Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service

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PART A: Outline of PPPG Steps

Title: Guideline on the use of the Child and Family Health Needs Assessment Framework (CFHNA) for the Public Health Nursing (PHN) Service

Background A1.0

A1.1 The PHN Service is committed to implementing the Child and Family Health Needs Assessment Framework to assist registered public health nurses (RPHN)/registered midwifes (RM) in identifying families with children who are in need of additional support and intervention. It is recommended that RPHN/RM undertake education and training in the use of the CFHNA framework prior to use in practice. The term child is used throughout this guideline, it is acknowledged that this may mean infant, child or children, depending on the individual case circumstances.

A1.2 National Healthy Childhood Programme Child Health Screening and Surveillance (CHSS) The primary purpose of the CHSS programme is prevention and early detection of deviations from normal growth and development and to provide support to parents to help them meet the needs of their child. The child is dependent on the capacity of the parents to reach his/her normal growth and development potential. Parent/s unmet needs can be a disenabling factor for the child's well-being and well-becoming. Where an issue/concern is raised either by a parent and/or child it should elicit a response from the RPHN/RM. Accordingly, it is in the context of child development, parenting capacity, and family and environmental factors that the RPHN/RM grounds her/his professional reflective practice.

Where a RPHN/RM identifies any area of concern e.g. developmental delay; disability; physical health problem; parenting capacity; family and/or environmental issues a referral should be made to the appropriate services. Where the RPHN/RM has concerns regarding the referral process or the availability of a service he/she should discuss this with their ADPHN and Primary Care Team. It is important to identify children who require services as early as possible. In the event that there are known waiting periods for services a referral should still be made and parents advised of the waiting period. The RPHN/RM can continue to implement the nursing care plan actions.

The RPHN/RM can link with the local Tusla Child and Family Support Network Coordinator regarding available supports and services in the community. https://www.tusla.ie/get-in-touch/child-and-family-support-network-co-ordinators/ The coordinator may also be made aware of unmet support needs in the area.

A2.0 Child and Family Health Needs Assessment Framework

The CFHNA is broadly based on the Framework for the Assessment of Children in Need and their Families (UK DOH 2000) and the Active Developing Child Domains and Dimensions from a Whole Child Perspective (Appendix V). The three key concept domains that primarily underpin the framework are:

- Child Development Needs
- Parenting Capacity
- Family and Environmental Factors

The Child and Family Health Needs Assessment Framework includes:
• Child and Family Health Needs Questions - incorporated into the National Healthy Childhood Programme CHSS assessments in the Child Health Record.

• A Child and Family Health Needs Assessment Record in the CFHNA tab of the Child Health Record.

• Known risk and protective factors – to assist with professional decision making (Appendix V).

• The Active Developing Child Domains and Dimensions – from a Whole Child Perspective (Appendix V).

• The Active Developing Child Domains, Dimensions and Indicators (Appendix V).

A3.0 When to complete a Child and Family Health Needs Assessment [CFHNA]
This is a level two assessment that takes place to assess if children and families have additional identified needs, for example with parenting and child welfare support.

A3.1.1 The assessment process is designed to be used if indicated by the RPHN/RM at the National Healthy Childhood Programme CHSS contact points or at any other contact if required. It should be carried out with the informed consent of the parent (see point A4.8). It is important that the RPHN/RM informs the parent of the role of the RPHN/RM and explore any concerns the parents have. The assessment process focuses on encouraging families to acknowledge their health needs and jointly plan appropriate interventions to address identified needs.

The following is not an exhaustive list of circumstances in which a CFHNA should be completed. The RPHN/RM should use her/his clinical judgement and discuss with her/his ADPHN if support is required.

A3.1.2 At any time if the RPHN/RM is concerned about the baby/child's health, welfare, behaviour, progress in learning or any other aspect of their well-being and/or their needs are not being met by their parent(s). This includes children with complex needs up to the age of 5 years.

A3.1.3 If the RPHN/RM has concerns about the mother's health and well-being and/or her capacity to care for her baby, for example, positive responses to the postnatal depression and anxiety screening questions.

A3.1.4 Where there is any change in the family circumstances or lifestyle as a result of illness, bereavement, homelessness, living in the international protection accommodation system (previously known as direct provision), newly acquired disability, alcohol/drug misuse, domestic violence and/or life/family changing event that impacts on the parents/carers capacity to

provide for the needs of the child/children.

A3.1.5 Where child protection and/or welfare concerns arise for a child.

A3.1.6 The CFHNA should be completed by the RPHN/RM in circumstances where other disciplines, including Tusla Child and Family Agency, are involved / pending involvement with child/family including:

- Where a Meitheal process is in place (in areas where Meitheal Model is in use). The CFHNA will also support the Signs of Safety strengths based approach utilised by Tusla.

- Where Tusla Child and Family Agency/ Family support worker is involved with the family.

- Where children and families move into the area and have social worker/ TUSLA involvement.

In the event a Tusla social worker contacts a RPHN to elicit information as part of the network checks regarding a child or family the RPHN should enquire if there are any new or emerging needs in relation to the child/family that require follow up by the PHN Service.

A3.1.7 The CFHNA should be completed by the RPHN/RM for Child Protection Conferences where RPHN service is involved with the child and family. This assessment will support the RPHN/RM in completing the national template for conference and court reporting facilitated within the Signs of Safety model of practice.

A3.1.8 National Childcare Scheme Referral
The National Childcare Scheme provides financial support to help parents meet the costs of childcare. The National Childcare Scheme (NCS) introduced by the Government of Ireland (2019) makes special arrangements for vulnerable children and families to be referred by certain sponsor bodies so they can receive free childcare. The HSE is one of the 5 sponsor bodies. The RPHN, on behalf of the HSE, can refer a child to NCS where there is an identified need for childcare as an additional support to the home environment to meet child development needs for children under the age of 4 years and who is not enrolled in a pre-school programme.

A3.1.9 Where a new concern/life/family changing event/significant issue arises a new assessment be completed. This may indicate that additional referrals (this may or may not include a referral to Tusla) and a careplan are necessary.

A3.1.10 If there is a positive response to any of the CFHNA questions (also see point A4.7).

A3.1.11 Where a parent has a disability and may require additional supports to enable them to parent effectively.

A4.0 Four Child and Family Health Needs Assessment Questions
The child and family health needs questions in the national standardised Child Health Record

will assist the RPHN/RM to reflect on the health and social information which is gathered in the context of a whole child approach to health promotion and protection.
The questions will assist the RPHN/RM to ground the information in the active developing child domains and dimensions (Appendix V), particularly where there is a concern or unmet need that is likely to have an impact on the child's health and development.

A4.1 The four CFHNA questions are incorporated into the Child Health Record at the primary visit, 3 months, 9-11 months, 21-24 months and 46-48 month assessments:
1. *Parenting Issues Expressed and/or Identified? Yes/ No (If Yes, Care Plan commenced Yes/No)*
2. *Housing/Environment Issues Expressed or Identified? Yes/ No (If Yes, Care Plan commenced Yes/No)*
3. *Access to Family/Community Supports Issues Expressed or Identified? Yes/No (If Yes, Care Plan commenced Yes/No)*
4. *Other concerns expressed or identified by parents or services involved with the family? Yes/No (If Yes, Care Plan commenced Yes/No)*

The RPHN/RM must also record a response to the following questions:
Is a CFHNA required? Yes/No
If yes, CFHNA Completed Yes/No

A4.2 The four CFHNA questions should be asked by the RPHN/RM at the primary visit.

A4.3 The prompt CFHNA question
Has there been any changes in the child or family circumstances from the previous contact?
is incorporated into the Child Health Record at the 3 months, 9-11 months, 21-24 months and 46-48 month assessments. The RPHN/RM should ask the prompt question of the parent at all other subsequent contacts. The response is recorded. If the response is yes, the RPHN must ask the four CFHNA questions outlined in section 4.1.

A4.4 The four CFHNA questions (section 4.1) may be used by the RPHN/RM during any contacts outside of CHSS with the child/family by the RPHN/RM. Responses to the CFHNA questions should be recorded in the additional CFHNA Question Sheet. These are filed in the CFHNA tab of the Child Health Record. (An additional CFHNA record is provided in Appendix V for printing and inserting in the Child Health Record if required).

A4.5 The RPHN/RM should use the Active Developing Child Domains and Dimensions (Appendix V) as a guide to systematically consider the questions and to decide whether or not to initiate a Child and Family Health Needs Assessment.

A4.6 Where the CFHNA questions have led to a concern, the RPHN/RM must complete the CFHNA record and initiate a care plan where needs are identified.

A4.7 Where the response to any of the four questions is yes, but the RPHN/RM using her/his clinical judgment deems a CFHNA not to be required, the RPHN/RM must record the rationale

for their decision in the 'PHN Progress/Communication Notes' section of the Child Health Record.

A4.8 The RPHN/RM must discuss the completion of a CFHNA with the parent unless doing so would put the child at additional risk.

A5.0 Child and Family Health Needs Assessment

A5.1 The assessment should consider:

- The reason for the assessment.
- The impact on the child's developmental needs.
- Parenting capacity - maternal and or paternal personal factors disclosed by the parent that may impact on the parents' capacity to respond to the needs of the child.
- Family and environmental factors which impact negatively on parents'/carers' capacity to respond to the needs of the child.
- Protective factors within the family that may help minimise the risk to the child and/or family.
- A summary of the facts including- what are the concerns? what is working well? and what needs to happen?
- RPHNs/RMs should record what they observe/ witness at the time of contact (in the clinic or home setting) or what is disclosed to them and this should be documented accurately and factually.

A5.2 The RPHN/RM should encourage the parents to acknowledge their health needs and jointly plan appropriate interventions to address identified needs.

A5.3 The RPHN/RM continues to offer support as appropriate to the child and family in line with the care plan.

A5.4 The RPHN/RM should continue to assess and monitor the child's development and refer to other services as appropriate.

6.0 Completion of the CFHNA Record

A6.1 In families where a need or concern is identified for more than one child in receipt of PHN Service, a separate CFHNA will need to be completed for each child (up to primary school entry) in the family for whom there is concern.

The RPHN/RM should:

A6.2 Complete the CFHNA record using the Active Developing Child Domains, Dimensions and

Indicators (Appendix V)as appropriate, to assist with the gathering and the interpretation of the information to be recorded.

A6.3 Record all identified family and environment risk and protective factors to support the assessment, professional judgement and decision making. Identify how strengths and challenges experienced by the family impact on a child's health and development.

A6.4 Complete the summary section of the CFHNA following completion of the care plan. The summary section of the CFHNA should reflect the concern/problem and the goals specified in the care plan.

A6.5 In the care plan be specific about the problem/need identified and the actions to be taken. Identify who is responsible for each action, including the role of the parent/primary carer and any services or resources that will be required to achieve the outcomes. The expected goals and the review date must be specified. The RPHN should use clinical judgement to decide on the appropriate timeframe to review the case/careplan goals.

A6.6 Number each problem/need identified in the care plan. This enables the RPHN/RM to link this issue to entries in the PHN progress/communication notes.

A6.7 Write the on-going narrative assessment of the care plan goals in the PHN progress/communication notes. There must be clear evidence of on-going assessment of the careplan documented.

A6.8 In the outcome/evaluation column of the care plan record the outcome and/or evaluation for each problem/need identified and whether the circumstances have resolved, improved, remains the same, or deteriorated.

A6.9 It may be necessary to commence a new care plan if the situation has deteriorated.

A6.10 Be responsible for the review of the care plan within the specified timeframe. Modifications or new interventions as a result of the review must be recorded and a new review date set.

A6.11 Record the location where all contacts take place in the PHN progress/communication notes.

A6.12 Record referrals made and supports recommended as a result of identified needs.

A6.13 Continue to have on-going involvement with the family according to the care plan goals agreed with the family and the delivery of the CHSS.

A6.14 The involvement of other health care professionals/agencies does not discharge the RPHN/RMs duty of care towards the child and their family.

A6.15 The CFHNA care plan must indicate when the intervention is complete and the outcomes documented by the RPHN/RM. Although children are routinely discharged from the RPHN caseload after the 46 - 48 month developmental as per the National Healthy Childhood Programme, if there is an open care plan in place they may remain on the caseload until age 6 (Health Act 1970). The RPHN should discuss the discharge of a child > 5 years and 11 months with an open CFHNA in place, with his/her ADPHN.

A6.16 Record all entries chronologically in the care plan and PHN progress/communication notes.

A6.17 Include details of telephone calls and discussions with parents and professionals in the PHN progress/communication notes and file a copy of emails in the Child Health Record.

A6.18 Avoid the use of abbreviations. Entries in the Child Health Record should be individualised, accurate, up to date, factual and unambiguous and relevant. Entries must be contemporaneous, signed, dated and timed as per best practice standards outlined in NMBI Recording Clinical Practice: Professional guidance (2015a).

A6.19 Document all findings and decisions. Discuss with her/his ADPHN for support/supervision if required.

A6.20 A copy of the CFHNA may be forwarded to Tusla to supplement a Tusla referral (See section 7.6). A completed CFHNA record will inform the completion of the Tusla referral. The CFHNA can also inform the completion of a court or child protection conference/review report.

A6.21 Inform the parent that the Child and Family Health Needs Assessment Record will be filed within the Child Health Record.

A6.22 The CFHNA record is filed by the RPHN/RM in the CFHNA tab of the Child Health Record.

A6.23 The care plan should be filed by the RPHN/RM in the care plan tab of the Child Health Record.

A6.24 Planned supervision with the RPHN/RM at regular intervals by the ADPHN is recommended.

A6.25 If there is no improvement on the impact of the issue/s on the child, the RPHN should discuss the case with the ADPHN and may contact the local dedicated contact point/ duty social worker to discuss the case if necessary. Refer to Children's First National Guidance (2017) and Appendix 1 in the HSE Child Protection and Welfare Policy (2019a).

A7.0 Sharing of Information

A7.1 Best practice indicates that professionals should obtain informed consent from parent(s)

before sharing information with any other discipline. For any intervention to be successful in achieving its goal and optimal potential; the consent, on-going consultation, co-operation and participation of families is crucial.

A7.2 The informed consent/awareness of children, young people and their parents or carers should always be obtained when sharing information, unless to do so would place the child/person at risk of significant harm.

A7.3 In the event a decision is made to share information when consent is withheld, the reasons for this should always be recorded in the Child Health Record and discussed with the ADPHN.

A7.4 All nurses including student PHNs, RPHNs and RMs are designated officers under the Protection of Persons Reporting Child Abuse Act 1998 and as such are mandated to report child abuse to Tusla via the Tusla portal or by contacting the local dedicated contact point. The Children First Act (2015) outlines Mandated Persons (18 in total) and relevant services (9 in total). The Registered Nurse or Registered Midwife are specified as mandated persons within the meaning of section 2(1) of the Nurses and Midwives Act 2011. Mandated persons have two main legal responsibilities under the Children First Act (2015)

- To report harm of children above the defined threshold to Tusla
- To assist Tusla, if requested, in assessing a concern which has been the subject of a mandated report.

A7.5 The proportionate provision of information to the statutory agencies necessary for the protection of a child is not a breach of confidentiality or data protection.

A7.6 The Tusla Portal allows users to securely submit Child Protection and Welfare Report Forms (CPWRFs) and Retrospective Abuse Report Forms (RARFs) to Tusla online- see the attached HSE reporting procedure and link https://www.hse.ie/eng/services/list/2/primarycare/childrenfirst/resources/hsestaffreportingprocedures.pdf and Tusla Guide for reporters - https://www.tusla.ie/uploads/content/4214-TUSLA_Guide_to_Reporters_Guide_A4_v3.pdf

A8.0 Management of the Child and Family Health Needs Assessment Record

A8.1 It is the responsibility of individual RPHN/RM to ensure that the appropriate security and data protection measures are observed for maintaining and storing records containing personal or other confidential information in compliance with HSE Standards and Recommended Practices for Healthcare Records Management (2011) and Data Protection Guidelines (HSE 2019b).

A8.2 The Child and Family Health Needs Assessment Record must be stored in the Child Health Record in the CFHNA tab. Accompanying documentation should be stored in the appropriate section of the Child Health Record i.e. care plan tab or correspondence tab for letters received

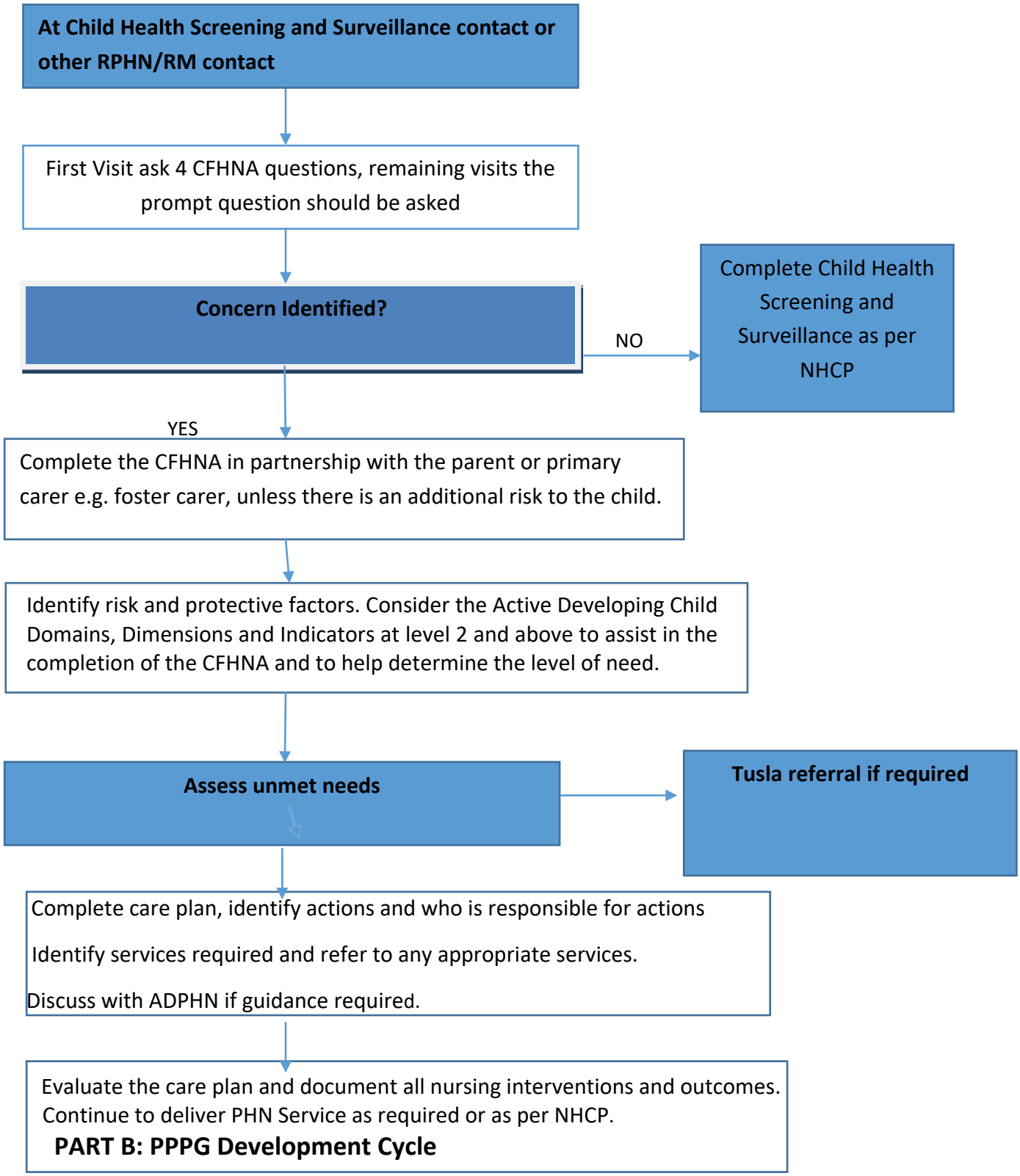
from social work etc.

A8.3 In the event there is a need to transfer the Child Health Record, refer to the Procedure for the Management of Safe Transfer of Child Health Records in the Public Health Nursing Service (2021) for guidance on the management of the child and maternal health records.

A8.4 The maternal postnatal record should be removed and archived separately (as per local procedures) when the child is discharged from the Public Health Nursing Service. It is important that should any request come in under FOI or GDPR that only information relating to the subject of the request is released with appropriate redaction of any third-party information.

A8.5 As per HSE Child Protection and Welfare Policy (2019a) and HSE Record Retention Policy (2013) as a result of childcare legislation, any child health records containing child protection and welfare concerns must be kept in perpetuity. If a child health record has any information captured that relates to a child protection and welfare issue, the cover of the child health record must be marked clearly with 'In Perpetuity' in black permanent marker or a 'In Perpetuity' sticker is placed on the front cover. This is to ensure that these child health records can be readily identified as not for destruction or shredding. These records should be archived as per local policy.

Child and Family Health Needs Assessment Process



1.0 INITIATION

1.1 Purpose

The purpose of this guideline is to inform Registered Public Health Nurses (RPHNs) and Registered Midwives (RMs) within the Public Health Nursing Service on the use of the Child and Family Health Needs Assessment Framework.

1.2 Scope

The scope of this guideline identifies what will (and will not) be covered by the guideline

1.2.1 **Target users:** This guideline applies to RPHNs who have responsibility for the delivery of child health services and RMs who have responsibility for undertaking the primary visit. RPHNs and RMs must have undertaken the approved programme of education. This guideline must always be used in conjunction with professional clinical judgement. This guideline also applies to Assistant Directors of Public Health Nursing (ADPHN) with a role in supporting staff in the implementation of the CFHNA. This guideline does not apply to Community Registered General Nurses (CRGN) however under the Child Care Act 2015 this group are listed as mandated persons with a legal obligation to report concerns to Tusla and assist Tusla in an assessment.

1.2.2 **Population to whom it applies:** this guideline applies to RPHNs and RMs providing a service to children and families in accordance with the National Healthy Childhood Programme.

1.3 Objectives

1.3.1 To ensure that there is a standardised approach to undertaking a Child and Family Health Needs Assessment in the Public Health Nursing Service, which is evidence-based and complies with best practice.

1.3.2 To assist relevant RPHNs and RMs in identifying families with children who are in need of additional support and early intervention.

1.3.3 To enable all relevant RPHNs and RMs to assess, interpret and analyse risk and protective factors to inform professional judgment with regard to safeguarding and promoting the welfare of children.

1.3.4 To assist RPHNs and RMs in exploring parenting/parents' life experiences that have the potential to impact on their capacity to parent safely and effectively.

1.3.5 To facilitate RPHNs and RMs to use their professional judgement in determining when this assessment is required.

1.3.6 To assist ADPHNs/ Child Protection CNS and ANPs in supporting and supervising staff with the implementation and use of the CFHNA.

1.4 Outcome(s)

The CFHNA is a core component of the national standardised Child Health Record. This guideline will provide a standardised approach to implementation and use of the Child and Family Health Needs Assessment Framework.

1.5 PPPG Development Group

1.5.1 See Appendix II for Membership of the PPPG Development Group.

1.5.2 See Appendix III for PPPG Conflict of Interest Declaration Form.

1.6 PPPG Governance Group

1.6.1 See Appendix IV for Membership of the Approval Governance Group.

1.7 Supporting Evidence

1.7.1 List relevant legislation/PPPGs.

Full text of all Legislation can be accessed on the Irish Statute Book website http://www.irishstatutebook.ie/

Government of Ireland (1991) *Child Care Act.*

Government of Ireland (1998) *Protection of Persons Reporting Child Abuse Act 1998*.

Government of Ireland (2011) *Nurses and Midwives Act Section 2 (1)*

Government of Ireland (2015) *Criminal Justice Act*.

Government of Ireland (2015) *Children First Act*.

Government of Ireland (1970) *Health Care Act*.

General Data Protection Regulation (2016) European Commission.

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/

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.*

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

1.7.2 **List PPPGs that are being replaced by this PPPG**.

Existing local CHO guidelines on the use of the Child and Family Health Needs Assessment informed the development of this guideline. This national guideline

replaces any previously developed local guidelines.

1.7.3 List related PPPGs.

Health Service Executive (2011) *Health Services Executive Code of Practice for Healthcare Records Management*.

Health Service Executive (2011*) Risk Management in the HSE: An Information Handbook.*

Health Service Executive (2011) *Developing and Populating a Risk Register: Best Practice Guidance.*

Health Services Executive (2011) *Standards and Recommended Practices for Healthcare Records Management.*

Health Services Executive (2013) *Record Retention Periods: Health Service Policy*.

Health Services Executive (2019) *National Consent Policy*.

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

Health Service Executive (2019b) *Data Protection Policy*.

1.8 Glossary of Terms

ADPHN	Assistant Director of Public Health Nursing
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
CFA	Child and Family Agency (Tusla)
CFHNA	Child and Family Health Needs Assessment
CHO	Community Healthcare Organisation
CHSS	Child Health Screening and Surveillance
CNS	Clinical Nurse Specialist
CPWRF	Child Protection and Welfare Report Form
DOHC	Department of Health and Children
DPHN	Director of Public Health Nursing
DNA	Did not attend
EPDS	Edinburgh Postnatal Depression Scale
GP	General Practitioner
GDPR	General Data Protection Regulations
HEI	Higher Education Institute
HIQA	Health Information and Quality Authority
HSE	Health Services Executive
NCS	National Childcare Scheme
NHCP	National Healthy Childhood Programme

NMBI	Nursing and Midwifery Board of Ireland
NPDC	Nursing Practice Development Co-ordinator
ONMSD	Office of the Nursing and Midwifery Services Director
PC	Primary Care
PCCC	Primary Community and Continuing Care
PCT	Primary Care Team
PDC	Practice Development Coordinator
PND	Postnatal Depression
PPPG	Policy Procedure Protocol Guideline
RM	Registered Midwife
RPHN	Registered Public Health Nurse

2.0 DEVELOPMENT OF PPPG

The PHN Service is unique in having universal access to all newborn infants and their parents. Current practices in Ireland are informed by the core programme for Child Health Screening and Surveillance (CHSS) outlined in the National Healthy Childhood Programme (NHCP 2020b). There are five NHCP contacts which address developmental milestones, physical development, screening, health promotion and education. The programme highlights the importance of taking account of the determinants of child health and recognises the need to work in partnership with parents to achieve positive health outcomes. The universality of the PHN child health service provides for the identification of family needs, which can be addressed by prevention and early interventions. Currently in Ireland there is no national guideline on the use of the Child and Family Health Needs Assessment (CFHNA) in the Public Health Nursing Service.

2.1 List the questions (clinical/non-clinical)

What is the guidance required by RPHNs/RMs to use the CFHNA?
What is the evidence base to support the use of the CFHNA by RPHNs/RMs?
Does the use of the CFHNA support interagency/interdisciplinary working?

2.2 Describe the literature search strategy

A review of the relevant literature regarding assessment frameworks or tools, similar to the CFHNA, which are designed to assist practitioners in family health needs assessment where there are child protection and welfare concerns was undertaken from 2000 to date. Due to a dearth of information relative to the role of public health nurses in child protection in Ireland, the literature review relies heavily on research from other jurisdictions, in particular the U.K. where public health nurses in Scotland and health visitors have a similar remit to public health nurses in Ireland. Literature relevant to issues experienced in the social work field in utilising structured assessment frameworks and tools was also considered.

An extensive search was undertaken utilising databases such as CINAHL, PubMed,

EBSCOHost and ScienceDirect accessed through the library at Trinity College Dublin and the HSE library. Keywords were used in different combinations to identify relevant literature. These keywords were: assessment frameworks/tools, child protection/welfare, safeguarding, family health needs, needs assessment, parents, child, public health nurs*/ health visitor/ community nurs* using AND and OR Boolean combinations to source articles of relevance. Only English language articles and articles published were included. The search was initially conducted in 2018 and reviewed in 2020 to include more recent publications relevant to the search criteria.

2.3 Describe the method of appraising evidence

Evidence in relation to utilising assessment frameworks in child protection and welfare was considered. In evaluating the evidence the following areas were considered:

- What are the results/conclusions?
- Are the results relevant to the PPPG?

The evidence consisted mainly of qualitative research involving interviews with practitioners, focus groups and ethnographic studies. Two studies encompassing case reviews and two mixed method studies were included. One meta-evaluation was included in the review. Additionally, journal articles containing critical reviews of relevant assessment frameworks were incorporated in the literature review.

National Practice Models in Child Protection and Welfare and Family Support Services in Tusla were referenced with relevant evidence and research literature.

2.4 Describe the process the PPPG development group used to formulate recommendations

From the evidence, subgroups of the PPPG development group drafted guidance in relation to the use of the CFHNA in PHN Service. This guidance was presented to the PPPG development group collectively for discussion. From the evidence statements and the experience of PPPG development members, recommendations were then drafted. The evidence presented answers to the clinical questions posed and provided the best available evidence-based information to guide RPHNs/RMs in their practice. Once the draft guideline received majority approval from the development group it was sent for steering group review.

2.5 Provide a summary of the evidence from the literature

The role of the Registered Public Health Nurse (RPHN) in child protection

RPHNs provide a universal service to all children and families from birth, visiting families in their home environment and reviewing children at defined intervals in early childhood. In some areas RMs may undertake the primary visit. The service to families with children is analogous to that of the health visitor in the UK where the focus is predominantly on prevention, early identification of problems and early intervention

(Hanafin 2013, Phelan & Davis 2015). The scope of practice of the RPHN includes child protection within their role and this places them in a prime position to safeguard children and respond to child protection concerns (Phelan & Davis 2015). The RPHN's knowledge of child development, parenting and family assessment are important in both preventing and ameliorating child protection concerns (Phelan & Davis 2015).

The Children First Act (2015) places legal obligations on groups of professionals, including RPHNs, as mandated persons to report child protection concerns to Tusla, the Child and Family Agency (CFA). RPHNs also have an obligation to assist TUSLA, if requested in assessing a concern which has been the subject of a mandated report. Phelan & Davis (2015) outlined child protection prevention strategies which may be employed by the RPHN including information sharing, mobilisation of support networks and listening to parents and children (Phelan & Davis, 2015). However, the role in child protection presents a conflicting experience for some RPHNs in managing their relationships with families whilst meeting their responsibilities in child care proceedings (Butler 1996, Kent *et al*. 2011, Phelan & Davis 2015).
The role of the RPHN in child protection has come under the spotlight in a number of recent statutory inquiries into child abuse. The Monageer Inquiry (Brosnan *et al*. 2008) identified issues with PHN documentation and record keeping, interdisciplinary communication and a failure of PHNs to refer to other services on the grounds that the service did not exist. The Roscommon Child Care Case (Gibbons *et al*. 2010) found a failure by RPHNs in the case to identify the extent of the abuse and neglect endured by the children. The authors identified issues around role clarity; a failure to undertake comprehensive assessments of the children, or of family functioning; failure to record the 'voice of the child'; failure to evaluate professional care given to children and inadequate record keeping by PHNs. The Commission to Inquire into Child Abuse (Ryan 2009) identified issues in regard to interagency and interdepartmental working and a need for professionals who work directly with children to be supported at an organisational level. Hanafin (2013), having considered the implications for PHNs arising from the above reports called on PHN management to provide leadership to prepare RPHNs to meet their child protection obligations by ensuring access to on-going training and education, equitable workloads, and nationally agreed records.

Theory underpinning the CFHNA Framework

In Ireland and the United Kingdom the provision of child welfare and protective services is broadly based on the Hardiker Model (Hardiker *et al*. 1991). The model demonstrates the increasingly focused services for children with protective welfare needs. Level one includes universal preventative and social development services for all children. Level two represents services targeted at children and families who have some additional identified need for example with parenting support or welfare support. Level three is where children and families have a more serious need and require interdisciplinary support and referral to Tusla Child and Family Agency. Level four represents where the family context for the child has either temporarily or permanently broken down and the state assumes care (Phelan & Davis 2015).

Assessment of family health needs

The assessment of family health needs is a skilled and multifaceted process which presents considerable challenges for health professionals (Appleton & Cowley 2007). Identifying and assessing child protection and welfare concerns involves complexity and uncertainty which is often not acknowledged by official accounts (Saltiel 2016). Helm (2011) contended that analysis of intuitive thinking is required of practitioners working in child protection and welfare and that an understanding of intuition is important for these practitioners. Practitioners may experience tension around the making and documenting of judgements which could have stigmatising implications for families (King 2016). Selbie (2009) identified the development and maintenance of good working relationships between health professionals and families to effectively manage risk to children, stating that it enables honesty and furthers good assessment.

The Child and Family Health Needs Assessment Framework

The development of the Child and Family Health Needs Assessment Framework is considered a major step in the progress of evidence informed practice for Public Health Nurses in Ireland (O'Dwyer 2012b, An Bord Altranais 2012). The CFHNA was developed as a standardised framework in response to criticism of PHN care in reviews into child neglect and abuse, and specifically of the failure of PHNs to carry out comprehensive assessments and clearly record decisions and actions taken (O'Dwyer 2012a). Utilising theories of development, attachment, parenting capacity, ecology and resilience, the framework provides a structure for assessing the family and environmental factors that impact on a child's health, development, welfare and protection (O'Dwyer 2012a).

The framework incorporates concepts from two U.K. frameworks: The Framework for the Assessment of Children in Need and their Families (Department of Health UK, 2000) and A Guide to Getting it Right for Every Child (Government of Scotland 2008). The UK assessment framework was introduced almost 20 years ago to address the high proportion of families who were finding it hard to manage for example because of financial and housing difficulties but did not cross the threshold of placing a child 'at risk' of significant harm. Assessments were to focus on children's developmental needs and parents capacity to respond to those needs and take account of the family's environment. The ecological approach sought to provide practitioners with the means to conduct a broad-based assessment.

The purpose of the CFHNA framework is to assist RPHNs in identifying children who are in need of additional support and early intervention. The framework consists of key screening questions, an assessment record, care plan, resource manual and practice guideline. The framework was developed and piloted in one Community Healthcare Organisation (CHO) in Ireland (O'Dwyer 2012a) and subsequently assimilated into PHN practice in some other CHOs in the country from 2013. Its implementation at local level followed a two day staff education programme. It was not universally adopted across all CHOs.

Professionals' opinions of assessment frameworks

Issues with form completion and care planning were identified in O' Dwyer's (2012) evaluation of the CFHNA pilot programme. This echoed findings from research of difficulties with assessment frameworks in other jurisdictions. Petitt (2008) argued that professionals' misunderstanding of assessment tools could affect the quality of their assessment and information sharing with parents.

Communication and partnership with parents

Poor communication has a negative effect on risk assessment (Selbie 2009). Assessment frameworks have the potential to improve communication and partnership with parents by involving them in the process (Millar & Corby 2006). However, Cowley & Houston (2003) cautioned that structured assessment tools can interfere with normal conversation and interaction. A number of participants in Horwath's (2011) study believed that the family and child needs assessment assisted them in actively working in partnership with parents or carers; however workload pressures and limited training opportunities were reported to inhibit their ability to meet the needs of the child. Parents' capacity to contribute towards the assessment may be inhibited by professionals' reluctance to involve them in the process (Millar & Corby 2006, Mitcheson & Cowley, 2003, Petitt 2008). Parents appreciated knowing what was being said about them and some welcomed the structure provided by a framework when discussing contentious issues with social workers (Millar & Corby 2006).

Support and education needs of PHNs

Working with families where complex child protection issues exist can be stressful and emotionally challenging (Austin & Holt 2017). The need to provide supportive management structures such as supervision and access to continuous professional development for PHNs, particularly in areas of high deprivation, has been highlighted (Austin & Holt 2017, Hanafin 2013). A need for PHN leadership and accountability in the area of child protection was identified by Hanafin (2013).

A recurring theme in the literature is professionals' perception of a need for more education in assessing and child protection processes, regardless of their work experience (Crisp *et al*. 2007, McAtamney 2011, Mitcheson & Cowley 2003). Mitcheson & Cowley (2003) called for education to include attention to consciousness raising and enhancing awareness of empowerment for practitioners and clients. Education that increases the capacity of practitioners to think critically and cope with complexity has been highlighted as important by Gillingham & Humphries (2010) who claim that this cannot be replaced by decision making tools.

Supervision and support for frontline staff

Supervision of professionals undertaking assessments using standardised frameworks needs to be comprehensive and on-going (Crisp *et al.* 2007) and delivered by practitioners with expertise in the area (Petitt 2008). O'Dwyer (2012a) identified the

need for supervision for public health nurses when completing the Child and Family Health Needs Assessment in Ireland. Lack of quality supervision may diminish the assessment process to a procedure rather than a means to focus on the child's needs (Horwath 2011). Crisp *et al.* (2007) cautioned that the introduction of frameworks should not be seen as a replacement for training in assessment and supervision. Gillingham & Humphries (2010) argued that tools tended to inhibit the development of expertise in assessment processes in less experienced practitioners.

McAtamney's (2011) study identified the importance of peer support from co-workers in helping practitioners deliberate on their problematic cases. O'Dwyer (2012a) recommended the provision of a 'buddy' system for PHNs who do not have regular exposure to families where a CFHNA would be indicated in order to maintain skills. The appointment of a specialist role offering staff advice and support has been regarded as having beneficial effects on staff engagement with the Common Assessment Framework in the UK (Powell 2013).

Tusla led Meitheal Early Intervention Practice Model and Child and Family Support Networks (TUSLA 2021)

The Meitheal Model is influenced by the Limerick Assessment of Needs System (LANS) and the Identification of Need (ION) Project operated in CHO 1. These initiatives, in turn, were influenced by the Common Assessment Framework in England and Wales, and the My World Triangle and Practice Model as part of Getting it Right for Every Child in Scotland. Both frameworks are based on the Assessment of Need three child developmental domains, the child, the parent, the family and wider world.

Meitheal is an old Irish term that describes how neighbours would come together to assist each other in the saving or harvesting of crops or other tasks. In this context, Meitheal is a Tusla-led early intervention practice model designed to ensure that the strengths and needs of children and their families are effectively identified, understood and responded to in a timely way so that children and families get the help and support needed to improve children's outcomes and realise their rights. It is an early intervention, multi-agency (when necessary) response, tailored to the needs of the individual child or young person. Meitheal is primarily designed to create a common method for identifying need across all agencies that work with children, young people and families. Meitheal is voluntary and can only be undertaken when the parent/carer provides their written consent. Meitheal is used in partnership with parents to help them share their own knowledge, expertise and concerns about their child and to hear the views of practitioners working with them. The ultimate goal is to enable parents and practitioners to work together to achieve a better life for the child.

Signs of Safety national approach to practice for Child Protection and Welfare Introduction

Signs of Safety is being implemented as a national approach to practice as part of Tusla Child Protection and Welfare Strategy (2017) and reflects best practice principles,

which are fundamentally underpinned by the principles of Children First: National Guidance for the Protection and Welfare of Children (2017). Children and families will be at the centre of assessment and decision making and the approach will be strengths-based, evidence-based and outcome-focused. The Signs of Safety approach to child protection casework is widely recognised internationally as an approach to child protection casework. It has evolved and developed over the last 20 years and is used across a range of fields including education, early intervention provision, and also work with adults. The Signs of Safety methodology is a 'strength based' model. This means there is an equal commitment to identifying what is already working well in the family network and identifying strengths which could be built upon to secure increased safety. See Signs of Safety information leaflet in Appendix VI.

2.6 Detail resources necessary to implement the PPPG recommendations

- RPHNs /RMs will require training in the use of CFHNA every three years.
- ADPHNs and specialist child protection ANPs/CNSs will require training in the supervision and support of staff in the use of the CFHNA every three years.
- HEI's will be required to educate student PHNs in the use of the CHFNA. There is a need to standardise the child protection education across the 3 HEI's that offer the Higher Diploma in Public Health Nursing. The curriculum is directed by the Standards and Requirements for Nurse Registration Programmes (NMBI 2015c). Currently the CFHNA 2 day training takes places in all 3 sites. Other training in child protection is delivered to student PHNs by a variety of means which include an inter-disciplinary workshop between students PHNs and student social workers and 2 universities include Children First training.
- Education will be supported and delivered nationally by the Centres for Nursing and Midwifery Education through a blended learning model.

2.7 Outline of PPPG Steps/Recommendations

See Part A

3.0 GOVERNANCE AND APPROVAL

3.1 Outline formal governance arrangements

This national guideline was commissioned by the National Lead for Public Health Nursing Services. Final approval of the guideline was issued from National Community Operations and follow up reviews will be initiated by National Community Operations. Refer to Appendix IV for Membership of the Approval Governance Group. This national document will be submitted to the National Central Repository Office for referencing

when this office is established. Steering Group membership is also available in Appendix IV.

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

The PPPG Checklist (Section 3.4) was reviewed in conjunction with the final revised guideline to ensure compliance with the standards as outlined in the HSE National Framework for developing Policies, Procedures, Protocols and Guidelines (2016). This completed checklist and the final draft of the guideline was submitted to the National Community Operations and to the Office of the Nursing and Midwifery Services Director to confirm that all stages in the revision of the guidleline had been completed and met the National Standards for Clinical Practice Guidance (NCEC 2015). The guideline was approved for national implementation. A signed and dated master copy will be retained within the Office of the Nursing and Midwifery Services Director, Dr Steevens Hospital.

3.3 Attach any copyright/permission sought

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

3.4 Insert approved PPPG Checklist

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	√
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	√
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	√
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	√
The views and preferences of the target population have been sought and taken into consideration (as required).	**N/A**
The overall objective(s) of the PPPGs are specifically described.	√
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	√
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	√

Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	√
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	√
There is service user/lay representation on PPPG Development Group (as required).	N/A
Information and support is available for staff on the development of evidence-based clinical practice guidance.	√

Stage 2 Development	**Checklist**
The clinical question(s) covered by the PPPG are specifically described.	√
Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented).	√
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described).	√
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	√
There is an explicit link between the PPPG and the supporting evidence.	√
PPPG guidance/recommendations are specific and unambiguous.	√
The potential resource implications of developing and implementing the PPPG are identified e.g. equipment, education/training, staff time and research.	√
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	√
Budget impact is documented (resources required).	√
Education and training is provided for staff on the development and implementation of evidence-based clinical practice guidance (as appropriate).	√
Three additional standards are applicable for a small number of more complex PPPGs: Cost effectiveness analysis is documented. A systematic literature review has been undertaken.	N/A ☐ ☐ ☐

Health Technology Assessment (HTA) has been undertaken.	
Stage 3 Governance and Approval	**Checklist**
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	√
The PPPG has been reviewed by independent experts prior to publication (as required).	√
Copyright and permissions are sought and documented.	N/A
Stage 4 Communication and Dissemination	**Checklist**
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	√
Plan and procedure for dissemination of the PPPG is described.	√
The PPPG is easily accessible by all users e.g. PPPG repository.	√
Stage 5 Implementation	**Checklist**
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	√
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	√
Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required).	√
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care.	√
Stage 6 Monitoring, Audit, Evaluation	**Checklist**
Process for monitoring and continuous improvement is documented.	√
Audit criteria and audit process/plan are specified.	√
Process for evaluation of implementation and (clinical) effectiveness is specified.	√
Stage 7 Revision/Update	**Checklist**
Documented process for revisions/updating and review, including timeframe is provided.	√
Documented process for version control is provided.	√

I confirm that the above Standards have been met in developing the following:

Title of PPPG: Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service

Name of Person(s) signing off on the PPPG Checklist:

Name: Sinead Lawlor **Title: National Practice Development Coordinator for PHN Services**	**Signature:** Sinéad Lawlor **Date:** 20/04/2021

4.0 COMMUNICATION AND DISSEMINATION

4.1 Describe communication and dissemination plans

The PPPG working group established in November 2020 consisted of National PHN Lead, representatives of all PHN grades, Tusla, and HEIs. It was chaired by the National Practice Development Coordinator for PHN Services.

A draft of this guideline was circulated to all DPHNs nationally for review by their respective departments. Feedback was also sought from other key stakeholder groups such as Higher Education Institutes (Nursing), CNMEs, TUSLA representatives, National Healthy Childhood Programme and the National Children First Office. All feedback submissions were considered by the PPPG working group and a final draft prepared. The final draft was submitted to the CFHNA steering group for recommendation for approval to HSE National Community Operations and to the Office of the Nursing and Midwifery Services Director for professional recommendation.

The approved document will be circulated to all DPHNs nationally for dissemination to their respective nursing departments and to other key stakeholders. A copy of the guideline is available on the HSE website to download at: www.hse.ie/phn. Communication in relation to this guideline will clearly identify that it supersedes all previous guidelines in relation to the use of the Child and Family Health Needs Assessment in place locally.

5.0 IMPLEMENTATION

5.1 Implementation Plan

As part of the exploring and preparing stage of implementation, existing guidelines in place in CHOs were reviewed prior to preparing the first draft of this national guideline (available on request). The draft copy of the guideline was circulated to all DPHNs for service review and feedback in February 2021. This assisted in assessing the ability/readiness of services to implement the guideline.

This guideline was identified as a key PPPG by the Child and Family Health Needs Assessment (CFHNA) Steering Group to support safe effective practice. On planning and resourcing, consultation took place with information and technology help desk on making the guideline available online. Discussions with DPHNs took place regarding the implementation of the guideline.

The introduction of the national standardised Child Health Record will also contribute to supporting the implementation of this guideline in Community Healthcare Organisations (CHOs). This guideline should be used in conjunction with the Public Health Nursing Service Child Health Record User Guide and Data Definitions manual (NHCP 2020a).

To implement and operationalise this guideline, CFHNA documentation will be monitored by the ADPHN as per local procedures. The ADPHN will assess the application of this guideline through team meetings, professional supervision sessions and through caseload audit reviews. The implementation of this guideline supports RPHNs/RMs to provide timely intervention and support to facilitate better outcomes for children and families. This will be facilitated by ensuring that all RPHN/RMs are aware of, understand and utilise this guideline. In order to support implementation of the guideline each RPHN/RM will be required to sign a Signature Sheet (Appendix I) confirming that they have read, understood and agree to adhere to the guideline or have confirmed this through the MAPS policy portal where it is in use.

5.2 Describe education/training plans required to implement the guideline

- Education will be supported and delivered nationally by the Centres for Nursing and Midwifery Education through a blended learning model.
- All relevant RPHNs/RMs must attend the education programme on the 'Child and Family Health Needs Assessment Framework for Registered Public Health Nurses and Registered Midwives working in the Public Health Nursing Service' to ensure they are up to date with the assessment processes and practice. The education programme will have Nursing and Midwifery Board of Ireland, Category 1 Approval. RPHNs/RMs should attend the training every three years.
- The Higher Education Institutes are responsible for coordinating the education to student PHNs in consultation with the CNMEs.
- Local induction programmes for new RPHNs/RMs commencing employment will include briefing on all PPPGs approved for use within the PHN Service.

5.3 Identify lead person(s) responsible for the implementation of the guideline

At national level the National Lead for PHN Services and the National Practice Development Co-ordinator for PHN Service will lead on the implementation of this guideline and address issues arising nationally with implementation.

Within the Community Health areas the DPHN will be responsible for ensuring all nurses under her/his remit are aware of, have read and have signed the verification document (Appendix I) or accessed it through the MAPS portal. Audit of the use of the guideline will be carried out as outlined in Section 6.1.2 of this guideline.

5.4 Outline specific roles and responsibilities

Steering Group for the Child and Family Health Needs Assessment (CFHNA): The steering group provides strategic oversight and governance of the introduction, implementation and

evaluation of a Child and Family Health Needs Assessment education and training programme for public health nurses and midwives across Ireland and the development of a written guideline to ensure standardised use of the CFHNA within the PHN Service.

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

National Practice Development Co-ordinator for PHN service will assist the National lead for Public Health Nursing with the implementation and operationalization of this guideline and address any issues that arise.

Director Public Health Nursing: The DPHN is responsible for resourcing, implementing and managing and auditing this guideline within her/his area of responsibility. The DPHN will identify and support ongoing related educational opportunities to further enhance knowledge and skills in relation to CFHNA. It is the responsibility of the DPHN to ensure all RPHN/RMs undertaking child health screening and surveillance have received the appropriate training in the use of the CFHNA and a record of this educational training is maintained by the DPHN.

Assistant Director Public Health Nursing: The ADPHN is responsible for the implementation of the guideline through ensuring that the current assessment tool and supporting documentation is available to all RPHNs/RMs in health centres. The ADPHN is responsible for ensuring that all RPHNs/RMs have knowledge of the procedures to be followed within the document. The ADPHN is responsible for ensuring new RPHNs/RMs are informed of the guideline on induction. The ADPHN will be responsible for providing continuing guidance and supervision to all staff using the tool and any staff involved in issues of child welfare and child protection. The ADPHN will ensure that all RPHNs/RMs are aware of any revisions to the guideline and ensure older versions of the guideline are removed from circulation. A database record of all RPHNs/RMs who have signed the signature sheet (Appendix I) will be maintained by the ADPHN and the DPHN will be notified of any noncompliance with sign-off of the guideline. MAPS portal where in use will support DPHN with this governance.

Role of the RPHN and RM: It is every RPHN/RMs responsibility to ensure they are working within their scope of practice at all times and that they identify their training needs to their manager to maintain standards of care (NMBI 2015b).

Each RPHN/RM is responsible for adhering to this guideline and to use it to guide their practice in use of the child and family health needs assessment. Each RPHN/RM is responsible for ensuring that they have read and understand the document and sign the attached signature sheet (Appendix I) or have confirmed this through the MAPS policy portal where it is in use. When areas of concern are identified, where legislation is known to have changed or where a health 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 guideline.

Role of Practice Development Co-ordinator in Public Health Nursing: The PDC (where in post) supports the implementation and operationalization of this guideline. She/he has a key role in the transfer of knowledge to frontline staff through the dissemination of current evidence

based practice.

6.0 MONITORING, AUDIT AND EVALUATION

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1 Monitoring of this guideline will be governed by the DPHN. ADPHNs are responsible for ensuring that there is a professional supervision process in place to support the use of the CFHNA. Implementation of an annual caseload review will also provide a level of monitoring.

6.1.2 Audit of the operation of this guideline will be the responsibility of each DPHN in consultation with the local audit lead at CHO or new regional integrated care area (ICA) once developed. Good governance arrangements and an identified lead person are required to ensure systematic monitoring (HIQA 2012). Audit of this guideline will take place retrospectively by the designated person appointed by the DPHN. This designated person may be the area PHN, a nursing peer, an ADPHN, Practice Development Co-ordinator or other. This guideline will be the standard for audit using the attached audit tool (Appendix VII). The objectives of the audit will be:

- To provide evidence of compliance with the national guideline
- To ensure standardisation of application of the guideline
- 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.

6.1.3 Evaluation

Evaluation will be initiated by the DPHN/ADPHN and will occur through feedback at professional team meetings and through structured review surveys of the PHN service. Feedback from Your Service Your Say and through local formal complaints processes will be considered in any revision of this guideline.

7.0 REVISION/UPDATE

7.1 Describe procedure for the update of the guideline (including date for revision).

This guideline will be revised every three years on the date specified on the front page of the document. This review will be triggered by the National Lead for Public Health Nursing Services.

7.2 Identify method for amending guideline if new evidence emerges.

Practitioners will assist in the revision of the guideline and also request an earlier review of this guideline where required if new evidence based practice is recommended.

7.3 Complete version control update on guideline cover sheet

This is the first version of a national guideline on the use of the Child and Family Health Needs Assessment for the Public Health Nursing Service.

8.0 REFERENCES

An Bord Altranais (2012) in a Foreword to O'Dwyer P., (2012) *A Report on the Child and Family Health Needs Assessment Framework Project in the Dublin Mid-Leinster Public Health Nursing Service Areas of Laois, Offaly, Longford and Westmeath*. Health Service Executive, Dublin.

Appleton J. V., Cowley S. (2007) Health visiting assessment processes under scrutiny: a case study of knowledge use during family health needs assessments. *International Journal of Nursing Studies* **45 (**5), 682-696.

Austin J., Holt S. (2017) Responding to the support needs of front-line public health nurses who work with vulnerable families and children. *Contemporary Nurse* **53 (**5), 524-535.

Brosnan K., McHugh J., Lunny L. (2008) *Monageer Inquiry.* Department of Health and Children; Department of Justice, Equality and Law reform, Dublin.

Butler S. (1996) Child protection or professional self-preservation by the baby nurses? public health nurses and child protection in Ireland. *Social Science and Medicine* **43 (**3), 303-314.

Cowley S., Houston A. (2003) A structured health needs assessment tool: acceptability and effectiveness for health visiting. *Journal of Advanced Nursing* **43** (1) 82-92.

Crisp B., Anderson M., Orme J., Green Lister P. (2007) Assessment frameworks: a critical reflection. *British Journal Of Social Work* **37 (**6)1059-1077.

Department of Children and Youth Affairs (2017) Children First national Guidance for the Protection and Welfare of Children. Department of Children and Youth Affairs, Dublin.

Department for Health; Department of Education, Schools; Home Office (2000) *Framework for the Assessment of Children in Need and their Families*. United Kingdom: Department of Health, United Kingdom.

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

Gillingham P., Humphries C. (2010) Child protection practitioners and decision-making tools: observations and reflections from the front line. *British Journal of Social Work* **40 (**8) 2598-2616.

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

Government of Ireland (2019) *National Childcare Scheme Policy Guidelines.* Governement of Ireland: Dublin.

Hanafin S. (2013) Child protection reports: key issues arising for public health nurses. Community Practitioner 86 (10) 24-27.

Hardiker P., Exton K., Barker M., (1991) The social policy contexts of prevention in child care, *The British Journal of Social Work* **21 (**4) Special Child Care Issue 341-359.

Hardiker P., Baker M. (1995). *The Social Policy Contexts of Child Care.* National Society of Prevention of Cruelty to Children, London.

Health Services Executive (2010) *Code of Practice for Healthcare Records Management – Abbreviations*. Health Service Executive, Dublin.

Health Services Executive (2011) *Standards and Recommended Practices for Healthcare Records Management*. Health Service Executive, Dublin.

Health Services Executive (2011) Child Protection and Welfare Practice Handbook https://www.tusla.ie/uploads/content/CF_WelfarePracticehandbook.pdf

Health Services Executive/Tusla (2017) *Joint protocol for interagency collaboration between the health service executive and tusla – child and family agency to promote the best interests of children and families.* Health Service Executive, Dublin

Health Services Executive (2019a) Child Protection and Welfare Practice Policy. Health Service Executive, Dublin

Health Service Executive (2019b) *Data Protection Guidelines*. Health Service Executive, Dublin

Health Service Executive (2021) *Procedure for the Management of Safe Transfer of Child Health Records in the Public Health Nursing Service* Health Service Executive, Dublin. www.hse.ie/phn

Helm D. (2011) Judgements or assumptions? the role of analysis in assessing children and young people. *British Journal of Social Work* **41** (5) 894-911.

Health Information and Quality Authority (2012) *National Standards for Safer Better Healthcare*. Health Information and Quality Authority, Dublin.

Horwath J. (2011) See the practitioner, see the child: the framework for the assessment of children in need and their families ten years on. *British Journal of Social Work* 41 (6) 1070-1087.

Kent S., Dowling M., Byrne G. (2011) Community nurses' child protection role: views of public health nurses in ireland. *Community Practitioner* **84** (11) 33-36.

King C. (2016) Sticking to carpets' - assessment and judgement in health visiting practice in an era of risk: a qualitative study. *Journal of Clinical Nursing* **25** (13-14) 1901-1911.

McAtamney R. (2011) Health Visitors' Perceptions of their Role in Assessing Parent-Infant

Relationships. *Community Practitioner* **84** (8) 33-38.

Millar M., Corby B. (2006)The Framework for the Assessment of Children and their Families - A Basis for a 'Therapeutic' Encounter? *British Journal of Social Work* **36** (6) 887-899.

Mitcheson J., Cowley S. (2003) Empowerment or control? an analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool. *International Journal of Nursing Studies* **40** (4) 413-426.

National Clinical Effectiveness Committee (2015) *Standards for Clinical Practice Guidance*. Department of Health, Dublin.

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.

Nursing and Midwifery Board of Ireland (2015a) *Recording Clinical Practice Professional Guidance*. Nursing and Midwifery Board of Ireland, Dublin.

Nursing and Midwifery Board of Ireland (2015b) *Scope of Nursing and Midwifery Practice Framework*. Nursing and Midwifery Board of Ireland, Dublin.

Nursing and Midwifery Board of Ireland (2015c) *Public Health Nursing Education Programme Standards and Requirements*. Nursing and Midwifery Board of Ireland, Dublin.

O'Dwyer P. (2012a) *A Report on the Child and Family Health Needs Assessment Framework Project in the HSE Dublin Mid-Leinster Public Health Nursing Service Areas of Laois, Offaly, Longford and Westmeath.* Health Service Executive Dublin.

O'Dwyer P. (2012b) *Report prepared for the management team on public health nursing services in HSE Dublin Mid-Leinster, Office of the Nursing and Midwifery Services Director, Dublin Mid-Leinster*. Health Service Executive, Dublin.

Petitt A. (2008) Health Visitor's Experiences of Using a Tool in Assessing Infant Attachment. *Community Practitioner* **81** (11) 23-27.

Phelan A., Davis M. (2015) Lessons learned: public health nurses practices in safeguarding children in the republic of ireland. *Global Pediatric Health* **2**, 1-9.

Powell J. (2013) Use of the Common Assessment Framework in an Acute Setting. *Nursing Children and Young People* **25** (5) 24-28.

Ryan S. (2009) *Commission to Inquire into Child Abuse*. Stationery Office, Dublin.

Saltiel D. (2016) Observing front line decision making in child protection. *British Journal of Social Work* **46** (7) 2104-2119.

Scottish Government (2008) *A Guide to Getting it Right for Every Child*. Scottish Government, Edinburgh.

Selbie J. (2009) Health visitors' child protection work: exploratory study of risk assessment. *Community Practitioner* 82 (5) 28-31.

TUSLA (2017) *Child Protection and Welfare Strategy*. Available at: https://www.tusla.ie/uploads/content/Tusla_Child_Protection_and_Welfare_Strategy.pdf

Tusla (2018) Child Protection and Welfare Practice Handbook 2, Dublin, Tusla.

https://www.tusla.ie/uploads/content/Tusla_Child_Protection_Handbook2.pdf

TUSLA (2018) *Interim Practice Guide Referral & Assessment Process.* Available at: http://hsenet.hse.ie/childfamilyagency/SOS_Interim_Guide_RA.pdf

TUSLA (2021) https://www.tusla.ie/services/family-community-support/prevention-partnership-and-family-support-programme/meitheal-national-practice-model/

Resources

https://www.tusla.ie/uploads/content/Meitheal_CFSN_Research_Study_Report.pdf

https://www.tusla.ie/uploads/content/PPFS_Low_Prevention_Services_Brochure.pdf

https://www.tusla.ie/uploads/content/Master_Meitheal_Toolkit.pdf

https://www.tusla.ie/uploads/content/Children_First_National_Guidance_2017.pdf

Signs of Safety References

https://www.signsofsafety.net/product/signs-of-safety-comprehensive-briefing-paper-2/

http://hsenet.hse.ie/childfamilyagency/Signs_of_Safety1.html

Parent Capacity and Child development References

https://www.tcd.ie/tricc/assets/pdfs/crc-archive/2006-Buckley-Horwath-Whelan-Framework-Assessment-Vulnerable.pdf

https://www.hse.ie/eng/services/publications/children/hidden-harm-practice-guide.pdf

Cleaver H., Unell I., Aldgate J. (2011) *Children's Needs – Parenting Capacity Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse, And Domestic Violence*. Her Majesty's Stationery Office. London, UK. Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/182095/DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

Bibliography

Baginsky M., Manthorpe J., Moriarty J. (2020) The framework for the assessment of children in need and their families and signs of safety: competing or complementary frameworks? *British Journal of Social Work* (May 2020), 1-19.

Bronfenbrenner U., Morris P.A. (2006) The bioecological model of human development. In *Handbook Of Child Psychology: Theoretical Models Of Human Development* R.M. (Lerner R.M. & Damon W., eds), John Wiley & Sons, New Jersey, pp. 793–828.

Buckley H. (2012) Using intelligence to shape reforms in child protection. *Irish Journal of Applied Social Studies* **12** (1), 63-73.

Children's Workforce Development Council (2007) *Early Intervention, Assessment of Needs and Intervention. The Common Assessment Framework for Children and Young People: A Guide for Practitioners.* Children's Workforce Development Council, Leeds.

Daniel B. (2015) Why have we made neglect so complicated? taking a fresh look at noticing and helping the neglected child. *Child Abuse Review* **24 (**2) 82-94.

Chamberlain C. (2010) Toward an general model for child welfare and protection services: a meta Leville -evaluation of international experiences regarding the adoption of the framework of children in need and their families (FACNF). *Children and Youth Services Review* **32** (7) 929-944.

Phelan A. (2014) Examining the synergy of practice: the Irish public health nurse's potential from the first postnatal visit and beyond. *Global Pediatric Health* **1**, 1-8.

Vis S.A., Lauritzen C.,Fossum S. (2019) Systematic approaches to assessment in child protection investigations: A literature review. *International Social Work* available online at: http://doi.org/10.1177/0020872819828333

White S., Hall C., Peckover S. (2009) The Descriptive Tyranny of the Common Assessment Framework: Technologies of Categorization and Professional Practice in Child Welfare. *British Journal of Social Work* **39** (7) 1197-1217.

Whittaker A. (2018) How do child protection practitioners make decisions in real-life situations? lessons from the psychology of decision making. *British Journal of Social Work* **0,** 1-18.

9.0 APPENDICES

Appendix I Signature Sheet

Appendix II Membership of the PPPG Development Group Template

Appendix III Conflict of Interest Declaration Form Template (held in ONMSD)

Appendix IV Membership of Approval Governance Group Template

Appendix V CFHNA Resource Manual

Appendix VI Signs of Safety information leaflet

Appendix VII Audit Tool

Appendix I:

Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service

Signature Sheet

I have read, understand and agree to adhere to this Guideline:

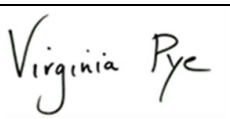
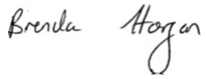
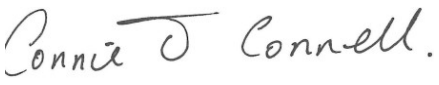
Print Name	Signature	Area of Work	Date

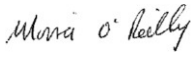
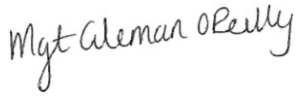
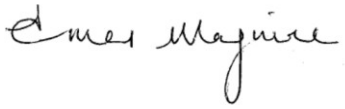
Appendix II:

Membership of the PPPG Development Group

Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service

Please list all members of the development group (and title) involved in the development of the document.

Virginia Pye National Lead PHN Services (HSE)	 Date: 20/04/2021
Caroline Jordan National Policy Manager Family Support and Social Inclusion (TUSLA)	 Date: 20/04/2021
Catriona O'Daly Lecturer/Assistant Professor Public Health Nursing (UCD School of Nursing)	Signature:  Date: 20/04/2021
Jackie Austin DPHN, CHO 9	Signature:  Date: 20/04/2021
Grainne Ryan DPHN, CHO 3	Signature:  Date: 20/04/2021
Brenda Horgan Practice Development Coordinator, CHO 9	Signature:  Date: 20/04/2021
Pauline Keogh ADPHN, CHO 7	Signature:  Date: 20/04/2021
Connie O'Connell	Signature: 

ADPHN, CHO 2	Date: 20/04/2021 Signature: 
Moira O'Reilly ADPHN, CHO 9	Date: 20/04/2021 Signature: 
Margaret Coleman O'Reilly ADPHN, CHO 9	Date: 20/04/2021 Signature: 
Emer Maguire ADPHN, CHO 7	Date: 20/04/2021 Signature: 
Nicola McMahon PHN, CHO 9	Date: 20/04/2021
Chairperson: Sinead Lawlor National Practice Development Coordinator for Public Health Nursing	 Date: 20/04/2021

Appendix III: Conflict of Interest Declaration Form (Held in ONMSD))

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the PPPG Development Group as applicable

Title of PPPG being considered:

Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____

_____

_____

_____

(Append additional pages to this statement if required)

Signature

Printed 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 committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG 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.

Appendix IV:

Membership of the Approval Governance Group

Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

TJ Dunford Head of Operations: Primary Care Virginia Pye National Lead for PHN Services	Date: 27/9/2021 Signature:  Date: 20/4/2021

Membership of the Steering Group

Virginia Pye	National Lead for PHN Services
Ina Crowley	Project Officer OMNSD
Brenda Horgan	Practice Development Co-ordinator CHO 9
Jacqueline Austin	DPHN CHO 9
Mairead Loftus	Nurse Tutor, CNME Mayo/Roscommon
Caroline Jordan	Tusla National Policy Manager Family Support and Social Inclusion
Grainne Ryan	DPHN CHO 3
Anne Pardy	Programme Lead – Nurture Programme
Catriona O'Daly	Lecturer Public Health Nursing, UCD
Sinead Lawlor	National Practice Development Co-ordinator for PHN Services

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Office of the Nursing & Midwifery Services Director

Child and Family Health Needs Assessment Framework

Public Health Nursing Service

Acknowledgements

The Child and Family Health Needs Assessment (CFHNA) Framework Resource Manual was initially developed by Ms. Patricia O'Dwyer as part of the Midlands Project (2011) in collaboration with the Public Health Nursing Services in Laois, Offaly, Longford and Westmeath with funding provided by the National Council for the Professional Development of Nursing and Midwifery and the Nursing and Midwifery Planning and Development HSE Dublin – Mid Leinster.

The resource manual was reviewed and updated by the **Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service Development Group** in 2021 supported by the ONMSD.

The resource manual should be used in conjunction with the guideline.

Child and Family Health Needs Questions

The Child and Family Health Needs questions will assist the RPHN/RM to reflect on the health and social information which is gathered in the context of a whole child approach to health promotion and protection.

The questions will assist the RPHN/RM to ground the information in the dimensions of an active developing child, particularly where there is a concern or unmet need that is likely to have an impact on the child's health and development.

The four CFHNA questions are incorporated into the National Healthy Childhood Programme Child Health Record at the primary visit, 3 months, 9-11 months, 21-24 months and 46-48 month assessments.

The questions may also be used by the RPHN/RM during any subsequent contacts with the child.

Additional Child and Family Health Needs Assessment Record

Affix label otherwise complete: Name, DOB, address IHI: Surname: Forename: DOB: dd/mm/yyyy

Additional Child and Family Health Needs Assessment Record (*applicable only if training has been provided)*
Has there been any changes in the child or family circumstances from the previous contact? Yes☐ No☐
If yes, the following must be addressed: Parenting issues expressed and / or identified? Yes☐ No☐ If Yes, Care Plan commenced Yes ☐ No ☐ Housing/Environment issues expressed or identified? Yes☐ No☐ If Yes, Care Plan commenced Yes ☐ No ☐ Access to Family/Community Supports issues expressed and/or identified? Yes☐ No☐ If Yes, Care Plan commenced Yes☐ No ☐ Other concerns expressed or identified by parents or services involved with the family? Yes☐ No☐ If Yes, Care Plan commenced Yes☐ No ☐
Child and Family Health Needs Assessment required? Yes☐ No☐ If Yes, CHFNA completed? Yes☐ No☐
Signature:_____PIN:_____Date: dd/mm/yy Time: hh:mm

HSE PUBLIC HEALTH NURSING SERVICES

CHILD AND FAMILY HEALTH NEEDS ASSESSMENT RECORD

The purpose of the CHILD AND FAMILY HEALTH NEEDS ASSESSMENT RECORD is to assess, identify and interpret the child and family health needs. The IMPACT of parenting capacity, family and environmental factors on the child's health and development should be examined and recorded. For the most appropriate service to be provided and to ensure the optimum health and well-being of this child please record risk and protective factors

NAME OF THE CHILD_____ **MALE**_____**FEMALE** _____

DATE OF BIRTH _____

ADDRESS _____

_____

_____

REASON FOR THE ASSESSMENT OF THIS CHILD (If there is more than one child requiring assessment in the family, a separate assessment record must be completed)

CHILD DEVELOPMENT NEEDS (Consider and record the child's physical health and well-being, emotional and behavioural development, education, family and social relationships, identity, social presentation, self-care skills which is most relevant to his / her development and well-being)

PARENTING CAPACITY (Consider and record the child's basic care, safety, emotional warmth, stability, guidance and boundaries and stimulation needs, which is most relevant to their development and well-being. Include any risk factors identified such as parent's ill-health, disability or substance misuse. Also record any protective factors)

FAMILY AND ENVIRONMENTAL FACTORS (Consider and record the family history and functioning, housing, employment, income, wider family, the family integration into the community, and use of community services. Please give details of history and current situation).

SUMMARY of the developmental needs of this child, the parent(s) capacity to respond appropriately to the needs of the child, and any family and environmental factors impacting on the child and or on the family

DISCUSSED WITH LINE MANAGER: YES ☐ NO ☐ **DATE:** dd/mm/yyyy

NAME OF LINE MANAGER: _____

Have the parents / guardians been informed that the information will be shared with other agencies and professionals, as required in the best interests of the child: YES ☐ NO ☐ If No state the reason:

ASSESSMENT DATE: dd/mm/yyyy NUMBER OF ASSESSMENT _____

If this is the first child and family health assessment for this child enter number 1

ASSESSMENT COMPLETED BY (PRINT NAME) _____

Signature: _____ **Pin:** _____ **Date:** dd/mm/yy **Time:** hh:mm

EXAMPLES OF RISK AND PROTECTIVE FACTORS FOR CHILD HEALTH AND WELL-BEING[1]

	Risk Factors from antenatal period to about 5 years of age	Protective Factors from antenatal period to about 5 years of age
CHILD CHARACTERISTICS	Low birth weight / Prematurity Perinatal exposure to infections or toxins Birth injury Disability Learning Disability Chronic illness / medical disorder Delayed development Unsafe sleeping practices Intense/reactive temperament Disorganised or insecure attachment Limited social skills Disruptive behaviour Impulsivity Low self- esteem Impact of trauma on the neurological development of the child Withdrawn	Good maternal care and maternal nutrition Breast feeding established early Secure attachment with primary caregiver Immunizations up to date Social skills Easy temperament active alert and affectionate Independence self help Positive self image Self-regulation skills Good problem solving skills
PARENTS AND PARENTING CAPACITY	Single parent Multiple partners Disability Drug or alcohol misuse Young maternal age / young parents Inadequate antenatal care Perinatal depression or other mental illness Drug or alcohol misuse in pregnancy Smoking/smoking in pregnancy Experience of intergenerational abuse/trauma Harsh discipline Inconsistent discipline Lack of sensitivity warmth and affection Unsupervised play Separation from or rejection of child Domestic Abuse / intimate partner abuse Neglect Parent in prison Inadequate supervision Lack of parenting knowledge One or both parents grew up in care Parents have history of anti-social / offending behavior	Maternal health and wellbeing is good Paternal health and wellbeing is good Healthy lifestyle Competent stable care Father is involved in parenting Positive attention from both parents Supportive relationships with other adults Mothers education and competence Parental involvement in learning and services/appointments Protective health behaviors e.g. cessation of smoking in pregnancy Psychological factors such as resilience, sense of belonging to home, family, community Strong cultural identity
FAMILY FACTORS AND LIFE EVENTS	Family instability stress or violence Marital disharmony Poverty Separation / Divorce Absence of father Social isolation Recent death of family member Long term unemployed Frequent relocations Living in emergency homeless accommodation/ domestic abuse refuges Asylum Seekers and refugees living in the	Family harmony and stability Consistency of primary carers Nurturing environment Positive relationships with extended family members Small family size

	international protection accommodation system (previously known as direct provision) Poor housing conditions/ living in disadvantaged communities Disorganised / Chaotic lifestyle Large family size / family spacing	
COMMUNITY FACTORS	Socio-economic disadvantage Lack of support services Neighbourhood violence/ crime Social or cultural discrimination Remote location and distance from services	Supportive social relationships and networks Participation in community networks Cultural identity and pride Access to health, mental health, maternal and child health, early intervention, disability, drug and alcohol, family support, parenting education, recreational facilities and other child and family support services and therapeutic services. Accessible and affordable child care and high quality preschool programs. Service system's understanding of neglect and abuse- promoting the safety and wellbeing of children (Children First)

[1] The above information was initially compiled by Ms. Patricia O'Dwyer in 2012 and was reviewed and updated by the Guideline on the use of the Child and Family Health Needs Assessment Framework for the Public Health Nursing Service Development Group in 2021.

Tusla (2018) Child Protection and Welfare Practice Handbook 2, Dublin, Tusla. https://www.tusla.ie/uploads/content/Tusla_Child_Protection_Handbook2.pdf

Centre on the Developing Child (2010). The Foundations of Lifelong Health Are Built in Early Childhood. Retrieved from www.developingchild.harvard.edu

Tierney, A. L., & Nelson, C. A., 3rd (2009). Brain Development and the Role of Experience in the Early Years. Zero to three, 30(2), 9–13. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3722610/

Prevention and Early Intervention Network Policy Paper (2019) Adverse Childhood Experiences (ACEs): Holding the child's hand in prevention and early intervention for children and families https://www.pein.ie/wp-content/uploads/2019/10/PEIN-ACEs-Policy-Paper_Every-Childhood-Lasts-a-Lifetime_2019-10.pdf

Prevention and Early Intervention Network Policy Paper (2019) Prevention and Early Intervention in Child Health Services: The foundations of a healthy adult life are laid in early childhood. https://www.pein.ie/wp-content/uploads/2019/10/PEIN-Child-Health-Policy-Paper_Every-Childhood-Lasts-a-Lifetime_2019-10-1.pdf

Child development and trauma guide Government of Western Australia Department of Communities (2014) https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Documents/ChildDevelopmentAndTraumaGuide.pdf

National Healthy Childhood Programme Child Health Assessment manual for Registered Public health Nurses (2020) https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/child-health-and-wellbeing/phn-manual.pdf

It is important to recognise the importance of education, training and professional judgement and critical thinking to understand how risk and protective factors interact within a 'bioecological' model (Bronfenbrenner and Morris, 2006), implying that development outcomes are seen as the result of a complex interplay between a large number of factors including the biology and makeup of the child, their immediate environment such as home, family and school, and wider influences such as the community and society. Changing the balance between risk and protective factors so that protective factors outweigh risk factors is a more effective prevention and intervention strategy. It can be a positive way to engage families because it focuses on families' strengths and what they are doing right and can provide a strong platform for building collaborative partnerships with other service providers as a basis for engaging families. These protective interventions have been shown to alleviate some of the predicted negative outcomes for children by building resilience.

NOTES PAGE

ACTIVE DEVELOPING CHILD DOMAINS AND DIMENSIONS [1]

	Dimensions
Domain 1 **Child Development Needs**	PHYSICAL HEALTH AND WELL-BEING EMOTIONAL AND BEHAVIOURAL DEVELOPMENT EDUCATION FAMILY AND SOCIAL RELATIONSHIPS IDENTITY SOCIAL PRESENTATION SELF-CARE SKILLS
Domain 2 **Parenting Capacity**	BASIC CARE ENSURING SAFETY EMOTIONAL WARMTH STABILITY GUIDANCE AND BOUNDARIES STIMULATION
Domain 3 **Family and Environmental Factors**	FAMILY HISTORY AND FUNCTIONING HOUSING EMPLOYMENT INCOME WIDER FAMILY FAMILY INTEGRATION INTO THE COMMUNITY COMMUNITY SERVICES

[1]

The indicators at this level can be linked to the Hardiker, Exton and Barker model at which Children and Families Need Support. (The Agenda for Children's Services A Policy Handbook (2007) Office of the Minister for Children Department of Health and Children).

The indicators for each level are explored over the following pages using a traffic light system to signify the progressively higher levels.

LEVEL 1: ACTIVE DEVELOPING CHILD Domains, Dimensions and Indicators	
LEVEL 2: ACTIVE DEVELOPING CHILD Domains Dimensions and Indicators	
LEVEL 3: ACTIVE DEVELOPING CHILD Domains Dimensions and Indicators	
LEVEL 4: ACTIVE DEVELOPING CHILD Domains Dimensions and Indicators	

LEVEL 1: ACTIVE DEVELOPING CHILD Domains, Dimensions and Indicators. [1] Examples of Indicators. The RPHN/RM should refer to The National Healthy Childhood Programme (NHCP) Child Health Assessment Manual for Registered Public Health Nurses. The manual provides a comprehensive list of age appropriate developmental milestones and warning signs.		
Domain	**Dimensions**	**Indicators**
1. Child Development Needs	Physical health and Well being	Developmental assessments have been carried as per NHCP and no developmental warning signs have been identified that are impacting on the child's day to day functioning. See NHCP Child Health Assessment manual for RPHNs for guidance.
	Emotional and Behavioural Development	Developmental assessments have been carried as per NHCP and social, emotional, language and communication are appropriate for age. No warning signs have been identified that are impacting on the child's social and emotional development. See NHCP Child Health Assessment manual for RPHNs for guidance.
	Education	Access to toys and books and ECCE scheme if appropriate
	Family and Social Relationships	Stable and affectionate relationships with parents caregivers and siblings
	Identity	Growing sense of self as separate from others
	Social presentation	Early practical skills in feeding and dressing
	Self-care skills	Appropriate dress, hygiene and cleanliness
2. Parenting Capacity	Basic Care	Provision of food, warmth, shelter and clothing
	Ensuring Safety	Provision of a safe environment where parents and carers act to safeguard the health and welfare of the child
	Emotional Warmth	Parents and carers feelings about the child are positive
	Stability	Home environment is stable. Child is not exposed to violence, alcohol or drug misuse
	Guidance and boundaries	Modelling appropriate behaviour and control of emotions and interactions with others
	Stimulation	Appropriate stimulation of learning
3. Family and Environmental Factors	Family history and functioning	Supportive family relationships
	Housing	Good quality housing
	Employment and Income	Family able to provide for the child
	Wider Family	Support of wider family members
	Family integration into the community	Formal and informal support networks
	Community service	Access community resources and activities

[1] The indicators at this level can be linked to the Hardiker, Exton and Barker model at which Children and Families need Support. (The Agenda for Children's Services A Policy handbook (2007) Office of the Minister for Children Department of Health and Children.

LEVEL 2: ACTIVE DEVELOPING CHILD Domains Dimensions and Indicators. [1] Examples of Indicators. The RPHN/RM should refer to The National Healthy Childhood Programme (NHCP) Child Health Assessment Manual for Registered Public Health Nurses. The manual provides a comprehensive list of age appropriate developmental milestones and warning signs.

Domain	Dimensions	Indicators
1. Child Development Needs	Physical health and Well being	Concerns identified or non-attendance at NHCP child health screening and surveillance appointments. Child welfare concerns or warning signs identified or reported (as per the NHCP Manual) that are impacting on the child's day to day functioning. Examples include recurrent minor injuries, unexplained bruising, concerns about growth measurements, identification of over or under nutrition).
	Emotional and Behavioural Development	Passive, withdrawn, uninterested, can be demanding, clinging, challenging behaviour at times
	Education	Identified language and communication difficulties. Reduced aces to books, toys, educational materials, ECCE scheme (if appropriate).
	Family and Social Relationships	Disharmony conflict within the family affecting child behaviour/safety/development
	Identity	Poor self-esteem, withdrawn, poor peer relationships, poor eye contact
	Social presentation	Unkempt: inappropriate clothes, social presentation and behaviour
	Self-care skills	Lack of consistency in role modelling to enable independent self skills
2. Parenting Capacity	Basic Care	Inconsistent care. Young inexperienced parent
	Ensuring Safety	Inappropriate childcare arrangement, Exposure to harmful substance misuse
	Emotional Warmth	Concerns regarding insecure attachment or poor bonding, parent unavailable to comfort the infant, child is self absorbed /depressed.
	Stability	Lack of consistency in routine
	Guidance and boundaries	Lack of response to concerns raised regarding the child. Discipline is a cause of concern.
	Stimulation	Reduced access to toys and books
3. Family and Environmental Factors	Family history and functioning	Relationship problems within the family which impacts on the family functioning as a unit
	Housing	Poor quality housing, overcrowding, damp, chaotic
	Employment and Income	Low income or unemployment casing stress/anxiety impacting on the family's ability to provide reliable care
	Wider Family	Family not connected or supported by extended family
	Family integration into the community	Family not assimilated into the local community
	Community service	Voluntary and statutory services not meeting the needs of the child and family

[1] The indicators at this level can be linked to the Hardiker, Exton and Barker model at which Children and Families need Support. (The Agenda for Children's Services A Policy handbook (2007) Office of the Minister for Children Department of Health and Children.

LEVEL 3: ACTIVE DEVELOPING CHILD Domains Dimensions and Indicators. [1] Examples of Indicators. The RPHN/RM should refer to The National Healthy Childhood Programme Child Health Assessment Manual for Registered Public Health Nurses. The manual provides a comprehensive list of age appropriate developmental milestones and warning

signs.		
Domain	**Dimensions**	**Indicators**
1. Child Development Needs	Physical health and Well being	Physical development raising significant concerns. Disability requiring specialist support.
		Chronic recurring health problems and hospital admissions. Misses appointments.
	Emotional and Behavioural Development	Looking for attention and approval. Unwilling to share toys etc. Acting out. Challenging behaviour.
	Education	No opportunities for play or interaction with other children. No access to books or toys or ECCE Scheme (if appropriate).
	Family and Social Relationships	Chaotic family lifestyle with significant impact on child health and development.
	Identity	Socially withdrawn. Isolated. Feel ashamed and guilty, bullied, victimised.
	Social presentation	Poor personal hygiene, general appearance of being cared for.
	Self-care skills	Lack of self-care skills impacting on development.
2. Parenting Capacity	Basic Care	Parent unable to manage day to day care of the child
	Ensuring Safety	High level of conflict in the home putting the child at risk.
	Emotional Warmth	Parent emotionally unavailable to the child.
	Stability	Multiple care givers.
	Guidance and boundaries	Difficulties in setting boundaries. Inadequate guidance provided to the child.
	Stimulation	Not receiving positive stimulation, with lack of new experiences or activities.
3. Family and Environmental Factors	Family history and functioning	Acrimonious family relationships. Suspicion of physical sexual emotional abuse or neglect.
	Housing	Overcrowded or inadequate housing that is likely to significantly impair health/development.
	Employment and Income	Poverty impacting on parent's ability to care for the child. Conflict as a result of financial debts.
	Wider Family	Family is isolated from immediate family and friends.
	Family integration into the community	Parents are socially excluded. Family under stress without extended network of support.
	Community service	

LEVEL 4: ACTIVE DEVELOPING CHILD Domains Dimensions and Indicators. [1] Examples of Indicators. The RPHN/RM should refer to The National Healthy Childhood Programme Child Health Assessment Manual for Registered Public Health Nurses. The manual provides a comprehensive list of age appropriate developmental milestones and warning signs.

Domain	Dimensions	Indicators
1. Child Development Needs	Physical health and Well being	Childs health requires specialist services. Physical disability.
	Emotional and Behavioural Dev.	Complex emotional and behavioural problems that requires specialist intervention. Emotional neglect.
	Education	Significant language and communication difficulties. No education provision.
	Family and Social Relationships	Family relations have completely broken down.
	Identity	Self harming and harming others.
	Social presentation	Dirty, unwashed, skin infestations.
	Self-care skills	Severe lack of age appropriate self-care skills resulting in isolation and bullying.
2. Parenting Capacity	Basic Care	Inability to recognise own health needs or those of the child to the extent that the child's health and development is seriously compromised.
	Ensuring Safety	Continued exposure to dangerous situations.
	Emotional Warmth	Mental or physical health needs or other health problems are significant and the child's emotional needs are neglected.
	Stability	Frequency of house moves is significantly affecting the child's health and development.
	Guidance and boundaries	Erratic or inadequate guidance and boundaries. No guidance or boundaries.
	Stimulation	Lack of response to concerns raised regarding the child's development and well-being.
3. Family and Environmental Factors	Family history and functioning	Imminent family breakdown and risk of child becoming 'looked after'.
	Housing	Accomadation places the child in danger.
	Employment and Income	Child health and development seriously affected by low income and unemployment.
	Wider Family	Family lack a support network.
	Family integration into the community	Family subjected to racial harassment or abuse. Chronic social exclusion, no supportive network.
	Community service	Family significantly disadvantaged by lack of service provision to meet additional needs.

[1] The indicators at this level can be linked to the Hardiker, Exton and Barker model at which Children and Families need Support. (The Agenda for Children's Services A Policy handbook (2007) Office of the Minister for Children Department of Health and Children.

Appendix VI Signs of Safety information Leaflet

TUSLA
An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Information for Professionals about Social Work

signs of safety®

Leaflet available online:

https://www.tusla.ie/services/child-protection-welfare/publications-and-forms/social-work-and-signs-of-safety-information-leaflets/

Tusla has adopted a new approach to child protection called the Signs of Safety. This guide explains the Signs of Safety and

How does this affect me?

Under **Children First: National Guidance for the Protection and Welfare of Children 2017**, everyone who works with children has a responsibility to keep them safe. Some professionals, known as mandated reporters, have more responsibilities under the ChildrenFirst Act 2015.

If you have a concern about a child, you may need to report to Tusla -Child and Family Agency.

Our Social Workers engage with families when the welfare, protectionor safety of a child is in doubt or if there are concerns that a child is being abused or neglected.

What will Tusla do if I contact them with a concern about a child?

When Tusla receives a report, our first consideration is alwaysthe immediate safety of the child. Tusla checks all reports and

information on the day they are received. If neccessary, we will takeemergency action to protect the child.

In some cases, we may not need to intervene and the issue can

safety and solutions. Social workers work collaboratively with families and children to conduct risk assessments and produce safety plans toincrease a child's safety and wellbeing.

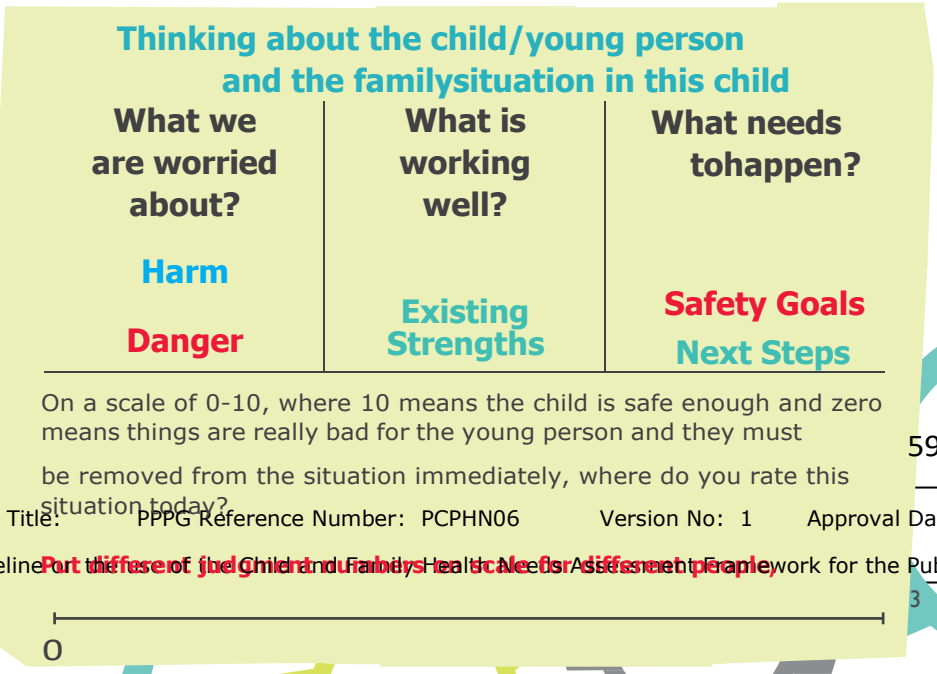
They focus on on the strengths, resources and the existing

- our immediate and long term worries about the child and

  a corressponding 'Safety Goal' which outlines the specific

The Assessment Framework

The assessment framework along with its associated tools assist everyone (the child and their family, social workers, professionals working with the child and their family, etc.) to jointly discuss and record the concerns, worries and strengths that exist within the familythat has led us to be concerned about their child.



Harm: Past hurt, injury or abuse to the child (likely) causedby adults. Also includes risk-taking behaviour by the child that indicates harm and/or is harmful to them.

Danger Statement: The harm or hurt that is believed likelyto happen to the child if nothing in the family's situation changes.

Complicating Factors: Actions and behaviours in and aroundthe family, the child and by professionals that make the situation more difficult to deal with.

Existing Strengths: People, plans and actions that contributeto a child's wellbeing.

Existing Safety: Actions taken by parents, caring adults and children to make sure the child is safe when

Practice Tools

Central to the Signs of Safety approach is the use of specific practicetools that let professionals and family members work together to address the worries about harm to the child. Some

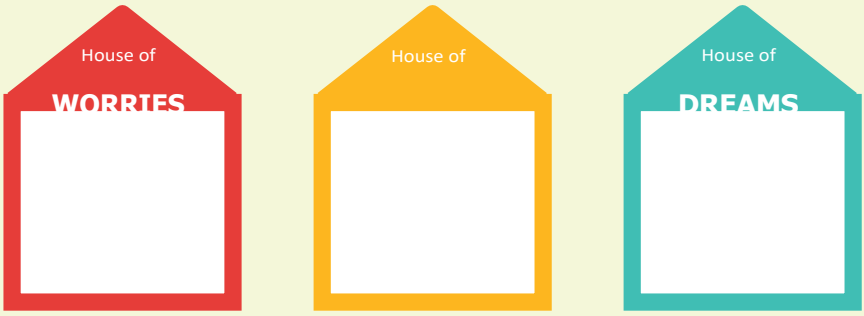
Safety Scales

Scaling questions help us measure the extent of the worries and concerns for the safety of the child at a point in time.

Talking to children is at the heart of Signs of Safety. We use specifictools such as My Three Houses (see page 5) to engage

My Three Houses

My Three Houses takes the three key assessment questions – what arewe worried about, what's working well and what needs to happen – and places them in three houses to make the issues



Words and Pictures Explanation

Words and Pictures is an agreed story, prepared in partnership withthe family, to enable the parents to explain to their child why theyare working with Tusla, what happened and what will change in thefuture.

Developing a Safety Network

A safety network is a group people, who are connected to the childand the family. It consists of family and community members whocommit to working with Tusla and the family to create a plan thatshows everyone how the worries about the child will be managed.

"No Network = No

The people in the network take part in the safety planning and monitoring process and commit to providing ongoing safety and

Developing and Monitoring a Safety Plan

A safety plan is a specific set of rules and arrangements that describes the family's everyday life and shows everyone - the professionals, the family's own supporting safety network and the child - how the child will be kept safe in the future, even if the dangeris present.

Building a Trajectory

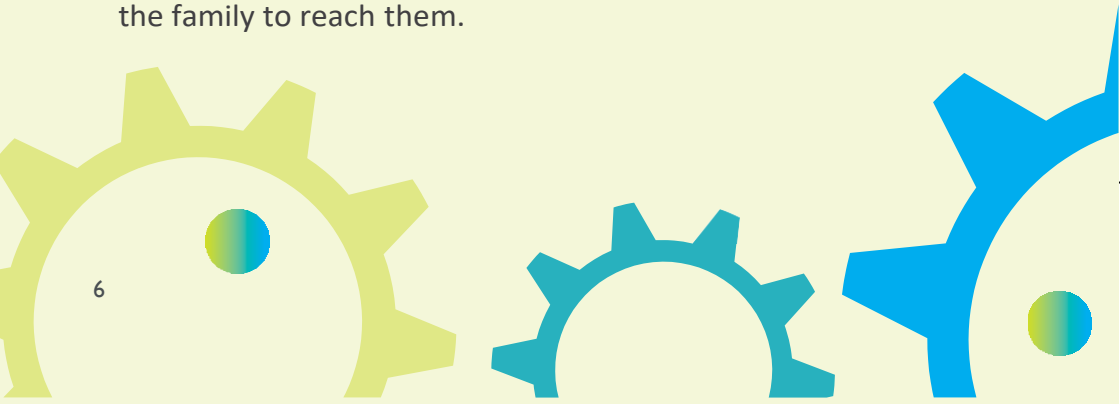
A trajectory is a document that sets out how the case will

- close the case; or

The document gives families a clear timeline for what needs to happen to show Tusla that the child is safe. It sets out step-by-step how the professionals and the family will work together and on whattasks to develop the safety plan.

- involving the child,
- developing a safety network,
- keeping the network is informed, and

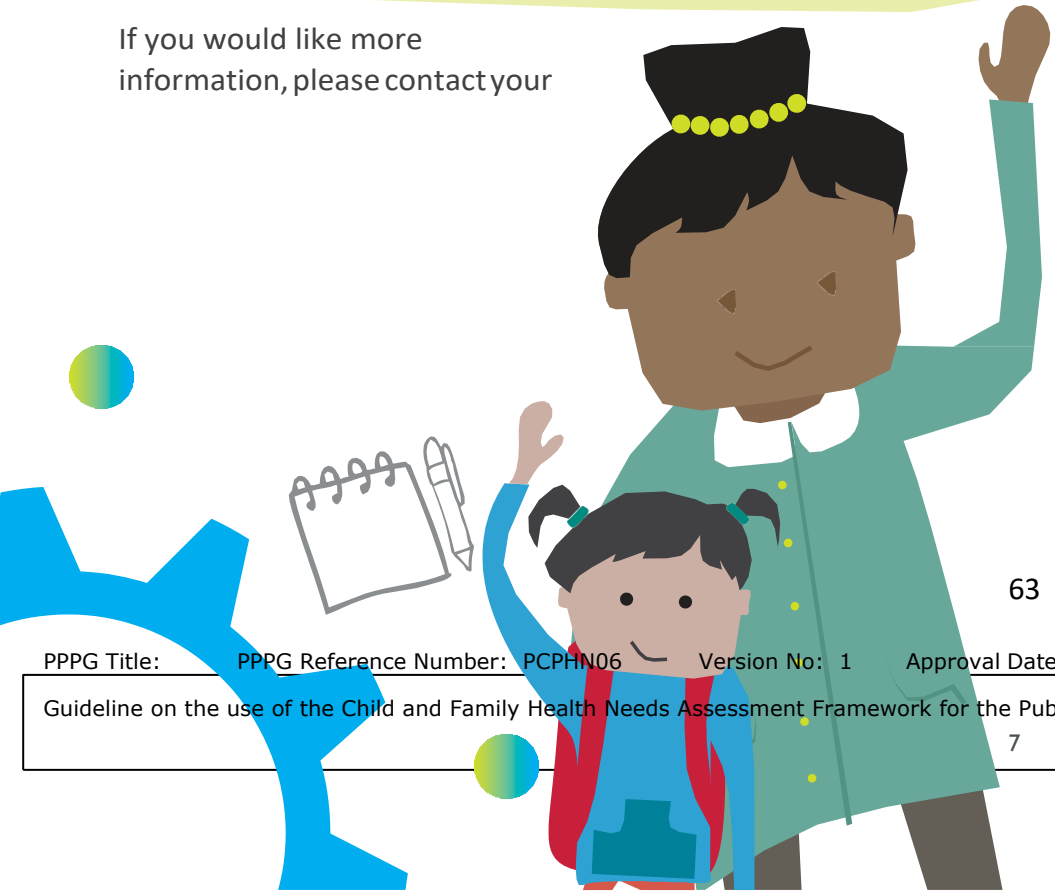
Having the timeline makes it possible to assess the family's ability to provide safety for the children. It also includes a specific case closuredate which provides clear goals, motivating the family to reach them.



What can I expect as a professional?

- The Signs of Safety is based on a questioning approach sothe social worker will ask more questions from the point of referral through to case closure. For instance, you maybe asked to rate the current safety of the child
- on a safetyscale based on thedanger identified.
- Social workers will use clearer, simpler language withfamilies.
- Parents and their safety network will take a greater part inmeetings s such as Child Protection
- conferences.

If you would like more information, please contact your



Social Worker's Name &

_____

Team Leader's Name &

_____

Tusla welcomes all comments, compliments and complaints from service users, carers, visitors andthe community about the services Tusla provides.

You can contact the Tusla Feedback andComplaints

Leaflet available online:

https://www.tusla.ie/services/child-protection-welfare/publications-and-forms/social-work-and-signs-of-safety-information-leaflets/

Early intervention and Family Support

Through its established network of 121 Centres nationwide, and two outreach Centres, the **Family Resource Centre** programme https://www.familyresource.ie is Ireland's largest family support programme delivering universal services to families in disadvantaged areas across the country based on a life-cycle approach. https://www.tusla.ie/services/family-community-support/family-resource-centres/

ABC Programme The Area Based Childhood (ABC) Programme is a national Prevention and Early Intervention (PEI) Programme funded by Department of Children, Disability, Equality and Integration (DCDEI), delivered through the Prevention Partnership and Family Support Programme (PPFS) within Tusla. The programme invests in effective services to improve outcomes for children and families 0-6 living in areas of disadvantage. The focus of the work under the ABC Programme covers, in the main: Child Health & Development; Children's Learning; Parenting; and Integrated Service Delivery. The programme is available in 12 areas- Grangegorman, Ballymun, Ballyfermot, Finglas, Dublin Docklands and East Inner City, Clondalkin, Dublin 5 & 17, Tallaght and Bray, Limerick, Cork and Louth. Further information about Covid 19 initiatives https://www.tusla.ie/Covid-19/

Parenting 24 Seven key messages on what works best for children and families at different ages and stages https://www.tusla.ie/services/family-community-support/parenting-24-seven/

Meitheal and Child and Family Support Network Coordinators Along with partners, Tusla are working to ensure that families can access the supports they need within their own communities. There are 117 Child and Family Support Networks across Ireland, and these networks are made up of a variety of agencies and local voluntary and community services. Tusla has developed the Meitheal early intervention practice model to help children and families where they may need the support of more than one service. The Meitheal process helps parents/ carers and children/ young people identify what changes need to happen in their lives to help and support them. The process helps bring supportive services together to work with the family. It creates a team around the child to agree a plan that is regularly reviewed. Reach out to your local Child and Family Support Network Coordinator to help you get the support you need- contact details available on https://www.tusla.ie/familysupport/

An Ghníomhaireacht um Leanaí agus an Teaghlach
Child and Family Agency

Interim Measures for Chid Protection Case Conference
Professional Report

Child's Name:	Child's DOB:	Name and address of person completing the form:
What are you worried about?	What is working well?	What needs to happen?
Safety Scaling Question: (Safety Scaling Question from the Social Work Report to be inserted here.) Please write a number on the scale and also your reason for choosing this number.		

_____

_____

Signature Date

Appendix VII: Audit tool for guidance on the use of the child and family health needs assessment framework for the public health nursing service

An Audit should be carried out within 6 months of implementation of this guideline using this audit tool. Frequency of audit, sampling processes and timescales for completions will be determined at local level following the first initial audit.

Please answer all questions indicating Yes or No or Not Applicable and give a comment if necessary.

	Question	**Please circle the answer**			
1	Is there documented evidence that the four Child and Family Health needs questions were asked at the primary visit?	YES		NO	
		3 month	**9-11 month**	**21-24 month**	**46-48 month**
2	Is there documented evidence that the prompt question was asked 'Has there been any change in the child and family circumstances from the previous contact?	YES NO	YES NO	YES NO	YES NO
3	If yes to the prompt question is there documented evidence that the four Child and Family Health Needs questions were asked?	YES NO N/A	YES NO N/A	YES NO N/A	YES NO N/A
4	Is there documented evidence that a Child and Family Health Needs Assessment was completed if required?	YES NO N/A	YES NO N/A	YES NO N/A	YES NO N/A
5	Is there documented evidence that a Care Plan was developed and evaluated?	YES NO N/A	YES NO N/A	YES NO N/A	YES NO N/A
6	Is there documented evidence that the outcomes were documented in CFHNA care plan?	YES NO N/A	YES NO N/A	YES NO N/A	YES NO N/A
7	Is there documented evidence that CFHNA care plan review dates were set?	YES NO N/A	YES NO N/A	YES NO N/A	YES NO N/A

No	Question	Yes	No	N/A	Comment
8	In the CFHNA/care plan have the principles of good documentation been adhered to: black ink, legible, date and timed with 24 hour clock, signature and NMBI number? **(recorded if applicable)**				
9	Is there evidence that the CFHNA/Care plan was discussed with the parents/guardians? **(recorded if applicable)**				
10	Is there evidence that consent was obtained from parents for information sharing? **(recorded if applicable)**				
	Totals				

Action areas identified **Quality improvement plan:**	
Date and time:	
Audit completed by:	**Title:**
Health Centre:	**CHO:**