Review of
Community Child Health Services
provided by South Eastern Health Board

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"Investment in our children's health must be our priority if we are to achieve health and social gains in the future for the people of the South East"
Part One
An Overview
Chapter 1

Summary

The Review of the Community Child Health Services provided by the SEHB

In 1996, the Chief Executive Officers of the Health Boards established a group to review child health surveillance in pre-school and primary school age children. The review group, chaired by Dr. Sean Denyer, published their report Best Health for Children - Developing a Partnership with Families in 1999.

In April 2000, when the South Eastern Health Board established a multidisciplinary committee to look at ways of implementing the recommendations of the report, it was decided to undertake a review of current child health services in the region and, in the context of Best Health for Children, to identify gaps in the service.

This review is the result of an extensive and comprehensive examination of community child health services in the South Eastern Health Board. It identifies many positive aspects, but finds deficiencies, some fundamental, in almost all areas of current practice. It identifies factors that prevent the provision of a quality service to all children.

There are shortcomings, particularly in management, staffing, organisation, investment and extent of service provision. There are many structural deficiencies that require immediate attention. Professionals have concerns that their contribution are made against a background of inadequate resources, personnel and management.

Where possible, this review makes recommendations for reorganisation and improvement in management, delivery and potential outcomes of the service in accordance with Best Health for Children. However, the recommendations of Best Health for Children can only be implemented in the South Eastern Health Board by a programme of revitalisation, significant investment and inclusion of input from all stakeholders.

The Professionals

There is no designated person, at community care level, with overall responsibility for managing or co-ordinating the child health surveillance programme.

Best Health for Children outlines the roles, responsibilities and key tasks of professionals involved in child health surveillance. In reality, roles, responsibilities and boundaries are poorly defined. At all levels staff are well motivated but morale is low. The present staff/client ratio needs to be addressed.
The Services

**Pre-school Service:** The contents and timing of the current pre-school programme are outlined in *Child Health in the Pre-school Years* (South Eastern Health Board, 1995). The contents are similar to, but the timing is at variance with, the recommendations of *Best Health for Children.*

With the present structure and resources, a flexible and comprehensive service tailored to the needs of the individual is impossible to deliver. Uptake of core visits varies from 100% for the primary visit to as low as 20% for the eighteen-month visit. Visits cannot always be delivered in a timely manner. Where it is not possible to provide the complete programme, services are provided according to need. However, there is no systematic method of identifying vulnerable parents and/or children who may require additional support.

All four community care areas have a multidisciplinary Early Intervention Team to co-ordinate services for pre-school children with disabilities. The concept is excellent and has great potential but the development of present follow up services is required.

**School Health Service:** Except where specialised school nurses exist, the school screening service receives much lower priority and is placed ninth out of the eleven PHN duties.

The booster immunisation programme is given the highest priority. Screening of vision and hearing are dependent on staff and time resources. There is limited opportunity for parents to meet with health professionals and less opportunity for health promotion in the school setting.

The emotional and psychological health of children receives insufficient attention in the present programme; follow-up services are over-stretched and under-resourced.

Waiting time for assessment of referrals from screening is, with a few notable exceptions, unacceptably long.

Screening of children in special education is usually prioritised, however, some staff training needs have been identified as a priority.

**Training**

All key health professionals acknowledged that a specific, structured and coordinated programme of in-service training and continuing education in child health surveillance, essential to the maintenance of a quality service, is not available to them.

**Guidelines**

There is no comprehensive Practitioner's Handbook with written and agreed checklists, guidelines for screening procedures, referral criteria and referral pathways covering the period birth to the end of primary school.
Clerical Support and Child Health Records

Insufficient clerical support is a major problem. Community child health professionals spend a considerable amount of valuable time (up to fifteen hours weekly) on clerical duties that could best be carried out by appropriately trained clerical staff.

There is no designated person charged with overall responsibility for these important and potentially legal documents. There is no agreed uniform child health records system, issues to be addressed include access to charts, a tracer system and archives co-ordination.

Accommodation and Equipment

Service providers considered accommodation in the majority of clinics used for screening to be unsuitable for its intended purpose. Most clinics are poorly equipped. The School Health Team is frequently offered facilities that are substandard.

Communication

All aspects of communication were found to be unsatisfactory. Disciplines exist in near isolation. There is no structured or co-ordinated approach to the dissemination of information to parents, especially in the early stages of the child’s life. There is no evidence to suggest that child health services are addressing the issue of the language barrier, ethnic minorities and cultural differences. In community care, modern communication technology is underdeveloped.

Data Collection and Evaluation of Services

The child health surveillance programme requires monitoring for effectiveness or efficiency. Data collected is of poor quality, uncoordinated, and difficult to use, I.T. solutions are required. The opinion of service users is not regularly sought nor used to plan for change. Due to lack of resources, the computerised Child Health System remains in an embryonic stage.

Despite the best efforts and goodwill of all professionals involved in the child health surveillance programme it has become increasingly difficult to provide a quality and comprehensive service to all children. Considerable disillusionment and frustration exists amongst the professionals. There is no specific training in child health, poor support structures and too much to do in too little time.
Chapter 2

Strategic Recommendations

*Best Health for Children* describes a blueprint for a modern child health surveillance programme for the pre-school and primary school age group. The report recommends changes necessary to move from the old bureaucratic, service-centred, static model based on orthodoxy to a new flexible, child-centred, dynamic model based on evidence. It acknowledges the strengths and weaknesses of the current programme and that many parts of the new model are already in place, but that some aspects will present significant challenges in both commitment and in implementation.

Following extensive examination of current child health practice in the South Eastern Health Board, recommendations are put forward to facilitate the transfer from the old model to the new model described in *Best Health for Children*.

Some recommendations will require National policy adoption, others regional or local change.

The Professionals

- The roles and responsibilities of professionals involved in community child services should be clearly defined.
- The Child Health Coordinators should be appointed to lead the multidisciplinary Child Health Team and manage the School Health Service.
- When the Child Health Coordinator is appointed, priority should be given to assembling a multidisciplinary child health team in each community care area.
- A hospital/community care liaison professional should be appointed in each community care area to facilitate early provision of community services to parents and/or children with special needs.
- The role, responsibilities and key tasks of the liaison professional should be developed with a strong emphasis placed on effective interdisciplinary liaison.
- Public health nurses (PHNs) should be granted sufficient protected time to allow all children to receive all visits recommended in the core surveillance programme.
- Time should be factored into the PHN schedule to allow for additional support visits to parents/children who require or request them, especially in the first three months of life.
- To facilitate a PHN-delivered, quality child health surveillance service, consideration should be given to the deployment of registered general nurses (RGNs) for clinical duties.
The Public Health Nurse/client group ratio should be evaluated and addressed. In addition to the number of parents/children in any PHN area, the agreed ratio should take into account (a) the needs of the client group, and (b) the proposed introduction of an antenatal visit.

The possibility of flexible working hours, to accommodate parents working outside the home, should be explored and a pilot project conducted in one community care area.

The post of School Nurse should be reinstated. Sufficient appointments should be made to guarantee that all children are offered an equitable and quality service. The school nurse/client ratio should be re-evaluated with needs taking precedence over client numbers.

A named school nurse and doctor should be assigned to each primary school (public, special and private) and notified to individual schools principals.

In consultation with professional bodies, and with lessons learned from the pilot project in the Midland Health Board, consideration should be given to creating the post of Community Child Health Nurse.

The feasibility of contracting developmental examinations to general practitioners should be examined, especially where staff shortage and/or inadequate clinic accommodation is a problem.

Services

Adequate, secure funding should be sought to ensure a comprehensive and quality child health surveillance programme.

The range of services that each discipline can offer the client should be clearly defined and made known to both service users and service providers.

There should be a shift of emphasis in the PHN workload to allow for priority to be given to the delivery of a comprehensive, equitable and first class child health surveillance programme to all children.

A strategy to develop parent-training services should be developed at regional level.

Screening of children in special schools should be re-evaluated to ensure that staff with sufficient expertise is assigned to the task. Discussion should be entered into with community audiologists and ophthalmic physicians to provide the service.

Where there are unacceptable waiting times for follow-up of suspected or confirmed defects/problems arising from screening, an action plan should be formulated to address the issue.
The SEHB should continue to support and encourage the development of more low-level family supports e.g. home support service, community parent support programmes, parent & child groups and student mothers groups.

The feasibility of providing developmental clinics in a more flexible manner, both in time and place, should be assessed. Lessons learned from the demonstration project by the South Western Area Health Board, Best Practice in Child Health Developmental Examinations, should be considered.

The second scheduled PHN visit should not be changed from six weeks to three months until a structure has been agreed and established to ensure that a doctor examines all infants at six weeks of age.

The structure, staffing, content and timing of the school health service should be standardised regionally to reflect the aims of a school health as outlined in Best Health for Children.

Learning points from the demonstration project by the North Western Health, Developing the School Health Service Model, should be incorporated into the restructuring.

Training

In order to provide a specific, co-ordinated, and nationally agreed programme of education in child health surveillance, the report of the National Conjoint Child Health Committee: *Training of doctors and public health nurses in child health surveillance* (draft), Dec.2000, should be adopted and implemented without delay.

The programme should be made available to all relevant staff. Time and workload should not be a prohibiting factor.

Time should be factored into the work schedule for staff training and regular updating.

If necessary, locum cover should be provided to ensure no diminution of services while staff avail of training or updating.

Guidelines

A standardised and agreed SEHB Practitioner’s Handbook for child health surveillance (of pre-school children) should be developed. It should reflect the changes proposed by *Best Health for Children* and should contain clear, agreed guidelines on screening procedures, criteria for review and/or referral, and referral pathways.
• Learning points from the demonstration project, Developing Referral Guidelines/Criteria and Referral Pathways for Child Health Services, Southern Health Board, should be incorporated into the Practitioner’s Handbook.

• Standardised referral forms, agreed with relevant disciplines, should be developed and made available.

• Structures should be examined and clear guidelines established to provide support for mothers and babies discharged from hospital when regular services are not available in the community.

• A checklist/guidelines to assist in the identification of vulnerable/at risk parents, families and/or infants should be developed and clearly defined referral pathways established.

• Each community care area should develop referral guidelines and pathways for the vulnerable family/parent/child and for mothers with suspected postnatal depression.

• A standardised and agreed SEHB Practitioner’s Handbook for child health surveillance (of school age children) should be developed. It should reflect the changes proposed by Best Health for Children and should contain clear, agreed guidelines for screening procedures, criteria for review and/or referral, and referral pathways.

• The regional guidelines should be backed up with specific training and updating of relevant professionals. Specific attention should be given to the identification of psychosocial problems.

Clerical Support and Child Health Records

• The child health programme should be given the status it deserves with sufficient trained clerical support to maintain the service and to allow professionals to use their time more effectively.

• The training needs of clerical staff involved in the Child Health System (CHS) should be assessed and upgraded as required.

• A suitably trained locum should be available when the designated clerical officer for the CHS is absent.

• An effective system should be devised and implemented for the safe filing, storage, movement and tracing of child health records, both active records and those in archives.

• A designated clerical officer should be appointed and trained to manage records.
Accommodation and Equipment

- The adequacy of health centres and equipment used for screening children should be assessed and a plan for addressing deficiencies drawn up.

- Staff should be supplied with the necessary equipment to perform child health screening in an effective manner.

Communication

- The importance of effective communication should be effectively communicated to all service providers.

- Appreciation of the goodwill and commitment that service providers have, and are prepared to give to the new model of child health surveillance should be communicated to them.

- Staff should be made aware that their individual contribution to the service is valued and their opinion should be sought prior to making change. Ownership of change should be recognised as an important staff motivational factor in achieving successful outcomes.

- A system of introducing new staff members to the local organisation should be developed.

- The range of services that each discipline can offer the client should be clearly defined and made known to both service users and service providers.

- A streamlined communication network should be developed and activated, to ensure optimum communication and liaison between all disciplines and services in child health and welfare, should undergo regular review.

- Community child health professionals should foster and strengthen their relationships with parents, teachers, childcare professionals, GPs, and paediatricians. Links should be forged with new services e.g. the Educational Psychology Service.

- A structured and co-ordinated approach to the dissemination of information to parents should be developed. The demonstration projects in the Mid Western health Board (Personal Child Health Record) and the South Eastern Health Board (Parent Information Pack) should be examined and learning points from these incorporated locally.

- Parents should receive feedback, positive and/or negative, from each health screening procedure.

- Health and health service information appropriate to ethnic minorities should be developed and made available locally.
• Provision of communication tools and training in their use are essential requirements for modern communication.

• There is an urgent need to develop a fully integrated computerised child health system to record, audit and collate relevant screening, follow-up and disease prevention information on children. At the same time, records should respect and safeguard the confidentiality of the child and family.

Data Collection and Evaluation of Services

• A fully integrated Child Health Information System should be developed to allow for all child health surveillance to be recorded.

• Systems used in different areas should be compatible and the data collected should be standardised nationally.

• Data collection should be upgraded and presented in a manner that would allow for regular evaluation of services.

• Services should be evaluated regularly to ensure effective and efficient delivery of a quality service.

• The opinion of service providers and service users should be considered in any evaluation of services.

• A review of community child health services should be carried out in five years.

Cost Neutral Changes

• Sponsored information packs should be in line with SEHB policy.

• The Maternity and Infant Care Scheme is a free service and parents should be made aware of its existence.

• Where a professional has been appointed to liaise between the maternity department and community care, they should be retained.

• Accepting that a PHN visit to all newborn babies within forty-eight hours of discharge from hospital is the ideal, this is not possible within the present five-day working week. The primary visit should, however, be made by the PHN as early as possible following baby’s discharge from hospital and within two working days.

• In the absence of Community Child Health Nurses, the ratio of PHNs to infants and preschool children should be reviewed.

• Accepting that a PHN visit to all expectant mothers in the antenatal period is the ideal, the resource implications should be examined.
• The second scheduled PHN visit should not be changed from six weeks to three months until a structure has been agreed and established to ensure that a doctor examines all infants at six weeks.

• The committee concur with the recommendations of *Best Health for Children* that the six-week examination of baby should be carried out by a medical practitioner.

Changes that Require National Adoption

• The practice of some health boards delaying notification of non-marital births should be addressed nationally to allow for a timely first visit.

• In addition to the recommendations of *Best Health for Children*, a brief assessment of speech and language development should be undertaken at core visits.

• *Dental Hygiene* listed under topics for education in the proposed surveillance programme should read *Oral Health*. Education at this stage should focus primarily on dietary issues, including the weaning diet, advice on oral hygiene and the appropriate use of fluoride.

• The recommendations of the national committee established to review the National Newborn Screening Programme should be awaited. In the meantime, the maternity department should be informed when the PHN performs a Guthrie Test in the community.

• A national group has been convened to examine the feasibility of universal hearing testing of the newborn and its recommendations should be awaited.

• Recommendations for facilities necessary to screen and vaccinate children in schools nationally should be drawn up and presented to the Department of Education.
Chapter 3

Summary of Recommendations of The Core Child Health Surveillance Programme

The implementation committee considered the recommendations, and as far as is as possible, prioritised the recommendations into short, medium, and long-term targets.

Priority (a): short term targets to be met by the end of 2002
Priority (b): medium term, by December 2003
Priority (c): long-term in 2004 or later

Recommendations from Chapter 7

Child Health Surveillance Programme

7.1 If "investment in our children's health must be our priority if we are to achieve health and social gains in the future for the people of the South East", adequate secure funding should be sought now to guarantee a comprehensive and quality child health programme. Priority (a)

7.2 A timetable should be put in place to address the issues of structure, staffing and training of professionals involved in child health surveillance. Priority (a)

7.3 Staff/client group ratios should be re-evaluated with consideration given, not only to client numbers, but also client needs. An equitable service should target resources to those with the greatest need. Priority (b)

7.4 In the absence of specialised child health nurses, PHNs should be granted sufficient protected time for child health surveillance. Priority (a)

7.5 To facilitate the provision of a quality child health surveillance service, consideration should be given to deploying registered general nurses (RGNs) for clinical duties. Priority (c)

7.6 Urgent consideration should be given to creating the posts recommended by Best Health for Children. They include Child Health Co-ordinators (a), Community Child Health Nurses (c), and to reinstating the posts of School Nurse across the region (b). Priority (a), (b), (c)

7.7 When the Child Health Coordinator is appointed, priority should be given to assembling a multidisciplinary child health team in each community care area. Priority (a)

7.8 A structured education programme with regular updating should be developed for professionals involved in child health surveillance. Priority (c)
The programme should be offered and available to all relevant staff. Time and workload should not be a prohibiting factor. **Priority (c)**

The possibility of flexible working hours should be explored. **Priority (c)**

The guidelines for the pre-school programme, *Child Health in the Pre-School Years* should be examined and updated to reflect proposed changes in the core surveillance programme. **Priority (a)**

The up-dated handbook should include, or be accompanied by:
- best practice guidelines for monitoring speech and language development
- guidelines for performing the distraction test of hearing
- the Edinburgh check list for postnatal depression
- checklist for mother/child bonding **Priority (a)**

Written and agreed regional guidelines should be developed from the School Health Service. **Priority (c)**

A copy of all checklists, booklets and referral forms referred to in the pre-school or school guidelines should be included in the pack. **Priority (c)**

Regular review of client (parent) and staff satisfaction with the child health surveillance services and its delivery should be sought and incorporated into future planning. **Priority (c)**

Key performance data and health outcome indicators should be collected routinely and used to identify local problems and plan action to address unmet needs. **Priority (a)**

A plan to address poor communication between all disciplines should be developed and activated, both locally and regionally. **Priority (a)**

Recommendations from Chapter 8

**Antenatal Period**

8.1 In the absence of Community Child Health Nurses, the ratio of PHNs to infants and pre-school children should be reviewed (a). Consideration should be given to reducing this ratio and allotting protected time for child health surveillance duties **Priority (a)**

8.2 The purpose of the antenatal visit should be established and regionally agreed guidelines should be developed for the visit. **Priority (a)**

8.3 Flexible working hours, to accommodate parents working outside the home, should be piloted in one community care area. **Priority (c)**
8.4 Accepting that a PHN visit to all expectant mothers in the antenatal period is the ideal, the resource implications should be examined (a). In the interim, a service that would target the vulnerable, especially young and first-time mothers should be initiated (c). Priority (a), (c)

8.5 A secure system should be established to identify, at community care level, all prospective parents or at least all young, first-time and/or potentially vulnerable parents. Priority (a)

8.6 A standardised referral pathway for the vulnerable mother, child and/or family should be established. Priority (a)

8.7 A specific programme designed to support the teenage mother and her family during pregnancy and to assist in planning future parenting responsibilities should be developed. A key worker should be assigned to each expectant teenager to coordinate the programme. Priority (a)

8.8 A regionally agreed core programme with agreed multidisciplinary input should be developed for antenatal classes. The programme should be evidenced-based empowering and evaluated. Priority (c)

8.9 A training programme should be initiated to train class facilitators. Priority (c)

8.10 The availability, accessibility, number and duration of antenatal classes must be consumer oriented in time and place and should not be restricted to hospital-based programmes. Priority (c)

8.11 Each community care area should have a co-ordinator for antenatal classes to arrange the timing and location of classes, to collect data on those starting, attending and completing courses, to evaluate the programme and ensure a client-friendly service. Priority (c)

8.12 An information booklet, similar to the Maternity Information Guide (SEHB) issued to expectant mothers in St. Luke's Hospital, Kilkenny, should be adapted locally and distributed to expectant mothers by all maternity departments in the SEHB region. Priority (a)

8.13 An antenatal pack should be developed which would target appropriate information and eliminate the non-essential. This pack could contain core information with add-on sections for specific parents e.g. travellers, lone parents or parents planning adoption. Priority (a)

8.14 Sponsored information packs should be in line with the SEHB policy on sponsorship. Priority (a)
Where a professional has been appointed to liaise between the maternity department and community care they should be retained (b). Areas without a liaison professional should assign a person to identify the vulnerable, offer antenatal services and support to those identified and set up appropriate referral pathways (c). Priority (b), (c)

The role, responsibilities and key tasks of the liaison professional should be developed with a strong emphasis placed on effective interdisciplinary liaison. Priority (a)

Partnership and closer liaison should be developed between Child Care/Protection and Child Health services to minimise overlapping functions, territorial conflict and duplication of resources. Improved co-ordination and co-operation would ensure a more child-centred service. Priority (b)

The Maternity and Infant Care Scheme is a free service and parents should be made aware of its existence. Priority (a)

Recommendations from Chapter 9

Perinatal Reporting System

9.1 A copy of the 36-hour notification form should be sent to the referring medical practitioner. Priority (c)

9.2 If the mother and baby's address on discharge from hospital differs from the address on admission, the 'discharge address' should always be entered on the 36-hour notification form. Priority (c)

9.3 The SEHB birth label should be adapted to allow for 'address on discharge from hospital' to be entered. Priority (c)

9.4 Electronic transmission of the 36-hour notice should be developed. Ideally by electronic mail from the maternity department to community care and, when facilities allow, directly to the relevant PHN. Priority (c)

9.5 The final birth notification form should also be transmitted from the maternity department by fax, electronic mail or computer link, ideally on the day of baby's discharge from hospital. Priority (c)

9.6 Training needs of clerical staff involved with the Child Health System should be assessed and upgraded. A suitable trained locum should be available when the designated clerical officer is absent Priority (a)
Recommendations from Chapter 10

Newborn Screening for Metabolic Disorders

10.1 The system of reporting should be examined to ensure that it is foolproof. In the interim, the Maternity Department should be informed when the PHN performs a Guthrie Test in the community.  
Priority (a)

10.2 The recommendations of the national committee recently established to review the National Newborn Screening Programme should be awaited.  
Priority (c)

10.3 An I.T. solution capable of tracking metabolic screening tests and results, and allowing for cross-reference between hospital and community care should be considered.  
Priority (c)

Recommendations from Chapter 11

Birth

11.1 A national group has been convened to examine the feasibility of universal hearing testing of the newborn and its recommendations should be awaited.  
Priority (c)

11.2 The availability of hospital/community care liaison personnel, preferably a nurse, to facilitate early provision of community services to parents and/or children with special needs cannot be over-emphasised.  
Priority (a)

11.3 Streamlined packs, containing only relevant information, should be developed and distributed to mothers at the appropriate time  
Priority (a)

11.4 A checklist to assist in the identification of vulnerable/at risk mother or infant should be developed and defined referral pathways established.  
Priority (a)

11.5 Following a procedural checklist in the event of stillbirth or neonatal death is good practice. A designated staff member should be assigned to ensure compliance with and completion of relevant procedures.  
Priority (a)

11.6 Notification of neonatal death should be standardised and reported early to the mother's GP.  
Priority (a)

11.7 A standard discharge reporting system to inform the relevant GP of the in-patient progress of both mother and infant should be developed.  
Priority (c)

11.8 Attention should be given to improving communication between all disciplines involved in the health and welfare of children.  
Priority (a)

11.9 In order to promote child safety in cars, the feasibility of discharging all newborn babies from SEHB hospitals in a suitable car seat should be explored.  
Priority (b)
Recommendations from Chapter 12

Primary Visit

12.1 Bearing in mind the objectives of the primary visit, the PHN should identify early, and with mother, what supports, if any, are needed and link mother with an appropriate form of support within the community. In certain circumstances it may be necessary to visit mother more than once to achieve this ideal. Priority (a)

12.2 Accepting that a PHN visit to all newborn babies within 48 hours of discharge from hospital is the ideal, this is not possible within the present five-day working week. The primary visit should, however, be made by the PHN as early as possible following baby's discharge from hospital and within two working days. Priority (a)

12.3 The provision of electronic mail, computer link or fax machines in all health centres would facilitate direct communication between the maternity and area PHN and ensure a timely first visit. Priority (a)

12.4 To further facilitate a timely first visit, the link between 36-hour notification and the discharge of mother and baby from hospital should be strengthened through liaison personnel. Priority (a)

12.5 The availability of hospital/community care liaison personnel, preferably a nurse, to facilitate early provision of community services to parents and/or children with special needs cannot be over-emphasised. Priority (a)

12.6 The contents, timing, route and mode of transmission of the 36-hour (preliminary notification) form should be standardised nationally. Priority (c)

12.7 The practice of some health boards delaying notification of non-marital births should be addressed nationally to allow for a timely first visit. Priority (a)

12.8 Structures should be examined and clear guidelines established to provide support for mothers and babies discharged from hospital at weekends and, more particularly, over festive holiday periods when everyday services are not available in the community. Priority (a)

12.9 The SEHB should continue to support and encourage the development of more low-level supports e.g. Home Support Service, Community Parent Support Programmes, Parent & Child Groups and Student Mothers Groups. Priority (c)

12.10 A strategy for developing family support, home visiting and parent training services should be developed at regional level. Priority (a)

12.11 An agreed and standardised checklist for the assessment of mother/child bonding and the recognition of postnatal depression should be developed and made available. Priority (a)
12.12 Each community care area should develop referral guidelines and pathways for the vulnerable family/parent/child and for mothers with suspected postnatal depression. Priority (a)

12.13 Appropriate training should be put in place to achieve the objectives of the primary visit. Priority (a)

12.14 The proposed parent held health record should facilitate feedback and transfer of information between relevant professionals. It should be introduced when the pilot study is complete. Priority (c)

12.15 At the primary visit the PHN should establish the name of the general practitioner or paediatrician who will carry out the six-week examination and encourage mother to attend. Every opportunity should be taken to remind parents that the Maternity and Infant Care Scheme is free and available to all mothers and newborn babies up to six weeks after birth. Priority (b)

12.16 Appropriate statistical data should be collected to monitor performance indicators. Priority (a)

Recommendations from Chapter 13

Six-week Visit

13.1 The committee concur with the recommendations of Best Health for Children that the six-week examination of baby should be carried out by a medical practitioner. Priority (c)

13.2 Appropriate guidelines should be developed to facilitate structured introduction of the doctor/baby examination and the collection of uptake data. In the interim, the PHN should continue to carry out a six-week visit. When a universal doctor/baby examination procedure is established, the second core PHN visit should be made at three months. Priority (c)

Recommendations from Chapter 14

Three-month and Other Visits

14.1 The second scheduled PHN visit should not be changed from six weeks to three months until a structure has been agreed and established to ensure that a doctor examines all infants at six week of age. Priority (c)

14.2 The PHN/client group ratio should be evaluated (a) and addressed (b) In addition to the number of parents/children in any PHN area, the agreed ratio should take into account the needs of the client group. Priority (a), (b)
14.3 PHNs should be granted sufficient and protected time to allow all children to receive at least all core visits in the surveillance programme. 

Priority (a)

14.4 Time should be factored into the PHN schedule to allow for additional support visits to parents/children who require or request them especially in the first three months of life. 

Priority (a)

14.5 Time should also be factored in for staff training and updating. 

Priority (c)

14.6 If necessary, locum cover should be provided to ensure no diminution of services when staff avails of training or updating. 

Priority (c)

14.7 A coordinated and nationally agreed training programme is urgently required to ensure that all staff involved in child health surveillance are confident that they have the necessary skills and expertise to provide a quality service. 

Priority (c)

14.8 The nature of PHN/parent contact (home visit, ineffective home visit, phone call or clinic visit) should always be recorded in the child’s chart. Where possible, appointments should be made for house calls. 

Priority (a)

14.9 To facilitate a PHN-delivered quality child health service consideration should be given to the deployment of registered general nurses (RGNs) for clinical duties. 

Priority (a)

14.10 The introduction of flexi-time for PHNs should be considered. 

Priority (c)

14.11 A handbook of child health surveillance for pre-school and school children should be developed and agreed regionally by child health teams: 
- it should reflect the changes proposed in Best Health for Children 
- it should contain agreed guidelines for screening procedures, referral criteria and referral pathways. 

Priority (a)

14.12 Standardised referral forms agreed with relevant disciplines should be developed and made available. 

Priority (a)

14.13 Where checklists, forms or booklets are referred to in the guidelines, they should accompany the handbook. 

Priority (c)

14.14 Information relevant to ethnic minorities should be developed and made available to service providers. 

Priority (a)

14.15 Feedback to parents and relevant professionals should be formalised and sufficient clerical support should be provided to make this a reality. 

Priority (a)

14.16 A streamlined communication network should be developed to ensure optimum communication and liaison between all disciplines involved in child health and welfare services. 

Priority (a)

14.17 Services should be evaluated on a regular basis to ensure efficient and effective delivery of a quality service. 

Priority (c)
14.18 Data should be collected routinely on the uptake and outcome of all core visits in the child health surveillance. Priority (a)

Recommendations from Chapter 15

'Developmental' Examination

15.1 A Child Health Co-ordinator, as recommended by Best Health for Children should be appointed to lead the multidisciplinary Child Health Team. Priority (a)

15.2 The report on the demonstration projects, Developing Best Practice in Child Health Developmental Examinations, Eastern Regional Health Authority, should be examined and learning points from them incorporated into the SEHB strategy. Priority (a)

15.3 An assessment of the adequacy of the centres used for development examination should be carried out. Priority (a)

15.4 The feasibility of providing developmental clinics in a more flexible manner, both in time and place, should be assessed. Priority (c)

15.5 The feasibility of contracting developmental examinations to general practitioners should be examined, especially where staff shortage and/or inadequate clinic accommodation is a problem. Priority (c)

15.6 The recommendation of Best Health for Children that a full physical examination of baby need not be carried out at the developmental visit if no problems have arisen and there is documented evidence of a medical examination at six weeks should be adopted. The introduction of parent held health records should facilitate this. Priority (c)

15.7 In addition to the recommendations of Best Health for Children, a brief assessment of speech and language development should be undertaken at this visit. Priority (c)

15.8 Dental Hygiene listed under Topics for Health Education in the proposed surveillance programme should read Oral Health. Education at this stage should focus primarily on dietary issues, including the weaning diet, advice on oral hygiene and the appropriate use of fluoride. Priority (a)

15.9 Referral criteria and pathways should be standardised locally and should be available in written form. Priority (a)

15.10 All referrals by community care professionals should be notified to the child's general practitioner. Similarly the report on all referrals should be sent to the referrer and the general practitioner. Priority (a)

15.11 Clear guidelines for the follow-up of non-attenders at developmental clinics should be developed regionally. Priority (a)
Recommendations for Chapter 16

School Health Service

16.1 *The decision to continue a School Health Service should not be made unless, and until, adequate resources can be guaranteed to provide an equitable and quality service.* Priority (a)

16.2 Consideration should be given to the early appointment of area Child Health Coordinators to, among other things, manage the school health service. Priority (a)

16.3 The structure, staffing, content and timing of the school health service should be standardised regionally to reflect the aims of a school health service as outlined in *Best Health for Children.* Priority (c)

16.4 The report on the demonstration project, *Developing the School Health Service Model,* North Western Health Board, should be examined and learning points from it incorporated into the SEHB strategy. Priority (d)

16.5 The post of School Nurse should be reinstated. Sufficient appointments should be made to guarantee that all children are offered an *equitable and quality service.* The nurse/client ratio should be re-evaluated with needs taking precedence over client numbers. Priority (c)

16.6 A named school nurse and doctor should be assigned to each primary school (public, special and private) and notified to individual school principals. Priority (c)

16.7 *Screening of children in special schools* should be re-evaluated to ensure that staff with sufficient expertise is assigned to this task. Discussion should be entered into with community audiologists and ophthalmic physicians to provide this service. Priority (a)

16.8 Arrangements should be put in place to facilitate an annual formal planning meeting between the school nurse and school principal. Priority (c)

16.9 An information leaflet should be developed that would fully inform parents and teachers of all relevant aspects of the school health service. Priority (c)

16.10 Clear guidelines for the school health service should be formulated regionally and agreed locally. They should outline:

- roles and responsibilities
- risk groups for individual defects
- criteria for review and referral, developed in consultation with appropriate specialists and local GP’s
- referral pathways to allow for timely and appropriate management of children who are positive on screening examination
- guidelines on appropriate feedback to parents and professionals Priority (c)
16.11 The regional guidelines should be backed up with specific training and updating of relevant professionals. Priority (c)

16.12 A standardised and specific training programme should be devised and made available to all relevant professionals. Special attention should be given to the identification of psychosocial problems. Priority (c)

16.13 With the introduction of the Educational Psychology Service, referral criteria and pathways to community psychology services should be re-defined and strengthened. Priority (a)

16.14 Where there are unacceptable waiting times for follow-up of suspected or confirmed defects/problems arising from screening, an action plan should be formulated to address the issue. Priority (a)

16.15 Sufficient clerical support should be provided to ensure full backup for the school health service and to protect valuable professional time. Priority (a)

16.16 Consideration should be given to developing a system of data transfer that would eliminate the need for removing charts from community care centres. Priority (a)

16.17 For ease of reference, all letters of referral should include the child's date of birth, school attended and GP's name. All referrals should be notified to the child's GP. Consideration should be given to developing standardised referral forms in consultation with referral services. Priority (c)

16.18 There is an urgent need to formulate and implement a policy for the storage, filing, movement and tracing of child health records. Designated record clerks should be assigned to care for these important documents. Priority (a)

16.19 Information technology should be developed which could record screening and referral information while safeguarding client confidentiality. Priority (a)

16.20 The collection of data should be upgraded and presented in a manner that would allow for regular evaluation of the service and could be used to make recommendations, where necessary, for changes in practice. Priority (a)
Chapter 4

Introduction

Best Health for Children – Developing a Partnership with Families is the report of a review of screening and surveillance services for children in Ireland. It was launched in December 1999.

The last review of child health services in Ireland was carried out between 1965 and 1967. Since then there have been rapid economic, social and health care advances, coupled with increased emphasis on quality, effectiveness and value for money in health and social services. There have also been major developments in our understanding of the influence of lifestyle, the role of the consumer of services and the factors that are likely to influence behaviour. These developments and the growing recognition of the need for change indicated that an evaluation of current practices was timely.

In September, 1996, at the request of the Chief Executive Officers of the Health Boards, the Directors of Public Health established a review group comprising Dr. Sean Denyer, Dr. Heidi Pelly and Dr. Lelia Thornton to "define a programme for Child Health Surveillance in the pre-school and primary school age group, the contents of which would be based on best available evidence". The review covers the age group from birth to 12 years and addresses the following areas:

- Content and timing of programme
- Roles and responsibilities, including accountability
- Partnership with parents
- Training
- Information management
- Resources
- Opportunistic health promotion
- Quality assurance

The report does not address: Maternity services; breastfeeding; immunisation; acute/episodic illness; chronic illness; dental health or mental health; disability, except in so far as it impinges on the screening services; child protection, except in so far as it impinges on the screening services.

Best Health for Children is presented in two sections:

Section 1: A Vision for Child Health.

- Develops a vision for child health in the future.
- Describes a model that would enable services to meet this vision.
- Outlines changes that will need to be made in current practice to enable the model to become reality.
The Vision

*Best Health for Children* envisages a move from the current bureaucratic, service-centred, static service based on orthodoxy to a new flexible, child-centred, dynamic paradigm. The emphasis would shift from one-dimensional "defect-detection" to promoting healthy families in their many dimensions.

The proposed Child Health Surveillance Service:

- Puts children and their parents at the centre of the service
- Acknowledges and respects the importance of communities and lay support as the first port of call for parents
- Works to increase the knowledge and skills of families and communities to enable them to continue to take responsibility for the health of their children
- Facilitates a system to identify and support families who need help in fulfilling their responsibilities
- Builds services around locations with which families have most contact, such as play groups, crèches, schools, community centres and health centres
- Operates in a co-ordinated way to deliver a flexible package of care
- Accepts the need for a high quality specialist service to back up local services, with excellent communication between these services and the families needing them
- Recognises that Health Boards and the Department of Health need high quality information on which to plan and develop policy
- Recognises that primary care should be the main focus of the health care

The *key principles of a quality child health programme* should underpin the service and should be the function and responsibility of service providers.

- Children should be enabled to achieve their *maximum health potential*
- Parents have the right to be actively involved in their children's health and supported in appropriate and effective ways
- Services should exist to serve the needs of children and parents
- Parents have a right to information about services
- Parents have a right to appropriate feedback from service providers
- Parents have a right to be consulted about service delivery
- Parents and children have a right to high quality services
The Model

The model described encompasses a more holistic child health promotion approach and emphasises the role of families as partners in the process. Services of the highest quality will be equitable, child-centred, flexible, integrated and co-ordinated.

The child health service will be managed through a multidisciplinary Community Child Health Team (CCHT) led by a Child Health Co-ordinator, who will have medical, epidemiological and public health skills.

More attention will be given to parents as partners and to improving information and support. A parent-training strategy will be formulated with the Department of Health Promotion.

Provision of training and continuing education of a standard sufficient to ensure a quality service will be essential.

The model recommended is an interim programme, which is likely to continue to change as the evidence base becomes more robust.

The Changes

The report identifies strengths and weaknesses within the current child health system and believes that, with reconstruction, the system has the potential to deliver a first class service.

A shift to the new model would entail a change in philosophy, changes in structure, roles and responsibilities, improved intersectoral liaison, training, continuing education, and rigorous quality control. Many parts of the proposed model are already in place or could be put in place with a minimum of reorganisation. Some aspects are likely to present significant challenges particularly in terms of commitment and implementation.

The authors of the report conclude that the need for change is widely recognised, and that it is apparent amongst the professionals involved that the goodwill exists to facilitate this change.

Section 2: A Technical and Operational Report.

- Describes the evidence concerning screening and surveillance
- Looks at professional roles and responsibilities
- Details the content and timing of a standardised national screening and surveillance programme

Section two of the report outlines the core programme of screening which can be justified on currently available evidence, noting the paucity of evidence on which to make a recommendation for or against many child health surveillance activities. It reiterates that the proposed programme is unlikely to remain static and that further changes are likely as evidence becomes available.
The roles and responsibilities of professionals in Community Child Health are clearly defined:

- Child Health Team
- Area Medical Officer
- General Practitioner
- Community Paediatrician
- Public Health Nurse
- Community child health nurse
- School nurse

as is the role of parents in the school health service.

The contents and timing of the core programme for child health, from diagnosis of pregnancy to the completion of primary school, is outlined in considerable detail.

The report *Best Health for Children* (subtitled *Developing a Partnership with Families*) is clearly designated as a progress report.

It is important to note the following in respect of the status of the report:

- the report has been designed so that it can be updated as necessary
- it seeks to get national agreement on core screening schedules
- it seeks to enhance or develop evidence-based practice
- there is a national committee to facilitate further development and implementation of the work
- the report was launched nationally in December, 1999 with the active support of Health Board Chief Executive Officers

It is not suggested that the entire report has been adopted as Department or Health Board policy. What can be implied is that the report is seen as a way forward and Boards should move to implementation stage.

Following the national launch of *Best Health for Children*, a decision was taken in the SEHB region to establish a committee to move towards implementation of the recommendation contained in the report.

The Implementation Committee comprises members from all four Community Care Areas and representatives from the following disciplines:

- Area medical officers
- Child care managers
- Child psychiatry
- Community ophthalmic physicians
Dental surgeons
Occupational therapy
Paediatricians
Physiotherapy
Psychology
Public Health Nurses
Social work
Speech and language therapy

The chairman is a general manager.

The terms of reference agreed by the committee are:

1. To undertake a review of current child health practice and compare it with the model proposed in the report, covering the period up to the end of primary school education
2. Identify divergence in practice against proposed model
3. Report on gaps in service provision as identified in the review
4. Implement cost neutral changes in practice to conform to the model proposed in the report
5. Identify cost implications of changes required
6. Identify recommended actions that require National Policy adoption/resourcing
7. Identify best practice, best models of care, possible outcome measures and set realistic targets

This Report

- Reviews current child health practice in the four Community Care Areas of the SEHB and compares it to the model proposed in *Best Health for Children*
- Identifies divergence in practice against the proposed model
- Reports on gaps in service provision as identified in the review
- Makes recommendations for moving towards the model of practice recommended by *Best Health for Children*
This review is presented in four parts.

**Part 1:** An overview

**Part 2:** The core child health surveillance programme

**Part 3:** General issues:
- Training and Continuing Education
- Administrative Support, the Child Health System and Child Health Records
- Communication
- Accommodation and Equipment
- Data Collection and Evaluation of Services

**Part 4:** Submissions from committee members reporting on behalf of their colleagues in the context of *Best Health for Children.*

- Child Care
- Dental
- Medical
- Nursing
- Occupational Therapy
- Ophthalmology
- Psychology
- Speech and Language
- Family Support and Home Visiting
- Processes and Outcome Indicators
Chapter 5

Methodology

Following the setting up of the Implementation Committee a sub-group was formed to establish how best to describe current child health practice in the South Eastern Health Board region. The group studied the report, *Best Health for Children*, concentrating particularly on the authors' vision of a new model for a child health surveillance programme.

From this, key questions were drawn up; questionnaires were formulated and distributed to professional groups identified in the report.

The following groups were addressed to outline *Best Health for Children* and the purpose of the review of child health services within the region. A question and answer session followed each meeting.

- **Public Health Nurses** - at their monthly meeting in Tipperary SR, Waterford and Wexford.
- **Community Ophthalmic Physicians** - at their quarterly meeting in Kilkenny.
- **Area Medical Officers** - at the September 2000 meeting of Irish Society for Public Health Medicine in Carlow.

An interview was conducted with the antenatal and postnatal sisters in the maternity department of Waterford Regional Hospital and the designated clerical officer in the Waterford Child Health Office (CHO). Senior midwives in St. Joseph's, St. Luke's and Wexford General Hospitals were visited for the purpose of explaining the project and to enlist their help.

The Questionnaire for Public Health Nurses (PHN) and Area Medical Officers (AMO) covered the following aspects of child health practice and service provision:

- the core surveillance programme
- training and continuing education
- communication and liaison
- accommodation and equipment
- evaluation of services

Because of the varied nature of the PHN role in child health surveillance their questionnaire was divided into sections and subsections:

- **Antenatal Period**

- **Preschool**
  - general
  - primary visit
  - child health clinics
  - six-week examination
  - developmental examination
  - other core examinations
- School service
  - mainstream schools
  - special schools

- Special groups
  - special needs children including Early Intervention Teams
  - travellers

Each Public Health Nurse (119) who carries out child health surveillance in the SEHB region was given a questionnaire and requested to complete only the sections relevant to her work practice. An unknown number of questionnaires were completed jointly by PHNs who job-share. Four PHNs (Wexford) returned blank questionnaires with apologies, stating that a heavy caseload did not allow time to complete the questionnaire.

All AMOs (20) were invited to complete a questionnaire which was also divided into sections and subsections:

- Preschool
  - developmental examination
  - children with special needs

- School service
  - mainstream schools
  - special schools

Eleven completed questionnaires were returned. One area (Tipperary SR), submitted a single questionnaire on behalf of three AMOs, thus the work practice of thirteen (65%) AMOs is included in the review.

A shorter questionnaire, on aspects of services that dovetail into the core surveillance programme, was given to the following in each of the four Community Care Areas:

- designated clerical officer for the child health system
- principal dental surgeon
- community ophthalmic physician
- maternity department (midwife)
- CGP representative (GP)

Questionnaires were identified by profession and Community Care Area only.
Table 1.5.1 Questionnaires distributed to (denominator) and returned by (numerator) each group regionally and by Community Care Area.

<table>
<thead>
<tr>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual questionnaires</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHN*</td>
<td>82/119 (69%)</td>
<td>24/35</td>
<td>22/26</td>
<td>22/36</td>
</tr>
<tr>
<td>AMO*</td>
<td>11/20 (55%)</td>
<td>3/5</td>
<td>1/3</td>
<td>6/6</td>
</tr>
<tr>
<td>COP</td>
<td>3/4 (75%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Midwife</td>
<td>4/4 (100%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Dentist</td>
<td>4/4 (100%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>CHO</td>
<td>4/4 (100%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>GP</td>
<td>3/4 (75%)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* A unknown number of questionnaires were completed jointly by PHN's who job-share.

** The completed questionnaire from Tipperary SR was submitted on behalf of three AMOs.

All (9) consultant paediatricians in the region were informed that, in the context of *Best Health for Children*, a review of child health practice in the community was underway and they were invited to comment, express their opinion or make recommendations to ensure that the review would be comprehensive and considerate of all points of view; three responded.
Table 1.5.2: Number of (a) PHNs and (b) AMOs who completed questionnaire sections, by region and community care area.

(a) PHN Respondents

<table>
<thead>
<tr>
<th>SEHB Region</th>
<th>Carlow/ Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal visit</td>
<td>69*</td>
<td>22</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>General pre-school surveillance</td>
<td>70*</td>
<td>22</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>Primary visit</td>
<td>70*</td>
<td>22</td>
<td>20</td>
<td>18</td>
</tr>
<tr>
<td>6-week visit</td>
<td>69*</td>
<td>22</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>9-month examination</td>
<td>69*</td>
<td>22</td>
<td>20</td>
<td>17</td>
</tr>
<tr>
<td>Other core visits</td>
<td>65*</td>
<td>22</td>
<td>20</td>
<td>15</td>
</tr>
</tbody>
</table>

School Service

<table>
<thead>
<tr>
<th></th>
<th>Preschool service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SEHB Region</td>
</tr>
<tr>
<td>Mainstream school</td>
<td>47 15 20 3*** 9</td>
</tr>
<tr>
<td>Special school</td>
<td>5 2 1 2 0</td>
</tr>
</tbody>
</table>

(b) AMO Respondents

<table>
<thead>
<tr>
<th>SEHB Region</th>
<th>Carlow/ Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-month examination</td>
<td>11 4 1**</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mainstream school</td>
<td>11 4 1**</td>
<td>5</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Special school</td>
<td>3 2 0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

* A unknown number of questionnaires were completed jointly by PHNs who job-share.
** The completed questionnaire from Tipperary SR was submitted on behalf of three AMOs.
***Four school nurses carried out all screening in mainstream schools in Waterford Community Care Area.
During Summer 2000, a survey of Child Health Record Cards (charts) was conducted in all four community care areas during summer 2000, to examine the primary visit, the 6 week examination and the developmental clinic visit in the context of the recommendations of *Best Health for Children*.

Charts of children born January 1st 1999 – January 31st 1999 inclusive and who remained in the SEHB region from birth to developmental examination (or at least the first developmental appointment) were reviewed.

In May 2000, 534 names were recorded on the child health system, of these 480 were eligible for inclusion in the survey. Of the 54 (10%) excluded, 42 (8%) had moved into, or out of, the region during the specified time, 5 (1%) had died, 5 (1%) held duplicate records, one elderly person and one visitor to the region were also excluded.

Altogether 474 charts were studied. Six were not available at the time of the survey.

### Table 1.5.3 Number (%) of charts from each area included in the survey.

<table>
<thead>
<tr>
<th>SEHB Region</th>
<th>Carlow</th>
<th>Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>474 (99%)</td>
<td>44 (100%)</td>
<td>69 (96%)</td>
<td>98 (100%)</td>
<td>118 (98%)</td>
<td>145 (97%)</td>
</tr>
</tbody>
</table>

Members of the Implementation Committee were invited to make a short submission, following consultation with colleagues, on their service in the context of *Best Health for Children*. 
Chapter 6

Health Status of Children in the South East

The South Eastern Health Board (SEHB) Region is comprised of Counties Carlow, Kilkenny, Tipperary South Riding, Waterford and Waterford County Borough and Wexford.

In the last census (April 1996), the region had a population of 391,046 of which almost one quarter (total 95,593; 24 %) were children under 15 years of age.

The health of children in the South East is the subject of the report of the Director of Public Health, 1998. Some statistics have been updated for this review and some initiatives are described.

Births

The birth rate in Ireland and the South Eastern Region had been falling since the early 1980s to a low in 1994 of 13.4 and 13.1 per 1000 respectively. In 1999, the national and regional rate had risen to 14.2 and 14.3 with 5,652 babies born to mothers living in the South East.

Table 1.6.1 Birth rate in Ireland, SEHB and counties, 1994 and 1999 (CSO).

<table>
<thead>
<tr>
<th></th>
<th>Ireland</th>
<th>SEHB</th>
<th>Carlow</th>
<th>Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth rate</td>
<td>13.4</td>
<td>13.1</td>
<td>14.8</td>
<td>12.4</td>
<td>11.9</td>
<td>12.9</td>
<td>13.6</td>
</tr>
<tr>
<td>1994</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth rate</td>
<td>14.2</td>
<td>14.3</td>
<td>14.8</td>
<td>12.8</td>
<td>13.0</td>
<td>14.7</td>
<td>16.2</td>
</tr>
<tr>
<td>1999</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Non-marital and Teenage Births

In 1999, 30.9 % of births in Ireland were non-marital.

In a survey of babies born, January 1st – 31st 1999, to mothers resident in the SEHB region, a similar proportion (32%) of births were non-marital, with Waterford and Wexford recording a higher proportion at 38% and 37% respectively.

Non-marital births are a poor indicator of deprivation or social/health need and are no longer considered to be a significant risk factor as many are in the context of stable two-parent families.

More emphasis is now placed on births to teenage mothers, who by virtue of age, have completed a lower level of education and are also less mature in terms of parenting skills.
Teenage births in this cohort accounted for 22 (5%) of births in the region, half (11) of these to mothers living in Co. Wexford.

Overall, teenage pregnancy is more likely to be associated with an increased risk of poor social, economic and health outcomes for both mother and child.

Prematurity and Low Birth Weight

A strong positive correlation exists between both prematurity and low birth weight and low socio-economic status.

In 1999, low birth weight babies (<2,500 grammes) represented 4.71% of total births nationally and 4.84% in the SEHB.

The SEHB has a higher proportion of mothers in the lower socio-economic groups (semi-skilled and unskilled manual workers, unemployed, not classified and house duties) compared to Ireland.

<table>
<thead>
<tr>
<th>County</th>
<th>SEHB</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary/SLR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-marital</td>
<td>152 (32%)</td>
<td>26 (23%)</td>
<td>27 (28%)</td>
<td>45 (38%)</td>
<td>54 (37%)</td>
</tr>
<tr>
<td>Teenage</td>
<td>22 (5%)</td>
<td>4 (4%)</td>
<td>2 (2%)</td>
<td>5 (4%)</td>
<td>11 (8%)</td>
</tr>
<tr>
<td>Total births</td>
<td>474</td>
<td>113</td>
<td>98</td>
<td>118</td>
<td>145</td>
</tr>
</tbody>
</table>

Table 1.6.3 Proportion of low birth weight babies and mothers in lower socio-economic groups, in Ireland and the South East, 1999.

<table>
<thead>
<tr>
<th>Category</th>
<th>Ireland</th>
<th>SEHB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birth weight</td>
<td>4.71%</td>
<td>4.84%</td>
</tr>
<tr>
<td>Lower socio-economic groups</td>
<td>38.4%</td>
<td>48.1%</td>
</tr>
</tbody>
</table>

Source: Economic and Social Research Institute, provisional data 1999
Breastfeeding

The National Breastfeeding Policy for Ireland (Department of Health, 1994) set a target of 30% breastfeeding at four months by the year 2000.

In 1999, rates for breastfeeding in Ireland are low at (36%)1 and even lower (31.5%)1 in the SEHB.

The most recent Cuidiú report (September 2000), records breastfeeding rates in SEHB maternity departments. These figures are self-reported from individual hospitals.

Table 1.6.4 Breastfeeding initiation rates and rates on discharge from hospital in SEHB maternity departments, 1999.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Initiation rate</th>
<th>Hospital discharge rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Luke's, Kilkenny</td>
<td>33%</td>
<td>24%</td>
</tr>
<tr>
<td>St. Joseph's, Clonmel</td>
<td>24.5%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Waterford Regional</td>
<td>31%</td>
<td>28%</td>
</tr>
<tr>
<td>Wexford General</td>
<td>34%</td>
<td>30.5%</td>
</tr>
</tbody>
</table>

Source: Cuidiú Infant Feeding Survey 2000.

The SEHB is proactive in promoting breastfeeding. In 1997, the SEHB

1. Launched a policy document Promoting and Supporting Breastfeeding setting out
   - regional objectives and targets
   - breastfeeding aims in the antenatal and postnatal period
   - breastfeeding guidelines
   - checklist for staff
   - management of breastfeeding problems and breast conditions

1 Source: Economic and Social Research Institute, provisional data for 1999.
2. Initiated an education programme for midwives and public health nurses - Breastfeeding and Lactation Management - which has continued to date;


Following a study of breastfeeding practice in the SEHB further steps were taken to increase breastfeeding rates.

1. In September 2000, an Officer for the Promotion of Breastfeeding was appointed whose principle objective is to demonstrate a 10% increase on current breastfeeding initiation and duration rates in Waterford Community Care Area.

   (In 1999, the breastfeeding initiation rate in Waterford Community Care Area was 34.7%.)


3. On 1st January 2001, a framework for systematic recording of breastfeeding initiation and duration was implemented in Waterford Regional Hospital and on 1st May 2001 in Wexford General Hospital.

All hospitals in the SEHB have a Certificate of Interest in the Baby Friendly Hospital Initiative. In June 2001, Waterford Regional Hospital was awarded a Certificate of Commitment to Baby Friendly Hospital Initiative. This certificate recognises that the hospital is working to bring its practices into line with the Ten Steps of Successful Breastfeeding and is committed to improving the services it provides to mothers and babies.

**Travellers**

- The Traveller’s Health Committee is active in each community care area. Study days focusing on traveller culture have been held in Tipperary SR and Wexford. A further conference is planned for Waterford.

- Traveller representatives have been invited onto the local health committees and, in Waterford, a project is ongoing to train traveller women to act as community health workers.

Source: ¹ A Study of Infant Feeding in the South East, Mairead Fennessy.

² Breastfeeding initiation rates - 36-hour birth notification form.
Immunisation

Immunisation rates in the SEHB region are persistently higher than the rates for Ireland.

Table 1.6.5 Annual immunisation uptake at 24 months, 1999 and 2000.

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th></th>
<th>1999</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SEHB</td>
<td>Ireland</td>
<td>SEHB</td>
<td>Ireland</td>
</tr>
<tr>
<td>3rd Diphtheria</td>
<td>85.9%</td>
<td>90.6%</td>
<td>86.2%</td>
<td>89.0%</td>
</tr>
<tr>
<td>3rd Pertussis</td>
<td>82.1%</td>
<td>85.4%</td>
<td>81.9%</td>
<td>84.8%</td>
</tr>
<tr>
<td>3rd Tetanus</td>
<td>85.9%</td>
<td>89.6%</td>
<td>86.2%</td>
<td>89.0%</td>
</tr>
<tr>
<td>3rd Hibriten</td>
<td>85.4%</td>
<td>89.3%</td>
<td>85.5%</td>
<td>88.7%</td>
</tr>
<tr>
<td>3rd Polio</td>
<td>85.7%</td>
<td>89.5%</td>
<td>86.0%</td>
<td>88.8%</td>
</tr>
<tr>
<td>1st MMR</td>
<td>78.9%</td>
<td>89.7%</td>
<td>76.9%</td>
<td>86.6%</td>
</tr>
</tbody>
</table>

Source: National Disease Surveillance Centre.

Children with Physical and Sensory Disabilities

- Within the past two years area Coordinators for Disability Services have been appointed in each community care area.

- An outreach service from the Central Remedial Clinic has been established in the grounds of Waterford Regional Hospital. A consultant paediatrician with a special interest in childhood disability liaises between this service and the Early Intervention Team.

- Specific services for children with Autism have been sanctioned and posts have been advertised. The Department of Education has provided educational facilities in mainstream and special schools.

- A pilot project on a physical and sensory database has been carried out in Tipperary SR and is in the process of extending to other areas within the SEHB.
Chapter 7

The Child Health Surveillance Programme

*Best Health for Children* recommends a shift of emphasis from the narrow base of developmental screening of whole populations of children at fixed intervals in order to detect unsuspected abnormality, to the broader scope of child health surveillance.

The report outlines the aims and goals of a child health surveillance programme.

Aims

- The detection of defects
- The formation of a relationship between the professionals involved and the family
- Improvement of immunisation uptake rates
- Accident prevention
- Health education

Goals

- That all children have an opportunity to realise their full potential in terms of good health, well-being and development
- That remediable disorder are identified and acted upon as early as possible

In drawing up proposals for a revised child health surveillance service which would meet the current needs of children and would be based on best available evidence, the authors of *Best Health for Children* considered the following points:

- The child health surveillance service is still the only free primary health examination service for all children
- The service has enormous potential for health promotion
- For many vulnerable families, the service has been an acceptable means of contact with the health services
- Many parents use the visits as an opportunity for informal discussion and support
- Contact with professionals can have negative outcomes for some parents, e.g. the anxiety attached to false positive diagnoses
• Evidence exists to support some aspects of surveillance programmes, but not to support other aspects, and for many components of child health surveillance programmes, there is no available evidence.

• Where evidence exists, its interpretation is often difficult, particularly where conflicting evidence is reported.

The report recommends:
• that the needs of the child must be the central focus of the programme
• a change of emphasis from disease detection to health promotion
• changes in roles and responsibilities of service providers, with the establishment of new posts and the reinstating of previously abolished posts
• improved communication and liaison between all service providers
• regular audit and evaluation of services
• that the programme be implemented in a standardised manner nationally

In order to ensure a streamlined, quality and coordinated service, *Best Health for Children* outlines the content (history and physical examination), topics for health education and professionals involved in the core surveillance programme and the timing of each core contact from birth to 12 years.

Current Practice in the South Eastern Health Board Region

In the South Eastern Health Board region, guidelines for the *Pre-school Programme* are contained in the booklet, *Child Health in the Pre-school Years* (SEHB, Nov. 1995).

The booklet outlines the benefits of surveillance.

• Formation of a constructive relationship between professional and family which allows the positive promotion of health, independent of the stress caused by acute medical problems

• Preventive work such as immunisation and reduction of accident hazards

• Guidance on important child health topics such as development, behavioural problems, nutrition and the use of services for children

• Maintenance of a body of knowledge in the community, among both parents and professionals, about child health and development
The booklet also describes the requirements of professionals undertaking developmental assessment/surveillance:

The ability to:

- listen to parents and take their concerns seriously
- take a full and complete developmental history at the primary visit and follow through on it at each subsequent contact/visit
- observe accurately at each visit/contact
- recognise atypical patterns of child development
- make appropriate referral arrangements in accordance with health board guidelines

coupled with

- a thorough knowledge of child development

Acknowledging that child development is part of the wider programme of child health surveillance, it describes, under history, physical examination and health promotion, the five core visits to be undertaken in the community.

1. Primary visit following discharge of baby from hospital
2. Six-week visit
3. Eight-month/clinical developmental examination
4. Eighteen-month visit
5. Thirty-nine month visit

Additional visits may be made where these are deemed necessary by the PHN or when requested by parents.

The philosophy underlying the South Eastern Health Board pre-school programme is in keeping with the aims and goals of the report. However, there are variations in content, timing and delivery.

The School Health Programme has changed in recent years in status, staffing and content. Child health professionals now perceive it as the Cinderella of services.

There are no written or agreed regional guidelines on policy, procedures, referral criteria or referral pathways in the school health service. Written guidelines have been developed locally in areas where district PHNs carry out school screening (Kilkenny, Tipperary SR and Wexford).
Only six school nurse posts remain in the SEHB region; Waterford Community Care Area retained the four original posts; there is one in Kilkenny and a vacant post in Carlow.

Across the SEHB region, school children are offered at least two core screening visits during the primary school years; the timing varies from area to area.

All school children are offered vaccination as recommended by *Immunisation Guidelines for Ireland* (National Immunisation Committee, Royal College of Physicians, 1999). Written procedural guidelines, agreed regionally, are available for the school vaccination programme.

Duties that demand priority over routine child health surveillance of pre-school children (i.e. except the primary and 'developmental' visit) include in the following order:

- care of the terminally ill
- wound care
- care of the young chronically ill
- vaccination
- care of the elderly
- clinic duties
- and lastly, school screening

Opportunity for staff to avail of training or updating in child health surveillance is limited. Education on offer is uncoordinated, unstructured and infrequent; it does not always meet the needs of the professionals. On occasion, staff are unable to attend due to pressure of work. PHNs often rely on sponsored seminars for updating.

Despite the best efforts and goodwill of all professionals involved in the child health surveillance programme it has become almost impossible to provide a quality and comprehensive service to all children. Considerable disillusionment and frustration exists especially among Public Health Nurses. There is too much to do in too little time.

An increasing birth rate, particularly in urban areas, an expanding workload for all professionals, lack of clerical support and difficulty with recruitment has meant that duties must be prioritised. Pre-school visits are not always timely or offered, the school health service has been curtailed and downgraded, most waiting lists for referrals from screening are lengthy – in some cases unacceptably so, and there is little time for formal or informal liaising between service providers.
The coordinated structure outlined in *Best Health for Children* does not yet exist. The post of Child Health Co-ordinator to assemble and lead a multidisciplinary team has not been established, there are no Community Child Health Nurses and only a limited number of School Nurses.

No data are collected on the proportion of children who receive any of the core visits in the child health surveillance programme.

Conclusion

- The primary visit to newborn infants and vaccination of school children (as per 1999 guidelines) are the only sections of the programme offered to all children.

- With the present level of resources, it is not possible to provide a comprehensive and quality child health surveillance programme especially to school age children.

- Services are inflexible, and overburdened staff have difficulty responding to different levels of need.

- Staff working in child health surveillance services (except school nurses) are overwhelmed by diversity of commitments and are unable to give sufficient time to any sector.

- Until the issues of structure, staffing, training and the necessary resources are addressed the child health surveillance programme will continue to deteriorate.

- Existing guidelines for the pre-school programme, Child Health in the Pre-school Years (SEHB Nov. 1995) are excellent; have been agreed and are used regionally. However, there are no written regional guidelines for the school health service.

- There is an urgent need for specific training and continued updating of professionals involved in child health surveillance.

- Valuable professional time is spent on clerical duties.

- No data are routinely collected on the target groups screened, on quality indicators or outcomes.
Recommendations

7.1 If "investment in our children's health must be our priority if we are to achieve health and social gains in the future for the people of the South East", adequate secure funding should be sought now to guarantee a comprehensive and quality child health programme.

7.2 A timetable should be put in place to address the issues of structure, staffing and training of professionals involved in child health surveillance.

7.3 Staff/client group ratios should be re-evaluated with consideration given, not only to client numbers, but also client needs. An equitable service should target resources to those with the greatest need.

7.4 In the absence of specialised child health nurses, PHNs should be granted sufficient protected time for child health surveillance.

7.5 To facilitate the provision of a quality child health surveillance service, consideration should be given to deploying registered general nurses (RGNs) for clinical duties.

7.6 Urgent consideration should be given to creating the posts recommended by *Best Health for Children*, (i.e. Child Health Coordinators, Community Child Health Nurses), and to reinstating the posts of School Nurse across the region.

7.7 When the Child Health Coordinator is appointed, priority should be given to assembling a multidisciplinary child health team in each community care area.

7.8 A structured education programme with regular updating should be developed for professionals involved in child health surveillance.

7.9 The programme should be offered and available to all relevant staff. Time and workload should not be a prohibiting factor.

7.10 The possibility of flexible working hours should be explored.

7.11 The guidelines for the pre-school programme, *Child Health in the Pre-School Years* should be examined and updated to reflect proposed changes in the core surveillance programme.

7.12 The up-dated handbook should include, or be accompanied by:

- best practice guidelines for monitoring speech and language development
- guidelines for performing the distraction test of hearing
- the Edinburgh checklist for postnatal depression
- checklist for mother/child bonding

7.13 Written and agreed regional guidelines should be developed for the School Health Service.
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- Staff working in child health surveillance services (except school nurses) are overwhelmed by diversity of commitments and are unable to give sufficient time to any sector.

- Until the issues of structure, staffing, training and the necessary resources are addressed the child health surveillance programme will continue to deteriorate.

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- Valuable professional time is spent on clerical duties.

- No data are routinely collected on the target groups screened, on quality indicators or outcomes.
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Chapter 8

Antenatal Period

*Best Health for Children* recommends that nursing services for infants and pre-school children be delivered by *Community Child Health Nurses* who work exclusively with children.

In addition to carrying out activities as outlined in the core programme, the proposed community child health nurse would be required

- to meet prospective parents and introduce the range of services
- to provide additional support for first time and vulnerable parents
- to adapt to flexible working hours to facilitate the needs of parents working outside the home

Current Practice in the South Eastern Health Board Region

Antenatal Visits

In the SEHB region, the antenatal visit is not a scheduled visit. Of 69 Public Health Nurse respondents, 5 (7%) always visit prospective parents (Tipperary SR & Wexford), 34 (49%) sometimes visit and 25 (43%) never visit. Those who sometimes visit, do so usually at the request of a social worker or a parent.

<table>
<thead>
<tr>
<th>Always visit</th>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 (7%)</td>
<td>0</td>
<td>4 (19%)</td>
<td>0</td>
<td>1 (10%)</td>
<td></td>
</tr>
<tr>
<td>Sometimes visit</td>
<td>34 (49%)</td>
<td>6 (29%)</td>
<td>16 (76%)</td>
<td>7 (41%)</td>
<td>5 (50%)</td>
</tr>
<tr>
<td>Never visit</td>
<td>30 (44%)</td>
<td>15 (71%)</td>
<td>1 (5%)</td>
<td>10 (59%)</td>
<td>4 (40%)</td>
</tr>
<tr>
<td>PHN respondents</td>
<td>69</td>
<td>21</td>
<td>21</td>
<td>17</td>
<td>10</td>
</tr>
</tbody>
</table>
No guidelines exist for antenatal visits; they have no priority status, and are done only when time permits. There is no system at community care level for identifying all first time or vulnerable parents. There are no flexible working hours to facilitate the needs of parents working outside the home.

In the antenatal period only informal links exist between hospital and community services. In St. Joseph’s Hospital (Clonmel), a social worker liaises between the Maternity Department and Community Care. A liaison PHN visits the Maternity Department at St. Luke’s Hospital (Kilkenny) twice weekly; in Waterford, the liaison PHN service has been discontinued due to lack of manpower. In one antenatal clinic (Wexford), first-time mothers are invited to complete a request form if they wish to meet the Public Health Nurse. In Tipperary SR, the antenatal department notifies all prospective births, of which they are aware, to the Director of Public Health Nursing (DPHN).

Vulnerable Parents

In general, identification of vulnerable parents at community and hospital level relies on the standard medical and social history and the developing relationship between parents and professionals.

In one area (Waterford), antenatal staff inform the hospital social worker of potentially vulnerable parents and the parent is given the social worker’s business card that includes a list of useful contact numbers. No formal referral is made but the social worker usually makes contact with mother when baby is born. This system is described as an "open door/partnership" arrangement.

In another area (Tipperary SR), the social worker is available for consultation at the antenatal outpatient clinic. In all areas, the social worker is the professional most frequently referred to by hospital staff; nursing needs are referred to the DPHN and financial difficulties to the Community Welfare Officer. Except in Wexford General Hospital, a list of support services with contact numbers is available to mothers.

The General Practitioner (GP) is also most likely to refer vulnerable parents to the public health nurse or community care social worker.

Mothers at risk of depression are usually referred to the psychiatric services by the obstetrician or general practitioner.

*In summary, there is no systematic identification of vulnerable parents and no guidelines for referral or follow-up.*
Antenatal Classes

All parents irrespective of parity, marital status, age or eligibility are offered the opportunity to attend parent-craft education classes in the antenatal period. The programme consists of 5 - 7 classes lasting 1½ - 2 hours. All aspects of pregnancy, birth, post-natal self-care and care of the baby are discussed.

In each SEHB maternity department, staff midwives lead the course with input from the physiotherapist; some areas also invite a psychologist (Tipperary SR), dietician (Waterford), Public Health Nurse (Tipperary SR & Waterford), dental hygienist (Carlow/Kilkenny) or a representative from Cuidiu (Wexford) to participate. In health centres, the Public Health Nurse leads classes.

Classes are held in health board premises (hospital or health centre) in Carlow, Kilkenny, Clonmel, Tipperary, Wexford, New Ross and Waterford. PHN-led classes in Dungarvan have been cancelled due to lack of staff. Both morning and evening classes are held to facilitate the attendance of working mothers and their partners. Waterford has recently set up a Saturday morning class for teenage mothers.

No figures are available for uptake of antenatal classes. Each individual class has an estimated attendance rate of 75 - 100 % of those enrolled. St. Luke's maternity department estimates an overall uptake by 12 % of mothers. The estimated uptake in Wexford General Hospital is 2 % by all mothers, 23 % by first-time mothers and 25 % by partners. In the survey carried out for this review, 37 % of births were to first-time mothers.

A Project Officer for Midwifery Services is currently reviewing the antenatal education service in the SEHB region.

Health Education

All GP respondents (3) always discuss the following topics with expectant mothers:

- pre & postnatal services
  - GP
  - hospital
  - community care
- health problems in pregnancy and how to deal with them
- smoking, alcohol and diet in pregnancy
- infant feeding/breast and bottle
- primary immunisation
GPs sometimes, but do not always discuss postnatal depression.

At the first visit to the antenatal outpatient clinic, all parents are given a *Pregnancy Information Pack*. It is the first of four packs sponsored by Bounty and contains:

- Bounty Pregnancy Guide
- Nutrition for Pregnancy (Bord Bia)
- What is Toxoplasmosis? (Health Promotion Unit - HPU)
- If You Smoke I Smoke (HPU)
- Commercial Advertising

In each maternity department, the midwife adds additional relevant information to the pack e.g.

- Blood tests at your first antenatal visit (HPU)
- Rhesus negative – what it means – Rhesus Project Group (sponsored)
- Breastfed is Best Fed (HPU)
- The Natural Way – Breastfeeding your Baby (SEHB)
- Food and Babies, Pregnancy and the first year of life (HPU)
- Treoir Booklet for single parents
- Feeding your Baby, Birth to 4 Months (SEHB)
- Postnatal Depression, Coping and Caring (HPU)
- HIV Antibody Testing and Pregnancy (HPU)

St. Luke's Hospital, Kilkenny issue *Maternity Information Guide* (SEHB). This booklet is designed to introduce prospective parents to the services on offer in the Maternity Department, St. Luke's Hospital and to answer pertinent questions.

A similar booklet for Waterford Regional Hospital is out of print.

Conclusion

- Community Child Health Nurses who work exclusively with children do not exist in the SEHB region. The Commission on Nursing 1998 (paragraph 8.25) highlights the point that "a number of nurses responding to specific needs in a narrowly focused manner (such as would occur by a proliferation of specialists) brings with it the danger of increased fragmentation of the nursing services".

- The PHN antenatal visit is not a routine part of the current child surveillance programme and no guidelines exist for this visit.

- The PHN is informed of prospective births in two areas only (Tipperary SR and Wexford) and, in these areas, coverage is incomplete.

- The identification of vulnerable parents is not a secure system.
There are no standardised referral pathways for a vulnerable mother, child or family, except expectant mothers under 18 years old who are dealt with under *Children First National Guidelines for the Protection and Welfare of Children* (Department of Health and Children 1999).

No data are collected routinely on the number of vulnerable/at risk parents attending antenatal services.

Antenatal classes are not equally accessible, in terms of time and place, to all expectant mothers.

Professionals involved, and information given in antenatal classes varies from area to area.

PHN working hours in the SEHB region are not flexible.

**Recommendations**

8.1 In the absence of Community Child Health Nurses, the ratio of PHNs to infants and pre-school children should be reviewed. Consideration should be given to reducing this ratio and allotting protected time for child health surveillance duties.

8.2 The purpose of the antenatal visit should be established and regionally agreed guidelines should be developed for the visit.

8.3 Flexible working hours, to accommodate parents working outside the home, should be piloted in one community care area.

8.4 Accepting that a PHN visit to all expectant mothers in the antenatal period is the ideal, the resource implications should be examined. In the interim, a service that would target the vulnerable, especially young and first-time mothers should be initiated.

8.5 A secure system should be established to identify, at community care level, all prospective parents or at least all young, first-time and/or potentially vulnerable parents.

8.6 A standardised referral pathway for the vulnerable mother, child and/or family should be established.

8.7 A specific programme designed to support the teenage mother and her family during pregnancy and to assist in planning future parenting responsibilities should be developed. A key worker should be assigned to each expectant teenager to coordinate the programme.

8.8 A regionally agreed core programme with agreed multidisciplinary input should be developed for antenatal classes. The programme should be evidenced-based, empowering and evaluated.
8.9 A training programme should be initiated to train class facilitators

8.10 The availability, accessibility, number and duration of antenatal classes must be consumer oriented in time and place and should not be restricted to hospital-based programmes.

8.11 Each community care area should have a co-ordinator for antenatal classes to arrange the timing and location of classes, to collect data on those starting. A training programme should be initiated to train class facilitators attending and completing courses, to evaluate the programme and ensure a client-friendly service.

8.12 An information booklet, similar to the 'Maternity Information Guide' (SEHB) issued to expectant mothers in St. Luke’s Hospital, Kilkenny, should be adapted locally and distributed to expectant mothers by all maternity departments in the SEHB region.

8.13 An antenatal pack should be developed which would target appropriate information and eliminate the non-essential. This pack could contain core information with add-on sections for specific parents e.g. travellers, lone parents or parents planning adoption.

8.14 Sponsored information packs should be in line with the SEHB policy on sponsorship.

8.15 Where a professional has been appointed to liaise between the maternity department and community care they should be retained. Areas without a liaison professional should assign a person to identify the vulnerable, offer antenatal services and support to those identified and set up appropriate referral pathways.

8.16 The role, responsibilities and key tasks of the liaison professional should be developed with a strong emphasis placed on effective interdisciplinary liaison.

8.17 Partnership and closer liaison should be developed between Child Care/Protection and Child Health services to minimise overlapping functions, territorial conflict and duplication of resources. Improved co-ordination and co-operation would ensure a more child-centred service.

8.18 The Maternity and Infant Care Scheme is a free service and parents should be made aware of its existence.
Chapter 9

Perinatal Reporting System

The Perinatal Reporting System is Twofold:

(i) **Notification** - The function of this strand is to alert the local health authority to the birth of a child in its area, so that the necessary services can be expedited to support the mother and her newborn baby. There is a need for urgency in passing on the information.

(ii) **Registration** - This strand is designed and used to collect information for statistical purposes and is less urgent.

Following discussions in the 1970s, a four-part notification of birth form was devised to provide an integrated system for notification and registration. However, this form did not facilitate notification in a *timely manner* and most areas developed a preliminary notification form (known as the *36-hour form*). This preliminary form varies from area to area in content and mode of transmission.

In order to streamline reporting and attain the ideal of a domiciliary visit from the public health nurse within 24 hours of discharge home of the newborn baby, *Best Health for Children* recommends:

- The review and modification of the notification of birth form
- The development of a system of preliminary notification, standardised nationally, in its content and mode of transmission
- The electronic transmission of data
- That the marital status of mother ought not to result in a delay of information transfer
- That a copy of the revised notification of birth form is sent automatically to the child's General Practitioner
Current Practice in South East Health Board Region.

The handbook *Procedure for Recording Birth at Community Care Offices, SEHB 1992* outlines the procedure for perinatal reporting in the region.

Two forms, standardised across the region, are used in South Eastern Health Board maternity units.

- **The 36-hour Birth Notification Form**, a duplicate form, is completed by the attending midwife following the birth of a baby. One part is retained by the hospital, the other part is forwarded to the local community care headquarters.

- **The four-part National Notification of Birth Form**, completed by a midwife following mother's discharge from hospital, is mailed between one and four weeks after discharge.
  - Part 1 is sent to the Registrar of Births, who forwards it to the Central Statistics Office
  - Part 2 is sent to the local Community Care Headquarters. Depending on mother's area of residence, the designated clerical officer retains or forwards it to the relevant community care headquarters
  - Part 3 is sent to the Economic and Social Research Institute
  - Part 4 is retained on file in the hospital

On the morning of each working day, the 36-hour form is sent by courier from each maternity unit to the local community care headquarters, except in Waterford where it is faxed and the original copy mailed. These forms are checked and area-coded by the designated public health nurse (director or senior). A designated clerical officer then enters, on the child health system, data for each child whose residence is in the community care area, and prints a *birth label*.

The birth label is standard for the four community care areas and contains all relevant information from the 36-hour form except address on discharge if it differs from address on hospital chart.
On the same day, these labels are mailed to the relevant area public health nurse. A copy of the 36-hour form is enclosed only when it includes clinical details.

Notification of birth is never phoned to community care. However, in exceptional cases, the midwife may give additional information by phone to the Director of Public Health Nursing.

On the day of receipt, the 36-hour form for children resident outside the community care area is faxed and mailed from the Child Health Office to the child’s community care headquarters by the designated clerical officer in community care.

There is no transfer of data to or from the Child Health Office at weekends or bank holidays.
Preliminary notification of birth for babies born outside the South Eastern Health Board region varies from area to area, and hospital to hospital. For example, in the Eastern Regional Health Authority (ERHA) and Southern Health Board (SHB) regions notification of birth to a one-parent family, with one Dublin hospital excepted, is delayed in community care headquarters, Dr. Steeven's Hospital and Abbey House respectively, to await clearance by the relevant hospital social worker. In some cases, notification to the child's community care area is further delayed until a discharge letter can be attached.

Dublin maternity hospitals notify birth to a married mother whose residence is outside the ERHA directly, and usually by fax, to her local community care headquarters. In the SHB, notification of birth to a married mother is routed through Abbey House for distribution to the relevant area. Delays in notification from hospitals outside the South Eastern Health Board region to community care headquarters within the region can range from 24 hours to four weeks.

Recording births on the Child Health System and issuing birth labels to the area PHN is considered a priority. Each Child Health Office has a designated clerical officer who is responsible for this task and for recording immunisation data on the system.

In the absence of the designated clerical officer, a colleague with knowledge of the system is always delegated to record births. Only one community care area (Tipperary South Riding (SR)) has a designated, trained locum clerical officer who can record both birth and immunisation data.

Conclusion

(a) Content:

A combination of the two forms used in the South East Health Board region contains the following information suggested for inclusion in the revised notification of birth form.

- Telephone number of parent
- Mother's occupation
- Surname of infant
- Apgar scores

They also include:

- Address on discharge
- Information relevant to mother/baby
Neither form includes any of the following:

- Mother’s smoking history
- Surname by which the child will be known
- Specific questions regarding foetal distress
- Infant’s length and head circumference
- Outcome of neonatal examination
- Guthrie test carried out – yes/no
- Feeding method on discharge
- Name of infant’s General Practitioner

(b) Delays

- The perinatal reporting system used in the South East Health Board region allows the relevant Public Health Nurse to be advised, on or before the day of baby’s discharge from hospital, that a baby born within the region will be discharged home to her area.

- There is frequently a delay in preliminary notification when baby is born outside the SEHB region.

- Electronic transmission of data is not used uniformly within the South East - this does not cause delays in information transfer within the region.

- Marital status of mother does not delay transmission or processing of information within the region.

- No formal notification of birth is sent to the child’s General Practitioner. The SEHB maternity departments always send a discharge report on mother to her GP within six weeks of delivery. Three of four, Waterford Regional Hospital excepted, include a report on baby.

- Except in the case of early discharge, when this information is phoned from the hospital, the PHN is not informed of the day of discharge of mother or baby. The PHN can estimate the day of discharge from the clinical details on the birth label but when discharge of baby and/or mother is delayed, she may have to make a number of phone calls or visits to gather this information.
Recommendations

9.1 A copy of the 36-hour notification form should be sent to the referring medical practitioner.

9.2 If the mother and baby’s address on discharge from hospital differs from the address on admission, the ‘discharge address’ should always be entered on the 36-hour notification form.

9.3 The SEHB birth label should be adapted to allow for ‘address on discharge from hospital’ to be entered.

9.4 Electronic transmission of the 36-hour notice should be developed. Ideally by electronic mail from the maternity department to community care and, when facilities allow, directly to the relevant PHN.

9.5 The final birth notification form should also be transmitted from the maternity department by fax, electronic mail or computer link, ideally on the day of baby’s discharge from hospital.

9.6 Training needs of clerical staff involved with the Child Health System should be assessed and upgraded. A suitable trained locum should be available when the designated clerical officer is absent.
Chapter 10

Newborn Screening For Metabolic Disorder

*Best Health for Children* recommends that:

- Responsibility for coordinating the newborn metabolic screening programme should be assigned to one body. Nationally agreed protocols for screening should be drawn up.

- The target uptake rate for neonatal metabolic screening should be set at 100%. In order to ensure that this is achieved, an audit should now be carried out of the screening programme, addressing in particular the completeness of cover, and the timeliness of testing and reporting.

- It is recommended that recent UK research on neonatal metabolic screening be examined by experts here to assess the relevance of the results to the Irish population and services.

- Guthrie test should be performed on day 5.

The most recent review of the screening programme for metabolic disorders in newborns - Report of Metabolic Disorders Working Party (January 1993) - forms the basis of guidelines followed by the maternity departments in the SEHB region. The Director of the Metabolic Screening Laboratory, Temple Street Hospital, has issued memoranda clarifying or updating issues in April 1996 and 2000.

Current Practice in the South Eastern Health Board Region

In all Maternity Units in the southeast, the Guthrie test is carried out on day 4, the day of discharge of an uncomplicated confinement, and is recorded in a birth book. All hospitals take special care in the case of breast-feeding infants to ensure the feeding is established before testing. In St. Joseph’s Hospital, Clonmel, it is documented that breast-fed babies should be tested on day 5. Infants transferred to neonatal units have the test performed there at the appropriate time.

The midwife usually advises parents verbally on the reason for Guthrie testing and a leaflet, *Has your infant been screened for metabolic disorder?* Health Promotion Unit (HPU) - is also available. One hospital (St. Luke’s) gives written information and requires the parent to sign consent (or refusal) for the Guthrie test.

There are no written guidelines for identification of high-risk groups. Travellers, because of their high incidence of galactosacmia (1/400 in the Irish population), are recommended to have a Beutler test performed on day 1, before feeding is commenced, and a Guthrie test on day 4.
Newborns with a family history of Phenylketonuria in a sibling or first cousin are required to have a Lithium Heparin sample and Guthrie card sent on day 2, 4 and 10 (memorandum, April 2000).

The National Neonatal Screening Laboratory in Temple Street Hospital request repeat samples when test results are unclear, the original is unsuitable for testing or sometimes when baby has been on antibiotics. No figures are available at local level for the number of repeat tests but the maternity department in Waterford Regional Hospital (WRH) estimates that 7 - 8% of Guthrie tests are repeated.

The public health nurse, following a request from the midwife through the Director of Public Health Nursing (DPHN), carries out Guthrie testing in the community. This occurs when mother and baby are unable to return to the hospital on day 4, when breastfeeding is not established at the time of discharge, when a repeat test is required or in the case of domiciliary birth. The DPHN keeps a record of requests made, and testing is noted in the baby's child health record. The hospital is usually not informed when the test has been carried out. Public health nurses have been issued with procedural guidelines for Guthrie testing in at least two areas (Tipperary SR and Wexford).

It is estimated (by WRH maternity department) that 5% of Guthrie tests are performed in the community.

Two lists of test results are sent from the National Neonatal Screening Laboratory between 2 and 4-weeks after receipt of samples.

- **Results sent to the hospital** give the outcome of tests submitted from that hospital
- **Results sent to community care** list the outcome of tests carried out on children resident in that community care area

In the maternity department, a midwife crosschecks each result against the birth book record of testing, forwards results for babies transferred, and files the report on the ward.

In community care, the designated clerical officer enters results on the Child Health System (CHS), forwards copies for babies resident outside the area to the relevant Child Health Office and files the report.

Results not recorded on the CHS are flagged and reported to the DPHN at intervals varying from 1 - 4 weeks.

In the case of positive results, the National Neonatal Screening Laboratory immediately contacts the hospital that submitted the test, the parents are sought and requested to bring the infant to Temple Street Hospital for confirmation and treatment immediately.
Table 2.10.1 The incidence, in Ireland, of the five conditions screened for in the Guthrie test.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenylketonuria</td>
<td>1/4500</td>
</tr>
<tr>
<td>Maple syrup urine disease</td>
<td>1/128000</td>
</tr>
<tr>
<td>Homocystinuria</td>
<td>1/68000</td>
</tr>
<tr>
<td>Congenital hypothyroidism</td>
<td>1/3500</td>
</tr>
<tr>
<td>Galactosaemia (settled community)</td>
<td>1/400</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(travelling community)</td>
<td>1/400</td>
</tr>
</tbody>
</table>

Source: National Screening Laboratory, Temple Street Hospital, Dublin

All maternity departments in the SEHB are confident that between hospital and community testing the target uptake rate (100%) for National Metabolic Screening is achieved.

Conclusion

- Written guidelines for newborn metabolic screening are not standardised across the region
- No accurate figures are available for the number of repeat Guthrie tests or for tests performed in the community
- No audit has been carried out to confirm completeness of cover, timeliness of testing or reporting
- The standard day for performing Guthrie test in the region is day 4

Recommendations

10.1 The system of reporting should be examined to ensure that it is foolproof. In the interim, the Maternity Department should be informed when the PHN performs a Guthrie Test in the community.

10.2 The recommendations of the national committee recently established to review the National Newborn Screening Programme should be awaited.

10.3 An I.T. solution capable of tracking metabolic screening tests and results, and allowing for cross-reference between hospital and community care should be considered.
Chapter 11

Birth

*Best Health for Children* recommends that the following interventions should take place at birth:

Table 2.11.1 Child Health Surveillance at birth as recommended by *Best Health for Children*.

<table>
<thead>
<tr>
<th>Content</th>
<th>Topics for Health Education</th>
<th>Professional Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Examination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note particularly colour, respirations, birth marks, Heart murmur, Developmental dysplasia of hip, testicular decent. Inspect eyes, view red reflex. Guthrie test on day 5. Universal hearing screening.</td>
<td>Feeding and nutrition.</td>
<td>Guthrie test usually carried out by hospital midwife or public health nurse (PHN).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current Practice in the South Eastern Health Board Region

In each maternity department in the South East, a hospital doctor examines all newborn infants at least once. The examination usually takes place within the first 24 hours. In most cases the newborn is examined by a non-consultant hospital doctor (NCHD) from the Paediatric Department, except in Waterford where it is performed by the NCHD training in Obstetrics. The Paediatrician examines infants born to private patients and infants about whom the NCHD has concerns. In St. Joseph's Hospital (Clonmel) the paediatrician examines all babies prior to discharge from hospital.
The history and physical examination are identical to the recommendations of *Best Health for Children* except for the following:

- no screening test for hearing is carried out in the neonatal period
- the presence of the red reflex may be sought but is not usually recorded
- in the South East, the standard day to perform the Guthrie test is day 4

Hospital midwives *always* advise mothers on the following:

- cot death
- feeding and nutrition
- vitamin K
- baby care

The advice is both verbal and written in the case of cot death, feeding and nutrition. Advice on the following topics is usually but not always given, and is verbal:

- sibling management
- crying and sleep problems
- transport in car

In addition, parents are always given verbal advice on what services to contact for help in the first 48 hours after discharge. They are usually informed about community services, how to contact the PHN and peer support groups for breast-feeding mothers. Mothers usually receive advice on bonding with baby, family planning, post-natal depression, smoking and the six-week examination of mother and child.

The *New Mother Pack*, the second Bounty information pack, is distributed to all mothers in maternity departments. This pack contains produce samples, commercial advertising and a variety of information e.g.

- Bounty babycare guide
- Iron nutrition for infants and young children (Bord Bia)
- Food and Babies (HPU)\(^1\)
- Folic acid—what every woman needs to know (DoH&C)\(^2\)
- Has your infant been screened for metabolic disorders (HPU)
- Gastroenteritis in children. Advice for parents (HPU)
- What to do about headlice (HPU)
- Postnatal depression. coping and caring (HPU)
- Child health record (HPU)
- Contraceptives. What are your options? (HPU)
- Vaccination (IPHA)\(^3\)
- Protect your child – immunise (HPU)
- Caring for your Child (HPU)
- Meningitis and Septicaemia – am I at risk? (HPU)

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1. Health Promotion Unit (HPU)
2. Department of Health and Children (DoH&C)
3. Irish Pharmaceutical Healthcare Association (IPHA)
Another pack, *Information Pack for Parents* (Child Health Programme, SEHB), is given to all mothers in the maternity department, St. Joseph's Hospital, Clonmel, and by PHNs to first-time mothers at the primary visit in Wexford. Other community care areas have discontinued distribution. Originally, the pack was intended to provide locally selected information for mothers. It was assembled by PHNs in community care and delivered by them to the maternity department for distribution by the midwife. The project failed in Carlow/Kilkenny and Waterford due to inadequate consultation between the professionals involved, unreliable supply of leaflets and duplication with other more established and consumer-acceptable packs.

This pack contains:
- Feeding your Baby, birth to 4 months (SEHB)
- Growing up safely (SEHB)
- Choosing day care for your child (SEHB)
- Feeding your Baby (The Kilkenny Health Project)

and a second copy of:
- Protect your child - immunise (HPU)
- Caring for your Child (HPU)
- Meningitis and septicaemia - am I at risk? (HPU)

### Vulnerable Parents and Infants

During the post natal period, by observation and conversation, the midwife is continually on the look-out for vulnerable/at risk mothers and babies – particularly in the case of first time mothers, teenage mothers or mothers with a history of post natal depression (PND).

There are no written guidelines on either the identification of these mothers and babies or on referral pathways.

Underage and teenage mothers, mother with physical or sensory disability and substance abusers are referred to the social work department. In some cases the area PHN is notified. The specialist PHN for travellers is contacted when a traveller gives birth. The nurse counsellor for children with disabilities is invited to meet the parents of a newborn with Down Syndrome, or other disabling condition and, with the parents' consent, a support group may be advised. Mothers at risk of PND are referred to a psychiatric counsellor or psychiatrist, as appropriate, and given the phone number of a self-help group in Dublin. Self-help groups in Waterford and Wexford have been discontinued. The reasons given for this include:

- failure of the group to evolve into a self-supporting group
- staff burnout
- lack of support by management of staff involved with the project

In all four maternity departments, midwives have been trained in mother/child bonding but in only two departments (St. Luke's and St. Joseph's) have midwives received training in the recognition of postnatal depression.
In the event of a stillbirth or neonatal death, all maternity departments in the region follow a procedural checklist and the midwife provides support for bereaved parents. The parents are always advised to contact the Irish Stillbirth and Neonatal Death Society (ISANDS).

Waterford Regional Hospital has a special room where the bereaved may sit quietly in the company of the newborn.

**Reporting**

All four hospitals report the date of mother and baby's discharge from the maternity department to the Director of Public Health Nursing (DPHN) using the national notification of birth form. This takes from two to four weeks to arrive at community care.

Information on the transfer of infants to a hospital outside the SEHB area or to a special care baby unit (SCBU) within the region is phoned to the DPHN. In Carlow/Kilkenny this information is also communicated via the liaison PHN. The liaison PHN in Waterford has been discontinued due to lack of manpower.

All SEHB maternity departments send a report to the General Practitioner (GP) on all mothers and, except in Waterford, on infants discharged with mother. Information received by the GP on babies not discharged with mother, or on babies born outside the SEHB region varies from area to area.

The GP representative from Waterford is notified when mother is discharged from a maternity department inside or outside the SEHB region, when baby is transferred to a special care baby unit and when baby is discharged from any SCBU except those outside the SEHB region.

In Tipperary SR, the GP is notified of mother and baby's discharge from the local maternity department only, and admits to receiving no information on baby's transfer to, or discharge from the special care baby unit.

The GP respondent from Carlow/Kilkenny receives notification of mother and baby discharges from hospitals outside SEHB only, is informed of baby's transfer to other units, but receipt of information on baby's discharge from these units is inconsistent.

Three hospitals, St. Luke's excepted, identified gaps in the postnatal hospital services for mother and baby. These include:

- no child health or family planning clinic
- no support group for mothers at risk of or suffering from postnatal depression
- no checklist/guidelines for identifying or referring vulnerable mother and/or infants

**Conclusion**

- Prior to discharge from hospital, all babies are examined by a doctor
- No screening of hearing is carried out in the neonatal period
- The standard day for Guthrie testing is day 4
- Topics for health education are similar to those recommended in *Best Health for Children*, however some topics are not always discussed
- Mothers are in danger of information overload from the deluge of leaflets and booklets distributed in the ante and postnatal periods
- A search for vulnerable/at risk mothers, while carried out routinely, is informal
- There are no written guidelines for the identification or referral of the vulnerable
- Training of midwives in the recognition of PND is not universal
- Communication between all sectors, maternity departments, neonatal units (inside and outside the SEHB region), community care, and general practice is poor and uncoordinated

Recommendations

11.1 A national group has been convened to examine the feasibility of universal hearing testing of the newborn and its recommendations should be awaited.

11.2 The availability of hospital/community care liaison personnel, preferably a nurse, to facilitate early provision of community services to parents and/or children with special needs cannot be over-emphasised.

11.3 Streamlined packs, containing only relevant information, should be developed and distributed to mothers at the appropriate time.

11.4 A checklist to assist in the identification of vulnerable/at risk mother or infant should be developed and defined referral pathways established.

11.5 Following a procedural checklist in the event of stillbirth or neonatal death is good practice. A designated staff member should be assigned to ensure compliance with and completion of relevant procedures.

11.6 Notification of neonatal death should be standardised and reported early to the mother's GP.

11.7 A standard discharge reporting system to inform the relevant GP of the in-patient progress of both mother and infant should be developed.

11.8 Attention should be given to improving communication between all disciplines involved in the health and welfare of children.

11.9 In order to promote child safety in cars, the feasibility of discharging all newborn babies from SEHB hospitals in a suitable car seat should be explored.
Postscript:

WATERFORD REGIONAL HOSPITAL

- Since the beginning of July 2001, *examination of the newborn* is performed by a Paediatric Registrar.

- Every Tuesday afternoon, during the first six weeks after baby's birth, a *drop-in clinic* is available to mothers and their babies in the postnatal ward in Waterford Regional Hospital.

- The *Community Midwifery Service* is in operation at Waterford Regional Hospital since 4th June 2001. This service is available to medically selected women, who live within a certain radius from the hospital. Antenatal care is shared between the Community Midwife and the woman's GP. Clinics are held in the hospital, in Waterford Community Care Centre and in Tramore Health Centre. Domiciliary antenatal visits may be arranged and any problems arising during the pregnancy are referred to the Obstetrician.

On discharge from hospital, the midwife provides postnatal care for mother and baby during the first five days liaising with the Public Health Nurse.
Chapter 12

Primary Visit

*Best Health for Children* recommends that the first postnatal (primary) visit by the PHN should take place within 48 hours of baby's discharge from hospital.

The report recommends that the following interventions should take place:

<table>
<thead>
<tr>
<th>Content</th>
<th>Topics for Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td></td>
</tr>
<tr>
<td>Examination</td>
<td></td>
</tr>
</tbody>
</table>

Current Practice in the South Eastern Health Board Region

*Child Health in the Pre-school Years (SEHB)* states that the primary visit by the PHN follows notification of birth but there is no given time limit. Guidelines followed in some community care areas are more specific, for example, the Tipperary SR guidelines recommend a primary visit "within 24 - 48 hours after discharge from hospital" and the guidelines for Wexford read "as early as possible after discharge but within two working days".
Timing of Primary Visit:

The ideal of the PHN visiting all babies within 48 hours of discharge from hospital is impossible to achieve within the current system.

Table 2.12.2 Number (%) of target group visited within 48 hours of discharge from hospital per region and community care area.

<table>
<thead>
<tr>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>199 (42%)</td>
<td>39 (35%)</td>
<td>39 (39%)</td>
<td>40 (34%)</td>
<td>81 (56%)</td>
</tr>
</tbody>
</table>

Some factors contributing to this include:

- the Public Health Nurse works a five-day week, Monday – Friday. Routine visits can occur on these days only.

- the Public Health Nurse may not be informed when mother and child are discharged to an address other than that recorded at hospital admission. There is no space for ‘address on discharge’ on the birth label.

- preliminary notification of birth within the SEHB may allow the Public Health Nurse to be alerted to a birth in her area on or before the day of baby’s discharge. However, delays in notification frequently occur when baby is born outside the region. *In the survey 11% of births occurred in hospitals outside SEHB.*

Table 2.12.3 Number (%) of births occurring in SEHB hospitals and in hospitals outside SEHB, per region and community care area.

<table>
<thead>
<tr>
<th>Hospital of Birth</th>
<th>Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within SEHB</td>
<td>423 (89%)</td>
<td>91 (81%)</td>
<td>88 (90%)</td>
<td>109 (92%)</td>
<td>135 (93%)</td>
</tr>
<tr>
<td>Outside SEHB</td>
<td>51 (11%)</td>
<td>22 (19%)</td>
<td>10 (10%)</td>
<td>9 (8%)</td>
<td>10 (7%)</td>
</tr>
</tbody>
</table>

- Except in the case of early discharge, the Public Health Nurse is not informed of the actual date of discharge of mother and baby. The Public Health Nurse must deduce the date of discharge from information on the birth label. *The date of discharge of mother and baby is recorded on the notification form, which arrives at Community Care between one and four weeks after discharge.*
The time sequence from birth in SEHB hospitals, to notifying the area Public Health Nurse through the Child Health Office, and the earliest possible opportunity for the primary visit after the standard 4-day hospital stay is set out in Table 1.6.4

Table 2.12.4 Earliest possible day of primary visit for babies born in SEHB Hospital and discharged on day 4.

<table>
<thead>
<tr>
<th>Day of Birth</th>
<th>Day of notification to:</th>
<th>Day of Baby’s discharge</th>
<th>Earliest visit possible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child Health Office</td>
<td>PHN</td>
<td>Day</td>
</tr>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Friday</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Wednesday</td>
<td>Thursday</td>
<td>Saturday</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Thursday</td>
<td>Friday</td>
<td>Sunday</td>
</tr>
<tr>
<td>Thursday</td>
<td>Friday</td>
<td>Monday</td>
<td>Monday</td>
</tr>
<tr>
<td>Friday</td>
<td>Monday</td>
<td>Tuesday</td>
<td>Tuesday</td>
</tr>
<tr>
<td>Saturday</td>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
</tr>
<tr>
<td>Sunday</td>
<td>Monday</td>
<td>Tuesday</td>
<td>Thursday</td>
</tr>
</tbody>
</table>

In the survey, of the 89% of babies born within the region, at least 11% (or those discharged on Saturday) could not receive a primary visit within the recommended 48 hours.

Of newborn babies discharged from hospital early in the week (i.e. Sunday to Wednesday inclusive) 53% were visited within 48 hours of discharge compared to 37% of babies discharged later in the week (i.e. Thursday to Sunday inclusive).
PHNs identified other factors that influence the timing of the primary visit. These include:

- heavy workload
- lack of appropriate locum cover for sickness and holidays
- inaccurate address on birth label
- absence of parent/guardian phone number
- poor communication between hospital and community care
- no flexitime
- no timely information on precise date of baby’s discharge.

Overall, the Public Health Nurse had visited 42% of babies within 48 hours of discharge from hospital (6% on day 1 and 36% on day 2). Of all visits within 48 hours only 2% were made to children born outside the region.

Table 2.12.5 Number (%) of primary visits carried out within 48 hours of discharge from hospital depending on hospital of birth (inside or outside SEHB).

<table>
<thead>
<tr>
<th>Day of Visit</th>
<th>Hospital of Birth</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SEHB</td>
<td>Outside SEHB</td>
</tr>
<tr>
<td>Day 1</td>
<td>29 (6%)</td>
<td>0</td>
</tr>
<tr>
<td>Day 2</td>
<td>159 (34%)</td>
<td>11 (2%)</td>
</tr>
<tr>
<td>Regional Total</td>
<td>188 (40%)</td>
<td>11 (2%)</td>
</tr>
</tbody>
</table>
Table 2.12.6 Comparison between proportion of visits made within 48 hours depending on hospital (inside or outside SEHB) of birth per region and community care area.

<table>
<thead>
<tr>
<th>Hospital of Birth</th>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within SEHB</td>
<td>44%</td>
<td>37%</td>
<td>40%</td>
<td>37%</td>
<td>58%</td>
</tr>
<tr>
<td>Outside SEHB</td>
<td>22%</td>
<td>23%</td>
<td>30%</td>
<td>0%</td>
<td>30%</td>
</tr>
</tbody>
</table>

In summary, 100% of babies received a primary visit. Of those who had been discharged from hospital within the SEHB region, 44% had been visited within 48 hours of discharge compared to 22% of babies who had been discharged from hospitals outside the SEHB region.

Interventions at the Primary Visit

In the SEHB region the PHN makes a primary visit to all (100%) babies born to mothers resident in her area. This visit takes place in the home of the newborn.

The primary visit

- is considered the most important visit in the pre-school programme. It is at this visit that the PHN establishes her relationship with the family and assesses their health care needs so that she can plan her future work with them.

- is given the highest priority of all child health surveillance visits by 91% of respondents. Particular priority is given to vulnerable families – teenage mothers, first-time mothers, children who have been ill in the neonatal period.

- takes up to one hour to carry out in 80% of cases and longer in 17%.

The proposed child health surveillance programme recommends that the PHN should carry out certain interventions at the primary visit. These are set out in table 1.6.1.

The regional booklet, Child Health in the Pre-school Years, contains detailed guidelines for conducting the primary visit in the SEHB region. The history and physical examination are more thorough than those recommended in Best Health for Children.

The SEHB guidelines contain checklists on:

- history - mother, child and family
- physical examination
- developmental assessment of the neonate
- risk factors for
  - developmental dysplasia of the hip
  - vision defect
  - hearing defect
- home accommodation/condition
- accident hazards
97% of PHN respondents always carried out a developmental assessment and an examination of the undressed infant including a check for developmental dysplasia of the hips.

Topics for health education recommended in the SEHB guidelines exclude
- the recognition of childhood illness and what to do;
- postnatal depression.

However, at the primary visit, 53% of PHNs always and 42% sometimes discuss the former; 85% always discuss the latter.

The SEHB guidelines further advise the PHN to:
- assess the physical and mental health of mother
- ascertain parental interaction and opinion of baby
- be aware of social 'risk' factors (Child Protection)
- discuss the Pre-school Health Programme.
- advise mother of PHN's name and phone number
- advise mother on the location of clinics
- advise mother on availability of other services, as appropriate

In the recognition of postnatal depression, 95% of PHN respondents check for signs at the primary visit. However, 56% have had no training in its recognition, 76% had no written guidelines or checklist to assist them, despite a reference to the Edinburgh Postnatal Depression Score in the 1995 SEHB guidelines, and 91% had received no guidelines on referral procedures. Two hospital-based (Waterford and Wexford) self-help group for this condition has been discontinued and mothers are advised to travel to Dublin for peer-led support.

In the survey, 92% of PHNs ascertain mother's opinion of her newborn at the primary visit. 98% of PHNs had no written guidelines or checklist for assessing the parent/child relationship.

Except in child protection issues, no community care area has written guidelines on the identification of, or recommended referral pathways for vulnerable/at risk parents or child.

PHNs frequently support suspected or identified vulnerable parents with extra home visits or appointments to the child health clinic. Other services, for example, childcare or family support workers are accessed through the social work department. The Community Parent Support Programme has been developed in Tipperary SR. The services of Cuidiu Education and Support for Parenthood in Waterford and Wexford, La Leche in Kilkenny, the First Steps Programme in Carlow and the Waterford Student Mothers Group are also available to support parents. Local pre-school facilities are available in almost 90% of PHN areas.

There is no regional or local policy on primary visiting at the weekend or at festive holiday period, and arrangements tend to be ad hoc. Babies born to first-time mothers or mothers who are breast-feeding, and who are notified to the DPHN on Friday, are priority-listed for weekend visiting. These support visits are carried out by the duty nurse (PHN or RGN). During festive periods, when a mother in need of additional supports is scheduled for discharge the midwife alerts the duty nurse, usually by phone, sometimes by fax. Situations where the midwife may request out-of-hours visiting include mother with poor coping skills, young first-time mother with limited family support, mother with history of postnatal depression, mother requiring wound-care or infant with feeding difficulties. Sometimes in Wexford maternity department the discharge of vulnerable mothers/infants is delayed until after the weekend.
At the first scheduled visit, 98% of PHNs establish the name of mother's and infant's GP; the GP who will immunise baby and the GP who will carry out the six-week examination.

Following the primary visit, the PHN discusses the outcome with the infant's parents and enters her findings in the relevant sections of the child health record card. No report is given to the GP of mother or infant, the hospital doctor or other members of the community nursing or medical staff. No data are recorded on the Child Health System.

Conclusion

- The primary visit is a high priority visit and the most important of the core Child Surveillance Programme.
- Within the present five-day working week it is not possible for PHNs to make a primary visit to all newborn babies within 48 hours of discharge from hospital.
- There are no formal guidelines for primary visiting at the weekend or during festive periods.
- At the weekend or during holiday periods, the duty nurse (PHN or RGN) conducts support visits, when requested, within 48 hours of baby's discharge from hospital.
- Designated hospital/community care liaison personnel are not available in all SEHB maternity departments.
- No data are collected routinely on the proportion of the target group visited. In the survey for this review, the PHN made a primary visit to all infants (100%) resident in her area.
- No data are collected on the proportion of the target group visited within 48 hours of discharge from hospital. The number of primary visits made within 48 hours of baby's discharge falls far short of the target.
- The interventions recommended by the SEHB guidelines for the 1st scheduled PHN visit are more extensive than those proposed for the primary visit by Best Health for Children.
- There is a lack of training of PHNs in the recognition of postnatal depression.
- No checklist is available to assist the PHN in the assessment of mother's relationship with her baby.
- There are no written guidelines (except child protection) to assist the PHN with the identification of a vulnerable family/parent/infant.
- There are no written guidelines (except child protection) on referral pathways for vulnerable parents/infants.
- There are no formal guidelines for primary visiting at the weekend or during festive periods.
There is no feedback from this visit to other relevant professionals.

There is no record of this visit or its outcome on the Child Health System.

Recommendations

12.1 Bearing in mind the objectives of the primary visit, the PHN should identify early, and with mother, what supports, if any, are needed and link mother with an appropriate form of support within the community. In certain circumstances it may be necessary to visit mother more than once to achieve this ideal.

12.2 Accepting that a PHN visit to all newborn babies within 48 hours of discharge from hospital is the ideal, this is not possible within the present five-day working week. The primary visit should, however, be made by the PHN as early as possible following baby's discharge from hospital and within two working days.

12.3 The provision of electronic mail, computer link or fax machines in all health centres would facilitate direct communication between the maternity and area PHN and ensure a timely first visit.

12.4 To further facilitate a timely first visit, the link between 36-hour notification and the discharge of mother and baby from hospital should be strengthened through liaison personnel.

12.5 The availability of hospital/community care liaison personnel, preferably a nurse, to facilitate early provision of community services to parents and/or children with special needs cannot be over-emphasised.

12.6 The contents, timing, route and mode of transmission of the 36-hour (preliminary notification) form should be standardised nationally.

12.7 The practice of some health boards delaying notification of non-marital births should be addressed nationally to allow for a timely first visit.

12.8 Structures should be examined and clear guidelines established to provide support for mothers and babies discharged from hospital at weekends and, more particularly, over festive holiday periods when everyday services are not available in the community.

12.9 The SEHB should continue to support and encourage the development of more low-level supports e.g. Home Support Service, Community Parent Support Programmes, Parent & Child Groups and Student Mothers Groups.

12.10 A strategy for developing family support, home visiting and parent training services should be developed at regional level.

12.11 An agreed and standardised checklist for the assessment of mother/child bonding and the recognition of postnatal depression should be developed and made available.
12.12 Each community care area should develop referral guidelines and pathways for the vulnerable family/parent/child and for mothers with suspected postnatal depression.

12.13 Appropriate training should be put in place to achieve the objectives of the primary visit.

12.14 The proposed parent held health record should facilitate feedback and transfer of information between relevant professionals. It should be introduced when the pilot study is complete.

12.15 At the primary visit the PHN should establish the name of the general practitioner or paediatrician who will carry out the six-week examination and encourage mother to attend. Every opportunity should be taken to remind parents that the Maternity and Infant Care Scheme is free and available to all mothers and newborn babies up to six weeks after birth.

12.16 Appropriate statistical data should be collected to monitor performance indicators.
Chapter 13

The Six-week Visit

*Best Health for Children* recommends:

- that a child health examination should be carried out by a doctor, usually a GP, at 6–8 weeks
- that a standard set of data be recorded on each child at the six-week examination
- the design of a standard form for use nationally by any doctor carrying out a six-week examination

Table 2.13.1 Child Health Surveillance at six-weeks as recommended by *Best Health for Children*

<table>
<thead>
<tr>
<th>Content</th>
<th>Topics for Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td><strong>Examination</strong></td>
</tr>
<tr>
<td>Check history.</td>
<td>Physical examination.</td>
</tr>
<tr>
<td>Parental concerns,</td>
<td>Weight and head circumference. Check for CDH, testicular descent.</td>
</tr>
<tr>
<td>particularly relating to hearing and vision.</td>
<td>As at 10-14 days* particularly immunisation, weaning.</td>
</tr>
<tr>
<td>Refer as appropriate.</td>
<td></td>
</tr>
</tbody>
</table>

*The Maternity and Infant Care Scheme includes a baby visit at two weeks

Current Practice in the South Eastern Health Board Region.

The SEHB guidelines state that the six-week visit, the second scheduled visit, is carried out by a PHN in the baby's home between 5 and 8 weeks.

Practice differs - three community care areas follow the SEHB guidelines. Carlow/Kilkenny carry out the second scheduled visit at, or around, three months (between 11 and 14 weeks).

In the survey, 88% of all infants had a second scheduled visit (known presently as the six-week visit) between 2 and 21 weeks inclusive. 47% were visited at 5-8 weeks and 17% at 11-14 weeks. A comparison of these figures by community care area, table 2.13.2 reflects the different area policies.
The second visit is considered high priority by 74% of PHNs surveyed and they always carry it out. 16% of PHN respondents think it is low priority and visit only when time permits.

The six-week infant examination is frequently carried out by more than one professional. 47% of PHN respondents always, and 35% sometimes repeat the examination when it has been carried out by:

- the GP, under the Maternity and Infant Care Scheme. GP representatives estimate that between 60% and 100% of babies attend for the six-week examination. In almost all cases the GP re-examines infants previously examined by the PHN;

- the paediatrician. No figures are available for babies examined by the paediatrician.

The six-week examination is no longer offered by any maternity department in the SEHB.

The aim of the second visit is to ascertain the physical, social and environmental health of the infant.

The history and physical examination recommended in the SEHB guidelines are in line with those recommended by Best Health for Children. The former does not specifically mention a check for testicular descent, but there is a space to enter this finding in the SEHB child health record card.

In addition the regional guidelines require the PHN to assess:

- the baby’s developmental progress
- the mother’s physical and mental health
- the mother/child interaction
- the family adjustment to the baby
- the sibling reaction to the baby

The topics recommended for health education in the SEHB guidelines extend beyond those in Best Health for Children in that the former includes advice on passive smoking.

The PHN continues to monitor mother for signs of postnatal depression. However, only 44% of PHNs surveyed have been trained to recognise these signs, and 76% have no written guidelines to assist them.
Following the six-week visit, the PHN completes the relevant section in the Child Health Record Card.

There is no formal feedback to or from the professionals involved in the delivery of this surveillance contact. 98% of PHNs surveyed always discuss the outcome with the baby’s parent(s). The PHN informs the GP in only 8% of cases and usually to report or refer a problem.

No GP respondent reports the outcome of the six-week surveillance visit to health professionals in community care. The vast majority of PHN respondents (75%) never get feedback from other professionals; only 2% are always informed of the outcome by either the GP or paediatrician.

No data are available on the number of mothers who attend for the six-week postnatal visit, but GP respondent’s estimate that between 60 – 100% of mothers attend for this examination. At this visit a search is always made by the GP for signs of postnatal depression and the need for addition supports for mother and/or infant.

Conclusion

- The six-week child surveillance recommended by the regional guidelines is at least equal to that recommended by Best Health for Children.

- In the region, 88% of all infants have a second scheduled PHN visit. The visit is currently scheduled to occur at 5 – 6 weeks except in Carlow/Kilkenny, where it is carried out at three months.

- 98% of PHNs surveyed discuss the outcome of this contact with the child’s parent(s).

- There is a lack of standardisation in the delivery of the six-week examination. Currently, a PHN and/or a doctor may carry it out. Best Health for Children recommends a doctor only.

- No standard set of data is recorded. The Maternity and Infant Care Scheme requires the doctor to provide minimum data. The PHN is required to record in detail the outcome of the physical examination and developmental assessment.

- Less than half of PHNs are trained in the recognition of postnatal depression. One in four has been provided with written guidelines.

- Communication of outcome between professionals involved in the six-week check is, at best, inconsistent and, at worst, non-existent.

- No data are collected routinely on the proportion of the target group screened.
Recommendations

13.1 The committee concur with the recommendations of *Best Health for Children* that the six-week examination of baby should be carried out by a medical practitioner.

13.2 Appropriate guidelines should be developed to facilitate structured introduction of the doctor/baby examination and the collection of uptake data. In the interim, the PHN should continue to carry out a six-week visit. When a universal doctor/baby examination procedure is established, the second core PHN visit should be made at three months.
Chapter 14

The Three-month Examination and Other Child Health Visits

*Best Health for Children* recommends that the second scheduled PHN visit should be changed from six weeks to three-months. The recommended activities for this visit are set out in table 1.8.1.

Table 2.14.1 Child Health Surveillance at three months as recommended by *Best Health for Children*

<table>
<thead>
<tr>
<th>Content</th>
<th>Topics for Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Examination</td>
</tr>
<tr>
<td>Parental concerns, particularly relating to hearing and vision.</td>
<td>External appearance.</td>
</tr>
<tr>
<td>Refer as appropriate.</td>
<td>Weight and head circumference if indicated by parental concern or appearance. Check for CDH.</td>
</tr>
<tr>
<td></td>
<td>As at 6-8 weeks.</td>
</tr>
</tbody>
</table>

Current Practice in the South Eastern Health Board Region

This three-month visit is not included in the present SEHB schedule and there are no guidelines. However, in Carlow/Kilkenny, a visit at this time has been substituted for the six-week visit. The activities carried out are similar to those recommended in the regional guidelines for the six-week check and are therefore more extensive than the recommendations of *Best Health for Children*.

In the survey, 90% of the target group in Carlow/Kilkenny, received a second scheduled PHN visit; 50% at age 11-14 weeks and 12% at age 5-8 weeks compared to 17% and 47%, respectively, in the other community care areas in the SEHB region.

Table 2.14.2 Proportion of all children in the SEHB region and in each community care area who received a second scheduled PHN visit between the primary and developmental visit, at age 5-8 weeks and 11-14 weeks.

<table>
<thead>
<tr>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd scheduled visit</td>
<td>88%</td>
<td>90%</td>
<td>92%</td>
<td>85%</td>
</tr>
<tr>
<td>At age 5-8 weeks</td>
<td>47%</td>
<td>12%</td>
<td>60%</td>
<td>53%</td>
</tr>
<tr>
<td>At age 11-14 weeks</td>
<td>17%</td>
<td>50%</td>
<td>9%</td>
<td>8%</td>
</tr>
</tbody>
</table>
Overall in the SEHB region, only 19% of second scheduled visits were made at age 11-14 weeks compared to 54% at 5-8 weeks. Figure 1.8.2. shows the comparison between visits made at the earlier and later time across the four community care areas.

### Table 2.14.3 Comparison of timing of the second scheduled visits in the region and in each community care area.

<table>
<thead>
<tr>
<th></th>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 5-8 weeks</td>
<td>54%</td>
<td>13%</td>
<td>66%</td>
<td>74%</td>
<td>62%</td>
</tr>
<tr>
<td>Age 11-14 weeks</td>
<td>19%</td>
<td>56%</td>
<td>10%</td>
<td>10%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The majority of PHN respondents are of the opinion that the time currently recommended for the second scheduled visit (6-weeks) is not optimum as it coincides with the recommended examination of baby by a medical practitioner. They agree that a visit at 3 months, to address parental concerns and advise on weaning before mother returns to work is more appropriate.

### Additional Support Contacts

In the period between the first (primary) and third (developmental) core visits, the PHN attempted to contact, or made contact with 464 (98%) children (or their carer) on at least one occasion. Of these contacts, 176 (38%) were to first-time mothers; 344 (74%) were in the first four to eight weeks of life (from birth in January 1999 to 28th February 1999); a further 102 (22%) occurred before baby was 3-4 months old (up to 30th April). 21 (4%) children received up to six additional visits in the first 4-8 weeks of life, 4 were firstborn babies.

### Table 2.14.4 Number (%) of infants (or their carers) in the SEHB region and in each community care area with whom the PHN made at least one, and up to six, additional contacts in the first 4-8 weeks after the primary visit.

<table>
<thead>
<tr>
<th></th>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>One additional contact</td>
<td>344 (73%)</td>
<td>78 (69%)</td>
<td>62 (63%)</td>
<td>101 (86%)</td>
<td>103 (71%)</td>
</tr>
<tr>
<td>Six additional contacts</td>
<td>21 (4%)</td>
<td>2 (2%)</td>
<td>4 (4%)</td>
<td>9 (8%)</td>
<td>6 (4%)</td>
</tr>
</tbody>
</table>

94
It is difficult to determine which type of contact, home visit, ineffective home visit,* clinic visit or phone call occurred, as this is not always documented. However from the data recorded, contact in the first four weeks of life usually take place at baby's home; later contact was more likely to occur in a clinic setting.

PHNs made additional contact:
- in the early days of breastfeeding
- to support young and first time mothers
- to support mothers with poor parenting skills
- to monitor babies who have been detained in the special care baby unit
- to monitor babies with congenital disorders
- to monitor families where risk factors for vulnerability were suspected
- at request of parent(s)

The facility for PHNs to offer additional support visits to parents/children in need is limited by time.

Other Core Visits

After the '9-month developmental' assessment, *Best Health for Children* recommends that the PHN carries out two further core assessments in the pre-school period.

Table 2.14.5 Contents and Timing of Child Health Surveillance programme in the second and third year of life as recommended by *Best Health for Children*

<table>
<thead>
<tr>
<th>Age at Examination</th>
<th>Content</th>
<th>Topics for Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>History</td>
<td>Examination</td>
</tr>
<tr>
<td>18-24 months</td>
<td>Parental concerns. Ask specifically about vision and hearing, comprehension, behaviour. Refer as appropriate.</td>
<td>Height and gait</td>
</tr>
<tr>
<td>3.25-3.5 years</td>
<td>Ask about vision, squint, hearing, behaviour, language acquisition and development. Refer as appropriate.</td>
<td>Measure height and weight if indicated. Check for testicular descent only if not previously recorded. Refer to doctor for physical examination where necessary.</td>
</tr>
</tbody>
</table>

*Ineffective home visit* is used by the PHN to indicate that baby was not at home when a visit was made.
PHNs place great importance on the pre-school programme and make every effort to complete all core visits recommended in the SEHB guidelines, *Child Health in the Pre-school Years*, however severe time constraints have forced each visit to be ranked and given a priority in the work schedule.

Table 2.14.6 Priority given by PHNs to the recommended core visits (SEHB guidelines)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Visit</th>
<th>Priority (out of 11 duties)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Primary</td>
<td>1st</td>
</tr>
<tr>
<td>2nd</td>
<td>Developmental</td>
<td>4th</td>
</tr>
<tr>
<td>3rd</td>
<td>6-week</td>
<td></td>
</tr>
<tr>
<td>4th</td>
<td>39-42 month</td>
<td>Joint 10th</td>
</tr>
<tr>
<td>5th</td>
<td>18-21 month</td>
<td></td>
</tr>
</tbody>
</table>

Table 2.14.7 Uptake of first three core assessments per region and community care area.

<table>
<thead>
<tr>
<th></th>
<th>SEHB Region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st (Primary)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>2nd (6-week)</td>
<td>88%</td>
<td>90%</td>
<td>92%</td>
<td>85%</td>
<td>87%</td>
</tr>
<tr>
<td>3rd (Developmental)</td>
<td>94%</td>
<td>99%</td>
<td>99%</td>
<td>92%</td>
<td>88%</td>
</tr>
</tbody>
</table>

In the absence of recorded data, PHNs estimate that the uptake achieved for the 18-month and 39-month visits ranged from 20-100 % for the former and from 40-100 % for the latter. The visit most likely to be omitted was the 18-month visit.
Each visit takes from 10-60 minutes, most frequently 20-30 minutes to complete, and the programme has five recommended core visits. In areas with a high, or increasing birth rate it is impossible for the PHN to offer the complete surveillance programme to all children, to make additional contact with parents/children in need of support and to provide nursing services to other client groups.

_Nursing duties that take precedence over core pre-school visits_ (excluding the primary and 'developmental' visit) include in the following order:
- care of the terminally ill
- wound care
- care of the young chronically ill
- booster immunisation programme
- care of the elderly
- assisting at clinics
- school screening

_Other factors_ that hinder a high uptake of core visits include:
- support visits to mothers/babies, especially in baby's early days
- difficulty contacting working parents
- unregistered change of address
- lack of nursing staff
- reluctance to employ Registered General Nurses for clinical duties
- insufficient clerical support leading to use of professional time for clerical duties

Problems Associated with Core Visits

PHNs identified several problems associated with delivery of the core child health surveillance programme. These include:
- unrealistic nurse/client group ratio
- no flexi-time
- insufficient written guidelines
- no written information tailored to the needs of ethnic minorities
- poorly coordinated and insufficient training, particularly for dealing with psychosocial issues
- inadequate continuing education and lack of time to attend courses on offer
- inadequate evaluation of the programme at local and regional level
- poor communication between professionals involved in services for children
- lack of time
Conclusion

- In the SEHB region, a scheduled three-month visit is carried out in one community care area (Carlow/Kilkenny) only. In all other areas, 5 – 8 weeks of age is the recommended timing of the second scheduled visit.

- The nature of PHN/parent contact, or attempted contact (home visit, ineffective home visit, phone call or clinic visit), is frequently not recorded in the child health record card.

- Additional PHN support contacts are most frequently made in the first 3 – 4 months of life. They are made for valid reasons but within the current time constraints may be at the cost of omitting core visits to older pre-school children.

- Many factors militate against PHNs offering the complete child health surveillance programme to all children.

- Time constraints have caused core visits to be ranked and each given a different priority status in the current PHN work schedule.

- In some areas the offer of a visit at eighteen to twenty-four months of age can fall as low as 20%. Omitting this assessment is not best practice because communication disorders such as autism, autistic spectrum disorders and specific language delay may become apparent in the later part of the second year of life.

- In some areas the offer of a 'three-year-old visit' may fall to 40%.

- Training and updating of staff involved in child health surveillance is inadequate and poorly coordinated.

- Insufficient clerical support necessitates the use of professional time for secretarial duties. This is an inefficient use of a valuable time resource.

- There is poor communication and liaison between disciplines involved in child health and child welfare services.

Recommendations

14.1 The second scheduled PHN visit should not be changed from six weeks to three months until a structure has been agreed and established to ensure that a doctor examines all infants at six week of age.

14.2 The PHN/client group ratio should be evaluated and addressed. In addition to the number of parents/children in any PHN area, the agreed ratio should take into account the needs of the client group.

14.3 PHNs should be granted sufficient and protected time to allow all children to receive at least all core visits in the surveillance programme.
14.4 Time should be factored into the PHN schedule to allow for additional support visits to parents/children who require or request them especially in the first three months of life.

14.5 Time should also be factored in for staff training and updating.

14.6 If necessary, locum cover should be provided to ensure no diminution of services when staff avail of training or updating.

14.7 A coordinated and nationally agreed training programme is urgently required to ensure that all staff involved in child health surveillance are confident that they have the necessary skills and expertise to provide a quality service.

14.8 The nature of PHN/parent contact (home visit, ineffective home visit, phone call or clinic visit) should always be recorded in the child's chart. Where possible, appointments should be made for house calls.

14.9 To facilitate a PHN-delivered quality child health service consideration should be given to the deployment of registered general nurses (RGNs) for clinical duties.

14.10 The introduction of flexi-time for PHNs should be considered.

14.11 A handbook of child health surveillance for pre-school and school children should be developed and agreed regionally by child health teams:
- it should reflect the changes proposed in Best Health for Children
- it should contain agreed guidelines for screening procedures, referral criteria and referral pathways

14.12 Standardised referral forms agreed with relevant disciplines should be developed and made available.

14.13 Where checklists, forms or booklets are referred to in the guidelines, they should accompany the handbook.

14.14 Information relevant to ethnic minorities should be developed and made available to service providers.

14.15 Feedback to parents and relevant professionals should be formalised and sufficient clerical support should be provided to make this a reality.

14.16 A streamlined communication network should be developed to ensure optimum communication and liaison between all disciplines involved in child health and welfare services.

14.17 Services should be evaluated on a regular basis to ensure efficient and effective delivery of a quality service.

14.18 Data should be collected routinely on the uptake and outcome of all core visits in the child health surveillance.
Chapter 15

‘Developmental’ Examination

*Best Health for Children* recommends that the following interventions take place at the ‘developmental’ examination:

<table>
<thead>
<tr>
<th>Content</th>
<th>Topics for Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Examination</td>
</tr>
<tr>
<td>Parental concerns. Ask specifically about general health and development, vision and hearing.</td>
<td>Weight and height as indicated or requested by parent. Check for CDH, and testicular descent. Observe visual behaviour and look for squint. Distraction test of hearing. Where there are concerns, a full developmental examination should be carried out.</td>
</tr>
</tbody>
</table>

The report further recommends that:

- all children should be offered an appointment for a developmental examination in the first year of life, ideally at age 7–9 months
- the physical environment of health centres should be improved
- access to the service should not be limited by geographic location or availability of staff
- efforts should be made to facilitate the attendance of babies of working mothers by extending clinic hours or establishing evening clinics on a pilot basis
- a Child Health Co-ordinator should be responsible for co-ordinating the programme
• the developmental service should be monitored on an ongoing basis. Reasons for non-attendance should be determined in each area with implementation of relevant policies to improve attendance rates

• it is essential that those professions who are involved in developmental surveillance should be adequately trained in normal child development

Current Practice in the South Eastern Health Board Region

The SEHB guidelines recommend that this, the third scheduled examination is offered by appointment, to all children between 8 and 10 months. The guidelines also recommend that the examination should be carried out by an AMO and PHN in a designated health centre.

No data are routinely collected on

• the number of children who are offered appointments

• the overall uptake

• the timing or timeliness of the examination

It is estimated by the professionals involved (PHN and AMO) that all children in all community care areas are offered at least one appointment for developmental examination.

In the survey of charts for this review, 3 (0.6 %) children in the SEHB region had no record of appointment to attend for development examination. Of those children invited 94 % were examined between the age of 7 and 22 months.
Appointments Offered

Overall, 471 (>99%) were sent at least one appointment, 85 (18%) a second, and 15 (3%) between 3 and 5 appointments.

Table 2.15.2 ‘Development’ examination: number (%) of children offered one or more appointment by SEHB region and community care area.

<table>
<thead>
<tr>
<th>Appointments offered</th>
<th>SEHB region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>386 (82%)</td>
<td>91 (81%)</td>
<td>79 (81%)</td>
<td>94 (81%)</td>
<td>122 (84%)</td>
</tr>
<tr>
<td>2</td>
<td>70 (15%)</td>
<td>18 (16%)</td>
<td>15 (15%)</td>
<td>16 (14%)</td>
<td>21 (15%)</td>
</tr>
<tr>
<td>&gt;3</td>
<td>15 (3%)</td>
<td>4 (3%)</td>
<td>4 (4%)</td>
<td>6 (5%)</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

There is no written policy on the number of appointments for developmental examination offered to any child but there is general consensus that each child is called at least twice.

In Carlow/Kilkenny, there is no limit on the number of appointments sent to a child but the PHN follows-up after the second default. In cases of persistent failure to attend, especially if a child is considered ‘at risk’, the GP and where appropriate, the social worker is informed.

In Tipperary SR, it had been the practice for the PHN to follow-up after the second non-attendance; a third appointment for developmental examination is offered to ‘at risk’ children. Recently, due to staff shortages, children are offered one appointment only.

In Waterford, in addition to sending a second appointment the PHN visits ‘at risk’ children after the first default to encourage and, if possible, confirm parents’ attendance at the second appointment.

In Wexford, only two appointments are offered except where a parent requests a reschedule. The second appointment is confirmed by a phone call from the PHN to the child’s parent(s).
Timing and Timeliness of ‘Developmental’ Examination

Overall, of 94% of children who attended for developmental examination 64% had been examined within the SEHB recommended 8 – 10 months of age.

80% of all children in the region had been examined by 1 year old.

Factors identified by both PHNs and AMO for delay in offering appointments for the developmental clinic include:

- lack of medical staff
- lack of nursing staff
- lack of clinic space
- no holiday cover for professionals leading to backlogs for the clinic
- repeated recall of ‘at risk’ children using valuable time resource especially in deprived urban areas
- difficulty tracking young, single mothers in private rented accommodation who may have changed address
- increase in PHN workload:
  - care of terminally ill patients
  - increase in early discharges from hospital
  - expanded booster immunisation programme
  - increased documentation at immunisation
- increase in AMO workload:
  - infectious disease
  - expanded immunisation programme
  - increased documentation ‘across the board’
  - difficulty in recruiting staff, especially medical staff

In two community care areas (Waterford and Wexford) the proportion of children who are examined at the recommended time, 8 – 10 months of age (61% and 38% respectively) is lower than in other areas. This reflects a shortage of medical staff when the cohort studied was of age for developmental examination.
Table 2.14.3 ‘Development’ examination: proportion of children examined at any age, at recommended ages (Best Health for Children, 7-9 months / SEHB, 8-10 months) and under 1 year old for the region and each community care area.

<table>
<thead>
<tr>
<th>Age at Examination</th>
<th>SEHB region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-22 months</td>
<td>94%</td>
<td>99%</td>
<td>99%</td>
<td>92%</td>
<td>88%</td>
</tr>
<tr>
<td>(BHFC guidelines)</td>
<td>38%</td>
<td>59%</td>
<td>30%</td>
<td>46%</td>
<td>19%</td>
</tr>
<tr>
<td>7-9 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(SEHB guidelines)</td>
<td>60%</td>
<td>78%</td>
<td>70%</td>
<td>61%</td>
<td>38%</td>
</tr>
<tr>
<td>8-10 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 1 year</td>
<td>80%</td>
<td>96%</td>
<td>94%</td>
<td>82%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Uptake of Examination

Overall uptake of ‘developmental’ examination is enumerated in table 1.9.4. 88% of PHN respondents consider this examination a high priority and every effort, including phone calls and home visits to parents, is made to encourage attendance.

Table 2.14.4 ‘Development’ examination: percentage uptake by SEHB region and community care area.

<table>
<thead>
<tr>
<th>SEHB region</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>94%</td>
<td>99%</td>
<td>99%</td>
<td>92%</td>
<td>88%</td>
</tr>
</tbody>
</table>

PHNs and AMOs identified the following factors for non-attendance of parents at the ‘developmental’ clinic:

- lack of transport
- other commitments, especially working parents
- change of address, especially young single mothers
- depressed or poorly motivated parents
- poor perception of the importance of the ‘developmental’ examination by a minority of parents
- prevailing weather conditions
There has been no recent regional or local evaluation of the reasons for non-attendance at the developmental clinic and parent's views have not been sought. However, some local changes have been implemented to improve attendance e.g.

- outreach clinics, for travellers in Tipperary SR and in an urban deprived area in Waterford
- specially timed appointments, on request, for working parents especially teachers
- appointment to a more conveniently located clinic, especially parents/children with special needs

Interventions at 'Developmental' Clinic

In the SEHB region, the purpose of the third scheduled examination, the developmental examination, is to review the physical, social and environmental wellbeing of the infant and to undertake a clinical examination. Important elements of health education are covered by the PHN and re-enforced by the AMO.

The SEHB guidelines for this visit are:

**History:** Establish the health profile of baby since last visit. Elicit health service, contact of other siblings or parents since that occasion.

**Weight:** Weigh naked, plot on centile chart and write in figures.

**Physical:** Review the baby's development with the parent. Are there any worries about growth, health, appetite or development? General observation of baby seated on parent's baby with toys nearby. Observe baby's response to parent.

**Physical Examination:** Clinical cephalo-caudal examination to be undertaken by AMO.

**Hips:** Refer to "risk" factors and undertake actual screening test.

**Testes:** Check for descent.

**Hearing:** Refer to "risk" factors and undertake actual hearing test i.e. distraction test according to Health Board guidelines.

**Vision:** Refer to "risk" factors. Do not undertake test for visual acuity. Screening for visual defects should be confined to history and observation and where necessary referred for a definitive opinion.

Developmental examination to be undertaken by AMO.
Health Promotion

The programme at this visit should centre on issues relating to the following topics:

- accident prevention – choking, falls, scalds, burns
- anticipate increasing mobility – stair gates, fire guards etc
- nutritional advice
- dental health
- re-enforce advice on safety in cars, passive smoking
- advise on ‘developmental’ needs – playthings/social activity
- advise on protection in the sun

The SEHB recommended interventions compare favourably with those recommended by Best Health for Children. History and topics for health education are similar. Best Health for Children recommends a full physical examination only where there are concerns, whereas, in the SEHB region all children are offered a full physical examination.

Clinic Location

The ‘developmental’ examination is always conducted in a clinic setting.

Guidelines

There are no written criteria for pre-school referral except to the vision clinic; unwritten criteria exist for referral to the audiologist. There are no guidelines on referral pathways.

Where procedural guidelines have been developed, they are not widely available. For example, only 45% of PHNs and a single AMO had written guidelines for conducting the distraction test of hearing; six PHN respondents (5/8 in Wexford and 1/22 in Carlow/Kilkenny) had a copy of the Cherryville booklet, recommended in the SEHB guidelines, for determining if referral for speech and language assessment is required.

Personnel

Throughout the SEHB region it has been the practice for the developmental examination to be carried out by the AMO and PHN.

Best Health for Children acknowledging:

- the evolving role of the AMO and the possibility of the child health service in each community care area being carried out by a number of dedicated AMOs who have developed specific expertise and a special interest in child health

- the pivotal role played by the GP is overseeing the health of children and in delivering child health services in the community

It recommends that the proposed Child Health Co-ordinator may contract with the GP to carry out the health examination at 7-9 months of age.
Conclusion

- In the current SEHB guidelines, content and topics for health education at developmental examination are similar to those recommended by *Best Health for Children*.

- Overall, 94% of the cohort studied attended for developmental examination between 7 and 22 months of age, 80% in the first year of life. In two areas, Carlow/Kilkenny and Tipperary SR, 96% and 94% of children respectively had been examined by 1 year old.

- Geographic location may play a part in parents' failure to attend the developmental clinic; professionals involved in developmental clinics identified lack of transport as a major factor for non-attendance.

- Availability of staff is identified as a factor for delay in timing of appointment to developmental clinic.

- No developmental clinics are held outside the hours of 9am - 5pm, Monday to Friday.

- The post of Child Health Co-ordinator has not yet been established in the SEHB region.

- There is no ongoing evaluation of the developmental service:
  - reasons for non-attendance have not been formally established in each area;
  - measures to improve attendance rates have been implemented in each community care area but they are based on informal evidence;
  - reasons for delay in issuing appointments to development clinic have not been addressed

- Professionals involved in developmental surveillance have not been offered refresher courses or updates for some years. Respondents have identified, in particular, psychosocial issues as an area in which they would value training.

Recommendations

15.1 A Child Health Co-ordinator, as recommended by *Best Health for Children* should be appointed to lead the multidisciplinary Child Health Team.

15.2 The report of the demonstration projects, 'Developing Best Practice in Child Health Developmental Examinations', Eastern Regional Health Authority, should be examined and learning points from them incorporated into the SEHB strategy.

15.3 An assessment of the adequacy of the centres used for development examination should be carried out.
15.4 The feasibility of providing developmental clinics in a more flexible manner, both in
time and place, should be assessed.

15.5 The feasibility of contracting developmental examinations to general practitioners
should be examined, especially where staff shortage and/or inadequate clinic
accommodation is a problem.

15.6 The recommendation of Best Health for Children that a full physical examination of
baby need not be carried out at the developmental visit if no problems have arisen and
there is documented evidence of a medical examination at six weeks should be
adopted. The introduction of parent held health records should facilitate this.

15.7 In addition to the recommendations of 'Best Health for Children', a brief assessment of
speech and language development should be undertaken at this visit.

15.8 'Dental Hygiene' listed under Topics for Health Education in the proposed surveillance
programme should read 'Oral Health'. Education at this stage should focus primarily
on dietary issues, including the weaning diet, advice on oral hygiene and the
appropriate use of fluoride.

15.9 Referral criteria and pathways should be standardised locally and should be available in
written form.

15.10 All referrals by community care professionals should be notified to the child's general
practitioner. Similarly the report on all referrals should be sent to the referrer and the
general practitioner.

15.11 Clear guidelines for the follow-up of non-attenders at developmental clinics should be
developed regionally.
Chapter 16

School Health Service

*Best Health for Children* recommends that the School Health Service be retained. The proposed service, managed by the Child Health Co-ordinator, would be more streamlined, operating in a standardised manner nationally. The report recommends the following contents and timing for the core Child Health Surveillance Programme for school-age children:

Table 2.16.1 Core Child Health Surveillance Programme for school-age children as recommended by *Best Health for Children*.

<table>
<thead>
<tr>
<th>Age at Examination</th>
<th>Contents</th>
<th>Topic for Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-6 years (senior infants)</td>
<td>Parental and teacher concerns. Review pre-school records. Measure height and weight, and plot on chart. Check visual acuity using Snellen chart. Check hearing by “sweep” test. Opportunity for general health check.</td>
<td>As per SPHE* Programme</td>
</tr>
<tr>
<td>7-8 years (2nd Class)</td>
<td>Parental and teacher concerns. Review school health records. Check visual acuity. Measure growth if concern about child’s health or growth. Opportunity for general health check.</td>
<td>As per SPHE Programme</td>
</tr>
<tr>
<td>11-12 years (6th Class)</td>
<td>Parental and teacher concerns. Review school health records. Check visual acuity. Check colour vision. Opportunity for general health check.</td>
<td>As per SPHE Programme</td>
</tr>
</tbody>
</table>

*Social Personal and Health Education
The report proposes the following changes in the role of key professionals involved in service delivery:

- A specialised school nurse, designated for each school, should be the key professional involved in child health screening of school-age children.

- The doctor, designated for each school should play an advisory and secondary referral role. The role of doctor as advocate and facilitator, particularly in relation to children with special needs, should be retained and enhanced.

Together the school nurse and doctor will carry out a limited programme of child health screening, support the development and implementation of health education and health promotion programmes in schools and advise teachers, parents and children about current health issues. They will aim to minimise the effects of childhood disability and social and health disadvantage by and playing a facilitatory, advocacy and monitoring role.

- The teacher, through the SPHE Programme, should be the key professional involved in health education. They should have access to any required support from health professionals in the school health team.

Teachers are well placed to identify children who may be at risk of neglect, and those with educational, emotional or behavioural problems. Their co-operation is vital in facilitating the work of the school health team.

The report also outlines the role of parents in the School Health Service:

In recognition of the fact that parents are very good at identifying their children's needs and recognising defects at an early stage, greater use needs to be made of this resource. This can be achieved by the following:

- At school entry, parents should receive an information leaflet outlining the school health service, including content and timing.

- Parents should be requested to complete a questionnaire at three key screening ages.

- Parents should be encouraged to attend school health screening visits, in particular the school entry visit.

- Parents should be informed that they may request a meeting with the school nurse at any stage if they have concerns about their child. Parents should be informed of any abnormality suspected or confirmed by the school health team.

*Best Health for Children* foresees the school doctor and nurse working closely with other professionals, including speech and language therapists, community physiotherapists, community occupational therapists, general practitioners, ophthalmologists, clinical psychologists, child psychiatrists, paediatricians, audiologists, social workers, dentists to form a School Health Team which would work in partnership with parents and teachers.
The school nurse should have a formal meeting with the school principal towards the end of each school year to outline the child health surveillance programme for the following academic year and to plan accordingly.

At school entry, parents should receive an information leaflet outlining the school health service, including content and timing of the programme. They should be made aware that they may request a meeting with the school nurse at any stage if they have concerns about their child, and should always be informed of any abnormality suspected or confirmed by the school health team.

The report recommends that parents should be asked to complete a questionnaire at three key screening ages and that each child of primary school age, irrespective of school attended (public, private or special), should receive three core visits from the school nurse. In Senior Infants class, the school nurse should see all children with their parents if possible, and sufficient time should be allowed for discussion with parents. The recommended ages and the contents of the core child health surveillance programme are outlined in table 2.16.1.

Current Practice in the South Eastern Health Board Region

Professionals Involved

In the SEHB region, the school health service has changed in recent years both in content and delivery. In some ways it has moved towards that recommended by Best Health for Children and in other ways it has diverged.

The AMO has been forced to prioritise duties because of:
- an increasing workload
- especially infectious duties
- expanding vaccination programme
- increased documentation
- and increased assessments, especially since the regulations changed for granting Domiciliary Care Allowance
- poor co-ordination of existing information (Child Health System and Pre-school Records)
- insufficient clerical back-up
- difficulty in recruitment of both PHNs and doctors

This has led to a gradual move away from the traditional role of providing medical examination in the school setting to all entrants (6 year olds), through examination of selected 6 year olds only, to the existing system whereby the AMO provides an advisory and secondary referral service, examining in a clinic setting, only those children referred by the screening nurse. This approximates to the role proposed for the designated school doctor by Best Health for Children.

In Carlow/Kilkenny, Wexford and Waterford each school has a named doctor. In Tipperary SR, no doctor is assigned to the school health service.
On the other hand, screening of school children by a specialised school nurse has been replaced in many areas with screening by the district PHN—a divergence from the proposals of *Best Health for Children*. Only six specialised posts remain, the original four in Waterford Community Care Area and two in Carlow/Kilkenny, one of which is currently vacant. These specialised school nurses have accumulated considerable experience and expertise but have been hampered by lack of opportunity to re-train and update.

At present, a specialised school nurse screens almost all children in Waterford city and county schools. An anomaly exists in Waterford city, where the PHN charged with screening in special schools, screens only in these schools. This PHN must screen a special and often challenging group but has no opportunity to develop expertise in standard procedures.

No children are screened by a specialised school nurse in Carlow town or its environs because the post is vacant, and in Kilkenny, the school nurse screens a minority only. Elsewhere, the area PHN is the key professional.

The District PHN is able to give increasingly less time and priority to school screening because of

- an ever-expanding workload especially
- child welfare (pre-school);
- providing support for vulnerable families;
- increase in the elderly population;
- care of the young chronically ill;
- care of the terminally ill;
- wound care;
- clinic duties;
- increased clerical workload,

Over half (52%) of respondents spend 10% or less of their time on the school health service, rating it almost lowest (9th of 11) in their list of priorities. School nurses in particular, are disillusioned with the lack of importance given to the school health programme and the gradual passive erosion of the service; while some district PHNs foresee a diminution in their own levels of expertise if they continue screening in schools.

In Kilkenny and Waterford, there is a named nurse assigned to each primary school.

No post of Child Health Coordinator exists to manage the school health service and no school health team exists to work in partnership with parents and teachers.
Formal Meetings between Health Professionals and School Principals

An annual, formal meeting between nurses involved in school health surveillance and school principals to agree plans for the screening and immunisation programme or for the special needs of individual children for the following academic year is not a standard procedure. Neither is a formal meeting between health and education professionals to discuss areas of mutual concern or benefit. These meetings are more likely not to take place (76% PHN respondents).

Each September, the principal is informed by letter, of the proposed immunisation programme and the age groups selected for screening examinations during the incoming academic year.

Except Tipperary SR, where booster immunisation is conducted in health centres, the date of immunisation sessions in each school is an ad hoc arrangement organised by the assigned nurse in consultation with the school principal and immunising doctor.

Parent Information Leaflet

The parent information leaflet developed in Waterford Community Care Area outlines services on offer within the school health programme, how to access services, consent and withdrawal of consent, screening, immunisation and the age groups targeted annually. It is given to parents of all new entrants. In the other three community care areas, parents are given information on screening prior to the event. The information is brief and is incorporated into the health questionnaire/consent form.

Content and Timing

Within the school health service, the vaccination programme takes precedence over all others and is delivered according to the recommendations of the National Immunisation Committee (RCPI, 1999). Children are vaccinated in the school setting in all community care areas except Tipperary SR where they and their parents are invited to a health centre. Follow-up of defaulters is arranged in local clinics. Uptake is estimated at 90+% regionally.

The contents of the school screening programme and the health questionnaire(s) for screening are similar in mainstream and special schools throughout the region. Each child in primary school is offered screening of vision and hearing on at least one occasion, all boys are screened for defective colour vision in either 5th or 6th class (10 – 12 years old) and in Waterford, height and weight are measured in Senior Infants class (5 – 6 years old). Children are no longer screened for scoliosis.

Routine medical examination by the AMO no longer takes place except for selected children in some special schools. During the past year the post of AMO for special schools has been vacant in Tipperary SR and Waterford city, while in Dungarvan and Kilkenny these schools have priority status.
The target group for screening of vision and hearing varies slightly from area to area. All children in Senior Infants (age 5-6 years) are offered screening of both. A second test of visual acuity and screening for defective colour vision (boys only) is carried out in 5th class (age 10-11 years) in Carlow/Kilkenny and Tipperary SR. This screening occurs in 6th class (age 11-12 years) in Waterford and Wexford. Wexford offers a second test of hearing in 5th class. Parents are usually requested to complete health questionnaires prior to each screening. No area offers the three core visits recommended by Best Health for Children.

Table 2.16.2 School health service: classes (age groups) routinely screened in each community care area.

<table>
<thead>
<tr>
<th>Class</th>
<th>Carlow/Kilkenny</th>
<th>Tipperary SR</th>
<th>Waterford</th>
<th>Wexford</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Hearing</td>
<td>Vision</td>
<td>Hearing</td>
<td>Vision</td>
</tr>
<tr>
<td>Junior Infants (4-5 years)</td>
<td>✓</td>
<td>(Repeats only)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Senior Infants (5-6 years)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1st Class (6-7 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd Class (7-8 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd Class (8-9 years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th Class (9-10 years)</td>
<td></td>
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<tr>
<td>5th Class (10-11 years)</td>
<td>✓</td>
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<td>6th Class (11-12 years)</td>
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<td>✓</td>
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</tbody>
</table>

All new pupils, with the exception of junior infants, and any pupils selected by a parent or teacher are screened irrespective of class (age group).

Since AMOs have withdrawn from routine examination of schoolchildren, parents are no longer invited to meet health professionals in school (except within the vaccination programme). Involvement of parents and the opportunity for them to express concerns about their children has become less personal and communication is now almost exclusively in written form. This weakens the bond of parents as partners and provides little opportunity to acknowledge parents' ability to recognise defects at an early age and to identify their child's needs. The infrequency of parent/child meetings with health professionals means less opportunity for health promotion.

In conflict with the recommendations of Best Health for Children, no time is allotted for the (school) nurse to interview parents with their children during the Senior Infants year.
Procedural and Referral Guidelines

There are no written and agreed regional guidelines for the school health programme. Three community care areas (Waterford excepted) and 80% of PHN respondents had written guidelines for screening of hearing and vision. The ophthalmic service is outstanding in having written guidelines for screening visual acuity and colour vision, referral criteria and pathways standardised across the region. In all areas, there is poor availability of guidelines for assessing and referring speech and language problems. There are no agreed referral criteria or pathways for suspected hearing defects. Procedural guidelines for assessing and monitoring growth do not exist and the lack of written guidelines on referral criteria and clear referral pathways to psychological services is a particular problem.

Where children fulfil referral criteria or where concerns arise the PHN refers:
- directly to a clinic, e.g. vision clinic
- to the AMO, e.g. poor response to hearing test, behaviour problem, poor academic progress or parental concerns expressed in the health questionnaire
- to the child’s GP

Referral pathways vary, not only from one community care area to another but also within areas.

Waiting time for follow-up at referral clinics is unacceptable; only paediatric and community vision clinics are considered satisfactory.

Equipment and Accommodation

In areas where area PHNs carry out school screening, equipment may be shared. This has caused delay or cancellation of screening when equipment was not available.

Some schools offer accommodation that is inferior for screening and/or vaccination. Accommodation is frequently cold, particularly in the late morning, too noisy to conduct hearing testing, too small for vision screening or with no hand-washing facilities for vaccination sessions. On occasion, vaccination is expected to take place in small kitchen areas.

Feedback

Parents are seldom informed when screening has been performed and is within normal limits but are always notified when a defect is suspected or confirmed, or when a child is referred for follow-up. However, feedback from the school health service to the child’s GP is inconsistent and generally poor; GPs may receive a copy of referral letters but no information on children immunised in schools. Feedback from referrals is also inconsistent, with one notable exception – Paediatricians, who always send a report, (and a copy directly to the child’s GP). In cases where the waiting list is long, the referral is seldom acknowledged nor is the referee informed of the expected waiting time.
Clerical Support and Child Health Record Cards

In this service, as in the pre-school service, there is a significant lack of clerical support. Nursing staff use valuable professional time (up to 15 hours per week) retrieving and preparing charts for screening, filing reports, making referrals and arranging consent/information for vaccination sessions.

The management of school health record cards is a major source of concern to professionals. Charts are frequently misplaced or lost and the use of replacement cards leads to confusion. Charts are important and sensitive documents. In bulk they are heavy and cumbersome. An alternative should be considered to the routine removal of records from community care centres for school screening.

All information relevant to a child (including consent to immunise, referral letters, reports particularly psychological/psychiatric reports) is not filed in the child health record. Neither is there computerised backup for records.

Training and Continuing Education

Most school nurses have been in post for many years and have considerable experience and expertise, however, there is little or no opportunity for re-training or updating. Area PHNs have neither sufficient time nor opportunity for continuing education and the relatively small target group that each PHN screens annually delays the rate of skill acquisition.

Best Health for Children identifies emotional and behavioural problems as the most common cause of disability in childhood. Training in the identification of these problems is noticeable by its absence.

A structured and coordinated programme of in-service training and continuing education in child health surveillance, essential to the maintenance of a quality service, is sadly not available to key health professionals.

Data Collection

Data collected on school screening, referral and outcome is poor and not available in a readily retrievable format. It is estimated that 100% of the target group in Tipperary SR was screened in the school year 1999/2000. Wexford estimates 90-95%, two of four school nurses in Waterford achieved 100%. In Carlow town and environs no children, except those requested by parents or teachers, were routinely screened and a two-year backlog has accrued. Schools in Borris and Bagnalstown were screened but the remainder of Carlow/Kilkenny community care area fell short of target because some PHNs, in dispute, did not perform school screening.

Within the SEHB region, booster immunisation is not universally recorded on the Child Health System (computer record). Percentage uptake rates are not readily available.

Screening unfinished during a school year is usually deferred to the following year. In a minority of rural schools it is policy for the nurse to visit for screening in alternate years.
Conclusion

- Overall, in the areas of staffing, training, structure and support services, the school health service, as a distinct arm of community health services for children has, by default, been given a very low priority, and unless resources are made available urgently, it will continue to deteriorate.

- Within the present system it is almost impossible to achieve the twin aims of a school health service:
  - to achieve the best possible level of health (mental and physical) and social well-being, current and future, for all children of school age
  - working in partnership with children parents and teachers, to enable children to benefit fully from education

- There is no Child Health Coordinator to manage the School Health Service.

- There is no school health team in place to coordinate the school health service, neither is the service operated in a standardised manner.

- Each primary school in the region does not have a designated and named doctor.

- Each primary school in the region does not have a designated and named school nurse.

- The role of the AMO in the school health service has evolved towards the role recommended by Best Health for Children. The doctor has assumed a role of advisor, secondary referee, facilitator and advocate. Except for a small number of selected children in special schools, medical examination no longer takes place outside the clinic setting.

- In recent years, the nurse/screener in the majority of schools has changed from the specialised school nurse to the area PHN. This has lead to a gradual downgrading and fragmentation of the service and to a dilution of expertise. School screening is placed 9th out of a possible 11 duties in the PHN schedule.

- Only 24% of nurse respondents involved in school health surveillance hold an annual formal meeting with school principals to agree screening and immunisation plans for the following year or to discuss areas of mutual concern or benefit.

- Except in Waterford Community Care Area, the information leaflet for parents is basic. In no area are parents informed that they may request a meeting with the (school) nurse at any stage if they have concerns about their child.

- In the school health programme, the vaccination programme is given the highest priority and is delivered in all schools in accordance with the recommendations of the National Immunisation Committee. Procedural guidelines for immunisation are available in all community care areas but no training has been provided on best practice in handling vaccines.
Computerised recording of booster immunisations is not standard practice throughout the SEHB region.

The contents and coverage of the screening programme falls short of that recommended by Best Health for Children. The target groups screened vary from area to area and no area offers all three core visits. No child in Carlow town and its environs has been routinely screened since September 1999. Only one community care area (Waterford) routinely monitors growth.

It is not policy, nor is time allowed, for a meeting between the nurse/screener and the parents of each child in Senior Infants class. In fact, there is little opportunity for parents of school children to meet with the key professionals involved in the school health service. This is in conflict with the spirit of ‘Best Health for Children’ and reduces the opportunities for health promotion.

In-service training and continuing education of key professionals involved in the School Health Service is minimal and does not support the ideal of a quality service.

Changes and scaling down of the school health service in recent years has resulted in an inequitable service of variable quality; it does not reach all children nor does it prioritise those children most in need.

Except for vision, there are no written and regionally agreed guidelines for screening. Guidelines on procedures, criteria for review, criteria for referral and referral pathways have not been standardised nor are they available in all community care areas.

With a few exceptions, waiting time for assessment of children referred to clinics from school screening is generally unacceptable.

Clerical support is markedly insufficient to meet the demands of the school health service.

The management of child health records, particularly those of school children, is a major cause for concern.

Feedback from ‘screening professionals’ to parents is satisfactory, but could be improved. Feedback between health professionals is basic.

Data collection is primitive.

Recommendations

16.1 The decision to continue a School Health Service should not be made unless, and until, adequate resources can be guaranteed to provide an equitable and quality service.

16.2 Consideration should be given to the early appointment of area Child Health Coordinators to, among other things, manage the school health service.
16.3 The structure, staffing, content and timing of the school health service should be standardised regionally to reflect the aims of a school health service as outlined in *Best Health for Children*.

16.4 The report on the demonstration project, ‘Developing the School Health Service Model’, North Western Health Board, should be examined and learning points from it incorporated into the SEHB strategy.

16.5 The post of School Nurse should be reinstated. Sufficient appointments should be made to guarantee that all children are offered an *equitable and quality service*. The nurse/client ratio should be re-evaluated with *needs* taking precedence over client *numbers*.

16.6 A named school nurse and doctor should be assigned to each primary school (public, special and private) and notified to individual school principals.

16.7 *Screening of children in special schools* should be re-evaluated to ensure that staff with sufficient expertise is assigned to this task. Discussion should be entered into with community audiologists and ophthalmic physicians to provide this service.

16.8 Arrangements should be put in place to facilitate an annual formal planning meeting between the school nurse and school principal.

16.9 An information leaflet should be developed that would fully inform parents and teachers of all relevant aspects of the school health service.

16.10 *Clear guidelines for the school health service* should be formulated regionally and agreed locally. They should outline:
- roles and responsibilities
- risk groups for individual defects
- criteria for review and referral, developed in consultation with appropriate specialists and local GPs
- referral pathways to allow for timely and appropriate management of children who are positive on screening examination
- guidelines on appropriate feedback to parents and professionals

16.11 The regional guidelines should be backed up with specific training and updating of relevant professionals.

16.12 A standardised and specific training programme should be devised and made available to all relevant professionals. Special attention should be given to the identification of psychosocial problems.

16.13 With the introduction of the National Educational Psychology Service (NEPS), referral criteria and pathways to community psychology services should be re-defined and strengthened.
16.14 Where there are unacceptable waiting times for follow-up of suspected or confirmed defects/problems arising from screening, an action plan should be formulated to address the issue.

16.15 Sufficient clerical support should be provided to ensure full backup for the school health service and to protect valuable professional time.

16.16 Consideration should be given to developing a system of data transfer that would eliminate the need for removing charts from community care centres.

16.17 For ease of reference, all letters of referral they should include the child's date of birth, school attended and GP's name. All referrals should be notified to the child's GP. Consideration should be given to developing standardised referral forms in consultation with referral services.

16.18 There is an urgent need to formulate and implement a policy for the storage, filing, movement and tracing of child health records. Designated record clerks should be assigned to care for these important documents.

16.19 Information technology should be developed which could record screening and referral information while safeguarding client confidentiality.

16.20 The collection of data should be upgraded and presented in a manner that would allow for regular evaluation of the service and could be used to make recommendations, where necessary, for changes in practice.
Part Three

General Issues
Chapter 17

17.1 Training And Continuing Education

Training is essential to a quality service and, to ensure delivery of the evidence based, nationally standardised screening programme outlined in Best Health for Children, the introduction of a specific co-ordinated training programme is imperative.

All professionals surveyed acknowledged the lack of structured, co-ordinated in-service training/continuing education in child health screening and surveillance, the time constraints and staff shortages that prevent attendance at sporadic symposia. Most professionals expressed a desire for training, re-training or updating especially in the emotional and psychological health of children.

The National Conjoint Child Health Committee has identified the training needs of doctors and public health nurses involved in the delivery of the core child health surveillance programme and has made recommendations to the Chief Executive Officers of the Health Boards to meet these training needs. This report should be considered and implemented without delay.

Recommendations

17.1.1 A co-ordinated, specific and nationally agreed programme of education is urgently required to ensure that staff involved in child health surveillance are confident that they have the necessary skills and expertise to provide a first class service.

17.1.2 The programme should be made available to all relevant staff. Time and workload should not be a prohibiting factor.

17.1.3 Time should be factored into the work schedule for staff training and updating.

17.1.4 If necessary locum cover should be provided to ensure no diminution of services while staff avail of training or updating.
17.2 Administrative Support

The Child Health System And Child Health Records

Clerical support to the community child health programme is good in quality but significantly lacking in quantity. Valuable professional time (up to 15 hours weekly) is devoted to filing reports/consent forms, tracing records, writing letters, sending appointments and following up missed appointments. Clerical officers are already overwhelmed with many masters, each demanding priority. Frequent staff changes compound the problem.

A computerised Child Health System is in the embryonic stage. The birth notification and childhood immunisation system was developed in the early 1990s but was not expanded to include the developmental aspect of child health or school screening due to lack of funds.

In all community care areas, a designated clerical officer is assigned to the Child Health System. Tipperary SR is the only area with a designated, trained locum to provide backup during periods of leave.

A handbook, Procedure for Recording Birth at Community Care Offices, (SEHB 1992), was issued as a guideline for processing notification of birth and generating birth labels for the area public health nurse.

The care of child health records gives cause for concern. Too many people have access. There is no designated clerical officer to file reports, monitor the local movement of charts, supervise an effective tracer system or oversee an archive. The fact that there is no named, designated person with overall responsibility for records has resulted, on occasion, in the confusing practice of making duplicate records, or worse, in missing records. This situation is untenable, especially in the age of litigation.

Recommendation

17.2.1 The child health programme should be given the status it deserves with sufficient trained clerical support to maintain the service and to allow professionals to use their time more effectively.

17.2.2 Consideration should be given to expanding the computerised child health system to include at least the results of developmental and school screening.

17.2.3 An effective system should be devised and implemented for the safe filing, storage, movement and tracing of child health records, both active records and those in archives.

17.2.3 A designated clerical officer should be appointed and trained to operate the system.
Effective communication is a vital ingredient in any multidisciplinary service. *Best Health for Children* states that the most important aspect of child health surveillance is communication between all professionals involved to ensure that the child receives all appropriate screening and follow-up and to eliminate duplication and omission.

Communication, the imparting or exchange of information, has many strands including interdisciplinary/interagency sharing of knowledge, dissemination of information and methods of transmission. Deficiencies have been identified in all areas.

Interdisciplinary/Interagency Sharing of Knowledge

With few exceptions, notably Community Ophthalmology, the survey found that service providers consider communication and liaison between all disciplines/agencies involved in child health and welfare to be less than satisfactory. Disciplines in child health and welfare services tend to exist in near-isolation, unaware of the full range of services each can offer the other and with no forum for sharing information. Communication between management and staff is also considered unsatisfactory. These findings, together with a perception of lost leadership and poor team spirit are contributing to a sense of isolation and low staff morale.

The liaison nurse linking the maternity department and community care now exists in one area (Kilkenny) only.

The GP is not specifically included in the information loop.

*The Early Intervention Team*, a multidisciplinary team in each community care area, co-ordinates services for pre-school children with special needs. The team holds regular meetings and gives feedback to parents and all relevant professionals. This is a good example of interdisciplinary communication and teamwork.

Dissemination of Information

In defining the key principles of a quality child health programme, *Best Health for Children* states that:

- parents have a right to information about services
- parents have a right to appropriate feedback from services

These ideals do not always receive the importance they deserve. For example:

- Many parents of pre-school children are not fully aware of the importance, or the sequence, of core surveillance visits

- Waterford is the only area where parents receive a written outline of the school health programme

- Parents of school-age children are not informed how to access services
- Parents are no longer given the opportunity to have a formal meeting with the school nurse (or school health team) to discuss their child’s health.

- Following screening, parents are usually informed when a defect is suspected but receive no confirmation that their child has been screened and all is well.

On the other hand, a vast range of health promotion information/literature is available to parents but there is little evidence that they receive the right amount at the right time or that it reaches those who most need it. Antenatal classes are poorly attended; whereas, in the postnatal period there is a risk of information overload. There is no structured or co-ordinated approach to the dissemination of information to parents, especially in the early stages of the child’s life.

The pilot project in Tipperary to develop information systems to meet the information needs of parents in relation to their child’s health and well-being and the introduction of parent held child health records may go some way to addressing these issues.

There is no evidence, at local level, to suggest that child health services are addressing the issue of the language barrier and ethnic minorities.

On another level, the information and consent forms sent to parents for perusal, prior to giving informed consent for booster immunisation, are often illegible and of poor quality. This is bad practice. It is discourteous to parents and reflects negatively on the corporate image of the SEHB.

Methods of Transmission

In community care, modern communication technology is underdeveloped. E-mail is not widely available and few health centres have access to fax machines. However, telephonic communication has improved greatly and many staff have now been provided with mobile phones.

Recommendations

17.3.1 The importance of effective communication should be effectively communicated to all service providers.

17.3.2 A streamlined communication network should be developed and activated, to ensure optimum communication and liaison between all disciplines and services in child health and welfare.

17.3.3 The relationship between community child health professionals and GPs should be fostered and strengthened.

17.3.4 The relationship between community child health professionals and paediatricians should be fostered and strengthened.

17.3.5 Links should be forged with new services e.g. the Educational Psychology Service.
17.3.6 Provision of communication tools and training in their use are essential requirements for modern communication.

17.3.7 There is an urgent need to develop a fully integrated computerised child health system to record, and also collate, relevant screening, follow-up and disease prevention information on children. At the same time, records should respect and safeguard the confidentiality of the child and family.

17.4 Accommodation and Equipment

Assessing the adequacy of accommodation used for child health screening is beyond the scope of this review. However, the following facts have emerged.

Clinics

A majority (87%) of PHN respondents considered the clinic to be conveniently located for parents, and (55%) user-friendly for parents but not for children; (55%) thought the clinic was unsafe for toddlers. Only 29% of PHNs considered the clinic suitably furnished; 20% suitably equipped.

Shortfalls noted in some clinics include:
- no facilities for breastfeeding
- no facilities for nappy changing
- no age-appropriate toys
- no pram parking facilities
- inadequate waiting area
- inadequate ventilation
- clinic room too small
- clinic room too noisy
- poor availability of clinic room

Area medical officers were in general agreement with these findings. 10 of 13 (77%) respondents considered clinic accommodation unsuitable for its intended purpose.

These findings are mirrored in a recent study conducted by the Department of Public Health, Western Health Board.

Of (3) Community Ophthalmic Physicians (COPs) who replied, one considered the accommodation available for children's clinics to be neither suitable nor fully equipped.

\[\text{A Report on the Structural and Operational Resources of the 9 Month Developmental Screening Check, November 2000.}\]
Schools

The accommodation offered in some schools is inferior for screening and/or vaccination. Accommodation is frequently cold, particularly in the late morning, inconvenient, too noisy to conduct hearing testing, too small for vision screening or with no hand-washing facilities for vaccination sessions.

In Tipperary SR, AMOs do not vaccination in the school setting. All other AMO respondents (10 of a possible 17) thought the accommodation offered for vaccination in school was unsuitable for the task, lacking either privacy, convenient hand washing facilities, accessible phone or space to resuscitate.

Equipment

All AMO respondents consider child health clinics to be poorly equipped for developmental screening examination. 80% of PHNs agree.

Specialised school nurses have all their own equipment for school screening. In areas where the area PHN carries out school screening, planned work is postponed or cancelled when shared equipment is not available.

All AMO respondents, except one, have been provided with resuscitation equipment.

One COP (Wexford) does not have all necessary equipment for children's clinics.

Recommendations

17.4.1 An assessment of the adequacy of health centres used for screening vaccination and child health clinics should be carried out.

17.4.2 In assessing child health clinics, attention should be given to toddler safety.

17.4.3 Discussion should be entered into with the Department of Education to address shortfalls in the accommodation available for screening and vaccination in schools.

17.4.4 An assessment should be carried out to ensure that all relevant clinics and/or professionals have been provided with all necessary equipment.

17.4.5 Sufficient equipment should be available to ensure that planned work is not cancelled or postponed due to lack of equipment.

17.4.6 All relevant staff should have a demonstration or, if necessary, training in the use of screening equipment.
17.5 Data Collection And Evaluation Of Services

*Best Health for Children* states that, "the success of child health surveillance programmes is dependent on rigorous monitoring of their effectiveness and efficiency." The report further states that, "there is increasing recognition of the need to concentrate on the outcomes of services" and that, "it is necessary to collect data in a standardised fashion in order to plan an equitable national service and to allow for valid comparisons between regions over time."

"Shaping a Healthier Future" emphasises the necessity for comprehensive and good quality information.

A sub-committee of the National Conjoint Child Health Committee is currently exploring the development of a small set of indicators by which the health of children and the effectiveness of the child health services can be measured in Ireland. Ideally this child health data would be held on computer, and systems used in different regions would be compatible to allow for comparison between areas and to allow for collation nationally.

In the South Eastern Health Board region, data collection on targets reached or outcomes is either non-existent or of poor quality. It is neither readily accessible nor available in a user-friendly form.

A computerised Child Health System is in the embryonic stage. The birth notification and childhood immunisation system was developed some years ago but expansion to include the developmental aspect of child health or school screening has been postponed due to lack of specific resources for the project.

The following evaluation of services has been undertaken by the SEHB in recent years:

A Review of the Audiology Services, 2000  
Ophthalmic Service Review, 1997  
Public Health Nursing – A Review, 1997  
A Review of Speech and Language Therapy Services, 1996

However, the opinion of the consumer, vital not only to evaluate satisfaction with, and provision of, services but also to assist in planning for change, is not sought systematically.
Recommendations

17.5.1 The expansion of the Child Health (computerised) System to include, at least, the proposed set of child health data (National Conjoint Child Health Committee).

17.5.2 The necessary clerical support and IT backup should be provided to collect and maintain this dataset.

17.5.3 If possible, the computerised information system should be linked and compatible with other regions.

17.5.4 The Child Health Information System should be accessible to those who need to know the information, and the need to observe absolute confidentiality in relation to personal data should be supported by appropriate training and security. (*Best Health for Children*)
Part Four

Submissions From Representatives
On The Implementation Committee
Chapter 18

18.1 Child Care and the Implementation of Best Health For Children

Mr. John Martin, Senior Social Worker.
Ms. Marie Kennedy, Child Care Manager.
Ms. Maeve Martin, Senior Clinical Psychologist.

Addressing the Child Care issues which will evolve as the Best Health for Children strategy is implemented will require a needs assessment of the current numbers who partake of pre-school services, new projects such as Community Mothers and Springboard, Family Support Services and the development of Children First within the region. While developing the Best Health for Children strategy it is important that those children who are most vulnerable to be (at risk) are identified, but that this form of identification does not lead to or suggest stigmatisation. It is important therefore, that preventative services under the Child Health Service are developed in a pro-active and inclusive manner. It is important therefore, that issues such as Health Promotion and Youth at Risk including such issues as the tracking of teenage parents have an identifiable fit into the strategy for developing the Best Health for Children strategy. It is important therefore, that in order to adequately target at risk groups it is critical that the focus is broad and inconspicuous and nevertheless capable of identifying without stigma, those who are in vulnerable situations.

Mental Health Issues also require identification within the Best Health for Children strategy and strategies need to be devised to identify and address depressive and risk factors within children and young persons, including postnatal depression in young mothers, vulnerability to victimisation, attachment disorders in children, and including malnutrition and all forms of abuse.

For Best Health for Children strategy to be a success within the region it is our opinion that it must focus on a holistic approach to children's health. Best Health for Children therefore, cannot only be an absence of ill health but must include mental, spiritual, physical, emotional and environmental health. The above should be read in conjunction with checklists on:

- Signs and Symptoms of Non-organic Failure to Thrive
- Behavioural Indicators of Emotional Rejection and Abuse
- Secure versus Insecure Attachments in infants
- Physical and Emotional Abuse
- Characteristics of Abusive Families
Checklist 1

Signs and Symptoms of Non-organic Failure to Thrive

**Growth retardation**

Child falls below the third percentile in weight.

**Developmental retardation**

Motor
Language
Social
Intellectual
Elimination

**Physical description**

Wasted body
Thin arms and legs
Large stomach
Red, cold and wet hands and feet
Thin wispy dull and falling hair
Dark circles around the eyes

**Psychological description**

Sadness
Expressionless face
General lethargy
Withdrawal
Detachment
Depression
Bursting into tears
Frequently whining
Minimal or no smiling
Diminished vocalisation
Staring blankly at people or objects
Lack of cuddliness
Unresponsiveness
Lack of proper stranger anxiety

**Physical symptoms**

Refusal to take feeds
Vomiting
Diarrhoea
Checklist 2

Behavioural Indicators of Emotional Rejection and Abuse

- The punishment of positive behaviour from the child (e.g. smiling, manipulation, movement)
- The discouragement, punishment or neglect of dependency needs or actions on the part of the child (e.g. seeking help, seeking proximity, affectionate contact, attention, from caregiver)
- The punishment of the child’s self-esteem (e.g. endless criticisms, ‘put downs’, denigration, scorn)
- The discouragement or punishment of the child’s inter-personal (social) skills which form the basis for his or her adequate performance at school, with peer groups, etc. — and thus their competence and self-confidence (e.g. friendliness, verbal contributions to conversation, self-assertiveness, curiosity)
- Actions which prevent or discourage parent-infant and infant-parent attachment/bonding (e.g. displays of affection, proximity-seeking)

See note 1

Checklist 3

Secure Versus Insecure Attachment in Infants

Secure attachments (infant-to-parent) may be indexed by the baby’s:

- Interest and attentiveness when with the parent (looking, gazing, listening)
- Relaxation and/or calmness in the company of the parent
- Dependency behaviours directed at the parent e.g. holding, proximity-seeking (later when more mobile seeking comfort and help)
- Evident preference for the parent to others
- Curiosity and exploration using the parent as a ‘base’
- Pleasure, enthusiasm, joy (e.g. smiling, vocalising) in the presence of the parent
- Protest, displeasure, concern when separated from the parent; comforted when he or she returns

See note 2

Note 1: Always record examples of what people do and say. Base your observations on a representative, fair sample of observations.

Note 2: By four months of age it is possible to observe each of these behaviours in a series of free exchanges between mother and baby. By the middle of their first year, most normal children begin to show attachment to significant people in their environment. From then on young children are much more vulnerable to separation from loved ones (see Schaffer, 1990, for detailed evidence).
Checklist 4

Physical and Emotional Abuse

**Alerting signs of physical abuse**
- Bruises, weals, lacerations and scars
- Burns and scalds
- Bone and joint injuries
- Brain and eye injuries
- Internal injuries

**Alerting signs of emotional abuse**
- Verbal or emotional assault (including threats of sexual or physical assaults)
- Close confinement (e.g. locking a child in a dark cupboard)
- Other forms such as withholding food, warm clothing/coverings

**Alerting signs of emotional neglect**
- Inadequate nurturance leading to physical, mental or emotional problems (e.g. non-organic failure-to-thrive)
- Encouraging or permitting serious maladaptive (problematic) behaviour
- Other forms of neglect such as refusing to allow a child to have a recommended and necessary treatment

Checklist 5

Characteristics of Abusive Families

- One or both parents have, when young themselves, been subjected to violence
- One or both parents have had an unhappy, disruptive and insecure childhood
- One or both parents are addicted to drugs, alcohol, or are psychotic
- There is a record of violence between the parents
- Another child has already been abused, or suffered an unexplained death
- The pregnancy was unwanted; the baby was rejected at birth or soon after
- Problems of early bonding
- Both parents are under 20 years of age. Immature for their years and socially isolated
- The family lives in poor housing and on a low income
- The family is suffering from multiple deprivation
18.2 The Dental Service and *Best Health For Children*

**Dr. Pádraig Creedon**, Principal Dental Surgeon, on behalf of the Principal Dental Surgeons, SEHB.

The Health Board child dental screening programme is largely determined by dental developmental factors and by the epidemiology of dental disease. This programme will be evaluated as part of a comprehensive programme of evaluation of the Health Board Dental Services. There, the core dental screening programme was quite rightly excluded from *Best Health for Children*, as it would have been inappropriate to suggest any alterations to this programme pending the results of ongoing evaluation. However, while the core Health Board Dental screening programme is essentially determined by dental factors, the *Best Health for Children* framework nevertheless provides opportunities for a significant degree of co-operation between dental and other services in a number of specific areas.

1. **Early Intervention.**

*Best Health for Children* provides for the establishment of a multidisciplinary Community Child Health Team in each Community Care Area, which would act as "the main clearing house for children identified as having problems by the screening and surveillance programme whether this be via a formal developmental check or opportunistically by General Practitioners". Many of those children identified as having problems would benefit from early intervention by the dental services. Therefore, it will be essential that the dental services have a formal link with the Community Child Health Team, perhaps with the Senior Dental Surgeon (paediatric) as a member of that team.

2. **Oral Health-Promotion.**

The prevention of dental disease is one of the core aims of the Public Dental Service. A significant number of children have already developed dental caries by age 5 years. Therefore, Oral Health Promotion initiatives and preventive programmes should commence at as early an age as possible.

*Best Health for Children* provides for a before birth visit by the Public Health Nurse to all new parents. This visit represents an ideal opportunity for the provision of preventive advice by the PHN at a stage when the dental services would not usually have ready access to these parents. The Parent-Held Child Health record, which will be given to parents at this visit, should contain information on oral health, on the normal developmental stages that children pass through, and on available dental services.

The proposed core Child Health Surveillance Programme provides for contacts with the PHN/Doctor within 48 hours of discharge, at 6 – 8 weeks, 3 months 18 – 24 months and at 3.25 – 3.3 years. All these contacts provide additional opportunities for the provision of further preventive dental advice and for the re-enforcement of advice already given, again at stages when the dental services might not necessarily have easy access to these children.
It will, of course, be necessary to ensure that appropriate training on *Oral Health* issues is provided to all the health professionals involved in child health surveillance. (Report on training issues in relation to *Oral Health* already submitted.)

It is also important to ensure that the dental services have an input into the future development of the Social and Personal Health Education Programme for schools.

3. Information Technology.

The proposed computerised Child Health System and any future Health Board Dental Services computer systems should be compatible, allowing for record linkages. This would be advantageous from both Child Health and Child Protection perspectives.
18.3 The Medical Profession and *Best Health For Children*

**Dr. Antoinette Rogers,** Senior Area Medical Officer,
on behalf of Senior and Area Medical Officers, SEHB.

The Area Medical Officer

*Best Health for Children* signals a change in the role of Area Medical Officers who wish to be involved in the delivery of community child health services.

The report acknowledges that, in recent years, the traditional role of the Area Medical Officer has been evolving rapidly. From delivering a wide range of services in a specified geographical area many AMOs have now developed expertise in specified functional areas such as infectious diseases, child health, disability, the elderly, child protection.

The authors foresee the role of the AMO continuing to evolve and that, in time, the delivery of child health services in each community care area would be carried out by a number of dedicated AMOs with specific expertise, and ideally holding an MSc. in Community Child Health. They expect that these doctors would be well placed to work in partnership with Paediatricians, perhaps running joint child health clinics in the community.

Current Practice in the South Eastern Health Board Region

In recent years, an increasing workload and difficulty in recruitment has forced AMOs to prioritise their duties. Infectious disease control, (contact tracing, TB clinics and data collection) is given precedence, accounting for approximately one third of their workload. Disease prevention, (an expanding vaccination programme, the issuing of appropriate prophylaxis and health promotion) accounts for a further 30%. This has put considerable pressure on the delivery of the more clinical aspects of AMO work (child health surveillance).

In some community care areas the 9-month developmental examination is frequently delayed until the second year of life. In all community care areas, the AMO role in the School Health Service has been contracting until it is now similar to the consultative and secondary referral role recommended by *Best Health for Children*. Except in Tipperary SR, where the post is vacant, an AMO continues to play an active role in the Early Intervention Service for children with special needs.

Where clinical services have been curtailed, priority is always weighted in favour of the 'at risk' or disadvantaged child and family with the AMO continuing to play a major part in advocacy and facilitation, especially in relation to children with special needs and children in marginalized groups.
The General Practitioner

*Best Health for Children* acknowledges the pivotal role played by the GP in overseeing the health of children and in delivering child health services in the community.

The report specifies the GP's role in relation to the core examination at 6-8 weeks and the health promotion opportunities afforded under the Maternity and Infant Care Scheme.

The report states that, in certain circumstances, the Child Health Co-ordinator may contract with appropriately trained GPs to carry out the health examination at 7-9 months and in school children.

The Community Paediatrician

*Best Health for Children* outlines the advantages of the Community Paediatrician. The advancement of these posts is the preserve of the College of Paediatricians.
18.4 Public Health Nursing and Best Health For Children

Ms. Rosa Gardiner, Director of Public Health Nursing, on behalf of the Directors and Acting Directors of Public Health Nursing, SEHB.

Public Health Nurses (PHNs) operate as key players within a multidisciplinary team to deliver care in the community (McCarthy, 1997). They are the largest and one of the longest established groups of professionals working in the community care programme. (National Economic and Social Council, 1987).

Professional/Client Ratio – Recommended and Actual Ratio

A PHN/population ratio of 1:2616 was recommended in the Department of Health Report, 1975. This ratio has never been reached in the intervening 26 years. For example, the actual ratio in Tipperary SR Community Care Area (CCA) can be calculated from the 1996 Census Report, which gives an overall population figure of 80,612 for this area. This population is serviced by 24 area PHNs, giving an actual PHN/population ratio of 1:3358.

A recent Demographic Study of this area (Ryan, B, 2000) indicates that children under the age of 15 years make up 24.68% of this population. From this figure we can calculate that each area is responsible for 829 children, that is 183 (or 28%) more than would be the case if the recommended ratio of 1:2616 was in place.

As regards client needs, all that is possible to conclude at this stage is that each of these 800+ children has general health needs and possibly other complex needs that are required to be met by each PHN. To attempt to identify more specific needs in a brief summary such as this is practically impossible given the diversity of needs and the diversity of the client base and social circumstances from one area to another. Another complicating factor in this exercise is the way in which PHN areas are assigned—sometimes on a geographic basis, other times, on the basis of District Electoral Divisions (DEDs). If all PHN areas were aligned to DEDs, client dependency ratios and client needs for all client groups could be determined more easily and resources allocated appropriately.

School Nurses as a Specialist Group

In the UK, While and Barriball, (1993) conducted a review of the literature pertaining to school nursing. The review revealed that school nurses have the potential to make major contributions to the health of school children. The Best Health for Children Report (1999), the SEHB Audiology Report (2000) and the SEHB Ophthalmic Service Review (1997) identified the need for specialist school nurses.
The Directors of Public Health Nursing in the SEHB would agree with all of the above findings. They would also recognise that the delivery of a comprehensive school health service requires the attention of full time dedicated school nurses. However, this service would need ongoing monitoring and evaluation. In conclusion, specialist PHNs as school nurses would enhance the service by:

- having a clearly defined role
- becoming experts in screening for vision and hearing defects, therefore providing quality service
- offering quality health promotion programmes in schools
- having clearly defined feedback and referral pathways
- participating in ongoing education and updating of programmes
- service could be audited more easily
- schools and parents could identify with the designated professional

The concepts of comprehensive specialised care and generalism continue to be fraught with considerable ambiguity in the community nursing literature. In Ireland and Finland, the work of PHNs covers both curative care and primary prevention with different age and client groups. In Ireland, most PHNs work as generalists but because they are educated to Higher Diploma level at university they are termed Specialists within the broad arena of community nursing in general. In the UK, health visitors work with families and children predominantly in preventive care. In the Netherlands, community nurses work as generalists but mother and child care is undertaken in Health Centres, and care of the elderly is done in the home. Up to 1997, PHNs in Ontario, Canada, worked as specialists but since 1997 they work as generalists in defined geographic areas with a nurse/client population ratio of approximately 1:3300. In Finland in 1992, three different models of Public Health Nursing Service were trialled – the Comprehensive model, the Semi-comprehensive model and the Specialist model. Evaluation of the three models showed PHNs within the comprehensive model had more positive experiences. This model included maternity and child health, school health, open health clinics as well as nursing responsibilities.

One can see from the above the ambiguity that surrounds the delivery of community nursing services – specialist v generalists. The specialist model would appear to have advantages in large urban environments but would seem unsuited to a dispersed rural population such as Tipperary SR and the other Community Care Areas (CCAs) within the SEHB.

The Disadvantages of the Specialist Model

- Increased bureaucracy
- Increased cost
- Deskilling of PHNs
- Splintering of services
- Confusion of responsibilities
- Confusion of clients

Available funds could be used to better advantage in achieving the recommended PHN ratios.
In Summary

- All PHN areas should be aligned to DEDs
- Each area should, as far as possible, have a PHN/client population ratio 1:2616
- Dependency ratios within each DED should be examined, and where appropriate, extra Registered General Nurses (RGNs) employed to cover the clinical nursing workload and allow the PHN to devote extra time to supporting vulnerable families
- Specialist PHNs as School Nurses would enhance the school health service
- Specialist Community Child Health Nurses would not enhance the child health service for all the reasons outlined above

The *Best Health for Children* report refers to PHNs, school nurses, the nurse and the Community Child Health Nurse at various stages throughout the document. These differing titles could confuse a non-medical/nursing individual, because in truth, they all apply to the Public Health Nurse. The role of the PHN according to Hanafin (1997a) encompasses three major functions, that of clinician, manager and health promoter. PHNs work with individuals, families and communities assessing needs on an ongoing basis. PHNs identify and prioritise individual and community needs and respond accordingly in an holistic manner working in partnership with all clients. PHNs are concerned with maternity and child health, child development, safety and protection issues and with holistic care of older people and their carers in the community. PHNs co-ordinate, communicate, co-operate and interact with voluntary and other statutory disciplines in an equitable, holistic, accessible and quality service with the objectives of health gain. In the area of disease prevention and health promotion, PHNs empower people to take control of their own health and well-being.

On scanning the report, PHNs are identified as the professionals to deliver:
- antenatal care in the community;
- undertake developmental screening
- undertake the core child health surveillance programme
- advise parents on the range of community-based options that would support them in their parenting
- support parents of children with special needs
- provide health promotion information and programmes for children and parents
- be a member of the community child health team
- PHN input into the Child Health Service would be coordinated and monitored by PHN management
- PHN service is available free of charge to all children. It is an accessible and equitable service
The school nurse would also be a PHN who would receive special training in screening methods for vision, hearing and growth. Specific health promotion programmes would be developed in conjunction with the Child Health Co-ordinator and the Child Health Team. The school nurse and other health professionals would deliver these programmes.

At present limited school screening is carried out by area PHNs. The all-important health promotion work with children initially loses out on priority due to clinical nursing workload (Hanafin, 1997a).

The UK recommendations for school nurse/school child ratio is 1:1500 to 1:2500 which, when applied to a CCA such as Tipperary SR with a primary school-going population of 12000, would require approximately six extra PHNs.

The Community Child Health Nurse could, according to Best Health for Children, be a PHN. They have the educational qualifications required. As already stated, there would not be a need for Community Child Health Nurses if PHN areas were at the Department of Health (1975) recommended ratio. The additional support these nurses would provide to vulnerable families, or those with special needs could be provided by the PHN, the family support worker and the community mother.

The nurse in the report refers to the PHN involved with the doctor/GP doing developmental examinations.
18.5 The Occupational Therapy Service and *Best Health For Children*

**Ms. Liz Hogan**, Senior Occupational Therapist, on behalf of the Occupational Therapists, SEHB.

The document *Best Health for Children* does not comment in any detail on children with disabilities. It briefly mentions:

- Cerebral Palsy (A new service model)
- Database
  - National Intellectual Disability Database
  - None on Physical & Sensory Disability

In relation to occupational therapy services the areas of input would be:

- Physical & Sensory Disabilities
- Intellectual Difficulties
- Behavioural Disorders and Psychiatric illness
- General and specific medical conditions

The Paediatric Occupational Therapy Process

The role of an Occupational Therapist is to maximise the child's level of independence within their own environment. The Occupational Therapy process is a complex system that must be ordered in terms of achieving improved functional and behavioural goals if the therapist is to achieve beneficial outcomes for paediatric patients and their families.

On evaluation, data is collected on the child's

- Physical
- Neurodevelopmental
- Motor performance
- Sensory integration
- Adaptive behaviour

Assessment enables the therapist to pinpoint levels of gross and fine motor skills, reflex maturation and sensory integration in daily living skills as a basis for planning the Occupational Therapy program. The Occupational Therapy plan should have stated goals. These are usually broken down into different stages/levels and should be reassessed at regular intervals until the time of discharge from the program.
The Role of the Occupational Therapist in Screening

As members of teams, Occupational Therapists contribute to the data collection process. A therapist would administer screening instruments along with other team members. The team would identify those who have or are at risk of developmental delay. The focus of screening in Occupational Therapy is to identify children who may present with problems in occupational performance (e.g., play). Screening is performed to determine if there is a cause for concern. The next appropriate course is evaluation and then treatment if indicated. Therapists who provide screening services should have specialized training to meet the complex demands of early identification and intervention (Hanfy, 1989). Specifically, the therapist must be able to recognize subtle signs of a sensorimotor/perceptual problem.

At present within most, if not all, health boards areas the Occupational Therapist is not involved in the screening process that is the practice in other countries. This is probably due to a scarcity of staff in all areas.

The Occupational Therapy services to children in most areas are scarce or non-existent due to the very small numbers nationally.
18.6 Ophthalmology and *Best Health For Children*

**Dr. Maureen P. Hillery**, Community Ophthalmic Physician.

Certain concerns must be addressed in the Core Child Health Surveillance Programme recommended in the Best Health for school-aged children, regarding ophthalmology (vision) issues.

1. **Initial Screening – Senior Infants (age 5 – 6 years)**

- **Age** Early detection of vision problems greatly benefits ultimate outcome and good results. The assumption that all Senior Infants range in age from 5 to 6 years may not be correct in all cases. If the ideal earlier Junior Infant group (presumed age 4 – 5 years) is not to be targeted for vision screening, then no child older than his/her 6th birthday should be targeted and must be screened between the 5th and 6th birthdays. The age of the child should determine the group targeted rather than school class.

- **Screening Methods** Assessment of stereo acuity/fusion has to be included in the screening protocol. This is a serious omission in the document.

2. **Intermediate Screening – Second Class (age 7 – 8 years)**

Vision screening of this age group seems a waste of resources and does not fulfil the criteria for effective screening because:

- Defects of ocular motility, anisometropia and amblyopia detected in this age group are often impossible to correct or result in very poor visual improvement with therapy. The appropriate initial screening in Junior Infants should identify these defects.

- Defects in refraction such as myopia (short-sightedness) only occasionally present in 7 – 8 year olds and are best left untreated initially as the visual outcome is better long-term if early defects are not treated.

These children do not suffer any long-term problems if left undetected.
A route of referral exists for individuals who have significant problems in this age group. Parents and teachers concerns can be expressed to the PHN and arrangements made for individual vision screening.

The re-introduction of the specialised School Nurse is welcomed as the experience and clinical expertise of the trained specialised School Nurse increase the yield of positive referrals. There is a corresponding drop in false positive referrals.

The Irish College of Ophthalmologists has arranged to meet with the 'Best Health for Children' Co-ordinator and hopefully this will clarify the appropriate vision screening for school-age children in the core Child Health Surveillance Programme.

Footnote

The Community Ophthalmic Service is the only service in the region that has written and agreed screening procedures, referral criteria and referral pathways for children.

Recommendation

Consideration should be given to providing specialist vision screening for children in special education.

Dr. Trudy Fitzgerald
18.7 Psychology Services and *Best Health For Children*

**Ms. Maeve Martin**, Senior Clinical Psychologist, on behalf of Psychology Services, Community Care, SEHB.

Psychology departments in the South Eastern Health Board warmly welcomed the report *Best Health for Children*, seeing it as a welcome breath of fresh air to the whole area of children's health.

Psychology departments in all Community Care Areas in the South Eastern Health Board have historically always played a large part in partnership with parents and other services in Community Care, in the development of children's psychological and emotional health by providing a wide range of assessment and therapeutic services. Therapeutic services are individual, group and family based and include the following range of services:

**Pre-school (0-5 years) with:**
- Attachment difficulties
- Behavioural difficulties
- Encopresis/eneuresis
- Abuse (emotional/physical/sexual)
- Phobias

**Children/Adolescents (5-18 years) with:**
- Behavioural difficulties
- Phobias – anxiety disorder
- Bereavement/Separation therapy
- Assessment and therapy service to schools for children with mild learning disability
- Service to children with physical and sensory disabilities
- Consultation services to centre for adults with challenging behaviour
- Contribution to antenatal classes (Tipperary SR only)
- Parent training courses on a regular basis
- Training programmes on child development and management of common childhood problems for community mothers, pre-school services, home support workers and foster carers
- Homework club for children who have learning problems or difficulties working at home.

However, in recent years, due to reorganisation of Psychological Services at regional and national level, following the establishment of the National Educational Psychology Service, there has been some confusion around the referral pathways to psychology services. We see the development of Child Health Teams at local level as a way of addressing this providing a seamless service for children's mental and physical health. In the interim period, while we await the establishment of such teams, one Community Care Psychology Service (Tipperary SR) has published an information leaflet on appropriate referral pathways to Psychology Services, which is available on request.
Training

Finally, the proposed National Training Programme for *Best Health for Children* mentions some specific areas where training is needed and where Psychology could have a direct input. These include:

- Antenatal classes (already in progress in Tipperary SR)
- Indicators for identifying postnatal depression and attachment difficulties
- Cognitive developmental delay
- Behaviour problems
- Learning difficulties/dyslexia
18.8 Speech And Language Therapy and *Best Health For Children*

**Ms. Eleanor White,** Principal Speech and Language Therapist, on behalf of the Principal Speech and Language Therapists, SEHB.

We have read and discussed the *Best Health for Children* report and are obviously very pleased to see the development of the child health area, in particular we welcome the proposed improvements in the child health surveillance programme.

We would like to make specific comments in relation to training and core surveillance guidelines.

**Training**

The success of this programme will depend on the early detection and referral to the appropriate service, therefore we would expect that nurses/GPs, whatever discipline is involved in screening, should have an appropriate and updated level of training e.g. it is not sufficient to know that a child should be talking at 2 years; they also need to know what structures i.e. noun/verb etc. the child should be using. A similar situation should apply at screening for Senior Infants, at 2nd class and 6th class.

We note from the report concern about behaviour problems. Very often children with language and associated reading difficulties present with behaviour difficulties arising from their inability to cope with the classroom situation and so early detection and appropriate referral of language problems, in particular, is necessary.

As it is essential for Speech and Language Therapists to be involved in devising the training programme in relation to speech and language development we would certainly be willing to facilitate this in any way we can.

**Core Health Surveillance Programme**

The structured approach to the content and timing of the child health surveillance is extremely welcome.

We would like, however, to ask that the following be included at various levels.

**Within 48 hours**

Many children have difficulties with feeding particularly those who cannot maintain intra-oral pressure or who regurgitate. This area needs to be addressed at a training level and these children, if the difficulties persist, need further investigation by a speech and language therapist.

**6 to 8 weeks**

Feeding difficulties still existing at this stage should be urgently referred, as in some cases may often be evidence of submucous cleft. Specific questioning regarding feeding needs to be included as part of the content aspect of the examination.
7 to 9 months
The vocalisation the child is using, the intonation patterns, the eye contact all need to be included as part of the parental discussion.

18 – 24 months
The trained surveillance nurse should use a standardised speech and language screening assessment, (a copy of a current standardised checklist is included). This assessment can also be used at the 3 and 3\textsuperscript{rd} year visit.

5 and 6 year screening
A specific screening assessment, not only of a child’s speech but also of his language structure should be administered. An informal observation of his communication abilities should be discussed with both parents and teachers.

Some children can have excellent speech and language skills but have extreme communication difficulties.

Perceptual difficulties, either auditory or visual, if detected at this stage can play a large part in preventing reading and spelling difficulties later.

The above comment is also essential at the 7, 8, 11 and 12 year screening as the earlier a child’s difficulty is detected the better the prognosis. We would also say that if a parent expresses concern or is worried, the child should be referred for a professional speech and language therapy opinion. In our experience, less than one percent of referrals in the South Eastern Health Board area are not necessary.
Best Practice guidelines for monitoring Speech and Language development

**Pre-school Children**

**48 hours**
- Note any sucking difficulties and, if present, refer to the speech and language therapist for a paediatric feeding assessment

**6-8 weeks**
- Method of feeding:
  - is there nasal regurgitation?
  - are there sucking difficulties?

**7-9 months**
- Ask if the child is vocalising
  - is there a rhythm or pattern?
- Does the child look at the person who is "talking" to them?

**18-24 months**
- Assess comprehension and use of language using The Yellow Book* (page 4) as a screening guide

**3.25-3.5 years**
- Ask about language acquisition - comprehension and expression (refer to The Yellow Book, pages 6, 7 and 8)
- Observe child’s fluency patterns

**School Children**

**5-6 years**
- Check speech and language development (The Yellow Book, page 9)
- Check child’s functional use of language in a variety of situations
- Note any difficulties with listening, attention, co-ordination, copying letters, reading and word retrieval
- Note any difficulties and naming
- Note hoarseness and fluency patterns

**7-8 years**
- Note any spelling difficulties or difficulties with sentence construction (both verbal and written)
- Note behaviour difficulties
- Ability to play group games and mix with peers
- No phonological errors should exist at this stage

**11-12 years**
- As above to specifically include fluency and voice problems

*Pre-school Speech and Language Referrals—what to look for and when to refer: North Tyneside Department of Speech and Language Therapy.*
18.9 Family Support and Home Visiting Service

Dr. Julie Heslin, Specialist in Public Health Medicine
Ms. Marie Kennedy, Child Care Manager

There is good evidence that universally available family support and home visiting services can:

- Improve the health, development and well-being of children, adolescents and adults (Hertzman, Wiens, 1996)
- Reduce the incidence of child abuse (Olds et al, 1997)
- Improve immunisation rates (Johnson et al, 1993)
- Reduce accident rates in children (Kitzman et al, 1997)
- Reduce juvenile crime (Olds et al, 1997)
- Improve a child's school readiness, especially when accompanied with pre-school educational opportunities, which in turn improves subsequent educational levels and economic potential (Berrueta-Clements, 1998)

Reviews of strategies which have proven to be effective at improving the health of large numbers of children reveal that they
- target populations rather than individuals
- have a high of community involvement
- are broadly intersectoral and
- have a settings approach to the delivery of services. (Roberts et al, 1996; Shean et al, 1994)

Services available to all populations (i.e. universally available services) are more acceptable to all strands of society.

Investment in early intervention services for children, their families and their communities is an investment for the health and economic development in the next generation.
Following the New South Wales, Australia approach, it is possible to look at family support services at three levels:

(a) core services
(b) low level support services
(c) specialised services

(a) core services would include good quality accessible information for parents or carers; good quality accessible and appropriate training in parenting; and core screening and support services.

(b) a low level support service could include services such as a community mothers programme; First Steps; parent and toddler groups; peer support groups. Parents and carers could be facilitated to access these services which they need to support themselves and their child

(c) some children and their parents would need access to more specialised services. These could include services for children with special needs; traveller support workers; bereavement/separation and counselling for children; young mother groups.

Recommendation

18.9.1 It is recommended that a strategy for developing family support, home visiting and parent training services in the South East be developed at a regional level.
18.10 Process and Outcome Indicators

Dr. Julie Heslin, Specialist in Public Health Medicine
Ms. Marie Kennedy, Child Care Manager

There are currently a number of national and international initiatives ongoing in relation to the development of performance and outcome indicators for child health and well-being.

The key players in this are:

- The National Children’s Office
- Best Health for Children Office;
- The National Anti-poverty Strategy Group in association with the Institution of Public Health
- Economic and Social Research Institute
- Child Health Demonstration Project for the Western Health Board;
- CHILD Project in the EU

It is vital that both performance indicators and outcomes indicators are developed at national and international levels as soon as possible in order:

- to identify a child health and well-being baseline
- to identify population trends
- to identify key child health priority targets
- to measure movement towards targets

Recommendation

18.10.1 It is recommended that the South Eastern Health Board keep abreast of developments in order to rapidly modify data collection systems to facilitate the collection and analysis of these indicators. It is also recommended that the Child Health Co-ordinators should collect and analyse relevant data on a regular basis.
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