjunction with PCPHN06 ‘Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service (HSE, 2021a)’. If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected, then the RPHN/RM, should complete a Child and Family Health Needs Assessment (CFHNA) and discuss with the ADPHN and make a report to Tusla (See section 12.2). Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern. Informal consultation with social work departments before any referral is an option on a case by case basis.

In clinical practice, the following steps to be undertaken by the RPHN/RM may follow a different order than described in this procedure. Children and families may receive additional PHN child health and development assessments/reviews where they are deemed necessary by the RPHN/RM or on parental request. This procedure is not intended to replace clinical or professional judgment. All actions must be clearly documented in the progress notes of the child health record (CHR), in line with Nursing and Midwifery Board of Ireland (NMBI) guidance on recording clinical practice (NMBI 2015).

A dynamic risk assessment is completed in accordance with the national HSE Policy and Guidance on Lone Working (2022c) and Policy on the Prevention and Management of Work-Related Aggression & Violence (2018) for new patient’s unknown to the PHN service based on the information supplied and on individual assessment. Any concern a RPHN/RM has in relation to lone working must be discussed with their ADPHN.

3.1.1 Awareness of Social Inclusion

Throughout the process of working in partnership with parents it is important for the RPHN/RM to have an awareness of planning and delivering care and support services in an equal, accessible and effective way, acknowledging and valuing the diversity of all service users. It may be necessary for the RPHN/RM to offer the service in a different way including consideration of the parent’s level of comprehension, language and literacy, cultural background, social isolation and barriers to accessing services. PHNs can link with Tusla Child and Family Support Network Coordinator (CFSNC) for information on parenting supports as outlined in CFHNA guideline (PCPHN06). The CFSNC are in post throughout the country and cover all regions.

This may necessitate reviewing how the programme is offered to

individual families and considering the factors below. The following list is not exhaustive and is given as a prompt. The priority is to keep the child at the centre of service provision and maintain the child's best interests at all times.

- Consideration should be given to the parent's capacity to give informed consent to participating in the programme.
- Consideration to whether the child/children are subject to care orders under the Child Care Act 1991
- Parents with additional vulnerabilities such as disability or mental health may need additional resources or assistance
- Is translation of any written information required?
- Is a translator necessary to communicate with the family verbally?
- Is the HSE building accessible and easy to reach? Could this have impacted on the nonattendance at an appointment?
- Is webtext or text facility available for scheduling appointments?
- Was the appointment letter in a format that the parent could read and understand? Is a letter the most appropriate way of communicating?
- Are there logistical issues that prevent the parent from coming to the clinic? E.g. no buggy, no bus, in temporary accommodation in another area
- Is the appointment time a factor affecting the likelihood of attendance?
- Using the principles of trauma informed practice, could the impact of previous trauma impact on the parent's ability to participate in the programme or struggle to attend? A parent may be triggered by staff member due to circumstances outside of their control - e.g. their name, a facial feature, a mannerism etc. has the potential to trigger memories associated with traumatic events.
- Consider if extra support may be necessary for vulnerable families.

3.2 Non-engagement

Non-engagement occurs when the RPHN/RM is unable to see a child to complete child health and development assessments/reviews for the following possible reasons**:**

3.2.1 Cancellation of PHN Child Health and Development Assessments by the Parents

Parents who make contact to inform the RPHN that they are unable to attend for a scheduled assessment/review appointment on two or more

occasions

3.2.2 Was Not Brought (previously referred to as DNA)

Children who have not been taken to a planned appointment without cancellation.

The term ‘Was Not Brought’ reflects the fact that children and young people rely on parents and carers to attend appointments. Therefore, ‘Was Not Brought’ should be used rather than ‘Did Not Attend’ if referring to appointments for children. This refers to any prearranged contact with a child, whether it is at the primary care centre or health centre, or any other type of contact arranged relating to the provision of the National Healthy Childhood Programme. The term ‘Was Not Brought’ is used only after consideration has been given to the factors mentioned in 3.1.1 and enquiry by the PHN with relevant services and consultation as appropriate with other relevant services e.g. Child and Family Services Network (CFSN).

3.2.3 No Access Visit (NAV)

The following situations may be described as no access:

No one at home for a prearranged visit which was made by appointment with the family

There is someone at home for a prearranged visit but they don’t open the door or you have reason to suspect that they are there and not opening the door.

Point of note: Ineffective Opportunistic Visit is not non-engagement. In the event there is no one at home or a ‘door step’ visit occurs for an opportunistic visit by the RPHN/RM this should be recorded in the progress notes as an “ineffective opportunistic visit – no reply”. This is not non-engagement.

3.3 Managing inaccessible primary visits

When managing inaccessible primary visits requiring New-born Bloodspot Screening the RPHN/RM must refer to the ‘HSE Procedure for all Community and Hospital Services Providing the National Newborn Bloodspot Screening Programme (NNBSP)’ (HSE 2022a NNBSP01) and inform the DPHN/ADPHN and maternity hospital with responsibility for the National Newborn Bloodspot Screening Programme.

3.3.1 The RPHN/RM should make at least two phone calls to contact the parent to arrange a primary visit at home. The RPHN/RM can also telephone the nominated support person to request the mother makes contact with the RPHN/RM as soon as possible.

3.3.2 The RPHN/RM should ascertain through the maternity hospital, referral

source or liaison ADPHN/office that all discharge details, discharge address (including the Eircode if possible) and additional contact details of nominated support person relating to the parent(s) are correct.

3.3.3 If no response to messages or contact from the parent to phone messages, the RPHN/RM should carry out a home visit.

3.3.4 If the above is not productive, the RPHN/RM should phone the GP. The GP, who is an independent Data Controller, can determine if and what information is shared. GPs and S38/S39 organisations routinely share both personal and health information of service users with the HSE in support of the provision of healthcare services for their patients. All of the above steps should be documented, dated, timed and signed appropriately in the child health record.

Please note that the HSE relies on Article 6(1)(e) of the General Data Protection Regulations (European Commission 2016) as lawful basis for processing personal data (name, address telephone number), such that processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. With regards to the processing of special category data (e.g. health data) the HSE relies on Article 9(2)(h) as a lawful basis, such that processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional.

3.3.5 When carrying out the following actions; in line with the national Key Performance Indicator (KPI) the primary visit should take place within 72 hours of discharge from the maternity service.

If there is no access at the home visit, the RPHN/RM should leave a PHN visiting card (PCPHN07) to include all contact details for the RPHN/RM (card template available at: www.hse.ie/phn see Appendix 7).

3.3.6 If unable to access the home e.g. Unable to leave a PHN visiting card at apartment or a rural home with no Eircode; following discussion with ADPHN a registered letter (non-engagement letter template Appendix 10) should be sent to the parent on the same day.

3.3.7 If no response to all attempted contacts the RPHN/RM should discuss the case with the ADPHN. Every effort is made to ensure that the primary visit is made, in collaboration with appropriate services (e.g. the Maternity Hospital/Unit, GP) as soon as reasonably possible.

3.3.8 If, at any point, there are reasonable grounds for concern that a child may

have been, is being, or is at risk of being abused or neglected, then the RPHN/RM, should complete a child and family health needs assessment (CFHNA) and following consultation with the ADPHN, should make a report to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern. Informal consultation with social work departments before any referral is an option on a case by case basis (See Section 12.2 Definitions: Reasonable grounds for concern). In all cases where a referral to Tusla is made, the referral should include details of all attempts made to contact the family (i.e. Hospital contact/ GP/ neighbour/ extended family) or any other information held regarding the child/family. If the information available to the nurse is limited, what is known of the circumstances should be included i.e. hospital attendance/ GP attendance/ nationality etc. and if there are grounds for concern what these might be or how the concerns were aroused.

3.3.9 The RPHN/RM should document each action taken stating the type of contact in the progress notes of the CHR. This should include time, date and indicate if a PHN visiting card was left or a letter was sent to the parent. Copies of any letters sent should be filed in the correspondence tab of the CHR.

3.3.10 The RPHN/RM should inform the referral source, liaison office or maternity service (depending on local practices) and the GP of the inability to contact the family and the inaccessible primary visit.

3.3.11 If discharging address/contact numbers are incomplete or inaccurate resulting in missed care (either in part or whole), the RPHN/RM in consultation with the ADPHN should complete an incident report form (National Incident Report Form NIRF 01 Person Form). NIRF available at: https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/nims/ (HSE, 2020).

3.3.12 In the event that the inaccessible visit has resulted in an episode of missed care the RPHN/RM in consultation with the ADPHN must complete an incident report form (NIRF 01 Person Form) in line with the HSE Incident Management Framework (2020).

3.3.13 Refer to the Guideline on Maternal Postnatal Care in the Public Health Nursing Service (PCPHN05) for guidance on steps to follow in the event the mother is discharged while the infant remains in hospital.

3.4 Managing non-engagement with subsequent PHN child health and development assessment appointments

3.4.1 If the parent makes contact with the RPHN to request a change to a scheduled appointment/visit, a rescheduled appointment should be offered

at a later date within the recommended timelines for the NHCP (NHCP, 2020b).

3.4.1.1 There is a template for appointment letters in Appendix 8.

3.4.2 If it is not possible to reschedule an appointment within the recommended timelines for the NHCP programme, the appointment should be given at the next earliest available opportunity and recorded as a late assessment in the child health record and Child Health Activity Metrics as per Child Health Record User Guide and Data Definitions (NHCP, 2020a) and Parent Held Record (PHR) where in use. Refer to the NHCP Child Health Assessment Manual for Registered Public Health Nurses (2020b) for definition of late visits (p.107).

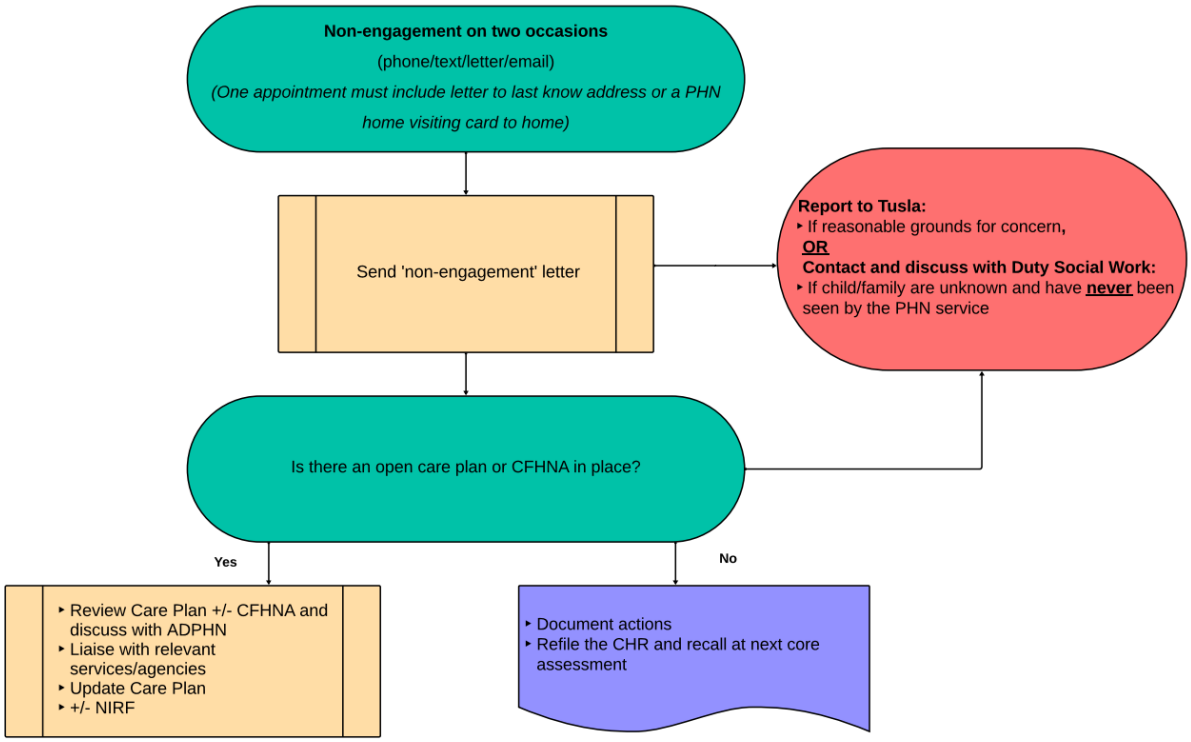
3.4.3 When a child is not brought to an appointment or the RPHN does not gain access to see a child for a visit scheduled with the parent in the home, the RPHN will check that they have the correct contact details and offer another appointment by phone/letter/text messaging service/webtext/voice message/email. Appointments are made using systems/processes in line with local practice in each area.

3.4.4 One communication regarding an appointment must include either a letter to last known address or a PHN home visiting card to the home (card template available at: www.hse.ie/phn see Appendix 7).

3.4.5 In the event of non-engagement with an appointment on two or more occasions (this may include two late cancellations provided at least one of the appointments was sent by letter to the home or a PHN visiting card to the home) follow flow chart below (Figure 1).

3.4.6 If the child/family have **never** been seen by the PHN service and they have been offered two or more appointments and consideration has been given to the factors mentioned in 3.1.1, and enquiry by the nurse with relevant services, a referral to Tusla should be made and the ADPHN informed. Informal consultation with social work departments before any referral is an option on a case by case basis (See Section 12.2 Definitions: Reasonable grounds for concern). In all cases where a referral to Tusla is made, the referral should include details of all previous attempts made to contact the family (e.g. Hospital contact/ GP/ neighbour/ extended family) or any other information held regarding the child/family. If the information available to the nurse is limited, what is known of the circumstances should be included e.g. Hospital attendance/ GP attendance/ nationality etc. and if there are grounds for concern what these might be or how the concerns were aroused.

FIGURE 1.0 Non Attendance at appointments on 2 or more occasions



3.4.6 The non-engagement letter (Appendix 10) must be sent by registered post to the parents following non engagement with appointments on two or more occasions. The RPHN should send a copy of the non-engagement letter to the GP and/or Child health office/ADPHN if relevant and file a copy in the CHR. This letter will be available in 20 languages: Arabic, Bulgarian, Czech, English, Farsi, French, Georgian, Irish, Lithuanian, Polish, Portuguese, Romanian, Russian, Simplified Chinese, Pashto, Slovak, Somali, Spanish, Ukrainian, Urdu.

.

3.4.7 If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected, then the RPHN/RM, should complete a child and family health needs assessment (CFHNA) and following consultation with the ADPHN, should make a report to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern. Informal consultation with social work departments before any referral is an option on a case by case basis (See Section 12.2 Definitions: Reasonable grounds for concern). In all cases where a referral to Tusla is made, the referral should include details

of all attempts made to contact the family (eg. Hospital contact/ GP/ neighbour/ extended family) the enquiry undertaken by the nurse, or any other information held regarding the child/family. If the information available to the nurse is limited, what is known of the circumstances should be included eg. Hospital attendance/ GP attendance/ nationality etc. and if there are grounds for concern what these might be or how the concerns were aroused.

3.4.8 The RPHN/RM should document each action stating the type of contact in the progress notes of the CHR. This should include time, date and indicate if a PHN visiting card was left or a letter was sent to the parent. Copies of any letters sent should be filed in the correspondence tab of the CHR. The CHR should be filed in line with local practice.

3.4.9 In the event that the non-engagement has resulted in an episode of missed care the RPHN/RM in consultation with the ADPHN and should consider completing a national incident report form (NIRF 01 Person) in line with the HSE Incident Management Framework.

3.4.10 At each timeframe for a PHN child health and development assessment the RPHN should make contact with the family where possible and if appropriate. In areas where PHR is in use the RPHN/RM should document failed visit on the PHR record. The child remains on the caseload until the child reaches the age for the final PHN child health and development assessment (46-48 months). This facilitates transfer requests for the child health record if the family presents to another health centre and gives their last known address. This standardised process has been recommended by the Children First office. When the child reaches 50 months of age the child health record is then archived or sent to the school RPHN team depending on local procedure. The child should be discharged from the PHN caseload and the discharge recorded in the child health activity metrics and birth/child register. It is recognised that in some areas depending on local practices the CHR may be held for longer to facilitate transfer to the school health team.

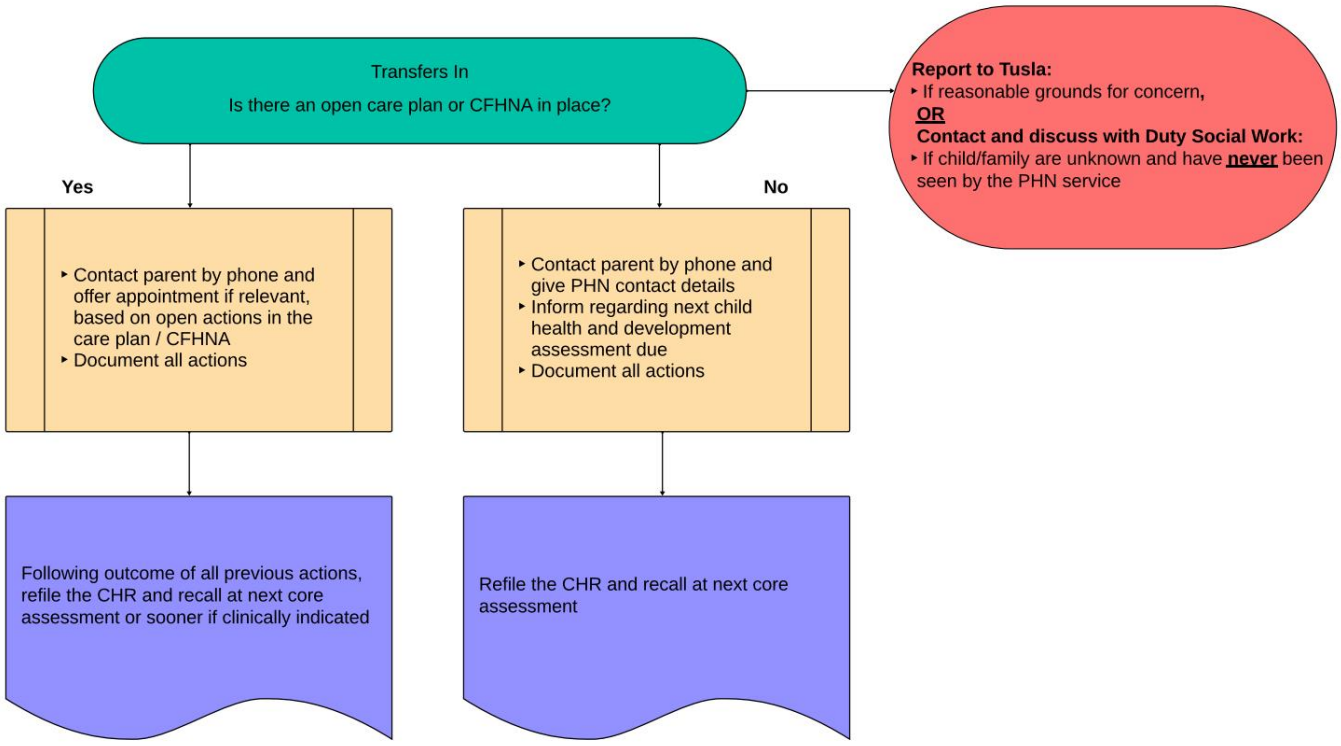
3.5 Transfers In and Out

3.5.1 For transfers in, follow flow chart below (Figure 2.0)

3.5.2 If, on receipt of a CHR in the case of a transfer in, the child/family have **never** been seen by the PHN service the RPHN should contact and discuss the case with Tusla Duty Social Work for advice regarding possible referral and the ADPHN should also be informed. In all cases where a referral to Tusla is made, the referral should include details of all previous attempts made to contact the family (e.g. Hospital contact/ GP/ neighbour/ extended family), the active enquiry by the PHN, or any other information held regarding the child/family. If the information available to the nurse is limited, what is known of the circumstances should be

included e.g. Hospital attendance/ GP attendance/ nationality etc. and if there are grounds for concern what these might be or how the concerns were aroused.

FIGURE 2.0 Transfer in



3.5.3 For transfers out, the procedures described in PCPHN04 Procedure for Managing Safe Transfer of Child Health Records in the Public Health Nursing Service should be adhered to (HSE, 2021b). The RPHN must complete the notification of change of address form (see Appendix 9). For example, this may occur if the GP or other source provides a new address for the child.

3.6 No forwarding address

3.6.1 This section should be read in conjunction with A7.0 of PCPHN04 *Procedure for Managing Safe Transfer of Child Health Records in the Public Health Nursing Service (HSE, 2021b)*. Follow flow chart below, no forwarding address (Figure 3.0). The PHN may become aware that the child no longer lives at that address e.g. a registered letter is returned by An Post or a new family is at the address. If a registered letter is returned undelivered by An Post, it should filed in the CHR.

3.6.2 If the child no longer lives at the address, and the RPHN/RM has been unable to locate the family, the RPHN/RM must record “no forwarding address” in the birth/child register and CHR. If there are any concerns regarding the child development needs, parenting capacity issues or environmental factors, the RPHN/RM should review the CFHNA and link with local TUSLA service if necessary.

3.6.3 If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected, then the RPHN/RM, should complete a child and family health needs assessment (CFHNA) and following consultation with the ADPHN, should make a report to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to inform them of the immediate concern. Informal consultation with social work departments before any referral is an option on a case by case basis (See Section 12.2 Definitions: Reasonable grounds for concern). In all cases where a referral to Tusla is made, the referral should include details of all previous attempts made to contact the family (e.g. Hospital contact/ GP/ neighbour/ extended family) or any other information held regarding the child/family. If the information available to the nurse is limited, what is known of the circumstances and the enquiry by the PHN, should be included e.g. Hospital attendance/ GP attendance/ nationality etc. and if there are grounds for concern what these might be or how the concerns were aroused.

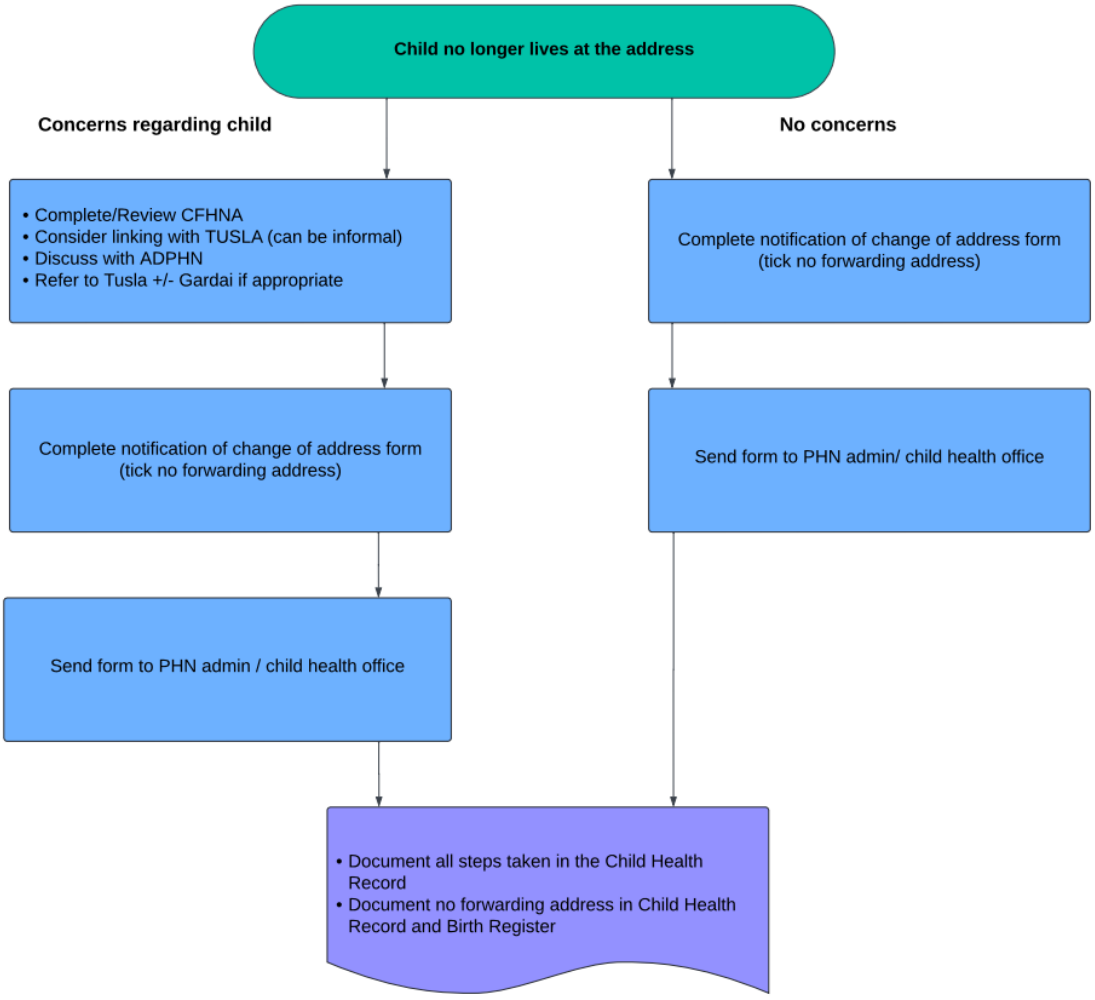
3.6.4 If there are no outstanding safety concerns, the RPHN/RM must complete the notification of change of address form (Appendix 9) and tick no forwarding address. This form is sent to the PHN administration/local child health office as per local arrangement, in order for the information to be recorded on CHIS/local system and a copy is filed in the child health record. For PHR areas ensure the check is submitted as a failed visit. The RPHN/RM should update database or birth/child register with no forwarding address status.

3.6.5 The RPHN/RM should document each action in the progress notes of the CHR. This should include time, date and indicate if a PHN visiting card was left or a letter was sent to the parent, a copy of any letter sent must be filed in the correspondence tab of the child health record.

3.6.6 At each timeframe for a PHN child health and development assessment the RPHN/RM should make contact with the family where possible and if appropriate. The child health record remains in the PHNs filing system until the child reaches the age for the final PHN child health and development assessment (46-48 months). This facilitates transfer requests for the child health record if the family presents to another health centre and gives their last known address. This is standardised process that has been recommended by the Children First office. When the child

reaches 50 months of age the child health record is then archived or sent to the school RPHNRM team depending on local procedure. This is recorded in the child health activity metrics and birth/child register. It is recognised that in some areas depending on local practices the CHR may be held for longer.

FIGURE 3.0 No forwarding address



3.7 Parents who opt-out of the service

The parent wishes to formally decline this child health and development assessment /review and/or all of the remaining child health and development assessments. See flow chart Figure 4.0.

NOTE: If the child/family have **never** been seen by the PHN service and they request to opt out, the RPHN should contact and discuss the case with Tusla Duty Social Work for advice regarding possible referral and the ADPHN should

also be informed. In all cases where a referral to Tusla is made, the referral should include details of all previous attempts made to contact the family (e.g. Hospital contact/ GP/ neighbour/ extended family) or any other information held regarding the child/family. If the information available to the nurse is limited, what is known of the circumstances should be included e.g. Hospital attendance/ GP attendance/ nationality etc. and if there are grounds for concern what these might be or how they were aroused. The parent should be informed that a referral is being made to Tusla also, unless to do so would be to increase any risk for the child, and this should be included in the information and the parent's response.

3.7.1 Where the parent(s) refuse to consent to an intervention which the healthcare worker reasonably believes to be in the best interests of the child, every effort should be made to reach a consensus position as regards the best interest of the child. In giving consent, the consent of one parent is usually sufficient. However, this is subject to an exception: where both parents have indicated a wish and willingness to participate fully in decision making for their child, this must be accommodated as far as possible by the service provider. If a consensus between the child's parents cannot be reached, the healthcare worker should notify the parents that the healthcare worker intends to proceed with the course of action which the healthcare worker considers to be in the best interests of the child on the basis of the consent of one parent (National Consent Policy, HSE, 2022b p.51). Refer to the HSE National Consent Policy for further guidance on any issues that arise in relation to consent. Missed appointments may lead to late diagnosis, delayed treatment and monitoring; potentially reducing a child's health outcomes.

3.7.2 If a parent(s) indicates that they do not wish to receive further PHN child health and development assessment/review appointments, the RPHN/RM should seek confirmation of this in writing from the parent using the opt-out form (see Appendix 11). In the event of a parent opting out of the NHCP, either verbally or by signing the opt-out form, the following points consider what should be included in the clinical documentation. The documentation should include all information provided to the parent(s), the associated risks and benefits of the screening being offered, and the possible consequences of declining the services. If the parent(s) provides a rationale for opting out, this should also be documented. In addition, if any supporting literature is provided to the parent(s) during the consultation, this should be referenced (including the version/edition of the literature) in the progress notes.

3.7.3 If, at any point, there are reasonable grounds for concern that a child may have been, is being, or is at risk of being abused or neglected, then the RPHN/ RM, should complete a child and family health needs assessment (CFHNA) and following consultation with the ADPHN, should make a report to Tusla. Where there is a concern for the immediate safety of a child, Tusla or An Garda Síochána should be contacted without delay to

inform them of the immediate concern. The parent should be made aware that Tusla will be notified in this situation. Informal consultation with social work departments before any referral is an option on a case by case basis (See Section 12.2 Definitions: Reasonable grounds for concern). The referral should include details of all efforts made to engage the family and any concerns for the health or welfare of the child that may exist and should be based on the experience of the PHN with this family and their knowledge or their observations of the child.

3.7.4 Template opt out form available for parents who wish to opt-out (Appendix 11). The opt out form will be available in 20 languages (see section 3.4.6). The opt out form should be sent by registered post to the parents and returned to the RPHN/RM **or** signed in the presence of the RPHN/RM. A copy of the signed opt out form is given to the parents – this can be sent by registered post or given to them by hand. The opt out form contains contact information for the parents to contact the PHN service if they change their mind in the future and they wish to opt back in. The opt out form is filed in the CHR in the correspondence tab. Copies sent as per point 3.7.7.

3.7.5 If the parent declines to sign the opt-out form this should be recorded in the CHR as per 3.7.2 and include the parent's rationale for opting out if known. The RPHN/RM should send the Confirmation of opt out letter (Appendix 12) by registered post to the parent confirming that the parent has formally declined the service and file a copy in the child health record in the correspondence tab. The letter will be available in 20 languages (see section 3.4.6). The option remains for the parent to opt back in, if they change their mind in the future, the details the PHN service should be provided in the confirmation of opt out letter. Copies sent as per point 3.7.7.

3.7.6 The RPHN/RM will discuss the case with the ADPHN throughout the process.

3.7.7 The RPHN/RM will forward a copy of the opt out form or confirmation of opt out letter to the child's GP, Child Health Office, DPHN/ADPHN and if relevant Tusla.

3.7.8 The child remains on the caseload until they reach the age for the final PHN child health and development assessment. This facilitates reactivation of the service if the parent opts back in to receive the NHCP. No further appointments for child health development assessments are offered by the RPHN/RM. When the child reaches 50 months the child health record is then archived or sent to the school RPHN team depending on local procedure. The child should be discharged from the caseload and the discharge recorded in the child health activity metrics and birth/child register.

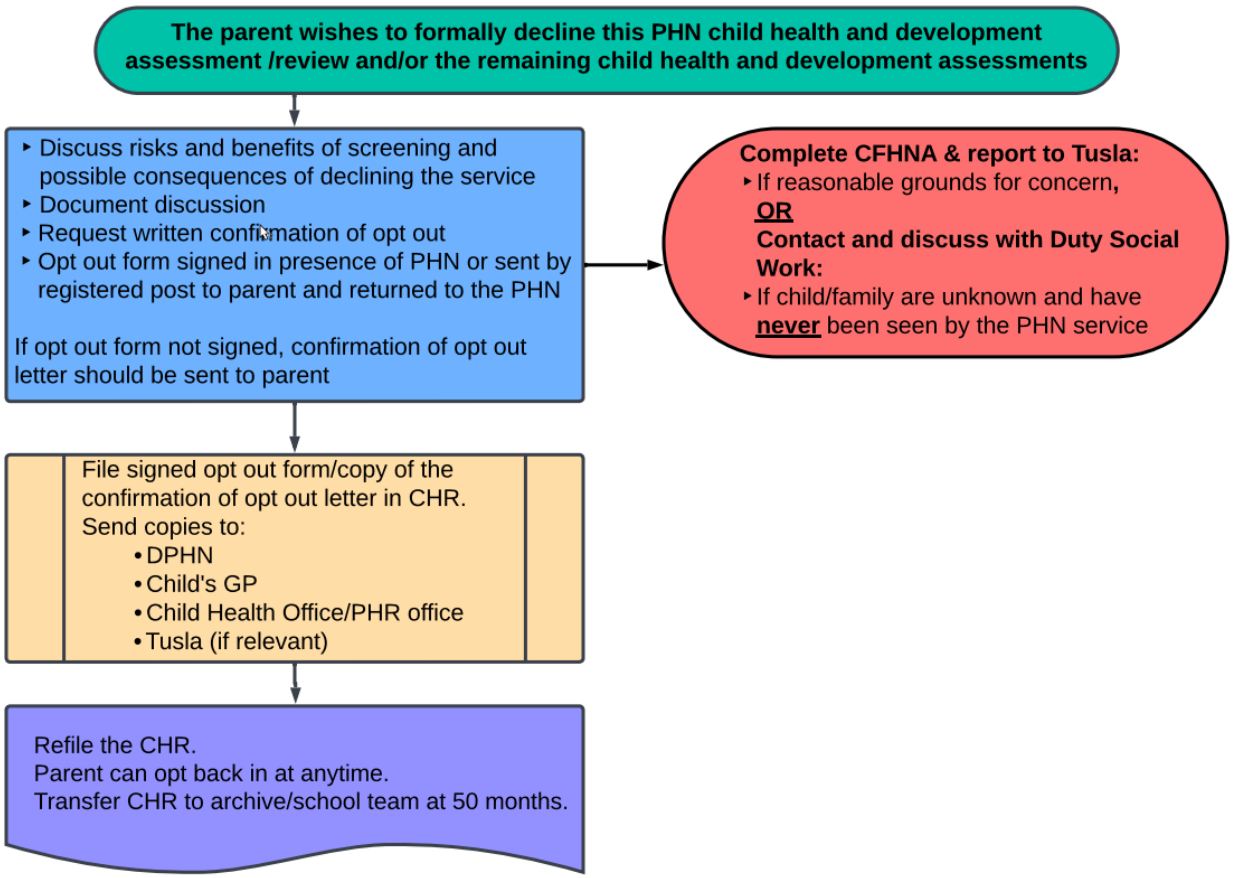
3.7.9 The parent may indicate at any time that they would like to avail of the

NHCP and if this occurs an appointment should be offered.

3.7.10 The RPHN/RM should document each action in the progress notes of the child health record.

3.7.11 The register should be updated to reflect the parents have opted out.

FIGURE 4.0 Opt out process



3.8 Parents request alternative RPHN/RM

3.8.1 In the event a parent requests an alternative RPHN/RM this should be addressed locally by RPHN/RM with ADPHN/ DPHN to seek a resolution.

4.0 Specific roles and responsibilities

Medical Officer of Health / Consultant in Public Health Medicine

The National Clinical Lead Child Health Public Health, Consultant in Public Health Medicine / Medical Officer of Health (MOH) has MOH responsibilities for the National Healthy Childhood Programme, as legislated for in the 1947 and

1970 Health Acts, at national level. This includes being part of the leadership responsible for sign-off of the non-engagement procedure document and addressing any issues nationally which arise from its implementation.

The PHN National QI Governance Group

The group will initiate a review of this procedure on the date on the front page of the document. The Group will initiate an earlier review date in the event of amendments to legislation, HSE policy or other related PPPGs.

National Lead for Public Health Nursing Service

The National Lead for Public Health Nursing will lead on the implementation of this procedure and address issues arising nationally with implementation. The National Lead will liaise with the DPHNs regarding implementation of the procedure.

The Role of the Director of Public Health Nursing

The DPHN is responsible for implementing, managing and auditing this procedure within their area. The DPHN is also responsible for ensuring that all RPHNs/RMs within their remit are aware of, have access to, have read and understood this procedure. This role may be delegated by the DPHN to the ADPHN. The DPHN will identify and support on-going related educational opportunities required to further enhance knowledge and skills. The DPHN will monitor risks and incidents relevant to this procedure.

The Role of the Assistant Director of Public Health Nursing

The ADPHN is responsible for the implementation of the procedure by ensuring that current documents are available to all RPHNs/RMs. The ADPHN is responsible for ensuring that all RPHNs/RMs and other designated staff have knowledge of the procedures to be followed within the document. The ADPHN is responsible for ensuring new RPHNs/RMs are informed of the procedure on induction. The ADPHN will ensure that all RPHNs/RMs are aware of any revisions to the procedure and ensure older versions of the procedure are removed from circulation. The electronic policy portal will support audit of compliance with this procedure. The ADPHN is the point of contact for RPHNs/RMs who experience difficulties tracking or tracing families (Monageer Inquiry 2009).

The Role of the RPHN/ RM

Each RPHN/RM is responsible for adhering to this procedure and using it to

guide their practice in the delivery of the service they provide. Each RPHN/RM is responsible for ensuring that they read and understand the document and have confirmed this through the electronic policy portal. When areas of concern are identified, where legislation is known to have changed or where a health, welfare and safety risk is identified, it is the responsibility of each RPHN/RM to ensure that their ADPHN is informed in order to ensure appropriate review and amendments are made to the procedure. RPHNs/RMs should adhere to HIQA and NMBI guidelines regarding documentation, record keeping and file management.

Role of Nursing Practice Development Co-ordinator: The NPDC where in post supports the development of best practice in the PHN service by promoting standardisation, quality assuring and evaluating nursing practice they have a key role in the transfer of knowledge to frontline staff through the dissemination of current evidence based practice.

5.0 Consultation

5.1 Stakeholder involvement

A draft of this procedure was circulated to all Directors of Public Health Nursing and their teams for consultation and feedback. The draft was also submitted to the HSE National Lead for Health and Social Care professions, Chief Officers, HSE GP Lead, Children First Office HSE and the National Healthy Childhood Programme. All feedback was collated and is held by the National Practice Development Coordinator for Public Health Nursing. This feedback was reviewed by the development group and recommendations accepted or rejected.

External review

A draft of this procedure was circulated Higher Education Institutes responsible for the training of PHN students, State Claims Agency, Dr Aoibhinn Walsh Consultant General Paediatrician (with a special interest in Inclusion Health working for Children's Health Ireland) and Tusla for consultation and feedback. All feedback was collated and is held by the National Practice Development Coordinator for Public Health Nursing. This feedback was reviewed by the development group and recommendations accepted or rejected.

6.0 National implementation plan

The procedure will be implemented within 6 months of approval.

This procedure was identified as a key procedure by the Nursing Practice

Development Co-ordinators National Group to support safe effective practice and ensure continuity and consistency of care for children and families. The National Quality Improvement Governance Group for the PHN Service endorsed the development of this procedure.

Information sessions will be offered to DPHNs/ADPHNs regarding the implementation of the procedure.

A copy of the procedure is available on the HSE website to download at National PHN Services: Primary Care www.hse.ie/phn and also on the electronic policy portal.

The introduction of the safe transfer of child health record procedure (PCPHN04 HSE, 2021b) and the national child health record will also contribute to supporting the implementation of this procedure. This procedure should be used in conjunction with the Public Health Nursing Service Child Health Record User Guide and Data Definitions and Manual (NHCP, 2020a and 2020b) and PCPHN06 Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service (HSE, 2021a).

Education/training required to implement the PPPG

Briefing sessions will be offered to the DPHNs and ADPHNs. Communication with the Higher Education Institutes responsible for student PHN education will occur to ensure awareness of this procedure. Local induction programmes for new nurses commencing employment will include briefing on all PPPGs approved for use within the PHN Service, including instruction on use of the electronic policy portal and signposting to the PHN page of the HSE website www.hse.ie/phn.

Persons responsible for the implementation of the PPPG

The National Lead for Public Health Nursing and the National Practice Development Co-ordinator for PHN Service will lead on the implementation of this procedure and address issues arising nationally with implementation.

The development group will initiate an earlier review date for this procedure in the event of amendments to legislation, HSE policy or other related PPPGs.

7.0 Governance and approval

This national procedure was commissioned by the National Quality Improvement Governance Group PHN Service. Final approval of the procedure was issued from National Community Operations and National Healthy Childhood Programme and follow up reviews will be initiated by National Quality Improvement Governance Group PHN Service. Refer to Appendix 1 for the development group details.

Appendix 2 details the Membership of the Approval Governance Group. This procedure will be submitted to the National Central Repository Office for referencing.

8.0 Communication and dissemination plan

The approved document will be circulated to all DPHNs nationally for dissemination to their respective nursing departments and to other key stakeholders involved in the management of non-engagement with child health assessments and reviews. A copy of the procedure is available on the HSE website to download at National PHN Services: Primary Care www.hse.ie/phn and also on the electronic policy portal.

Communication in relation to this procedure will clearly identify that it supersedes all previous local procedures regarding management of non-engagement with child health assessments and reviews.

9.0 Sustainability

9.1 Plan for national monitoring and audit

Monitoring of this procedure will occur by the ADPHN through professional supervision, team meetings and documentation audit.

Audit of the operation of this procedure will be initiated by the DPHN in consultation with the local CHO audit lead. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA, 2012b). Audit of the procedure will be carried out retrospectively by the designated person appointed by the DPHN. This procedure will be the standard for audit using the attached audit tool (Appendix 5).

The objectives of the audit will be:

- To provide evidence of compliance with the national procedure
- To ensure standardisation of application of the procedure
- To identify areas of improvement, make recommendations and prioritise actions.
- Frequency of audit, sampling processes and timescales for completions will be determined at local level following the first initial audit.

9.2 National audit tool

This procedure will be audited using the attached audit tool (Appendix 5).

10.0 Review / update

This procedure will be revised after 3 years on the date specified on the front of the document. This review will be triggered by the National PHN QI Governance group.

11.0 References

Appleton J., Powell C., Coombes L. (2016) Children's missed healthcare appointments: professional and organisational responses, Archives of Disease in Childhood, 101 (9), pp. 814- 818.

Arai, L., Stephenson, T. and Roberts, H. (2015) *'The unseen child and safeguarding: 'Did not attend' guidelines in the NHS'*, Archives of Disease in Childhood, 100, pp. 517-520.

Ballard, J., George, L., Zazeta-Lara, E., Turner, L., Aguado, J., Law, J. and Alger, R. (2019) *'Trauma informed public health nursing visits to parents and children'* Public Health Nurse, 36, p.694-701.

Chapman KA, Machado SS, van der Merwe K, Bryson A, Smith D. (2022) Exploring Primary Care Non-Attendance: A Study of Low-Income Patients. *Journal of Primary Care & Community Health.* doi:10.1177/21501319221082352

Department of Children, Equality, Disability, Integration and Youth (2022) Supporting Parents: A National Model of Parenting Support Services.

Department of Children and Youth Affairs (2017) Children First: National Guidance for the Protection and Welfare of Children.

European Commission (2016) General Data Protection Regulations.

Gibbons N., Harrison P., Lunny L., O'Neill G. (2010) Roscommon Child Care Case: Report of the Inquiry Team to the Health Service Executive.

Government of Ireland (1947) & (1970) Health Act – Irish Statute Book. Available online from:

www.irishstatutebook.ie/1970/en/act/pub/0001/print.html

Government of Ireland (2015) Children First Act. Stationery Office, Dublin.

Hanafin S. (2013) Child protection reports: Key issues *arising for Public Health Nurses.* Community Practitioner, 86 (10) pp. 24-27(4).

Health Information and Quality Authority (2012a) National Standards for Safer Better Healthcare.

Health Information and Quality Authority (2012b) National Standards for the Protection and Welfare of Children.

Health Information and Quality Authority (2021) Draft Overarching National Standards for the Care and Support of Children using Health and Social Care Services for public consultation.

Health Services Executive (2011) Child Protection and Welfare Practice Handbook

Health Services Executive National Clinical Programme for Paediatrics and Neonatology (2015) Model of Care for Neonatal Services in Ireland.

Health Service Executive (2016) National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs).

Health Service Executive (2019a) Child Protection and Welfare Policy.

Health Service Executive (2019b) Data Protection Guidelines.

Health Service Executive (2020) Incident Management Framework

Health Service Executive (2021a) Guideline on the use of the Child Family Health Needs Assessment in the Public Health Nursing Service. www.hse.ie/phn

Health Service Executive (2021b) Procedure for Managing the Safe Transfer of child health records in the Public Health Nursing Service. www.hse.ie/phn

Health Service Executive (2022a) Procedure for all Community and Hospital

Services Providing the National Newborn Bloodspot Screening Programme

Health Service Executive (2022b) National Consent Policy.
Health Service Executive (2022c) HSE Policy and Guidance on Lone Working.

Koball, A.M., Domoff, S.E., Klevan, J., Olson-Dorff, D., Borgert, A. and Rasmussen, C. (2021) *'The impact of adverse childhood experiences on healthcare utilization in children'* Child Abuse & Neglect, 111.

Miccoli, A., Song, J., Romanowicz, M., Howie, F., Simar S. and Lynch, B.A. (2022) *'Impact of Parental Adverse Childhood Experiences on Offspring Development in Early Head Start: Parental Adversity and Offspring Development'*, Journal of Primary Care & Community Health,13 pp. 1-8.

Monageer Inquiry (2009) Available at: <http://health.gov.ie/wp-content/uploads/2014/03/monageer_inquiry.pdf>

National Clinical Effectiveness Committee (2015) Standards for Clinical Practice Guidance.

National Healthy Childhood Programme (2020a) Public Health Nursing Service Child Health Record User Guide and Data Definitions.

National Healthy Childhood Programme (2020b) Child Health Assessment Manual for Registered Public Health Nurses.

National Institute for Health and Care Excellence (2017) Faltering growth: recognition and management of faltering growth in children NG75. https://www.nice.org.uk/guidance/ng75/chapter/recommendations

Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework.

Nursing and Midwifery Board of Ireland (2015) Recording Clinical Practice: Professional guidance.

Nursing and Midwifery Board of Ireland (2021) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives.

Office for Standards in Education, Children's Services and Skills (2011) OFSTED Annual report https://www.gov.uk/government/publications/the-annual-report-of-her-majestys-chief-inspector-of-education-childrens-services-and-skills-201011

Phelan A. & McCarty S. (2016) Missed Care: Community Nursing in Ireland. University College Dublin and the Irish Nurses and Midwives Organisation, Dublin.

Powell, C. and Appleton, J.V. (2012) *'Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for practice'*, Journal of Research in Nursing, 17(2), pp. 181-192.

Rahman, N.A., Idris, I.B., Idris, A. (2020) Why Missed Attendance among Children High at Well Child Clinics in Primary Care: A Literature Review. *Journal of Nursing and Health Science* 9(1) pp.1-8. DOI: 10.9790/1959-0901100108

Reder P, Duncan S, Gray M (1993) *Beyond Blame: Child Abuse Tragedies Revisited*. London: Taylor and Francis.

Substance Abuse and Mental Health Services (SAMHSA) (2014) Trauma-Informed Care in Behavioral Health Services. https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816?referer=from_search_result

Shannon G, Gibbons N (2012) Report of the Independent Child Death Review Group. Dublin, Government Publications.

United Nations Convention on the Rights of the Child (1989 & 2010) https://www.childrensrights.ie/sites/default/files/UNCRCEnglish.pdf

12.0 Glossary of terms

12.1 Abbreviations

ACE	Adverse Childhood Experience
ADPHN	Assistant Director of Public Health Nursing
CFHNA	Child and Family Health Needs Assessment
CFSNC	Child and Family Support Network Coordinator

CHIS	Child Health Information System
CHO	Community Healthcare Organisation
CHR	Child Health Record
DNA	Did not attend
DOH	Department of Health
DPHN	Director of Public Health Nursing
GDPR	General Data Protection Regulation
GP	General Practitioner
HIQA	Health Information and Quality Authority
HSE	Health Services Executive
INMO	Irish Nurses and Midwives Organisation
KPI	Key Performance Indicator
NICE	National Institute for Health and Care Excellence
NIRF	National Incident Report Form
MOH	Medical Officer of Health (Consultant in Public Health Medicine)
NMBI	Nursing and Midwifery Board of Ireland
NHCP	National Healthy Childhood Programme
NPDC	Nursing Practice Development Co-ordinator
ONMSD	Office of the Nursing and Midwifery Services Director
PC	Primary Care
PHR	Parent Held Record
PPPGs	Policy Procedure Protocol Guideline
RM	Registered Midwife
RPHN	Registered Public Health Nurse
Tusla	Child and Family Agency
WNB	Was not brought

12.2 Definitions

Abuse

Neglect occurs when a child does not receive adequate care or supervision to the extent that the child is harmed physically or developmentally. It is generally defined in terms of an omission of care, where a child's health, development or welfare is impaired by being deprived of food, clothing, warmth, hygiene, medical care, intellectual stimulation or supervision and safety

Emotional abuse is the systematic emotional or psychological ill-treatment of a child as part of the overall relationship between a caregiver and a child. Abuse occurs when a child's basic need for

attention, affection, approval, consistency and security are not met, due to incapacity or indifference from their parent or caregiver. **Physical** abuse is when someone deliberately hurts a child physically or puts them at risk of being physically hurt. It may occur as a single incident or as a pattern of incidents. **Sexual** abuse occurs when a child is used by another person for his or her gratification or arousal, or for that of others. It includes the child being involved in sexual acts or exposing the child to sexual activity directly or through pornography. **(Department of Children and Youth Affairs, 2017).**
Appointment: This is when a time and date has been allocated to the child for the assessment/reassessment or screening and the parent/legal guardian has been notified by letter/email or verbally over the phone/by text messaging service. The appointment may be scheduled face to face in clinic/primary care centre, in the home or by virtual consultation.
Cancellation: Is defined when prior notice is given to the service that the child will not be attending an appointment.
Child: means a *person under the age of 18 years, excluding a person, who is or has been* married (Children First Act 2015).
Child Health Record: All information collected, processed and held in manual formats pertaining to a child under the care of a RPHN/RM including demographic information, routine developmental assessments, personal care plans, correspondence and communications relating to the person and her/his care.
Child Health/Birth Register held by each RPHN, this register includes details of all children on the caseload noting name, date of birth and address.
Consent: Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication in which the service user has received sufficient information to enable him/her to understand the nature, potential risks and benefits of the proposed intervention (HSE National Consent Policy, 2022b)
Legal Guardian: Legal guardians are individuals that have legal authority to care for another person. A person lawfully invested with the power, and charged with the obligation, of taking care of and managing the property and rights of a person who, because of age, understanding, or self-control, is considered incapable of administering his or her own affairs.

Missed Care: Missed care is defined as 'any aspect of required client care that is omitted (either in part or in whole) or delayed' (Phelan & McCarty, 2016)
Must: Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed. (NMBI, 2021)
No Access Visit (NAV): A 'No Access Visit' refers to when the family are not available at home to be seen for a pre-arranged appointment. It is defined as a PHN child health and development assessment visit at their home, and when the RPHN/RM attends their place of residence at the pre-arranged time, they are not available, without having provided notification to the service. The following situations may be described as no access: A. No one at home for an opportunistic visit B. No one at home for a visit which was made by appointment with the family C. There is someone at home but they don't open the door D. A 'door step' visit occurs where the door is opened but RPHN /RM is not invited in. (Powell and Appleton, 2012).
Non-engagement with NHCP: Refers to when the RPHN is unable to see a child to complete the child assessment contacts for the following possible reasons: • Cancellation of PHN Child Health and Development Assessments by the Parents • Was Not Brought (previously referred to as DNA) • No Access Visit (NAV)
Opt Out: The parent has formally declined this child health and development assessment.
Parent: Parent refers to any person with a parenting role, which is any person with primary or major responsibility for the care of a child under the age of 18 years. The term parent is applied in the most inclusive manner as possible, and includes biological parents, adoptive parents, foster carers, step-parents, kinship carers, and guardians (Department of Children, Equality, Disability, Integration and Youth, 2022).
Professional Judgement: A nurses' professional judgement is based on the principles of responsibility, accountability and autonomy as outlined within her professional scope of practice. (NMBI, 2015)
Reasonable grounds for concern exist where a child may have been,

is being, or is at risk of being abused or neglected. It is not necessary to prove that abuse has occurred - all that is required is that there are reasonable grounds for concern. It is Tusla's role to assess concerns that are reported. Reasonable grounds for concern may include but are not limited to the following: ➢ Evidence, for example, an injury or behaviour, that is consistent with abuse and is unlikely to have been caused in any other way. ➢ Any concern about possible sexual abuse. ➢ Consistent signs that a child is suffering from emotional or physical neglect. ➢ A child saying or indicating by other means that they have been abused ➢ Admission or indication by an adult or a child of an alleged abuse they committed. ➢ An account from a person who saw the child being abused
Should: Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, 2021)
Was Not Brought (previously referred to as DNA): A Was Not Brought (WNB) occurs when a parent does not bring a child to an appointment. It is defined as any scheduled PHN child health and development assessment appointment to see the child, who, without notifying the service, was not brought/did not attend for the appointment. This refers to any prearranged contact with child, whether it is at the primary care centre, community clinic, at a community team building, or any other type of contact arranged relating to the provision of this service.

13.0 Appendices

Appendix 1: Membership of Development Group
Appendix 2: Membership of Approval Governance Group
Appendix 3: Conflict of Interest Declaration Form
Appendix 4: National Implementation plan
Appendix 5: National Audit Tool
Appendix 6: Checklist
Appendix 7: PHN Visit Card
Appendix 8: Sample Appointment Letter
Appendix 9: Change of Address Form
Appendix 10: Non-engagement Letter

Appendix 11: Opt Out Form

Appendix 12: Confirmation of Opt Out letter (to be used when parents decline to sign the opt out form).

Appendix 1: Membership of Development Group

Membership of the Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service Procedure Development Group	
Name	**Role and position**
Olivia O'Connor	Practice Development Coordinator CHO2
Yvonne Delaney	Practice Development Coordinator CHO8
Brenda Horgan	Practice Development Coordinator CHO9 – Retired 30/05/2024
Emma Reilly	National Healthy Childhood Programme – Child Health Programme Development Officer CHO7
Mary McFeely	Public Health Nurse CHO1
Edel Byrne	Public Health Nurse CHO7
Sharon Boyle	Assistant Director of Public Health Nursing CHO7
Elaine Cowley	Public Health Nurse CHO7 (left group as took up a new post)
Niamh Dempsey	Assistant Director of Public Health Nursing CHO7 / QI Group Rep (left group as took up a new post)
Mary O'Malley	Assistant Director of Public Health Nursing CHO2
Claire Staunton	Assistant Director of Public Health Nursing CHO9
Floraidh Dunn	Public Health Nurse for Travelling Community Sligo/Leitrim/West Cavan PHN services
Helen Sheehy	Public Health Nurse CKCH
Liz Balfe	INMO Rep – resigned from group Jan 2024
Brid McCarrick	Public Health Nurse CHO9
Edel McAweeney	Director of Public Health Nursing Cavan/Monaghan

Dolores O'Keeffe	Public Health Nurse North Cork
Edel Marken	Assistant Director of Public Health Nursing CHO9 (left group as took up a new post)
Chairpersons: Sinead Lawlor	National Practice Development Coordinator
Edel Maxwell	Practice Development Coordinator CHO6

Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service was formally ratified and recorded in the minutes of the procedure development group on 07/06/24. The procedure was submitted for approval.

Appendix 2: Membership of Approval Governance Group

Membership of Non Engagement in the NHCP procedure approval governance group

Name	Role and position
T.J Dunford	Operational Lead, Primary Care
A Collins	National Clinical Lead Child Health Public Health

Sign-off by Chair of Approval Governance Group

Name: (print) Abigail Collins

Title: National Clinical Lead Child Health Public Health

Signature:

(e-signatures accepted)

Registration number: (if applicable)

Appendix 3: Conflict of Interest Declaration Form

CONFLICT OF INTEREST DECLARATION FORM

This form must be completed by each member of the Development Group.

Title of National 3PG being considered: Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service

Please indicate the statement that relates to you

I declare that **I DO NOT** have any conflicts of interest ☐

I declare that **I DO** have a conflict of interest ☐

Details of conflict (please refer to specific National 3PG)

(Append additional pages to this statement if required)

Signature:

Print name:

Registration number (if applicable):

Date:

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that Development Group act in the best interests of the members. The information provided will not be used for any other purpose.

A person who is covered by this National 3PG* is required to furnish a statement, in writing, of:
(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

*policy, procedure, protocol or guideline.

Appendix 4: National Implementation plan

National 3PG Title: Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service
Date National 3PG approved: 12/08/2024
Expected date of full implementation: 6 months following approval
National 3PG implementation lead/role: Grainne Ryan National Lead for Public Health Nursing

IMPLEMENTATION ACTION	Implementation barriers / enablers	List of tasks to implement the action	Lead responsibility for delivery of the action	Expected completion date	Expected outcomes
Disseminate approved document to all staff	Electronic Policy Portal in use in all areas and includes compliance reports	Circulate to DPHNs for onward circulation to all staff	S Lawlor	2 weeks from approval date	The procedure will be available for use across the PHN services nationally within 1 month from approval date.
		Communications to be sent to the Higher Education Institutes responsible for student PHN education to ensure this procedure forms a component of the module relevant to caseload management.	S Lawlor	2 weeks from approval date	The procedure will be available for use across the PHN services nationally within 1 month from approval date.
		Inform DPHN forum of updated version	G Ryan	2 weeks from approval date	The procedure will be available for use across the PHN services nationally within 1 month from approval date.
		Email of approved document to all ADPHNs for circulation to all staff	S Lawlor	2 weeks from approval date	The procedure will be available for use across the PHN services

					nationally within 1 month from approval date.
Information sessions developed nationally and delivered via webinar.	Enabler: Webinar will be recorded for all nurses/midwives to watch back. Enabler: PowerPoint slide set available to support implementation. Barrier: IT access is variable.	Development group to develop session Set date for national live webinar. Provide and record webinar to DPHNs, ADPHNs, Clinical Learning Facilitators (CNM2), PDCs, Child Health Programme Development Officers. Disseminate recorded webinar and slides.	Development Group	6 months from approval date	The standardised clinical care plans and associated procedure will be available for use across the PHN services nationally 6 months from approval date.

Education / training required to implement the National 3PG:

Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service Powerpoint information session

Launch webinar and recording of same for all staff

Adapted from National Clinical Effectiveness Committee (NCEC) Implementation Guide and Toolkit (Department of Health 2018)

Appendix 5: National Audit Tool

Audit tool for the procedure on the Management of Non-engagement with the National Healthy Childhood Programme in the Public Health Nursing Service

No	Question	Yes	No	N/A	Comment
1	Is it clearly documented in the child health record that there has been non-engagement with the National Healthy Childhood Programme in the PHN service?				
2	Is there evidence the progress notes were updated during each attempted contact?				
3	Have the principles of good documentation been adhered to: black ink, legible, date and timed with 24 hour clock, signature and NMBI number?				
4	Is it evident from the child health record that a new appointment had been offered where a parent has notified the RPHN/RM to cancel a scheduled appointment?				
5	Is it documented that the RPHN/RM has discussed the case with the ADPHN if necessary?				
6	If there are any child safeguarding concerns is there evidence that these have been reported to TUSLA?				
7	Is there evidence that the information leaflets (including version numbers) provided to the parents were recorded in the CHR?				
8	In the case of opt out, be it verbal or opt out form complete, are the parent's views represented?				
9	Is there evidence that the GP has been informed (*where applicable)*?				
10	Are there copies of all letters sent filed in the correspondence tab?				
Action areas identified: **Quality improvement plan:**					
Date and time: **Audit completed by:** **Title:** **Health Centre/PCC:** **CHO:** **Compliance Rate %:** **/10**					

Please answer all questions indicating Yes or No or Not Applicable

Appendix 6: Checklist

[This is the responsibility of the chairperson of the Development Group]

Checklist for Best Practice in Developing HSE National 3PGs

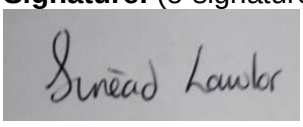
Stage 1	**Deciding the need**	
1.	Aligned with HSE National Priorities	☒
2.	Clearly defined document type (P,P,P or G)	☒
3.	Approval obtained to develop	☒
Stage 2	**Planning**	
4.	Governance clearly established	☒
5.	Appropriate stakeholder involvement	☒
6.	Defined in-scope and out-of-scope	☒
7.	Development Group (terms of reference/conflict of interest forms)	☒
Stage 3	**Development**	
8.	Evidence methodology based	☒
9.	Creation of guidance / recommendations	☒
10.	Explicit link between the evidence to guidance / recommendations	☒
11.	Circulated for national consultation/independent expert review (as required)	☒
12.	Audit Tool developed	☒
Stage 4	**Implementation**	
13.	Implementation plan completed / Team established	☒
14.	Communication and dissemination plan developed	☒
15.	Supports: advice, tools, resources developed and where to access	☒
Stage 5	**Sustainability**	
16.	Monitoring and Audit Plan outlined	☒
17.	Audit outcomes: structure in place to link to quality improvement and risk management processes	☒
Document Control		
18.	Mandatory pages 1+2 of this template are fully completed.	☒

I confirm that all of the above key activities have been met: ☐

Chairperson name: Sinéad Lawlor

Title: National Practice Development Coordinator for Public Health Nursing

Signature: (e-signatures accepted)



Date: 14/8/2024

14/08/2024

Appendix 7: PHN Visit Card

CARE COMMITMENT COMPASSION

Public Health Nursing Services aim to deliver safe, quality, and person centred community nursing care across the lifespan: we are committed to promoting health and wellbeing and enabling people to live healthy and fulfilled lives.

Public Health Nursing Service

Date_____ Time_____

To: _____

I called to this address today to visit you but received no reply:

Please contact me at: _____

Primary Care Centre/ Health Centre

Phone Number_____

Between the times of:_____

Name (block capitals)_____ Title_____

Card Code: PCPHN07

Appendix 8: Sample Appointment Letter

Public Health Nursing Service National Healthy Childhood Programme

	The aim of this programme is to assess your child's health and development. We can discuss any concerns you have in relation to your child. Following assessment, we can offer advice and refer to other services if required. This programme is offered to all children up to 4 years of age.
	A child health and development assessment appointment has been made for your child with the Public Health Nurse as follows:
	**Childs Name:**
	**Date:**
	**Time:**
	**Venue:** **Eircode:**
	**Please Bring**: - This appointment letter - Your Child's ***ORANGE*** Health Record Book (if relevant)
	**Appointment Support Tel No/Email:**
Can Not Attend	If you cannot attend your appointment or you are having difficulties bringing your child to an appointment, please contact our appointment support on the number/email above as soon as possible to arrange a new appointment. If you have changed address please let us know.

Acknowledgements:
This letter was developed by Cavan Monaghan Primary Care Management Team sub group – Edel McAweeney DPHN, Angela Walsh, SLT Manager and Irene Cunningham, Dietitian Manager. It was adapted for this procedure with their kind permission.

Appendix 9: Change of address form

NOTIFICATION OF CHANGE OF ADDRESS

CHILD HEALTH RECORD (CHR)

Tick relevant box:

Request for Child Health Record (Transfer in) □ Forward Child Health Record (Transfer out) □

Unknown address □ Setup on CHIS/Local System□

Child 1	*(Block letters please)*	**Child 2**	*(Block letters please)*	**Child 3**	*(Block letters please)*
Surname		Surname		Surname	
Forename		Forename		Forename	
DOB		DOB		DOB	
Gender		Gender		Gender	

Mother/Legal Guardian: Surname Maiden name Forename Phone Number DOB	**Father**/Legal Guardian: (For CHIS/System set up) Surname Forename Phone number
Previous Address **EIRCODE** **Transferring Out RPHN Area code** **Transferring Out Health Centre**	
Previous School (if applicable):	
New home address (if known): **EIRCODE** **New School (if applicable)** **New RPHN Area code (if known)**	
Current GP:	**New GP (If known)**
RPHN/RM Signed:	**Date**

To Director of Public Health Nursing

□ I request CHR for child/ children listed above, now residing in County _____

□ I enclose CHR for the child/children listed above who have transferred to your area

□ Family have moved unknown address – copy to Child Health PHN/IMM-PHR IT Office

Signed: _____ **Date:** _____
ADPHN/Child Health Office Admin

Acknowledgement of receipt by PHN receiving the chart; return to local child health office/admin

Signed: _____ **Date:** _____

Appendix 10: Non-engagement letter

Public Health Nursing Service

Click or tap here to enter text. **Health Centre,**
Click or tap here to enter text.
Phone: Click or tap here to enter text.
Date: Click or tap to enter a date.

Re: Click or tap here to enter text. ***(Child's name)***

Address: Click or tap here to enter text. **DOB:** Click or tap to enter a date.

Dear Parent/Guardian,

Your child was offered a Choose an item. assessment on the Click or tap to enter a date. and Click or tap to enter a date. as part of the National Health Childhood Programme.

The aim of this programme is to assess your child's growth and overall development. I can also discuss any concerns you have in relation to your child. Following assessment, I can offer advice and refer to other services if required.

(Tick as appropriate)

☐ I have been unable to make contact with you by phone or at the above address.
☐ Your child was not brought to their appointment.

Please can you email ☐ call ☐ or text ☐ me to arrange a new appointment. The contact details are: Click or tap here to enter text.
If you have changed address please let me know.

If you do not contact me, no further appointments will be offered until your child's next routine child health and development assessment is due. Choose an item.

If you have any queries please do not hesitate to contact me.

Yours sincerely,

_____
Public Health Nurse
cc. GP ☐
ADPHN ☐
PHR/Child Health Office ☐

Appendix 11: Opt out Form

NATIONAL HEALTHY CHILDHOOD PROGRAMME IN THE PHN SERVICE OPT OUT FORM

Baby's Unique Perinatal Identifier (UPI): _____
Childs Surname: _____
Childs First Name: _____
DOB: ____/____/____
Gender: M □ F □ Other □
Birth Surname: *(if different)* _____

Childs Address including Eircode)
(use addressograph if available)

Mother's Name: _____Mother's Date of Birth: ____/____/____
Father's Name: _____Father's Date of Birth: ____/____/___

- I _____being the parent/Legal guardian of *(Child's name)* _____ wish to opt out from the National Healthy Childhood Programme in the PHN service.
- I have read the information on the National Public Health Nursing Service Leaflet. *(available in 12 languages)*
- I fully understand the importance of the decision that I am taking by not allowing my child to avail of the National Healthy Childhood Programme and that not consenting to the child health and development assessments for my child may result in an undiagnosed developmental delay.
- I understand that Tusla, the Child and Family Agency, may be notified that I have opted out of the National Healthy Childhood Programme for my child, if appropriate.
- Reason for opting out
  _____

Signed 1st (Parent/ Legal Guardian): _____
Full Name (PRINT): _____ Date: _____
Signed 2nd (Parent/ Legal Guardian) *if relevant*: _____
Full Name (PRINT): _____ Date: _____
Signed by Public Health Nurse: _____ PIN No: _____
Date: _____Location: _____ Health Centre Phone number _____

NATIONAL HEALTHY CHILDHOOD PROGRAMME IN THE PHN SERVICE OPT OUT FORM PAGE 2

Child's Name: _____ Date of Birth: ____/____/____

Ensure copies of opt out form are sent to all locations below

5/6 copies of this completed form, signed by parent/legal guardian and RPHN/RM should be made.

- The original version is kept in the child health record ☐
- Copy to be given to each parent/legal guardian ☐

Copy posted to each of the following:

- Director of Public Health Nursing ☐

Child's General Practitioner ☐

PHR/Child Health Office ☐

Tusla (if appropriate) ☐

Parents do have the right to opt-out from the programme on behalf of their child. However, parents should be actively discouraged from doing so in the best interest of their child's well-being. It is important that the RPHN/RM discusses the decision to opt out with the parent(s) in order to understand the rationale and motivation behind her decision. RPHNs/RMs should consider seeking the support of the General Practitioner and the Director of Public Health Nursing/ADPHN to consult with parents regarding consent to the programme. If parents do decide to opt out, it is essential that they are fully informed of the potential clinical consequences for their child.

Parents should be informed that they may change their mind in the future. However, it is their responsibility to make their change of mind known to the PHN service.

Note:

In the event of a parent opting out of the national Healthy Childhood Programme, child assessment contacts, be it verbally or by signing the opt out form, the documentation should include:

- all information provided to the parent(s), including copies of any supporting literature or including the version/edition of the literature given to the parent(s) during the consultation ☐
- the associated risks and benefits of the PHN child health and development assessments being offered ☐
- the possible consequences of declining the services ☐

If the parent(s) provides a rationale for opting out, this should also be documented. If the parent(s) declined to sign the opt-out form, this should be documented and a confirmation of opt out letter sent to the parent.

Signed (Public Health Nurse): _____ PIN No: _____

Date: _____

Appendix 12: Confirmation of opt out letter (to be used when parents decline to sign the opt-out form)

Public Health Nursing Service

Click or tap here to enter text.Health Centre,
Click or tap here to enter text.
Phone: Click or tap here to enter text.
Date: Click or tap to enter a date.

Opt-out of Public Health Nursing National Healthy Child Programme

Re: Click or tap here to enter text.*(insert child's name)*

Address: Click or tap here to enter text. **DOB:** Click or tap to enter a date.
Dear Parent/Guardian,

I acknowledge your verbal request to opt out of the National Healthy Childhood Programme in the Public Health Nursing Service.

I have enclosed information on the public health nursing service for your information. If you wish to avail of the service at any stage please contact me at:
Click or tap here to enter text.Health Centre by phone Click or tap here to enter text. or email Click or tap here to enter text.
I have sent a copy of this letter to the services specified below.

If you have any questions please contact me.

Yours sincerely,

_____
Director of Public Health Nursing

cc.
GP ☐
ADPHN/DPHN ☐
Tusla ☐
Child Health Record ☐
PHR/Child Health Office ☐