Dudley NHS Primary Care Trust

The Dudley Group of Hospitals NHS NHS Trust

# Antenatal, Neonatal and Child Health Surveillance Policy

**May 2007**

**(The policy includes Dudley Group of Hospitals Midwifery Service Guidelines – Appendix 1 – and are outside of the PCT's remit**

# Antenatal, Neo-natal and Child Health Surveillance Policy

### Members of the Child Health Surveillance Programme Group

Director of Public Health, Dudley PCT
Consultant Paediatrician. Dudley Group of Hospitals
Consultant Obstetrician and Gynaecologist, Dudley Group of Hospital
2 General Practitioners
4 Clinical Specialist Community Public Health Nurses
Clinical School Health Advisor
Locality General Manager
Screening Midwife, Dudley Group of Hospitals
PCT Commissioning Representative
Specialist Health Visitor, Child and Adolescent Mental Health Service
Paediatric Physiotherapy Manager
General Services Manager – Child Health
General Manager – Children's Services
Specialist Children's Services Representative

### Target Audience
This policy is targeted at all healthcare professionals employed by the Dudley Group of Hospitals Trust and Dudley Primary Care Trust working with antenatal mothers, and children from birth to 18years.

### Approval and ratification
Following approval and ratification by the Core Polices, Guidelines and Protocols Committee, the policy will be circulated to all relevant staff.

### Measure of implementation and effectiveness
Clinical audit will take place as detailed by each service involved in providing care.

### Risk
The risk of not implementing this policy could lead to a lack of standardisation of core provision by Dudley Group of Hospitals Trust and Dudley Primary Care Trust.

### Introduction
The antenatal, neo-natal and child health surveillance programme incorporates measures for preventive health care and health promotion to meet the needs of mothers, children and young people. It consists of a series of researched based interventions and screening tests, offered to all pregnant women and children, which facilitate early identification of possible problems in order to improve health outcomes.

Some of these screening tests and interventions, the Core Universal Programme, are offered to all antenatal women and children irrespective of assessed risk of health needs, others are applied only on the basis of risk assessment or the clinical judgement of the relevant health professional.

This policy details the Core Universal Programme, which will be offered to all pregnant women and children in Dudley. It incorporates national guidance from the UK National Screening Committee, Health for all Children Fourth Report and the NSF's for Children, Young People and Maternity Services.

The policy provides a consistent, cost effective and co-ordinated approach to maternal and child health, across both the Dudley Group of Hospitals NHS Trust and Dudley Primary Care Trust.

**The Core Universal Programme**

| **Test/Intervention** | **Age** | **Undertaken by** | **Appendices** |
|---|---|---|---|
| Antenatal | Antenatal period | Midwifery team | Appendix 1 |
| Antenatal contact | Antenatal period | SCPHN | Appendix 2, 3 & 4 |
| Newborn examination | Within 48 Hours | SHO, Trained Midwife or Advanced Neo-natal Nurse Practitioner | Appendix 1 |
| Neonatal Blood Spot Screening | 5 days | Midwife | Appendix 1 and Neo-natal Blood Spot Screening Policy |
| Postnatal | Up to 28 days | Midwifery team | Appendix 1 |
| Neonatal hearing screening | 10 - 21 days | SCBU or SCPHN | Appendix 2 and Appendix 8 |
| Primary Visit | 10 – 14 days | SCPHN | Appendix 2, 3 & 4 |
| Review | 6 – 8 weeks | GP or Community Medical Officer (CMO) | Appendix 5 |
| Immunisation | 2, 3 and 4 months | GP, Practice Nurse, CMO or SCPHNs | Vaccination and immunisation policy |
| SCPHN contact | 7 – 9 months | SCPHN team | Appendix 2, 3 & 4 |
| Immunisation | 12 months | GP, Practice Nurse, CMO or SCPHNs | Vaccination and immunisation policy |
| Immunisation | 13 months | GP, Practice Nurse, CMO or SCPHNs | Vaccination and immunisation policy |
| SCPHN contact | 18 – 24 months | SCPHN team | Appendix 2, 3 & 4 |
| Immunisation | 3 – 5 years | GP, Practice Nurse, CMO or SCPHNs | Vaccination and immunisation policy |
| Vision screening | 4 ½ years | Orthoptist | Appendix 6 |

| Test/Intervention | Age | Undertaken by | Appendices |
|---|---|---|---|
| New parent meetings | Prior to school entry | School Health Advisor | |
| SCPHN hand over to SHA | Prior to school entry | SCPHN | Appendix 2, 3 & 4 |
| Health questionnaire to all parents | 4 -5 years | School Health Advisor | Appendix 7 |
| Measurement of height and weight | 4 -5 years | School Health Advisor | Appendix 7 |
| Hearing test | 4-5 years | School Health Advisor | Appendix 7 |
| Measurement of height, weight | 10 – 11 years | School Health Advisor | |
| Health questionnaire | 10 – 11 years | School Health Advisor | |
| Immunisation | 12 – 13 years | School Health Advisor | Vaccination and immunisation policy |

**CONTENTS**

**APPENDIX 1**

# THE DUDLEY GROUP OF HOSPITALS NHS TRUST

# WOMEN AND CHILDREN'S SERVICE

# GUIDELINES FOR PLANNED AND UNPLANNED CONFINEMENT IN THE COMMUNITY

## 1. INTRODUCTION

Home confinement is a service offered by Dudley Community Midwifery, to all women who reside within the borough.

## 2. REFERRALS

Referrals can be made to the midwife from the following:

- The woman herself either prior to being referred for booking, during booking or at any other stage of pregnancy
- The woman's own GP
- Another midwife, usually outside the borough

## 3. MIDWIFE'S ROLE FOR BOOKING A WOMAN FOR HOME CONFINEMENT

On receiving a request for home confinement, the midwife should:

- Undertake a clinical risk assessment (as booking risk assessment/referral form) to confirm physical, psychological and social suitability for home confinement
- Consider ideal criteria:
  - Parity between Para 1 and Para 3
  - No past medical history of significance
  - No past obstetric history of significance
  - No previous midcavity forceps/ventouse
  - No previous caesarean section
  - No previous retained placenta/primary post partum haemorrhage
- Complete booking procedure and ensure the woman is registered on the hospital maternity information system (in case of admission at any time during pregnancy, labour or postnatally)
- Ensure all necessary blood serology and other antenatal investigation are actioned as appropriate, using recognised procedures and counselling as required
- Good communication, between the midwife and GP, should be maintained throughout the period of care
- The Midwife should discuss with women who have previously experienced a precipitate labour the possibility of a home confinement.

## 4. MIDWIFE'S ROLE IF WOMAN IS FOUND UNSUITABLE FOR HOME CONFINEMENT

If, following initial risk assessment or any time during the antenatal period, the midwife feels a woman is unsuitable for home confinement, the midwife should:

- Discuss the risk factors with the woman (and partner) offering possible alternative options, eg early transfer home following hospital delivery
- Seek professional advice and assistance from the Senior Midwife Manager and the Supervisor of Midwives
- Communicate with woman's GP or in the absence of GP care being available, the midwife may make referral to a hospital consultant at Wordsley Maternity Unit

However, if despite advice the woman wishes to continue with her planned home confinement, the midwife must provide appropriate antenatal, intrapartum and postnatal care in so far as she is able to do so as a midwife. The midwife is not expected to be an obstetrician nor a GP and as long as the following procedure is followed the Trust will support the midwife who should – inform the patient that she has formed an opinion based upon her professional expertise and will have to:

- Record all advice and action taken in the woman's hand held notes and hospital held care plan
- Inform the Senior Midwife Manager and discuss case with Supervisor of Midwives. Develop action plan as necessary
- Ensure notification is given to all community midwives who may be involved in the care
- Alert Clinical Director, Neonatal Unit Paediatricians and contact delivery suite if unsuitable home confinement continues
- Consider involving Social Services if the decision to continue with home confinement is considered dangerous to the foetus
- Inform the Obstetric unit shift leader of onset of labour

## 5. ANTENATAL CARE FOR WOMEN BOOKED FOR HOME CONFINEMENT

Antenatal care may be undertaken in the woman's own home or at her GP's surgery as appropriate, giving evidence based antenatal care. This will include routine blood serology and other investigations as required.

The following represents the routine antenatal plan of care, which should be given by the midwife to a woman booked for home confinement:

- An initial booking visit undertaken in the woman's home
- The midwife should make at least another one home visit within the last month of pregnancy. Other antenatal consultations may be conducted either in the woman's home or GP surgery
- The midwife will ensure emergency contact numbers are available to the woman
- Any deviation from norm must be referred to the GP or directly referred to an obstetric consultant

## 6. HOME DELIVERY REQUIREMENTS

The midwife should instruct any woman booked for home confinement that the following requirements would be beneficial during labour and delivery. Ideally, from 36 weeks of pregnancy.

THE ROOM

Adequate space with easy access
Appropriate heating
The use of a good light
Availability of hot and cold water, soap and a towel
Appropriate protection for chosen delivery area
Container and appropriate bag for rubbish
Suitable working area

PERSONAL ITEMS

Maternity pads
Hot water bottle (not to be used in direct contact with mother or baby)
Suitable bed, clothing, toiletries for baby
Large towel for baby

## 7. MIDWIFE'S REQUIREMENTS WHEN ATTENDING HOME BIRTH

Any community midwife who, when on duty is available to be called to a home confinement, must ensure she carries or has immediate access to the following:

**Delivery box containing**

Sterile delivery pack
Gauze swabs
Disposable gloves
Disposable apron
Suture material/suture pack
Kleihauer equipment
Clinical waste bag (Yellow)
Inco pads
Catheter Fg12
Syringe with needle

- Entonox
- Resuscitation equipment with $O_2$ supply
- Sonicaid
- Appropriate documentation
- Sharps container
- Sphygomomano meter
- Stethoscope

## 8. DRUGS

Following discussion and choices for analgesia during labour, the woman's GP should be requested to prescribe any analgesia required as necessary. If there is no GP support or the GP refuses to prescribe drugs, the midwife may obtain the community midwifery drug pack available on the Obstetric unit, this pack contains:

- Pethidine 100 mg

Other drugs which should be carried by the midwife are:

- Syntometrine 1 ml
- Ergometrine 500 mcg/ml
- Zylocaine 1 in 2000,000 10 mls
- Konakion 1 mg

## DISPOSAL OF UNUSED PETHIDINE

Any woman having been prescribed Pethidine injection by a GP should be instructed to destroy the used injection following delivery. This should be done as soon as possible following delivery in the presence of and witnessed by the midwife; this should be documented in the woman's care plan. Safe disposal of any sharps can then be ensured. The woman may herself return the Pethidine to the dispensing Chemist. Alternatively, if the woman requests the midwife to remove the Pethidine, the midwife should return the Pethidine to a Supervisor of Midwives and request she witnesses the destruction.

## 9. RESPONSE BY THE MIDWIFE WHEN CALLED TO A POTENTIAL HOME CONFINEMENT

- If labour commences prior to 37 weeks gestation, then the woman should be transferred to the consultant unit by ambulance, accompanied by the midwife. The GP should be informed as appropriate
- If labour and delivery continue in the home, the midwife in attendance should undertake appropriate care and observation
- The constant attendance of the midwife during early labour is not always necessary and should be discussed with the woman and undertaken according to professional clinical assessment
- A second midwife should be called towards the end of the 1$^{st}$ stage of labour or before if deemed necessary by the midwife in attendance
- The woman's GP should be informed as necessary during labour and following delivery or as previously agreed
- If any deviation from normal or emergency situation occurs, arrangements should be made to transfer the woman into the consultant unit. This should be undertaken via an ambulance with a midwife in attendance

## 10. MIDWIFE ACTION FOLLOWING DELIVERY

- Immediate routine observation of mother and baby are undertaken, including perineal repair as necessary
- All relevant documentation should be completed. Postnatal care plans and a clean apron should be left in the home
- The midwife should ensure she is satisfied with the condition of mother and baby before leaving the home. A 24 hour emergency contact phone number should be given
- The midwife should ensure placenta and membranes are transported to delivery suite in the appropriate clinical wastage bag. Equipment should be returned and replaced as necessary
- Delivery details should be entered on Central Delivery Suite computer maternity information system and birth notification sent to child health department.
- Community register should be completed as soon as possible
- The woman's GP should be informed and paediatric check requested to be undertaken within 24 hours
- If oral Vitamin K is requested by the woman, the GP should be requested to prescribe

## 11. WATERBIRTH AT HOME

Following request for waterbirth at home, the midwife should:

- Undertake the usual arrangements for home confinement
- Advise the woman on specific issues regarding water birth at home
- Give the woman 'Woman's responsibilities for Water Birth at Home' information sheet (Appendix 1)
- During labour the agreed guideline for undertaking a home confinement should be adhered to by the midwife and also taking note of the additional requirements when conducting a waterbirth. See 'Midwife's action when conducting a Waterbirth' (Appendix 2)

## 12. MIDWIFE ACTION WHEN ATTENDING UNPLANNED BIRTH AT HOME (BBA)

When a midwife receives an urgent call, she should respond immediately. She should note the time of the call, name and address of patient and reason for urgency, eg BBA, PPH.

A midwife on duty should always carry a home delivery pack.

If the midwife needs medical aid and the patient's doctor is not available, she can try any doctor on the obstetric list in the area or the consultant obstetric unit. A paramedic from the ambulance service may be requested as necessary.

The following telephone numbers should be in the midwife's diary: -

| | |
|---|---|
| Consultant obstetric unit | 01384 244357 |
| Russells Hall switchboard | 01384 456111 |
| Ambulance control | 01384 215502 |

When the crisis is over, inform the Matron – Antenatal Clinic/Community Midwifery Service or Matron/Bleep Holder or Director of Midwifery Services of the emergency and provide an incident form of the case to the Community Midwife Co-ordinator

Assuming that an accurate and legible report of the circumstances is made, and that the midwife acts in a manner consistent with her professional responsibilities, the Trust will support the midwife's actions.

The additional appropriate documentation should be undertaken for a BBA delivery.

## 13. MIDWIVES ACTION WHEN CALLED TO LATE MISCARRIAGE AT HOME

A midwife who responds to and attends a woman who is delivering at home before 24 weeks of pregnancy should:

- Give immediate care to the woman
- Notify GP
- Arrange the woman's admission to hospital as required
- Arrange transport of products of conception to hospital
- In the event of a live birth, the appropriate care should be given to the baby and immediate transfer to hospital arranged
- Inform the Matron/Supervisor of Midwives and any other community midwives who may be involved in the woman's care
- Cancel hospital booking and any hospital antenatal appointments
- Update hospital computer maternity information system, if not admitted into hospital

If a midwife attends to a woman who has already miscarried at home, she should:

- Assess the foetus and give immediate and appropriate care to the woman
- Follow action as above

## 14. MIDWIVES ACTION WHEN IN ATTENDANCE FOLLOWING STILLBIRTH AT HOME

A midwife who attends a woman following stillbirth at home and is present at delivery should:

- Give immediate attention to the baby and certify stillbirth
- Continue immediate and appropriate care to the woman and family
- Request medical assistance – inform woman's GP or a GP on the obstetric register
- Arrange admission to hospital as necessary
- Complete stillbirth certificate and notification
- Immediately notify the Matron and Supervisor of Midwives
- Continue care as guidelines for home confinement
- Complete incident form

A midwife who attends a woman following stillbirth at home and is not present at delivery should:

- Request another midwife to attend
- Make an immediate assessment of the baby
- Give immediate attention to the woman
- Request medical assistance from woman's GP or a GP from the obstetric register
- Inform the police via Russells Hall switchboard
- Should document those present at the home when she arrived
- In an emergency, the midwife should organise admission of the woman into hospital
- Complete stillbirth certificate and notification
- Complete care as guidelines for home confinement
- Complete incident form
- Notify the Matron and Supervisor of Midwives

## 15. REFERENCES

UKCC Midwives rules and code of practice 2004
UKCC Standards for the Administration of Medicines 1992
UKCC The Scope of Professional Practice 1992

**Originator: S Mansell, Senior Midwife Manager, Antenatal Clinic and Community Midwifery Services**

**Reviewed by: Sue Morris, Clinical Co-ordinator, Community Midwifery**
**Steph Mansell, Head of Midwifery**

**Signature:** **……**

**Head of Midwifery:** **Steph Mansell**

**Signature:** **……**

**Clinical Director:** **Mr. R. Callender**

**Signature:** **……**

**Date:** **February 2005**

**WATERBIRTH**
WOMAN'S RESPONSIBILITIES FOR WATERBIRTH AT HOME

It is necessary to have electrical circuits checked by a qualified electrician and to use a circuit breaker.

The pool when full can be very heavy, so it is advisable to situate it on a solid floor.

You will need to ensure that there is easy access in and out of the pool.

It is advisable to consider the distance from a water supply and drain when siting the pool, to make filling and emptying easy.

It is advisable to have adequate waterproof floor covering.

Remember that the pool may take a while to fill, so don't wait until you are ready to use it before setting it up.

Condensation can be a problem, especially if heating is used in the room. It can result in damp furniture and furnishings.

Please note that the filling and emptying of the pool is your responsibility and not the midwife's.

It is advisable to have a practice run and actually fill the pool and get in, prior to the onset of labour.

If you have other children, it is advisable to arrange for extra adult supervision, as you partner may be busy providing support for you or making adjustments to the pool.

It is advisable to have an alternative area outside the pool for labouring. This may be necessary if you decide not to use the pool, if the midwife requests you to leave the pool because of concerns for you or the baby, or for delivery of the placenta.

Please provide plenty of towels for when you get in and out of the pool.

Once the baby's head is above the water, do not put him/her back under.

It is advisable not to use essential oils etc if you plan to deliver your baby into the water, as some babies can develop a skin rash.

It is advisable not to enter the pool until labour is well established. The midwife will advise you.

If your contractions decrease, a spell out of the water may encourage them to be re-established.

The water should help as a form of pain relief.

Pethidine cannot be given to you in the pool.
Entonox should only be used if absolutely necessary – you may be advised to leave the pool to use it.

You will need to expose your abdomen to the air in order for the midwife to listen to your baby's heartbeat. You can relax in the pool and allow yourself to float to the surface for this.

A sample of water will be taken before you enter the pool and after the delivery to check for infection.

It is important that the water temperature does not fall below $37^{o}$ when the baby is about to be born.

The baby will be allowed to be born into the water. The midwife will only assist you if she feels it is necessary.

Once the baby is delivered, pull him/her towards you.

It is advisable not to leave the baby under the water for longer than 1-2 minutes.

You must leave the pool for the delivery of the placenta (afterbirth), as it may be unsafe for you to remain there.

If at any time the midwife asks you to leave the pool, it will be because she is concerned about the safety of you or your baby.

You may or may not wish to follow the advice you receive, but if you choose not to take the advice of your midwife at this stage, you must realise that you are taking responsibility for what happens to you and your baby from now on.

Please be advised by her clinical judgement.

Have a good supply of cool drinks available.

**Ref: SM/JMS**
March 2000

**WATERBIRTH**
MIDWIVES ACTIONS WHEN CONDUCTING A WATERBIRTH

Wear comfortable clothes.

Advise mother to stay out of the water until active phase of labour.
If contractions decrease, advise a period of mobilisation for 10-15 minutes.
Pethidine not to be given whilst mother is using the pool.
Entonox only if absolutely necessary – not advised in the pool.

Normal observations during labour. Sonicaid to be used on dried abdomen. Mother can allow herself to float to the surface.

VE's are advisable out of the pool. If it is necessary to perform only whilst in the pool, wear a pair of gloves a size smaller than normal to prevent water leaking in.

Take a sample of water before mother enters the pool. Take a further sample after delivery. Send for C&S.

Water temperature should not drop below $37^{o}$ once the delivery is imminent, to prevent baby gasping.

Second stage usually diagnosed by visualising presenting part.
Allow spontaneous delivery of the head. The head should not be touched unless absolutely necessary.
The cord should not be checked for unless absolutely necessary. If the cord needs to be cut, stand mother up or sit her on the side. Do not cut cord underwater and deliver baby out of the water.
Allow spontaneous delivery of body. Encourage mother to pull baby towards her.

Do not allow baby to be immersed for more than 1-2 minutes. Once out, do not reimmerse.
If mother plans to delivery her baby into the water, it is not advisable to use essential oils etc, in the water.

Suction as necessary.

Mother to leave pool for third stage. There is a theoretical risk of water emboli if mother remains in the pool for the third stage. Physiological management of the third stage. Please assess mother before administering an oxytocic drug.

Estimate blood loss as less than or more than 500 ml.

The midwife's clinical judgement is paramount – if you are concerned about the safety of mother or baby, get them out of the pool.

March 2000

# THE DUDLEY GROUP OF HOSPITALS NHS TRUST

# WOMEN & CHILDREN'S SERVICE

# GUIDELINE ON REFERRAL TO CONSULTANT OBSTETRICIAN OF WOMEN BOOKED UNDER COMMUNITY CARE

## 1. INTRODUCTION

Any woman booked for community care may be referred to any consultant obstetrician at Russell's Hall Maternity Unit at any time during her pregnancy at the discretion of the midwife or general practitioner. All changes in care will be fully discussed with the woman at the time and documented appropriately.

## 2. CRITERIA FOR REFERRAL

Referral should be made if a deviation from normal pregnancy occurs and the woman is no longer deemed low-risk. If unsure of referral, all consultants are willing to discuss cases before a referral is booked.

## 3. REFERRAL DURING THE ANTENATAL OR POSTNATAL PERIODS

- In the event that a referral is necessary, the midwife/GP will **clearly record in the woman's hand-held notes the reason for this and detail all relevant information.**
- The referring midwife/GP should make an appointment via the antenatal appointment desk at Russell's Hall Maternity Unit. This will automatically transfer the care from community care to consultant care. The appointment should be made with either the consultant or registrar. Liaison with the appropriate antenatal clinic midwife should be undertaken as necessary.
- Where an ultrasound scan is indicated, e.g. suspected IUGR, an appointment for this should be arranged to coincide with the hospital antenatal clinic appointment or before this appointment.
- A permanent change to the booking arrangement from community care to consultant-led care should only occur if the consultant or registrar decides that further medical input is required.
- The referring midwife/GP should ensure that she is aware of the outcome of the consultation and provide appropriate follow up care.
- If following the consultation the woman's care is to return to community care, the referring midwife must ensure that this change is made on the 'Patient Care System' via the antenatal clinic appointment desk at Russell's Hall Maternity Unit.

## 4. REFERRAL OF WOMEN FOR INDUCTION OF PROLONGED PREGNANCY

- Women with no other complicating factors will normally be referred directly to the obstetric unit for induction of post-term labour at Term + 12 days. The expected date of confinement will be calculated by ultrasound scan and not the last menstrual period. Dating from an ultrasound scan performed between 8-12 weeks gestation should be used if available or alternatively calculation should be made from the 18-20 week anomaly scan (see guidelines for induction of labour).
- Women may be offered a vaginal examination for cervical assessment and 'sweep' after 41 weeks gestation. This will normally be performed by the community midwife with the woman's consent and documented.
- Women who require post-term induction of labour but do not meet a low-risk criteria should be referred to a consultant obstetric antenatal clinic prior to induction of labour.

## 5. REFERRAL DURING LABOUR AND POSTNATAL PERIOD

- In the event that referral is necessary the midwife providing care will refer the woman to the consultant on-call via the on-call registrar and record the information in the notes. The relevant consultant and his team will then take lead responsibility for the care of the woman in labour or in the immediate postnatal period.
- The information will be recorded on the 'Maternity Information System' and in the Maternity Register.

**References:**

National Institute for Clinical Excellence (2001) Induction of labour. NICE

National Institute for Clinical Excellence (2003) Antenatal care: routine care for the healthy woman. RCOG

**Originator:** **Mrs S. Mansell, Senior Midwife Manager**

**Reviewed by:** **Sue Morris, Lead Midwife Community**
**Steph Mansell, Head of Midwifery**

**Signature:** **…….**

**Head of Service:** **Adrian Warwick**

**Signature:** **…….**

**Risk Management Board Approved:……..**

**Date:** **September 2005**

# THE DUDLEY GROUP OF HOSPITALS NHS TRUST

# WOMEN & CHILDREN'S SERVICE

# GUIDELINE ON POSTNATAL CARE IN THE HOME

## 1. INTRODUCTION

The purpose of postnatal care is to provide professional support to the woman and her family during the postnatal period. Midwives also have a statutory duty "to care for and monitor the progress of the mother in the postnatal period and to give all necessary advice to the mother on infant care to enable her to ensure the optimum progress of the new-born infant" (NMC 2004).

## 2. PROCEDURE

- Wherever possible the woman's named midwife should provide continuity of care. In her absence another midwife known to the woman should provide the care. A maximum of 3 midwives should be involved with postnatal care in the home. Postnatal visits should be planned on an individual basis considering physical, psychological and social needs, as well as continuity of carer.
- The first visit in the home should be made on the day following transfer from hospital. On the first visit the midwife should take with her an apron and blank postnatal care plans.
- Name stickers should be attached to the care plans or if not available the woman's name, address and unit number should be written clearly on all sheets. The woman's name should also be written on the baby care plan. Name labels should be sent out from the ward with the discharge letter.
- It is important to read the discharge letter as well as obtaining a verbal history of events during pregnancy, labour, birth and the early postnatal period. An opportunity to "debrief" and reflect on the woman's experience should be offered.
- The midwife will remind the woman that the emergency contact numbers are printed on the discharge envelope. She will also remind the woman that she may wish to inform the G.P. that she is home. A faxed copy of the postnatal discharge letter from the hospital will have been sent to the GP surgery on the day of discharge.
- Baby care and feeding related demonstrations should be given as required.

## 3. CARE OF THE WOMAN

During the postnatal visit, the extent of the woman's physical postnatal care should be individually assessed and undertaken by the midwife. Continuous emotional and psychological support should be given with special attention being paid to the early signs of postnatal depression. Other care may include:

- Suture removal from abdominal wounds as per regime for each closure method, using an aseptic technique.
  i.e. Prolene and beads – day 5-6 cut prolene at one side of wound and pull thread through from the other side.
  Interrupted sutures – removed day 5-6.
  Subcuticular Dexon – cut the thread protruding from either or both ends of skin level on day 5-6.
  Perineal sutures may be removed at the midwife's discretion if causing discomfort. These usually dissolve by around 5 weeks.

- The midwife should advise the woman that her Health Visitor will make her first home visit by appointment between days 10-14
- Communication is imperative between the midwife and other professionals, e.g., H.V. and G.P. during the postnatal period, especially where problems have arisen or a change in circumstances occurs, e.g., change of address.
- Contraception should be discussed prior to the last postnatal visit.
- Following examination of the woman, the midwife must wash her hands and put on the apron before examining the baby. This is to prevent cross infection primarily, but also to prevent soiling of uniform.

## 4. CARE OF THE BABY

The baby's check should include a full top to toe check by any midwife visiting the baby for the first time. Other care includes:

- Blood for serum bilirubin should be taken from the baby as necessary by the midwife. See guideline on Neonatal jaundice (No 12)
- The baby is usually weighed between days 5-6, 10-12, and again in the 3rd-4th week. If there is a feeding problem, the baby will be weighed at the midwife's discretion, but always on the same scales. Liaison with the Health Visitor during this period is very important. The Midwife must be reassured that the baby has regained the birth weight prior to discharge.
- Blood is taken for Neonatal screening between days 6-10. For procedures see Guidelines for Neonatal Blood Screening (No 46)
- Once the baby check is completed the baby should be dressed and the Midwife should again wash her hands before the notes are completed.

### 5. FINAL POSTNATAL VISIT

On the final postnatal visit the midwife returns the woman's care plans to the Maternity Unit. The brown envelope should be left with the woman as it has the emergency and contact numbers printed on it, which the woman may need at a later date.

- The midwife must "recognise the warning signs of abnormality in the mother or infant which necessitate referral to a doctor and to assist the latter where appropriate" (UKCC 1998).
- When there has been no access during the postnatal period the midwife should undertake the appropriate action as directed in Guidelines for Postnatal care in the home when access if difficult. (No 187).

### 6. REFERENCES

NMC (2004). Midwives rules and code of practice. Nursing and Midwifery Council

**Originator:** **Y. Jones, Community Midwife/Supervisor Of Midwives**
**S. Mansell, Senior Midwife Manager**

**Reviewed:** **Sue Morris, Community Midwife/Supervisor of Midwives**

**Signature:** **…….**

**Head of Midwifery: Mrs Yvonne O'Connor**

**Signature:** ……

**Clinical Director:** **Mr R Callender**

**Signature:** ……

**Date:** **December 2004**

# THE DUDLEY GROUP OF HOSPITALS NHS TRUST

# WOMEN & CHILDREN'S SERVICE

# GUIDELINE ON FOLLOW-UP ANTENATAL VISITS FOR LOW RISK WOMEN BOOKED UNDER CONSULTANT CARE

## 1. INTRODUCTION

These guidelines are to assist in reducing the amount of unnecessary consultant antenatal clinic visits for 'low risk' women.

Any woman booked under consultant care that is deemed to be 'low risk' following clinical risk assessment will usually be referred for follow-up to Dudley Community Midwives for antenatal care. (See Appendix 1) Women who live out of area will be referred for follow–up antenatal care at the consultant unit at 41 wks gestation. This is in accordance with current evidence-based practice.

## 2. REFERRAL PROCESS

- The GP/Midwife referral letter for consultant unit booking is screened by the appropriate midwife in antenatal clinic.
- The consultant unit antenatal clinic booking appointment and ultrasound scan appointments are arranged and sent with the booking pack to the community midwife or posted directly to the woman's home.
- The community midwife or the antenatal clinic midwife undertakes the initial booking procedure, including the screening advice.
- The woman attends the hospital antenatal clinic booking appointment.

## 3. FOLLOW-UP ANTENATAL VISITS

- A clinical risk assessment is made during the antenatal clinic booking appointment to confirm the individual level of clinical risk.
- Appropriate follow-up appointments are arranged according to clinical, psychological and social findings.
- A routine 41-week follow-up appointment is given to women deemed to be 'low risk' according to the clinician's judgement for OOA booked women.
- Documentation is completed by the clinician, entering all findings and indicating the reason for follow-up before 41 weeks gestation. The recording should be made in the woman's hand held record and in the antenatal care plan.
- Women will be made aware that referral back to consultant antenatal clinic can be made by herself, GP or community midwife at any time during the pregnancy, as deemed necessary.

## 4. REFERENCES

Clement S et al (1999) 'Does reducing the frequency of routine antenatal visits have long term effect?'

*British Journal of Obstetrics and Gynaecology April 1999;* 106 (4): 367-70.

Berglund A C and Lindmark G C (1998) 'Health Service effects of a reduced routine programme for antenatal care'

*European Journal of Obstetrics and Gynaecology 1998 April;* 77 (2): 193-199.

**Originator:** **Antenatal Quality Practice Development Team.**
S Mansell, Senior Midwife Manager, ANC/Community Midwife

**Reviewed:** **Gerry Thurley, Lead Midwife, Antenatal Clinic**
**Steph Mansell, Head of Midwifery**

**Signature:** **……**

**Head of Midwifery: Steph Mansell**

**Signature:** **……**

**Clinical Director:** **Mr R Callender**

**Signature:** **……**

**Date:** **January 2005**

# THE DUDLEY GROUP OF HOSPITALS NHS TRUST

# MATERNITY & CHILDREN'S SERVICE

# GUIDELINE FOR COMMUNITY ANTENATAL CARE (INCLUDING DEFAULTER POLICY)

## 1. INTRODUCTION

Community antenatal clinics are held in most General Practitioner practices within the Dudley Borough. Within individual practices, clinics may be held several times a week or as little as only once a month dependent on the number of pregnant women who attend the practice. An appointment system should be identified to ensure waiting times are minimised. This reflects the NICE antenatal guidelines for routine care for the pregnant healthy woman (2003).

Women can be offered Consultant shared care or community care. Arrangements can be made to facilitate those women requesting home confinement. Choice of place of confinement is routinely offered and discussed with the woman.

## 2. PROCEDURE FOR THE FIRST ANTENATAL VISIT

Women are encouraged to access a midwife as soon as possible following diagnosis of pregnancy. The midwife should use her discretion as to the amount of information discussed at this first contact. However the following items must be part of every woman's care:

- Fully discuss screening blood tests and provide the woman with the information leaflet.
- Arrange a dating scan, a second scan form should be completed and the woman instructed to arrange a repeat scan at 20 weeks.
- Issue the woman with maternity hand held records, Breastfeeding 'Off to a good start' booklet, and the DOH Pregnancy book. Instruct the woman regarding self-completion of the hand held records with her personal details.
- Undertake baseline recordings of the blood pressure, urinalysis and weight assessment/BMI.
- An examination of the cardiovascular system may be undertaken at this stage by the GP (or later in pregnancy).
- Undertake an abdominal palpation and auscultation of the foetal heart with sonicaid, if appropriate.
- Discuss the preferred place of birth and complete the booking risk assessment form/referral letter
- If booking the woman for a home confinement, complete the necessary procedure according to the 'Guidelines for Home Confinement'.
- Inform the woman of the home booking system and arrange a convenient appointment.
- Undertake blood serology as clinically indicated.
- Provide any necessary advice, eg diet, smoking, life style etc.
- Issue the maternity exemption form.
- Document all findings and action in woman's hand held records and surgery notes.

## 3. BOOKING PROCEDURE

The community midwife offers all antenatal women who book for delivery at Russell's Hall Maternity Unit and who reside in Dudley Borough a home visit in order to complete the booking procedure.

Women who reside outside Dudley Borough but who are booked for delivery at Russell's Hall Maternity Unit are offered one of the following:

- Cross border visits undertaken by a Dudley community midwife
- A visit by a community midwife from their area of residence.
- A booking appointment within the maternity unit antenatal clinic undertaken by a hospital antenatal clinic midwife.

The booking is normally completed in the woman's own home by a prearranged appointment. For women who are unable to be booked at home, a hospital appointment is offered.

## 4. BOOKING PROCESS

The booking process is usually undertaken between 10-15 weeks gestation and includes:

- Fully completing and checking documentation in the woman's hand held notes, ensuring all consent signatures are documented.
- Completing documentation of the woman's hospital antenatal record including identifying named lead professional
- Discussion or confirmation of all antenatal blood tests, ultrasound scans and other investigations undertaken as necessary
- Issue information and discuss – parentcraft, benefits, smoking, and domestic violence, other public health and life style issues as appropriate.
- Discussion as required of antenatal, intranatal and postnatal care including, plans for pregnancy, birth plan and feeding options.
- Ensuring contact phone numbers and emergency phone numbers are recorded in the hand held notes.
- Undertaking and recording blood pressure and urinalysis as appropriate
- Performing and recording abdominal palpation and auscultation as appropriate
- Referral and notification to other agencies eg Health Visitor, Teenage Pregnancy service. (See pathway for communication between Midwives and health visitors guideline No 75)

## 5. FOLLOW-ON ANTENATAL VISITS

This programme is a guide to antenatal clinic attendance for low risk women and reflects the NICE antenatal guidelines, routine care of the healthy pregnant woman (NICE 2003). Alteration to the frequency of these visits or the professional involved should be made as necessary, considering any physical, psychological or social problems:

| | |
|---|---|
| 12-16 weeks | Midwife (Booking visit at home) |
| 20 weeks | Midwife |
| 26 weeks | Midwife |

| | |
|---|---|
| 30 weeks | Midwife |
| 34 weeks | Midwife |
| 36 weeks | Midwife |
| 38 weeks | Midwife |
| 39 weeks | Midwife |
| 40 weeks | Midwife |

In GP practices where clinic sessions are held fortnightly or monthly, home visits should be offered by the community midwife as necessary to provide antenatal care.

The social benefit form Mat B1 should be signed and issued to the woman at the appropriate stage of pregnancy.

Referral to a consultant may be made at any time as the midwife or GP feels necessary, ie when the woman is no longer deemed 'low risk' for community care or when pregnancy becomes post mature and there are additional complications (see guideline 'Referral to Consultant Obstetrician of women booked under midwife-led care'). Details of any request for a consultant referral should be entered in the woman's hand held records.

Liaison and good communication between the GP and midwife should be maintained. If midwife led care is being undertaken, liaison with the GP for medical reasons should be made as necessary, eg for prescription requirements.

Midwives who conduct antenatal clinics at GP surgeries should undertake a total care episode for the woman and should not be expected to undertake part of the antenatal examination of the woman for the GP, eg the midwife only undertaking blood pressure, urine testing and weight.

Abdominal measurement should be performed as per guidance (No 298) and plotted onto the individualised growth chart.

## 6. FACILITIES AND EQUIPMENT

To ensure an efficient and effective service, the availability of the following facilities and equipment for use by the midwife undertaking the antenatal clinic within the GP practice or children's centres would be useful/necessary:

Examination room/office - ensuring privacy
Telephone - for calls related to the woman's care
Urine testing sticks
Adult weighing scales
Scan request forms
Maternity exemption certificate
Triple test forms

The midwife should ensure that a full booking pack is available at the clinic venue containing:

Maternity personal hand held record
DOH pregnancy book

The midwife will carry the following:

Sphygmomanometer/stethoscope
Pinard's Stethoscope/sonicaid
Tape measure
Name stamp
Urine testing sticks

## 7. DEFAULTER POLICY

A procedure for the follow-up of all women who fail to attend for antenatal care should be identified to ensure all pregnant women receive appropriate antenatal care.

Contact of women who fail to attend antenatal clinic:

**First occasion**

- Check appointment is correct
- Check woman has not been seen anywhere else eg hospital, antenatal clinic, general surgery with GP, liaise with other professional as necessary
- Check woman is still pregnant
- Phone the woman at home or send appointment
- Indicate that the woman has defaulted appointment in the appointment book/computer clinic screen

**Second occasion**

- Letter from GP/midwife from surgery

**Third occasion**

- Community midwife visit at home

Continued and reasonable attempts to communicate with any woman who defaults antenatal clinic should be maintained until a positive outcome is secured, ensuring contact is made with all appropriate agencies.

All attempts to contact the woman should be documented.

## 8. EMERGENCY CALLS

A midwife conducting any antenatal clinic must respond when called to attend or assist at a community emergency, including home delivery or BBA. Arrangements to continue the antenatal clinic should be secured as necessary, but in these circumstances the emergency must be the midwife's priority.

## 9. PROLONGED PREGNANCY

When a woman is booked under community care and her pregnancy goes beyond 41 weeks, the midwife must ensure appropriate action is taken as per guideline 'Referral to Consultant obstetrician of women booked under community care' (No 80).

## 10. REFERENCES

UKCC Midwives rules and code of practice 1998

Maternity Care in Action – Part 1 1982

National Institute for Clinical Excellence. Routine care of the pregnant healthy woman. (2003) NICE

Dudley Group of Hospital NHS Trust.(2005) Referral to Consultant Obstetrician of women booked under community care. Guideline No 80

Dudley Group of Hospitals NHS Trust (2005) Fundal height measurements. Guideline No 298

Dudley Group of Hospitals NHS Trust (2005). Guideline for community midwife/health visitor pathway for communication. Guideline No 75.

**Originator** **Mrs S Mansell, Senior Midwife Manager**
**Antenatal Clinic/Community Midwifery Service**

**Reviewed by:** **Steph Mansell, Head of Midwifery**
**Adele Cox, Specialist Midwife - Screening**

**Signature:** **… …….**

**Head of Midwifery** **Steph Mansell**

**Signature:** **…….**

**Clinical Director** **Mr A Warwick**

**Signature:** **……**

**Risk Management Board Approved:…….**

**Date:** **September 2005**

# DUDLEY GROUP OF HOSPITALS NHS TRUST

## WOMEN & CHILDREN'S SERVICE

### GUIDELINE FOR COMMUNITY MIDWIFE/HEALTH VISITOR PATHWAY FOR COMMUNICATION

### 1. INTRODUCTION

This process originated in order to address recommendations in Child protection Part 8 reviews. The following process should be followed to ensure 'best practice' and inter-professional channels of communication.

### 2. PROCESS

The following process refers to the use of the attached Appendix 1 – Midwife/Health Visitor (MW/HV) Antenatal Record

- The MW/HV Antenatal record is generated at the booking contact by the Midwife. This is usually at around 8 - 14 weeks of pregnancy
- The MW/HV Antenatal record is submitted by the Midwife to the Community Ward Clerk following booking.
- The Community Ward Clerk generates the Individualised Growth Chart (IGC) and marks on the MW/HV Antenatal record that this has been completed.
- A copy of the MW/HV Antenatal record is forwarded by the Community Ward Clerk using fax or hard copy and sent to:
    - the appropriate Health Visitor via Child Health
    - **when indicated** to the Teenage Pregnancy Service team
    - **when indicated** to the appropriate Children's Centre/Sure Start

**The ward clerk marked on the form when this action has been completed.**

- The MW/HV Antenatal record and Individualised Growth Chart is returned to the Midwife.
- During the next antenatal contact the Community Midwife appropriately files the Individualised Growth Chart into the woman's hand held notes.
- The Hospital Midwife must ensure that bookings completed in the Hospital Antenatal clinic have the same information appropriately shared.
- The original MW/HV Antenatal record is returned to the Community Midwife and is used as her personal record.

### 3. FOLLOW UP

Both the Community Midwife and Health Visitor should ensure any relevant clinical or non-clinical changes to circumstances are informed, by updating the MW/HV Antenatal record and faxing to the appropriate area. As necessary this information should also be shared during face to face meeting or by phone contact.

### 4. DISCHARGE

On completion of the episode of care the Community Midwife should ensure that the MW/HV Antenatal record is either filed in the woman's hospital notes or is shredded using an appropriate method to ensure confidentiality.

**3. REFERENCES**

‘Working Together to Safeguard Children’ (D.O.H 1999).

**Originator:**
**Head of Midwifery: Steph Mansell**

**Signature: …….**

**Clinical Service Lead: Adrian Warwick**

**Signature: ……..**

**Date: January 2006**

**Reviewed: November 2006**

**Risk management approved: ……**

The Dudley Group of Hospitals NHS

NHS Trust

**MW/HV Antenatal Record**

The Community Midwife will complete this form at the booking contact (8-14 weeks) and a copy will be forwarded to the appropriate Health Visitor via Child Health and to the Teenage pregnancy and Sure Start services as required. Community Midwives **and** Health Visitors must ensure any amendments to this information are appropriately shared at the earliest opportunity. In circumstances were a form is not completed by the Community Midwife, the hospital midwife will complete a record.

**Name**
**Address**

**Postcode**
**Date of Birth:**
**Unit number:**

**Change of details**
**From: ……..**

(Please use a sticker when available)

Telephone …… Mobile ……..……

Ethnicity ……..

EDD …… Calculated by scan: Yes/No

GP ……

Surgery …… Phone number……

Height: **……**
Weight **…….**
BMI: **…….**

**IGC** generated ☐

**Previous Children:**

| | |
|---|---|
| **Name**<br>**MALE /FEMALE**<br>**Birth weight**<br>Gestational Age<br>**Comment** | **Name**<br>**MALE /FEMALE**<br>**Birth weight**<br>Gestational Age<br>**Comment** |
| **Name**<br>**MALE /FEMALE**<br>**Birth weight**<br>Gestational Age<br>**Comment** | **Name**<br>**MALE /FEMALE**<br>**Birth weight**<br>Gestational Age<br>**Comment** |
| **Name**<br>**MALE /FEMALE**<br>**Birth weight**<br>**Gestational Age**<br>**Comment** | **Name**<br>**MALE /FEMALE**<br>**Birth weight**<br>**Gestational Age**<br>**Comment** |

**Additional information:**

**Referral to:**

| | | | |
|---|---|---|---|
| Brierley Hill Children's Centre/Sure Start | Yes | No | Sent |
| Kate's Hill Children's Centre/Sure Start | Yes | No | Sent |
| Lye Children's Centre/Sure Start | Yes | No | Sent |
| Netherton Children's Centre/Sure Start | Yes | No | Sent |

| | | | |
|---|---|---|---|
| **Referral to Teenage Pregnancy Team**: | Yes | No | Sent |

Age: (18 years or under)
Parents/Guardian aware of Pregnancy: Yes/No
Living with Parents/Guardian: Yes/No
Attending School: Yes/No Name of School ……
Name of Social Worker …….. (as appropriate)
**(Teenage Pregnancy service hard copy Courier 5 St. John's House or Fax: 01384 366485)**

**Signature**
Named Midwife …….. Stamp……
Team ……..
Contact number …….. Date…….

**Amendments**
Midwife/Health Visitor…… Print……..
Date …….
Amended date1……
2……
3……

**Forwarded copies:** **Tick when completed**

**Health Visitor via Child Health (hard copy or Fax: 01384 361294)** ☐

**Community Midwifery Service (Fax: 01384 244576)** ☐

November 2006

# DUDLEY GROUP OF HOSPITALS NHS TRUST

# MATERNITY & CHILDRENS SERVICE

# GUIDELINE FOR THE DISTRIBUTION AND COMPLETION OF PERSONAL CHILD HEALTH RECORD (PARENT HELD RECORD/ 'RED BOOK')

## 1. INTRODUCTION

This initiative was originally introduced in order to address recommendations in Part 8 review 'Working Together'. Dudley Area Child Protection Team, Dudley PCT's and Dudley Group of Hospitals have produced the strategy for implementing these recommendations.

The following process should be followed to ensure 'best practice' and use of this shared information.

## 2. PROCESS

### Dudley Child Health

- Personal Child Health Record books (PCHR) are provided by the PCTs, a monthly supply of the books will be distributed by Child Health to the Maternity Unit at Russell's Hall Hospital.

### Maternity Unit

- A Personal Child Health Record book will be issued to:
    - every woman with a Dudley GP delivering in the Dudley Borough
    - every woman residing outside the borough with a Dudley GP

    (if in doubt a book is always issued)

NB: There is a separate book for Boys and Girls - Boy books have a blue spot sticker on the front, from July 2006 unisex books will be issued.

- The PCHR will contain the following:
    - PCHR information sheet for parents explaining the use of the book. (Appendix 1)
    - Important advice leaflet (Appendix 2)
    - NHS numbers for babies leaflet
    - Blood Spot Screening leaflets
    - Hearing screening leaflet
    - Registering the birth leaflet
    - Smoke free homes sticker IF identified as a smoking household
    - Paper tape measure
    - Meningitis baby watch leaflet
- The Midwife when issuing the book will place the baby's NHS number label on the front of the book and complete the first part of Page 3.

N.B: The first page of the book is left blank for completion by the Health Visitor.

- The Paediatrician or appropriately trained Advanced Neonatal Nurse Practitioner or Midwife who performs the newborn examination will complete the documentation on the second part of page 3 and all page 4
- Page 5 will normally be completed on discharge from hospital, however, some information may need to be completed by the community midwife e.g. neonatal blood screening when performed in the community.
- The key to the summary of examination on discharge (Page 5) relates to the following code:

  S: Satisfactory
  P: Problem
  O: Observation
  T: Treated
  R: Referred
  N: Not examined

N.B: It is accepted that when more than one code applies the last code will be selected i.e.: R takes priority over T, T over O etc.

- Birth weight and additional weight, when performed, should be recorded on page D of the 'growth charts and other information' section. Weight should also be plotted on the appropriate chart.
- Immunisation:
  - Babies who require Hepatitis B vaccination must have the administration of the injection documented on page 5.
  - If the BCG vaccine is administered this should be documented on page 5
  - If a baby remains in the NNU at two/three and four months Diptheria/Tetanus/Whooping Cough/Polio, Haemophilus influenza and Men C injections should be administered with parents consent and documented on page 29.
- Hearing screening observation should be documented on Page 6.
- Following discussion with the parents the smoke free homes 'elephant' sticker will be placed on the front of the PCHR when it is identified that the baby is being discharged to a smoking household. (Appendix 3)
- Parents should be encouraged to carry the book wherever possible and especially if the child is to undergo medical treatment/care.

Any relevant information relating to delivery, hospital or community postnatal care should be recorded on the notes page at the back of the book by the hospital and community Midwife.

**Carbonised copies**

The carbonised copies should be removed and distributed as follows:

- Page 3 & 4 - Birth details and neonatal examination :
  - copy removed by midwife and stapled onto paediatric sheet
- Page 5 - Discharge summary:
  - Top copy - Hospital copy: removed by community midwife and returned with the community postnatal notes for filing in Trust notes. If **fully** completed in hospital the copy will be stapled into the paediatric sheet.
  - 2nd copy - HV copy: returned to Child Health by the HV.
  - 3rd copy - GP copy: for removal by the GP at the first postnatal check.

- Page 6 - Newborn hearing screening programme:
  - Top copy - HV copy: returned to Child Health by HV, or NNU staff when the screening is completed in hospital.
  - 2nd copy - Hospital copy: will be stapled to the paediatric sheet or returned to the hospital by the HV for filing.
  - 3rd copy - GP copy: for removal by the GP at the first postnatal check.

NB: with the introduction of the regional baby postnatal notes, following completion the hospital carbonised copies will be removed and placed directly into these notes.

**Neonatal Unit (NNU)**

- When a baby is transferred home from the NNU the staff will fully complete all the relevant information and issue the PCHR to the parents before the baby is discharged from the Neonatal Unit.

**Community Midwifery**

- Women who:
  - Deliver at home.
  - Deliver out of the borough but have a Dudley GP.
  - Or any baby who has not been issued with a PCHR (for whatever reason) will be issued with a book by the community Midwife and the relevant information completed. A small stock of books will be stored in the community midwives' room for this purpose.
- Relevant documentation should be made in the notes section and at the final postnatal community Midwife visit. The documentation should record a short summary of any relevant information or a comment to confirm an uneventful postnatal period.

**Paediatric Wards/A&E Department/NNU**

- The PCHR should be completed during any outpatient appointment or following an inpatient period.
- Parents should always be encouraged to carry the book wherever possible especially if the child is to undergo medical treatment/care.

## 3. REFERENCES

'Working Together to Safeguard Children' (D.O.H 1999).

**Originator:** **S Mansell - Senior Midwife Manager**
**Reviewed:** **S Mansell – Head of Midwifery**

**Head of Midwifery: Steph Mansell**
**Signature:** **…….**

**Head of Service: Adrian Warwick**
**Signature:** **……..**

**Original:** **October 2001**
**Date:** **June 2006**

**Information for Parents - Personal Child Health Record Book**

Dear Parent
We are pleased to give you your Personal Child Health Record Book. Please have a look through the book as this will be used for all routine health reviews and is the main record of your child's health, development and immunisation. The book is for you and all health professionals to complete as your child develops.

Some information will have been completed in hospital or by your Community Midwife; this information will include any screening that has been performed. Staff will be happy to explain this recording; they will also tell you about the additional leaflets given out with the book.

Your Health Visitor will go through the book with you in more detail, usually at the first contact at home. Please take the book with you to all health appointments when your child is being seen or to any hospital visits. You can also use the book to record your own observations on your child's development, any questions you have or to record appointments.

The usual times for health and development checks and immunisation can be found on the card at the back of the book. This card can also be used to record any appointments. Your Health Visitor will explain the contacts currently carried out in Dudley.

If you have any concerns about your child's development do not wait for a routine appointment, contact your GP or Health Visitor via your GP surgery. We hope the information contained in this book is valuable and reassuring to you.

Issued on behalf of:
Dudley Group of Hospitals
Beacon and Castle PCT
Dudley South PCT

# Important Advice when taking your baby home

Following your delivery the Midwife has carefully checked your baby from head to toe, and when necessary a Paediatrician will also have examined your baby. However, there are some conditions that cannot be identified at this early time despite a thorough examination. These include some heart disorders, hip problems and early jaundice. It is important that you contact your GP or Community Midwife if you notice any of the following:

- **Blueness of the face/lips**
- **Breathlessness**
- **Not feeding well**
- **Not passing urine (in the first 24 hours after birth)**
- **Bowels not open (in the first 48 hours after birth)**

Your Midwife will check for these problems during her routine visits at home. Your GP will in the next few weeks provide a routine examination of your baby.

***Jaundice***

Jaundice is a common condition where a baby's skin and eyes may turn yellow for a few days after birth. Many babies become jaundiced between 3 to 7 days old and this generally requires no treatment. Jaundice that appears in the **first 24 hours** after birth is **not normal** and needs to be investigated. If you are at home **you must seek advice** from your Community Midwife or GP. If your Midwife or GP is concerned about the jaundice then a blood test may be sent to the hospital. Admission to hospital may be required if the level is very high. Jaundice that is still present when the baby is more than 3 weeks old may indicate that there is a problem. **You should ask your Community Midwife or GP to investigate this.**

**Well Baby Record Name ……..……**
**Date and Time of Birth** ……..……

| **Date Time** | **Age of Baby** *Days* | **Breast Feeding** *For how long One breast or two* | **Formula Feeding** *Type…… …… How much* | **Interest** *Keen Slow Fed well* | **Baby** *Active Sleepy* | **Colour of Skin** *Pink Yellow* | **Wet Nappy** *Yes No* | **Dirty Nappy** *Colour Dark/Yellow Soft, Hard/loose* | **Comments** *Content Unsettled Crying Screaming* |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

**This chart may be started when you go home but please do not feel you have to use it. Some parents find recording their baby's daily habits helpful, especially when you are trying to explain them to your midwife. This information may also be useful to your midwife when offering advice and reassurance to you. Please ask if you need help or advice at any time and most importantly; HAPPY PARENTING.**

## Guide to using Smoke Free Home 'elephant' sticker

## Key Health Message – Increased risk of Cot Death

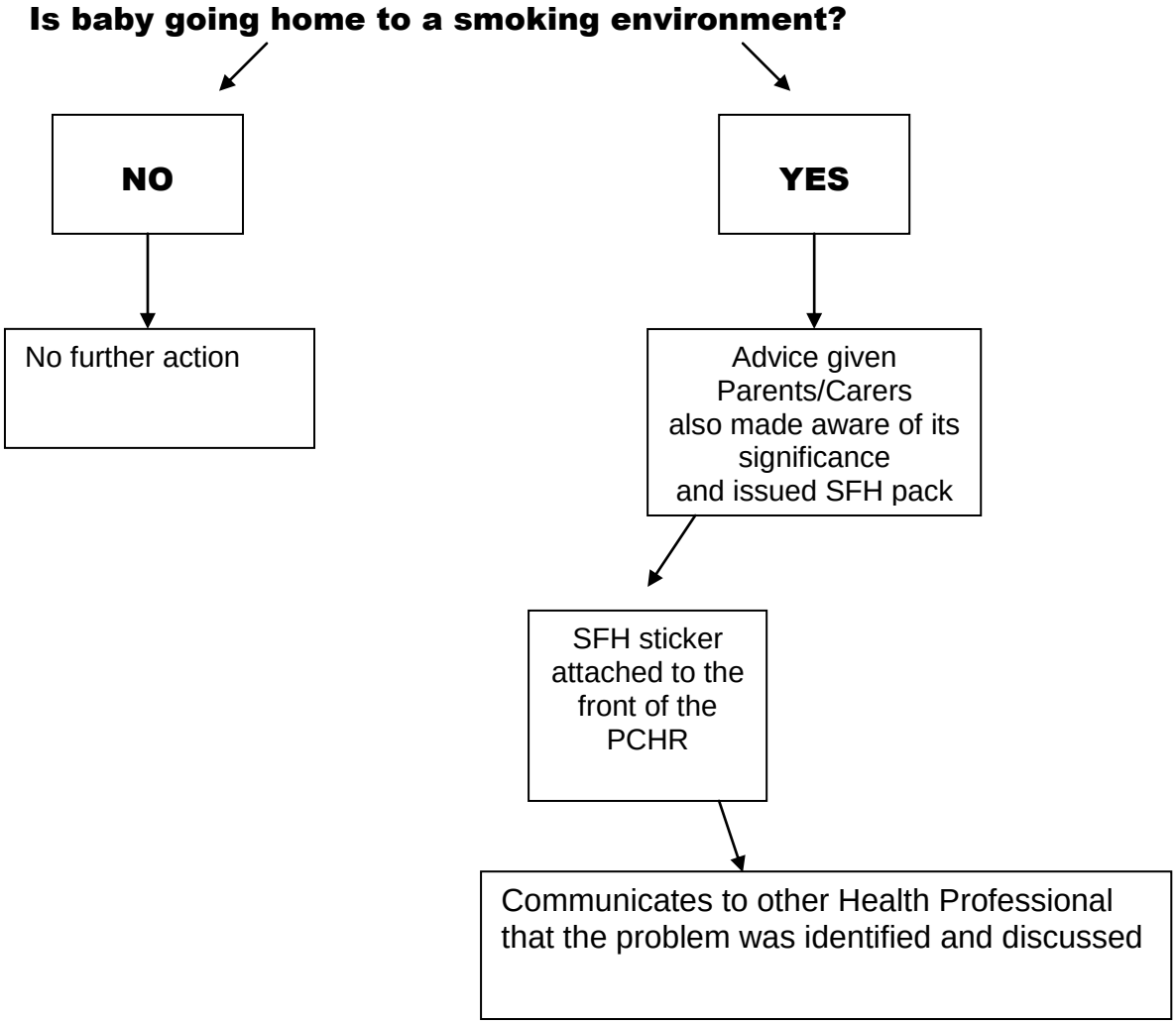
**Aim**

- To reduce risk of cot death amongst babies exposed to second hand smoke
- Used by Dudley Group of Hospitals Midwives in conjunction with Dudley Stop Smoking Service – Smoke Free Homes campaign

**Objective**

To raise awareness to parents/carers of babies and young children of the dangers of exposure to Second Hand Smoke

- The woman Mom is asked her smoking status at delivery by the Midwife.
- The result is documented on the delivery notes and IT system.
- Pre-discharge the question asked is:



**APPENDIX 2**

Dudley NHS
Primary Care Trust

# The Child Health Surveillance Guidelines

**Guidelines for the delivery of The Child Health Surveillance programme by the SCPHN Teams in Dudley Primary Care Trust**

**SEPTEMBER 2007**

**Members of the group involved in producing the guidelines:**

| | |
|---|---|
| Jenny Darby | Health Visitor/ CPT |
| Alison Cutler | Health Visitor |
| Barbara Baker | Health Visitor/ CPT |
| Ann Rainsford | Health Visitor |
| Sue James | Health Visitor |
| Clair Horne | Health Visitor |

**Target Audience**
These guidelines are targeted at all the members of the Health Visiting Teams and will clarify and legitimise new ways of working.

**Approval and Ratification**
Following approval and ratification , the guidelines will be circulated to all relevant staff and a copy will be kept in all Health Centres. The implementation date will be from the date of ratification and the policy will be reviewed in 2 years.

These guidelines are underpinned by the NMC Code of Professional Conduct for Nurses, Midwives and Health Visitors (NMC 2000) and will be reviewed annually with changes being disseminated to the relevant staff. It underpins the **Packages of Care** (appendix 1) and will be reviewed in conjunction with this documentation

Measures of Implementation and Effectiveness
Clinical Audit will take place prior to the review date to measure effectiveness and appropriateness. This will be done by a random audit of health visiting records.

Risk
The risk of not implementing these guidelines could lead to a lack of standardisation of the service with the possibility of inequality for clients.

**INTRODUCTION**
The Health visiting service has a strong tradition of working with individuals, families and communities to promote health. The family, in all its diverse forms, is the basic unit of society and the place where the majority of health care and preventative work takes place. *The National Service Framework for Children, Young People and Maternity Services (DOH 2004)* and *Every Child Matters (DOH 2004)* emphasise the need for preventative action and early detection of problems to ensure children have the best possible chance to realise their full potential and recognise the importance of the health visiting role in achieving improved child and family health. *Choosing Health: making healthier choices easier* (DOH 2004) also recognises the importance of working with families with young children to improve the lifetime health chances of all children.

Child health surveillance checks by the health visiting team were viewed historically as the only way of recognising children's health and development problems, and have accounted for a large proportion of health visiting time. The development of a family-centred public health role supports a more proactive approach to promoting child health with a reduced emphasis on surveillance. This shift reflects *Health for All Children: 4th Report* (Hall 2003) and the increasing emphasis on child health promotion as opposed to child health surveillance with a reduction in the number of *routine* contacts. It is recognised that child development cannot be viewed in isolation and that more can be achieved by adopting a holistic family and community approach.

The **Aim** of the Child Health Surveillance Policy is to:

- Provide a consistent and co-ordinated approach to Child Health Surveillance across the PCT.

The **Objectives** of the Child Health Surveillance Policy is to:

- Reflect 'best practice' with regard to surveillance programmes
- Provide a framework for Community Practitioners within which to practice
- Reflect the philosophy of targeting within a universal service
- Underpin practice with the Users' perspective.

**Underpinning principles**

1. Finding out which population groups have significant health needs and targeting resources to address these
2. Planning work on the basis of local need, evidence and national health priorities rather than custom and practice
3. Giving users informed choices and managing their expectations

**Core and Additional Packages of Care**

| | | | |
|---|---|---|---|
| **Package of Care 1** | Antenatal contact | Antenatal period | CORE |
| **Package of Care 2** | Primary Visit | Age of Child: 10 – 14 days | CORE |
| **Package of Care 3** | 6-8-week contact | Age of Child: 6-8-weeks | ADDITIONAL |
| **Package of Care 4** | Weaning Contact | Professional Judgement | ADDITIONAL |

| | | | |
|---|---|---|---|
| **Package of Care 5** | 7 – 9 Month Contact | Age of child: 7-9-months | CORE |
| **Package of Care 6** | 18 – 24 Month contact | Age of child: 18 – 24 months | CORE |
| **Package of Care 7** | 36 – 48 months Additional input | Professional Judgement | ADDITIONAL |
| **Package of Care 8** | Transfer in to caseload | Change of GP / Circumstances | As Required |

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Core Contract**

  **All antenatal women will receive a contact from the health visiting service (Package of Care 1)**

**Rationale**

- To establish contact with all antenatal mothers during pregnancy
- To promote the physical and mental health of ante-natal women
- Primary prevention of post-natal depression by the identification of predisposing factors
- To increase the breast feeding rates
- To establish a supportive partnership between parents to be and the health visiting service

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Core Contract**

  **All new births will receive a contact from the health visiting service between day 10 and day 14. There will also be a face-to-face meeting at a mutually agreed venue and time.**

**(Package of Care 2)**

**Rationale**

- To offer support and information to parents/carers and assist in engaging with peer support
- To discuss the scope of the health visiting service
- To undertake a family health assessment
- To outline the developmental screening and immunisation programme
- Early identification of hearing loss

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Additional Contract**

  **All families will receive a contact between 6- 8 weeks from the health visiting service**

**(Package of Care 3)**

**Rationale**

- Provision of support to family
- Assessment of family health and social care needs
- Support for chosen feeding method

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Additional Contract**
  **Families identified as requiring enhanced or intensive health visiting interventions (see dependency rating appendix 2) will receive a contact 12 - 16 weeks following the birth from the health visiting service**

**(Package of Care 4)**

**Rationale**

- To promote healthy nutrition by providing information on good eating practices
- To provide additional support to family
- Reassessment of family health and social care needs

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Core Contract**

  **All families will receive a contact between 7 – 9 months from the health visiting service**

## (Package of Care 5)

**Rationale**

- Provision of support to family
- Assessment of health and development of child
- Identification of hearing loss or developmental delay
- Identification of post natal depression
- Assessment of family health and social care need

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Core Contract**

  **All families will receive a contact between 18 – 24 months from the health visiting service**

**(Package of Care 6)**

**Rationale**

- To promote positive parenting
- Assessment of health and development of child
- Family health assessment
- To assist in engaging with peer group support

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Additional Contract**

  **Families identified as requiring enhanced or intensive health visiting intervention (see dependency rating appendix 2) may require additional input at 36 – 48 months**

**(Package of 7)**

**Rationale**

- To promote positive parenting
- Assessment of health and development of child
- Family health assessment
- Preparation for entry into nursery/school

**POLICY STATEMENT AND DESIRED OUTCOME**

- **Additional Contract**

  **All families new to caseload with children under 5 will receive a contact from the health visiting service within 5 working days of notification to the health visiting service**
  **(Package of Care 8)**

**Rationale**

- To establish a supportive relationship between parents and health visitor
- To assess the family health and social care needs

# Policy Statement

## Transfer onto School Health caseload

In line with Family Vulnerability and Service Needs Indicators (appendix 2) transfer to the School Health Service will take place as follows:

1. Children in receipt of the **Core** Health Visiting service – records to be sent to the relevant School Health office.

2. Children in receipt of the **Enhanced** Health Visiting service – Pre-school summary for school entrants form to be completed and this form to be sent to the relevant School Health Advisor (appendix 3).

3. Children in receipt of the **Intensive** Health Visiting service – face to face handover with the relevant School Health Advisor.

## References


Department of Health (2004). **Choosing Health: Making healthier choices easier**. HM Government**,** London

Department of Health (2004). **Every Child Matter: The next steps.** HM Government**,** London

Department of Health (2004). ***The National Service Framework for Children, Young People and Maternity Services.*** HM Government**,** London

Hall, D. and Elliman, D (2003) ***Health for All Children: 4th Report.*** Oxford University Press, Oxford.

## Appendix 3

## Dudley Primary Care Trust
## Family Vulnerability and Service Need Indicators

### Introduction

**Within any population, community or caseload there will be a continuum of need. This tool allows the health professional to consider the key factors that predispose to higher levels of vulnerability and service need and then offer the appropriate level of Service Provision.**

There are three levels of service provision

1. **Core** Health Visiting Service Provision – Low levels of vulnerability (green)

2. **Enhanced** 'Short – Term' HV Interventions – Medium levels of vulnerability (yellow)

3. **Intensive** 'Long – Term' HV Interventions – High levels of vulnerability (red)

### Rationale

Inevitably there will be an element of subjectivity in the use of this tool but the overall aim is to:

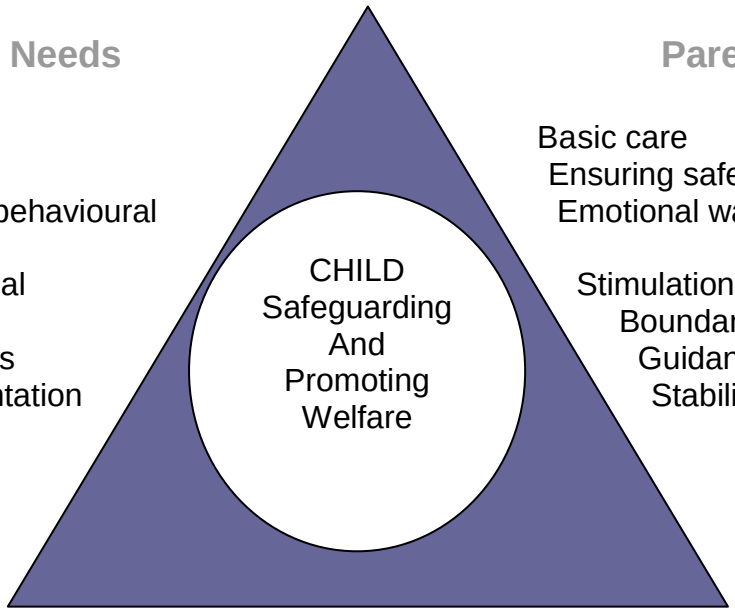
- Quantify levels of vulnerability and service need using a standardised process
- Demonstrate the diversity of need across the Borough and facilitate caseload comparison
- Support argument for equity of staff provision
- Facilitate auditing of outcomes
- Enable efficient use of resources and targeting of services

  - **All** clients will be offered the **Core Health Visiting Service** in accordance with the Packages of Care (see App 1)

  - Clients requiring short-term HV Interventions in addition to the Core Service will be offered an **Enhanced** Service (see App 2)

  - Clients requiring long term HV Interventions in addition to the Core Services will be offered an **Intensive** Service (see App 3)

The “**Framework for the Assessment of Children in Need and their Families**” is a guide to interagency working to safeguard and promote the welfare of children. (Interagency Protocol for the Assessment of Children in Need and their Families 2001) This Assessment Framework has been used to inform the parameters of vulnerability within the 3 dimensions of Child Development Needs, Parenting Capacity and Family and Environmental Factors.




**Child Development Needs**

Health
Education
Emotional & behavioural Development
Family & social Relationships
Self care skills
Social presentation

**Parenting Capacity**

Basic care
Ensuring safety
Emotional warmth

Stimulation
Boundaries
Guidance
Stability

**Family and Environmental Factors**

Community resources
Income
Housing
Family history & functioning
Wider family
Employment
Family’s social integration

**Appendix 1: Packages of Care**
The Core Packages of Care will be offered to all families where, in the opinion of the professional, there are no obvious concerns about:

**Child Development Needs**

- Health
- Education
- Emotional and behavioural development
- Family and Social Relationships
- Social presentation
- Self-Care skills

**Parenting Capacity**

- Basic Care
- Safety Factors
- Emotional warmth
- Stimulation
- Guidance and Boundaries
- Stability

**Family and Environmental Factors**

- Family History and Functioning
- Housing
- Income
- Community Resources
- Family's Social Integration
- Employment
- Wider Family

**Appendix 2: Enhanced Health Visiting Interventions**

An Enhanced Health Visiting Service will be offered in addition to the Core Service, to families who, in the opinion of the professional, require short-term HV Interventions. (For this purpose 'enhanced short term intervention' is defined as a clearly defined time limited intervention with a measurable outcome.) Factors indicating the potential need for an enhanced service could include one or more of the following:

**Child Development Needs**

- Low birth weight baby
- Prematurity
- Centiles indicate need for extra monitoring
- One or more family members diagnosed with short-term depression
- One or more family member diagnosed with short-term psychiatric problem
- Feeding problem
- Behavioural problem
- Child with short-term problem or special need (physical, emotional, psychological, social, educational)

**Parenting Capacity**

- Known parenting problems
- Unsupported Adult (physically, emotionally, socially, financially)
- Previous sudden infant death syndrome
- Relationship problem
- One or both parents aged 17 or under
- One or both parents have learning disabilities
- Family member has abuse of / dependence on alcohol, illegal drugs, prescribed drugs, tobacco, other substances
- One or more family member diagnosed with depression / other psychiatric problem
- Multiple births
- Four or more children under the age of 10
- Additional Caring for older adult
- History of non-attendance at appointments

**Family and Environmental Factors**

- Adult member of the household with a problem or a special need (physical, emotional, social, educational)
- Literacy problems
- Non-English speaking /English 2nd language
- Life crisis e.g. divorce, bereavement
- In receipt of social work, probation, CPN or other professional support
- Financial problems
- Employment related problems (e.g. main wage earner unemployed)
- Unrealistic expectations by adult of their abilities, services offered, child's capabilities
- Multiple occupancy / overcrowding

**Appendix 3 : Intensive Health Visiting Interventions**

An Intensive Health Visiting Service will be offered in addition to the Core Service, to families who, in the opinion of the professional, require long term intensive HV Interventions (For this purpose 'long term intensive intervention' is defined as the support required over an indeterminate time period to address multiple problems). Factors indicating the potential need for intensive intervention could include some of the following:

**Child Development Needs**

Very low birth weight baby
Centiles indicate failure to thrive / neglect
One or more family members diagnosed with long-term depression
One or more family member diagnosed with long-term psychiatric problem
Long-term feeding problem
Severe behavioural problem
Child with long-term problem or special need (physical, emotional, psychological, social, educational)

**Parenting Capacity**

Other children 'in care' or on Child Protection Register
Serious family dysfunction
Collapsed family network
No person has parental responsibility
One or both parents in care or abused as children
Family member has long-term abuse of / dependence on alcohol, illegal drugs, prescribed drugs, tobacco, other substances
One or more family member diagnosed with severe depression / other psychiatric problem
Multiple births
Four or more children under the age of 5

**Family and Environmental Factors**

Adult member of the household with a long-term problem or a special need (physical, emotional, social, educational)
Identifiable risk of accident / injury to a family member
Poor housing (i.e. unsuitable for the needs of the family)
Temporary Accommodation
Frequent change of address (X3 or more in one year)
History of violence within the family / domestic violence
History of criminal activity of family members
On the Child Protection Register
Any child in the 'looked after' system
One or more children or adults in the household have been or are being abused

**APPENDIX 4**

Dudley NHS
Primary Care Trust

**HEALTH VISITING SERVICE**
**AUDIT FORM FOR CORE CONTACTS**

**HEALTH VISITOR NAME:** .....

**CASELOAD NUMBER:** .....

**BASE:** .....

**DATE OF AUDIT:** .....

**COMPLETED BY:** .....

**SIGNATURE:** .....

**CORE CONTACTS**

| PACKAGE OF CARE | | | COMMENTS RE FACTORS AFFECTING OUTCOME * | | | |
|---|---|---|---|---|---|---|
| **Package of Care 1 Antenatal Contact** | NUMBER OF RECORDS AUDITED | NUMBER OF CARE PACKAGES COMPLETED | 1 | 2 | 3 | 4 |
| **Package of Care 2 Primary Visit** | NUMBER OF RECORDS AUDITED | NUMBER OF CARE PACKAGES COMPLETED | | | | |
| **Package of Care 5 7–9 month Contact** | NUMBER OF RECORDS AUDITED | NUMBER OF CARE PACKAGES COMPLETED | | | | |
| **Package of Care 6 18-24 month Contact** | NUMBER OF RECORDS AUDITED | NUMBER OF CARE PACKAGES COMPLETED | | | | |

*** 1 = Number of DNA's**
**2 = Number requiring more than 1 contact to complete Care Package**
**3 = Number requiring follow-up**
**4 = Number requiring Referral**

# Dudley Primary Care Trust

# Health Visiting Service
# Core and Additional
# Packages of Care

## Health Visiting Service
PACKAGE OF CARE 1 - CORE

**ANTENATAL**

**Rationale:**

- To establish contact with all antenatal mothers during pregnancy
- To promote the physical and mental health of ante-natal women
- Primary prevention of post-natal depression by the identification of predisposing factors
- To increase the breast feeding rates
- To establish a supportive partnership between parents to be and the health visiting service

**Process guidelines:**

1. Discussion/Information about the Health Visiting Service and packages of care
2. Assessment of family health and social care needs
3. Discussion of infant feeding methods
4. Discussion of parent held records
5. Discussion of emotional effects of pregnancy and parenthood.

**Specific outcome measures:**

- Early detection of physical and mental health problems
- Early detection of post-natal depression
- Support and management of identified problems /difficulties within the ante-natal period
- Opportunity to discuss feeding methods
- Increase in breast feeding rates
- Family health profile commenced

**Materials/action required:**

- Liaison with Community midwife and GP practice for identification of ante natal clients
- User friendly documentation
- Information leaflets on feeding methods

**Review: Sept.2007**

**Bibliography**


- Acheson, D. (1998) Independent enquiry into the inequalities in health, London, Stationery Office
- Brugha, T et al (2000) Pragmatic randomised trial of antenatal intervention to prevent post natal depression by reducing psychosocial risk factors. Psychological Medicine. Vol. 30 (6) Nov 2000, 1273-1281. London, Cambridge University Press
- Hoyer, S. and Horvat, L. (2000). Successful breast-feeding as a result of a health education programme for mothers. Journal of Advanced Nursing. Vol. 32, (5) pp1158-1167
- Jenkins, R. et al (1992) Prevention of depression and anxiety – the role of the primary health care team. London, HMSO.
- Takka, M., Paunonen, M. and Laippala, P. (1999) Factors related to successful breast-feeding by first-time mothers when the child is 3 months old. Journal of Advanced Nursing. Vol. 29 (1) pp113-118.

## Health Visiting Service
PACKAGE OF CARE 2 - CORE

**Primary Visit**
**Rationale**

- To offer support and information to parents/carers and assist in engaging with peer support
- To discuss the scope of the health visiting service
- To undertake a family health assessment
- To outline the developmental screening and immunisation programme
- Early identification of hearing loss

**Process guidelines**

1. Use of PHR discussed with the parents
2. Discussion of health visiting service, child health clinics and other support
3. Discussion of immunisations/Inclusion on to child health programme.
4. Family health and social care needs assessment
5. Physical observations of baby including weight, length and head circumference
6. Hearing test
7. Discussion of feeding method and relevant equipment
8. Advice on SID research and reducing risk factors
9. Maternal post natal advice/contraception/diet and exercise/continence (SIFCRAT) score
10. Smoke free homes pack. Given yes / no

**Specific outcome measures**

- Visit carried out 10-14 days post delivery
- Parents receive information about immunisations and developmental screening
- Reduction of risk factors in line with current SID research
- Parents know how to access the health visiting service
- A family health profile is continued
- Opportunity given for parents to discuss feeding
- Early detection of hearing impairment

**Materials/action required**

- Parent held record
- Family master card
- Discharge letter
- Health promotion literature
- Birth to 5 book (1st time mothers only)
- Otto Acoustic Emissions (OAE) Machine
- Child information service leaflet
- Scales and measuring equipment
- Smoke free homes pack.

| Review: Sept. 2007 | **Bibliography** |
|---|---|


- Barlow, J and Coren, E (2001) Parenting programmes and maternal psychosocial health: findings from a systematic review, Health Services Research Unit, Oxford University.
- DOH (2004) The National service Framework for Children, Young people and Maternity Services. HM Government
- DOH (2004) Every Child Matters: Change for Children. HM Government
- Elkan, R et al (2000) The effectiveness of domiciliary visiting: a systemic review of international studies and a selective review of the British literature, Health Technology Assessment, vol. 4, 13
- Hall, D and Elliman, D (2003) Health for all children: 4th Report, Oxford Medical Publications, Oxford
- Sadler, C. (2002) Hearing the message. Community Practitioner. Vol. 75 no 10.
- SIFCRAT Sandwell Incontinence following Childbirth assessment Tool.
- St. Aubyn, B. and Perkins, E (2003) Health visitors listening to mothers' perspectives of self-care. Community Practitioner. Vol.76 no 2
- Twinn, S. and Cowley, S. (1992) The principles of Health Visiting a re-examination. London HVA

## Health Visiting Service
PACKAGE OF CARE 3 – ADDITIONAL

**6-8 week contact**

**Rationale**

- Provision of support to family
- Assessment of family health and social care needs
- Support for chosen feeding method

**Process guidelines**

1. Family health and social care needs assessment
2. Physical observations of the baby including weight, length and HC
3. Discussion/Information of chosen feeding method
4. Discussion of immunisation
5. Maternal and paternal post-natal health

**Specific outcome measures**

- To continue family health and social care needs assessment
- Early detection of infant feeding problems
- Opportunity for parents to discuss family health and well being
- Detection and monitoring of post natal depression

**Materials/action required**

- Scales and measuring equipment
- Parent held record
- Health promotion literature

**Review: Sept. 2007**

**Bibliography**


- Murray, L and Cooper, P (1997) Effects of postnatal depression on infant development. Archives of disease in childhood. 77, 2 pp99-101
- Takka, M et al (1999) Factors related to successful breast-feeding by first time mothers when the child is 3 months old. Journal of Advanced Nursing. Vol. 29 pp113-118

## Health Visiting Service
PACKAGE OF CARE 4 - ADDITIONAL

**Weaning Contact**
**Rationale**

- To promote healthy nutrition by providing information on good eating practices
- To provide additional support to family
- Reassessment of family health and social care needs

**Process guidelines**

1. Information of which foods should be included in a healthy diet
2. Discussion of when and how to introduce suitable foods
3. Advise on the preparation of food and associated equipment
4. Discussion of safety issues
5. Discussion of family health and social care needs

**Specific outcome measures**

- To reduce the incidence of early weaning
- To identify the presence of food allergies or food intolerance
- Early prevention of coronary heart disease, obesity, diabetes and cancer
- To continue the family health and social care needs assessment

**Materials/action required**

- User friendly weaning leaflets
- Additional documentation for other family members on diet and nutrition

**Review: Sept. 2007**

**Bibliography**


- Department of Health (2004) Choosing Health: Making healthier choices easier. HM Government
- Dudley South/Beacon and Castle PCT Infant Feeding Policy Guidelines.

## Health Visiting Service

PACKAGE OF CARE 5 - CORE

**7-9 month contact**
**Rationale**

- Provision of support to family
- Assessment of health and development of child
- Identification of hearing loss or developmental delay
- Identification of post natal depression
- Assessment of family health and social care need

**Process guidelines**

1. Advice on accident prevention, dental care, diet, sleep and speech and language development
2. Information on appropriate toys and play
3. Continuation of the health assessment of the family
4. Observation of the child's weight and length.
5. Discussion of aspects of maternal mental health
6. Discussion of any concerns regarding hearing
7. Completion of schedule of growing skills development check
8. Smoke free homes pack given yes / no
9. Book start pack given yes / no

**Specific outcome measures**

- Early detection of visual problems
- Early detection of hearing problems, prevention of speech and language delay
- Prevention of accidents
- Early detection of gross motor developmental delay
- Prevention of dental decay
- Promotion of immunisation programme
- Prevention of feeding difficulties in later childhood
- Continuation of family health assessment
- To raise awareness of expected developmental milestones.

**Materials/action required**

- Parent held record
- Measuring equipment
- SOGS tool box
- Health promotion leaflets
- Smoke free homes pack
- Book start pack

| Review: Sept. 2007 | **Bibliography** |
|---|---|


- Arblaster, L et al (1996) A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health. Journal of Health Services Research and Policy, Vol. 1, 2, pp93-103
- Cox, A. D. (1998) Preventing child abuse: A review of community based projects 11: issues arising from reviews and future direction, Child Abuse Review, vol. 7, pp30-43
- Department of Health (2004) Choosing Health: making healthier choices easier, HM Government
- Department of Health (2004) Every Child Matters: The next Steps. HM Government
- Department of Health (2004) The National Service Framework for Children, Young People and Maternity services. HM Government
- Hall, D. and Elliman, D. (2003) Health for all Children: 4th Report Oxford medical publications, Oxford
- The Royal Society for the Prevention of Accidents @ www.rospa.com

## Health Visiting Service

PACKAGE OF CARE 6 – CORE

**18-24 month contact**

**Rationale:**

- To promote positive parenting
- Assessment of health and development of child
- Family health assessment
- To assist in engaging with peer group support

**Process guidelines:**

1. Advice on toilet training
2. Management of temper tantrums
3. Socialisation with peers
4. Observation of walking and gait
5. Information on appropriate toys and play
6. Advice about diet and nutrition
7. Advice on dental care
8. Advice on safety and supervision
9. Assessment of development complete the Schedule of Growing Skills if required
10. Measurement of weight and height
11. Smoke free homes pack given yes/ no
12. Book start pack given yes / no

**Specific outcome measures**

- Prevention of behavioural difficulties
- Increased awareness of developmental milestones
- Prevention of speech and language delay
- Early referral to specialist services as required
- Prevention of dental decay
- Prevention of childhood accidents
- Reduction in coronary heart disease, diabetes and obesity

**Materials/action required**

- Scales
- Standing height measure
- SOGS toolkit
- Health Promotion Leaflets
- Child Information Service Leaflet
- Smoke free homes pack
- Bookstart pack

| | |
|---|---|
| Review : Sept. 2007 | **Bibliography**<br>➢ Arblaster, L et al (1996). A Systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health. Journal of Health Services Research and Policy, Vol. 1,2, pp 93 – 103.<br>➢ Barlow J. (1999) Systematic Review of the effectiveness of parent training programmes in improving behaviour problems in children aged 3 – 10 years.<br>➢ Health Services Research Unit, University of Oxford.<br>➢ Cox, A.D. (l998) Preventing Child Abuse: A review of community based projects 11: issues arising from reviews and future direction, Child Abuse Review, vol. 7, pp 30 – 43.<br>➢ Department of Health (2204) Choosing Health: making healthier choices easier, HM Government.<br>➢ Department of Health (2004) Every Child Matters: The Next Steps. HM Government.<br>➢ Hall, D and Elliman D. (2003) Health for all Children: 4th Report Oxford medical publications, Oxford.<br>➢ St Auby, B and Perkins E (2003) Health Visitors listening to mother's perspectives of self-care. Community Practitioner. Vol 76 no 2.<br>➢ The Royal Society for the Prevention of Accidents @ www.rospa.com<br>➢ |

## Health Visiting Service
PACKAGE OF CARE 7 - ADDITIONAL

**36-48 month contact**

**Rationale:**
- To promote positive parenting
- Assessment of health and development of child
- Family health assessment
- Preparation for entry into nursery/school

**Process guidelines:**

1. Advice on diet and nutrition
2. Advice on dental care
3. Information on appropriate toys and play
4. Advice on safety and supervision
5. Discussion of socialisation with peers
6. Observation of walk and gait
7. Information on toilet training
8. Assessment of development complete the Schedule of Growing Skills if required
9. Discussion of immunisation programme and vision screening
10. Information on commencing nursery school
10. Height and Weight.

**Specific outcome measures**

- Raising awareness of expected developmental milestones
- Referral to specialist services as necessary
- Prevention of behavioural difficulties in later childhood
- Prevention of dental decay
- Prevention of childhood accidents
- Reduction in coronary heart disease, obesity and diabetes

**Materials/action required**
- Health promotion leaflets
- SOGS screening tool
- Scales
- Stand up height measure

| | |
|---|---|
| **Review: Sept. 2007** | **Bibliography**<br>➢ Arblaster, L et al (1996) A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health. Journal of Health Services Research and Policy, Vol. 1, 2, pp93-103<br>➢ Barlow, J. (1999) Systematic review of the effectiveness of parent training programmes in improving behaviour problems in children aged 3-10 years, Health Services Research Unit, University of Oxford.<br>➢ Cox, A. D. (1998) Preventing child abuse: A review of community based projects 11: issues arising from reviews and future direction, Child Abuse Review, vol. 7, pp30-43<br>➢ Department of Health (2004) Choosing Health: making healthier choices easier, HM Government<br>➢ Department of Health (2004) Every Child Matters: The next Steps. HM Government<br>➢ Hall, D. and Elliman, D. (2003) Health for all Children: 4th Report Oxford medical publications, Oxford<br>The Royal Society for the Prevention of Accidents @ www.rospa.com |

## Health Visiting Service
PACKAGE OF CARE 8 - ADDITIONAL

**Transfer in to caseload**
**Rationale:**

- To establish a supportive relationship between parents and health visitor
- To assess the family health and social care needs

**Process guidelines:**

1. Discussion of health visiting service and local provision
2. Family health and social care needs
3. Discuss and complete care package appropriate for the child's age
4. Assess immunisation status

**Specific outcome measures**

- Contact made within 5 working days of transfer in
- Family health and social care needs assessment
- Awareness of service available
- Joint identification of next care package required

**Materials/action required**

- Parent held record
- MasterCard
- Children's information service leaflet
- SOGS tool kit

**Review: Sept 2007**

**Bibliography**


- Acheson, D. (1998) Independent enquiry into the inequalities in health. The Stationery Office, London.
- Department of Health (2004) Choosing Health: making healthier choices easier, HM Government
- Department of Health (2004) Every Child Matters: The next Steps. HM Government
- Hall, D. and Elliman, D. (2003) Health for all Children: 4th Report Oxford medical publications, Oxford.

**Appendix 5**

# Child Health Surveillance

**Universal 8 weeks physical examination of babies:**

- The examination coincides with the first vaccine dose in the current UK schedule of immunisation. It can be also combined with the postnatal examination of mothers, at which physical health, contraception, social support, depression, etc. can be discussed as appropriate.

- There are arguments for an earlier examination, outcomes for Developmental Dysplasia of Hips (DDH), cataract and jaundice due to biliary atresia may be better, if they are detected and treated before 6 weeks. However if this examination were to be brought forward, parents might be less likely to attend again for immunisation, resulting in decline in immunisation rate with it's potential serious public health consequences compared with the modest and (currently) largely theoretical reduction in good outcomes for the treatment of DDH and cataract.

- Currently the physical examination of babies is performed by General Practitioners and Community Doctors. The aim should be to complete this examination in all babies by 8 weeks.

- The physical examination:

    1. Measure weight and head circumference.
    2. Full physical and neurological examination, including eyes for squint and red light reflex, femoral pulses, hips, testes.
    3. Developmental examination: babies at this age are smiling, fixing and following, head control better.

- Babies should be referred urgently for further assessment, if found to have:

    - Heart murmur
    - Absent or weak femoral pulses.
    - Cataract
    - Prolonged jaundice because of possible biliary atresia
    - Signs of hip disorder- limitation of abduction, asymmetry and abnormal skin creases.
    - Failure to thrive.

- For Undescended testes- see Undescended testes policy.

**Reference: Health for All Children, Fourth edition, Edited by Prof. David Hall& David Elliman.**

**Appendix 6**
# EXECUTIVE SUMMARY

## Protocol

The School based Vision Screening Protocol.

## Purpose

To inform the Core Policies, Guidelines and Protocols Committee of the change in practice of vision screening for all children aged 4 to 5 years in Dudley schools.

## Summary

The document describes the change from screening from children aged 3½ years in Health Centres and Clinics to 4 to 5 years in school. The screening will continue to be carried out by an Orthoptist.

The test will change from the Uncrowded LogMAR Test to Crowded LogMAR test.

The administrative function will be carried out by Child Health.

Percentage of children screened will increase from 58% to 95%+.

## Recommendation

The vision programme will change from 3½ years of age in Clinics and Health Centres to 4 to 5 years of age in primary schools.

This document has been approved for use in the specified clinical areas. It is deemed to meet the required quality standards and both the risks associated with implementation, and the resources required, are deemed reasonable given the benefits provided.

**Signed by Lead for document production ……..**

**Position ……Date……..**

**Signed by Chair of Core policies……**

**Date……**

Dudley NHS
Primary Care Trust

# SCHOOL BASED VISION SCREENING PROTOCOL

## Background

The fourth edition of the report **'Health for all Children'** by David Hall states that the 'gold standard' for universal vision screening would be '**an examination of all children between 4 and 5 years of age.'** The report further recommends that this screening is best done by Orthoptists, who are experts in the examination of binocular vision and eyesight, rather than by School Health Advisors, Doctors or Optometrists. It is also recommended that the vision or sight test carried out is a Crowded LogMAR linear test.

## Outcomes

In Dudley children are currently assessed by Orthoptists at 3½ years of age in clinics and health centres where they have an assessment of the state of eye movements, binocular co-operation of the eyes and vision. Due to poor uptake of appointments only 58% of children attend for their eye test. It is anticipated, using data from other local screening programmes, that approximately 95% of children will be screened in school under the new programme. The remaining 5% will be offered an appointment for screening at the Guest Hospital. A number of children with eye defects are missed under the current system because of poor attendance; because we would be assessing a 'captive' population these children will now have the opportunity to access the service.

Vision at screening is currently assessed using the UnCrowded LogMAR test. In this test a single letter is displayed for the child to match. A more accurate way of testing vision is a Crowded LogMAR linear test, which tests vision using a row of letters, rather than single letters and has increased sensitivity and specificity to the target condition amblyopia; using this test should reduce false referrals. However, because of the young age of the child it is not possible to do the Crowded LogMAR linear vision test with our current screening cohort.

Currently 16% of children have to be re-tested because of lack of understanding or co-operation, this figure should be less when testing slightly older children. Also the children will be assessed in an environment they are familiar with which should help them to feel more at ease. A further advantage will be improved communication between Orthoptists and teachers, with teachers being able to pass on helpful information about any eye problems they may have noted, and Orthoptists being able to advise teachers how best to help children with eyesight deficits.

The screening system in Dudley will be changed from 3½ years of age in clinics and health centres to 4 to 5 years of age in primary school.

**SCREENING PROTOCOLS**

1. Pre-screening process

    - In September Child Health will obtain class lists and numbers and in the first half of the autumn term all schools will be contacted to inform them of the screening programme and their responsibility within that.
    - Child Health will formulate a screening programme to run from after October half term up to the first week of July. This would comprise seven sessions per week over approximately 28 weeks during term time.
    - Prior to a school visit Child Health will send a letter **(Appendix 1)** to the school to be distributed to each child informing parents that an eye test will be carried out during the current academic year. As advised by Clinical Governance a negative consent route will apply and parents will need to complete and return the form **(Appendix 2)** to the school if they wish to opt out of the test.
    - Prior to the school visit Child Health will provide the Orthoptist carrying out the session with a class list and a form on which to record results **(Appendix 3).** This will be emailed to the relevant Orthoptist.

2. Screening Process – Information to Parents
    - A letter **(Appendix 4)** will be completed by the Orthoptist for children who pass the tests and will be sent to the child's parents via the school secretary.
    - A letter **(Appendix 5)** will be sent via the secretary to the parents of those children who are absent on the day of screening or who do not co-operate sufficiently with the tests. A further appointment for a re-test will be offered at the Guest Hospital Orthoptic Department.
    - For children who are found to have an eye defect and need further referral either letter **(Appendix 6) or (Appendix 7)** will be sent out to parents via the school secretary, depending on the clinical findings. Children with possibly serious eye pathology and children who are unco-operative are best assessed in the Hospital Eye Service (HES) within the Paediatric Ophthalmology Clinic at the Guest Hospital. Children with suspected serious eye pathology will be fast tracked into the HES. Some children with very dark eyes do not respond well to the pupil dilating drops available for use in the Community Optometry service and need a stronger drug; these children will also be referred into the HES.
    - Each school secretary will be given a letter **(Appendix 8)** to be given to children who may move into a Dudley school after the school has had its screening visit. This letter offers parents the opportunity to have their child's screening test carried out at the Guest Hospital. The appointment will be given within 4 weeks of the parent contacting the Orthoptic Department.

3. Post-screening process
    - Following the screening session the Orthoptist will complete the results sheet **(Appendix 3)** for those children screened and email it to Child Health and the Head Orthoptist.

- Children absent on the day of screening in the first intake (September) will be offered another appointment when the Orthoptist returns to school to screen the second intake.
- Children absent on the day of screening for the second intake (January) will be offered an appointment at the Guest Hospital Orthoptic Department within four weeks of the screening visit. Child Health will be notified of the outcome of this visit.
- Children who did not co-operate sufficiently at screening will be offered an appointment at the Guest Hospital Orthoptic Department within 4 weeks of the screening visit. Child Health will be notified of the outcome of this visit.
- Forms **(Appendix 2)** on which parents notified the school that they wished to opt out of the screening assessment process will be returned to Child Health for appropriate filing.
- For children needing referral for further investigations a form **(Appendix 9)** will be completed and sent either to the DGOH Outpatient Booking Team (for those children referred to HES) or given to the Deputy Head Orthoptist who will organise referral to the Community Optometry service within 13 weeks.
- Children who attend Dudley schools, but who live out of the area will be screened and referred as per the above process, but if the parents prefer to access care at a more convenient location the Orthoptic Department will refer them on appropriately using form **(Appendix 9).**
- Follow up care for children referred can be arranged to suit the parent at the Guest Hospital, Halesowen Health Centre or Feldon Lane Clinic.

4. Storage of Results
    - Results of tests will be stored by Child Health electronically using the SPOTRN coding system. Paper copies of results could be provided to the Orthoptic Department if required.
    - Screening result sheets **(Appendix 3)** will be stored on the Orthoptist's laptop computers. Results will also be emailed to the Health Orthoptist and stored centrally on her computer to enable ease of monitoring and `audit of data.

3. Telephone and Written Enquiries
    - Child Health will be responsible for queries from schools or parents relating to the pre-screening process, and for passing on to the Orthoptic Department such queries as they are unable to answer adequately.
    - The Orthoptic Department at the Guest Hospital will be responsible for queries from either the school or parents relating to the screening process itself and for queries relating to the post-screening referral process and eye care follow up.

**MONITORING AND AUDIT**

- The service will be monitored by the Head Orthoptist who will collect relevant data about number of children being assessed to ensure completeness of coverage.

- The service will be audited as appropriate to establish effectiveness in terms of criteria for referral using the Crowded LogMAR vision test to monitor referral patterns and especially to note any changes in the false referral rate and to monitor outcomes of treatment.

**RISKS**
The risks identified would be :

- Screening a child whose parents have expressed their wish not to be tested.
- Equipment giving faulty readings
- School refusing to allow the vision screening to take place.

It is felt that the benefits of introducing the “gold standard” (as described by David Hall in ‘Health for all Children”) for universal vision screening, together with the large increase in the numbers of children screened outway the small risks involved.

**RECOMMENDATION**
From September 2006 vision screening will be offered by Orthoptist to children aged 4 to 5 years in primary school.

**Protocol produced by *:***

**Lois Parks**
**Head Orthoptist**
**Dudley Group of Hospitals**

**Sue Preston**
**General Manager – Childrens Services**
**Dudley South Primary Care Trust**

**July 2006**

**CONSULTATION**

- Orthoptists
- Child Health
- Clinical Lead – School Nursing
- Child Health Surveillance Programme Group
- Headteachers Consultative Forum
- PCT Strategic Commissioning Lead for Children
- Consultant Community Paediatrician

**APPROVAL**

- Child Health Surveillance Programme Group

**Dudley NHS Primary Care Trust**
CHILD HEALTH DEPARTMENT
**Falcon House**
**5th Floor**
**Dudley**
**West Midlands**
**DY2 8PG**
Telephone 01384 361317/361309/361547
Email : child.health@dudley.nhs.uk

**VISION SCREENING**

Date:

Dear Parent/Guardian

As part of national guidelines it is required for Orthoptists to carry out a routine eye test in school. During this academic year your child will have a vision screening test by an Orthoptist who is specially trained to investigate and treat eye problems in children.

The tests which check your child's vision and co-ordination are short simple matching games with letters which will include the wearing of a pair of glasses with one eye covered to test the vision of the other eye.

Following the screening test the Orthoptist will send you information about the results.

Should you not wish your child to have the eye test please complete the attached form and return it to the above address.

Yours faithfully

L PARKES
HEAD ORTHOPTIST
Appendix 1

# Dudley NHS Primary Care Trust

CHILD HEALTH DEPARTMENT
5th Floor
Falcon House
Dudley
West Midlands
DY2 8PG

Telephone 01384 361317/361309/361547
Email : child.health@dudley.nhs.uk


**VISION SCREENING**

Date:

I **DO NOT** wish my child to have a routine eye test at school.

Name of Child ……..

Address……..

…….

…….

…….

Date……

Signed……

(Parent/Guardian)

Appendix 2

**Dudley NHS Primary Care Trust**
Child Health Department
5th Floor
Falcon House
Dudley
West Midlands
DY2 8PG
Telephone : 01384 361317/361309/361547
Email : child.health@dudley.nhs.uk

## VISION SCREENING

**SCHOOL**_____

**CLASS** _____

**DATE** _____**ORTHOPTIST**_____

| NAME | DOB | RESULT | COMMENTS |
|---|---|---|---|
| | | | |
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Appendix 3

DUDLEY NHS PRIMARY CARE TRUST
CHILD HEALTH DEPARTMENT
5th Floor Falcon House
Dudley DY2 8PG.
Telephone 01384 361317/361309/361547
Email : child.health@dudley.nhs.uk

# VISION SCREENING

Dear Parent/Guardian

I am pleased to inform you that …….passed the Orthoptic Vision Screening Examination on ……..

Tests showed that vision and eye co-ordination were normal for this age group.

Yours faithfully

**ORTHOPTIST**

(Please place this letter in your Personal Child Health Record Book "Red Book.")

**APPENDIX 4**

**DUDLEY NHS PRIMARY CARE TRUST**
CHILD HEALTH DEPARTMENT
5th Floor Falcon House
Dudley DY2 8PG
Telephone 01384 361317/361309/361547
Email : child.health@dudley.nhs.uk

## VISION SCREENING

Date:

Dear Parent/Guardian of ……

Your child did not co-operate fully for reliable eye testing, a further appointment will be sent for your child to attend the Guest Hospital Orthoptic Department. ☐

Your child was absent today when eye tests were carried out by the Orthoptist, a further appointment will be sent for your child to attend the Guest Hospital Orthoptic Department. ☐

Your child was not tested today, to comply with your written request. ☐

Yours faithfully

ORTHOPTIST
(Please place this letter in your Personal Child Health Record "Red Book.")

APPENDIX 5

**The Dudley Group of Hospitals NHS Trust**
The Guest Hospital
Tipton Road
Dudley
West Midlands
DY1 4SE

Telephone 01384 244840
Fax 01384 244828

ORTHOPTIC DEPARTMENT
TELEPH0NE 01384 244840

Dear Parent/Guardian of ……

The Orthoptist who examined your child's eyes is of the opinion that he/she needs further investigation for……

He/She has therefore been referred to see a Community Optometrist. An appointment to attend Halesowen Health Centre, Brierley Hill Health Centre or Cross Street Health Centre, Dudley will be sent to you in due course.

On this first visit the Orthoptist will assess your child, and then your child will need to have drops in his/her eyes to enable the doctor to make an examination of the eyes. These drops can cause blurred vision and a sensitivity to light for a few hours.

The visit will take a **minimum of one hour, but could take longer**, so where necessary it may be advisable to make arrangements for collection/care of any other children.

If your child is already receiving treatment for any eye condition and you do not wish the referral to proceed, or if you have any queries regarding this referral, please contact the Orthoptic Department on **01384 244840**.

Yours faithfully

**ORTHOPTIST**

APPENDIX 6

The Dudley Group of Hospitals NHS Trust
The Guest Hospital
Tipton Road
Dudley
West Midlands
DY1 4SE

Telephone 01384 244840
Fax 01384 244828

ORTHOPTIC DEPARTMENT
TELEPH0NE 01384 244840

Dear Parent/Guardian of ……

The Orthoptist who examined your child's eyes is of the opinion that he/she needs further investigation for…….

……..

He/She has therefore been referred to see a Paediatric Ophthalmologist at the Guest Hospital, Dudley.

On this first visit the Orthoptist will assess your child, and then your child will need to have drops in his/her eyes to enable the doctor to make an examination of the eyes. These drops can cause blurred vision and a sensitivity to light for a few hours.

The visit will take a **minimum of one hour, but could take longer**, so where necessary it may be advisable to make arrangements for collection/care of any other children.

If your child is already receiving treatment for any eye condition and you do not wish the referral to proceed, or if you have any queries regarding this referral, please contact the Orthoptic Department on **01384 244840**.

Yours faithfully

**ORTHOPTIC DEPARTMENT** Appendix 7

The Dudley Group of Hospitals NHS Trust
The Guest Hospital
Tipton Road
Dudley
West Midlands
DY1 4SE

Telephone 01384 244840
Fax 01384 244828

## VISION SCREENING

Date

Dear Parent/Guardian

As part of national guidelines it is required for Orthoptists to carry out a routine eye test in school. Unfortunately, we visited your child's school before he/she started attending the school. However we would still like to offer you the opportunity to have the test done.

The tests which check your child's vision and eye co-ordination are short simple matching games with letters which will include the wearing of a pair of glasses with one eye covered to test the vision of the other eye. The tests are done by an Orthoptist who is specially trained to investigate and treat eye problems in children.

If you wish your child to have the eye test please contact the Orthoptic Department at the Guest Hospital, telephone 01384 244840 to arrange an appointment.

Yours faithfully

L PARKES
HEAD ORTHOPTIST

Appendix 8

Dudley Group of Hospitals

CHILD HEALTH SERVICES

## VISION SCREENING TEST BY ORTHOPTISTS

Name_____

Date of Birth_____

Address_____

_____

GP_____

A vision screening test was carried out on the above child :

On_____

At_____School.

Result
Visual Acuity

| R | L |
|---|---|
| | |

**Squint**

| | |
|---|---|
| Absent | |
| Present | |
| Uncertain | |

Action (if any) _____

Signature of Orthoptist_____

Date_____

Appendix 9

**Appendix 7**

Dudley NHS
Primary Care Trust

# School Nursing Service

# Protocol and Guidelines for Initial School Health Contact and Selective School Health Contact

# FOREWARD

The Initial School Health Contact and Selective School Health Contact protocol and guidelines pack and assessment tool, were formulated as part of the school nursing development plan. The pack adds to the developments currently being undertaken by the Dudley PCT School Nursing Service, who continuously work to improve and develop best practice within the services they provide to Dudley school children in line with the current public health agenda and Government policy.

The pack should be used to enable School Health Advisors/School Staff Nurses to deliver a standardised evidence based package of care to children aged five.

The pack should also be used as a resource for the training and induction of new School Health Advisors/School Staff Nurses who should be encouraged to discuss the package with senior members of staff. Regular training updates will be given to ensure that the package of care given is within the competencies of the nurses involved.

The authors would like to acknowledge the aid of Clinical Leader, Jane Carey, the school nursing audit group, School Health Advisors, senior management and other professionals for their support and contributions to the pack.

- Bee Tang RGN, School Nurse Cert., BSc. (Hons), PGCE
- Chris Palmer RGN, School Nurse Cert., RSCN

Updated January 2007 JC

## CONTENTS



## APPENDICES

# INITIAL SCHOOL HEALTH ASSESSMENT

**Rationale**

The Initial School Health Contact and selective School health Contact introduces the child and family to the School Health Service and provides as Hall (2004) recommends a holistic view of the child's health status. The School Health Advisor (SHA) reviews all Child Health and Health Visitor pre-school records of children in reception class to ascertain developmental, emotional, social problems and immunisation status, therefore identifying current needs. This provides the opportunity through the health assessment to encourage full parental participation in the child's health and development.

Following the Initial School Health Contact the SHA can help school, parents and the child wherever possible; develop individual health care plans, following the guidelines in Supporting Children with Special Medical Needs (1999). Conditions such as epilepsy, asthma, cerebral palsy or peanut allergy may require such a plan. Opening pathways of care will aid collaboration and consistency between home, school and health professionals (Bagnall 1999).

**Prior to Initial School Health Contact**

1. The School Health Department will correlate the Health Visitor records and any GP developmental screening information within the (10M) School Medical Records.

2. The Health Visitor will liaise/discuss with the SHA any children on their caseload with whom they have concerns.

3. The SHA will arrange a convenient date with the school for the Initial Health Contact to take place.

4. A letter will be sent to parents along with a SHA leaflet, and questionnaire. The questionnaire forms enclosed for completion to be returned to the SHA via school within three days (see Appendix 1).

5. Before commencing the Initial School Health Contact in school the SHA will liaise with the class teacher or Special Needs Co-ordinator to discuss concerns about any particular children.

**Procedure for Initial School Health Assessment**

1. The SHA must use the standardised equipment and stationery to perform the assessment (this will be audited) (See Appendix 2).
2. The SHA will check that 10M is available
3. The front of the 1OM should be completed and the questionnaire should be read.
4. The findings from the assessment should be recorded clearly and accurately in the child's 10M according to UKCC (1998) guidelines on record keeping.

**The Outcome of the Initial Health Contact Procedure will determine the next course of action:-**

1. Where there are no identified health problems no further action will be taken
2. The SHA with the Parent/Carer's consent may arrange a Selective Health Assessment
3. The SHA may with the parents/carers consent refer direct to other appropriate agencies and review children accordingly.
4. Where there is an identified problem and parents are agreeable the SHA will liaise with the Community Medical Officer CMO to make a decision as to whether a Medical/Griffiths developmental assessment is necessary.

**The Initial School Health Contact will include :-**

**Growth (Refer to Guideline)**

a) Children should have their height and weight centiles recorded using Leicester height measure. If height and weight are above the 98$^{th}$ centile but following the same growth curve, check again in six months.
b) If height and weight are below the 2$^{nd}$ centile but following the same growth curve check again in six months.
c) Familiar patterns should be taken into account before a referral is made.
d) If a child is under the care of a GP or hospital surveillance for growth, there is no need for regular growth monitoring.

**Hearing**

1. All children will be offered a hearing test as part of the Initial School Health contact check with questionnaire if there are any hearing concerns expressed.
2. If a child passes the sweep test, but there are still parental concerns refer to Audiology Department for further assessment.
3. If a child only fails at one frequency this may be repeated in three/four months in school. It may be only due to a cold or congestion.
4. If a child fails on two or more frequencies refer to Audiology Department (see appendix 4).

**Speech**

Observe speech during contact with the child:-

1. The child can speak in full sentences.
2. Whether child understands sequencing of instructions.
3. Whether speech is clear.
4. Any stammering or lisp.

If necessary discuss concerns with Speech Therapist or make direct referral if parents are concerned (see appendix 5).

**Enuresis/Encoporesis**

If the parental concerns are noted contact parents to give initial advice and offer a referral to the Enuresis/Encopresis services (appendix 9)

**Behavior (Refer to Guideline and Sheridan Chart)**
Throughout the Health Assessment the SHA should observe for :

1. Attention span.
2. Distractability.
3. Interest and Alertness.
4. Degree of co-operation (refer to assessment tool/Sheridan chart).

NB If parental concerns or school concerns are noted call for selective school health assessment

**SELECTIVE SCHOOL HEALTH ASSESSMENT**
**Children who need to be referred for a selective health assessment**:-

1. Poor history of the child from discussion or as contained in the Health Visitor Records.
2. Information from the school via class teacher or Special Needs Co-ordinator.
3. Present history gained from health assessment and parent questionnaire.
4. Child protection/cause for concern information or looked after children.
5. Any children with chronic conditions or who are on regular medication may need to be discussed with the CMO
6. The SHA to liaise with the CMO for any children who have been referred for medicals/assessments.
7. The SHA will acknowledge that parents should be kept informed at all times of any communications between professionals. Any issues of child protection will be dealt with according to Dudley Area Child Protection Policy.

**Parents will be sent an appointment letter and consent form**
The selective school health assessment may include

**Measurement of height and weight**

**Hearing test**

**Assessment of speech**

**Behaviour problems**

**Vision Screening**
Vision screening should be carried out in reception class by the ophthalmology department

If there are concerns the SHA may carry out a visual acuity test following ophthalmology guidelines (see appendix 3) Both distance and near vision may be checked.

**Referral Criteria**

**Referral to Optician**

1. Unequal vision e.g. 6/6 R 6/9 L (test with glasses if concerned)

2. Squint observed.
3. Ocular symptoms/parental concerns.
4. Marked reduced vision

**Balance**
Ask child to remove shoes and socks:-
1. Ask the child to stand on tiptoes.
2. Stand on each foot for 10 seconds.
3. Hop on each foot.

NB This may be difficult for some children to do at this age. If there are no undue concerns, review in six months. Any signs of pain, weakness in a limb the SHA should refer to CMO/GP (Refer to Guideline).

**Feet**
Check child's :-
1. Gait.
2. Signs of in-toeing/out-toeing.
3. Flat feet or high arches.
4. Ingrowing toenails.
5. Any other abnormality.

If parents are concerned or the child is complaining of discomfort or pain when walking refer for a chiropody assessment (see appendix 7).

**Fine Motor (Refer to Guideline)**
In line with Sheridan's (1975) Charts. Observe the following :-
1. Right-handed or left-handed.
2. Pencil grip style.
3. Ability to draw a person.
4. Ability to copy circle, triangle and square shape.
5. Ask if child is able to use scissors.

If any difficulties noted discuss with parents/class teacher and refer to CMO for further developmental assessment.

**Oral Hygiene**
Discuss oral hygiene and if necessary look in the child's mouth for any obvious dental problems. Refer to school dental services or own dentist.

**Posture**
1. Check hips are level.
2. Check for any curvature of the spine (see appendix 6).
3. Ask child to remove or lift top clothing.
4. Check general posture.
5. Check shoulders are level.

# DUDLEY PRIMARY CARE TRUST

**INITIAL SCHOOL HEALTH ASSESSMENT**

**Child's Name……DOB……**

**Date of Screening……School……**

**Parent Present YES/NO**

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**BEHAVIOUR**

| | | |
|---|---|---|
| O = Observed | M = Reported by Mother | T = by Teacher |
| Normal | Unco-operative | Overactive |
| Nervous | Shy | Aggressive |
| Withdrawn | Tantrum | Distractable |

**HEARING, SPEECH AND LANGUAGE**

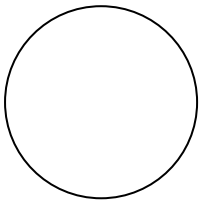
| | |
|---|---|
| Audio Screening | Pass/Fail |
| Comprehension | Normal/Difficulty |
| Speech & Language | Full Sentences heard |
| | Only Single Words |
| | Clear/Indistinct |

**LOCOMOTION AND BALANCE**

| | |
|---|---|
| Gait | Normal/Awkward/Limp |
| Walks on Tiptoes | Normal/Awkward/Unable |
| Stands on each foot (5 – 10 sec) | Steady/Unsteady |
| Hops on each foot | Steady/Unsteady |
| Posture | Satisfactory/Unsatisfactory |
| Spine | Satisfactory/Unsatisfactory |

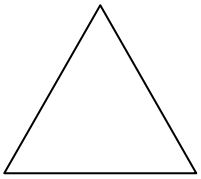
**FINE MOTOR**

Ask the child to copy the designs below :-

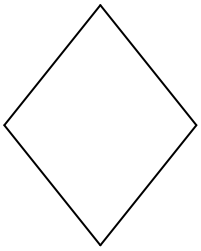


3 years

4½ - 5 years



5 – 6 years



7 years

Draw a man

Describe pencil grip Correct/Immature

Laterally R/L

Signed…….
**School Health Advisor/School Staff Nurse**

**GUIDELINE** **Review Date**

<table>
<tr><td colspan="2">and Weight Surveillance</td></tr>
<tr><td>Indications</td><td></td></tr>
<tr><td>To monitor growth and physical development</td><td></td></tr>
<tr><td>GENERAL REQUIREMENTS<br>1. An understanding of normal growth, physical development and its variations.<br>2. Ensure that the measuring equipment is correctly positioned.<br>3. Record the measurement on percentile and 10M record.<br>4. Refer to Clinical Medical Officer or GP as appropriately when:-<br>- recording drop below 2nd centile on two occasions.<br>- Recordings are falling away on centiles and are crossing 2 centile lines.<br>- Recordings are above 98th centile, or when the child's parent, teacher or professional is concerned.</td><td>MATERIALS REQUIRED<br>1. A quiet room with minimal disturbance.<br>2. Leicester Height measure.<br>3. Self calibrating electronic scale.<br>4. Percentile charts (Child Growth Foundation) for Boys and Girls.</td></tr>
<tr><td>SPECIFIC OUTCOME MEASURES<br>Procedure carried out with minimum embarrassment to the child, confidently and competently.</td><td>PROCESS GUIDE<br>Inform child of procedure<br><br>For Height<br>1. Shoes removed.<br>2. Standing height should be measured using the Leicester height measure.<br>3. Door/wall free from radiators, pipes or large skirting board.<br>4. Feet together.<br>5. Heels, buttocks and shoulder blades against the measure.<br>6. Head positioned – looking straight ahead (ears and eyes in alignment).<br><br>Weight<br>1. Shoes removed<br>2. Lightweight indoor clothes (minimum clothing).<br>The child to stand as still as possible.</td></tr>
<tr><td>REASONS FOR MONITORING HEIGHT AND WEIGHT:<br>▪ According to Polnay (1995) growth monitoring has always been a cornerstone of child health surveillance with poor growth being recognised as chronic ill health and social deprivation.<br>▪ Failure to thrive e.g. due to milk allergy.<br>▪ Growth impairment<br>▪ Malnutrition or calcium deficiency. High doses of corticosteroids.</td><td>BIBLIOGRAPHY<br>Hall D (2000) Health for All Children<br><br>Polnay L (1995) Health Needs of School Age Children, London BPA</td></tr>
</table>

**GUIDELINE** **Review Date:**

<table>
<tr><td colspan="2">GROSS MOTOR (LOCOMOTOR)(Posture and Large Movements)</td></tr>
<tr><td>INDICATIONS</td><td></td></tr>
<tr><td>To assess the Gross Motor Development</td><td></td></tr>
<tr><td>GENERAL REQUIREMENTS<br>1. An understanding of normal gross motor development and its variations.Training available for new staff.<br>2. Record the assessments on the School Entry Health Assessment form, Parent Held Record and 10M as appropriate.<br>3. Refer to Clinical Medical Officer or GP when :-<br>- School Health Advisor has concerns.<br>- Parental concerns.<br>- Child complaining of pain or discomfort.<br>- Any abnormalities identified.<br>- If in doubt, review and/or refer.</td><td>MATERIALS REQUIRED<br>1. A quiet room with minimal disturbance.<br>2. School Health Assessment Form.<br>3. Child’s 10M (Record Card).</td></tr>
<tr><td>SPECIFIC OUTCOME MEASURES<br>1. Procedure carried out with minimum embarrassment to the child, confidently and competently.<br>2. To maintain child’s interest and to carry out each test quickly.<br>3. It is strongly recommended that parent/guardian attends the assessment.</td><td>PROCESS GUIDE<br>Inform the child of procedure.<br>The child should be assessed in the following areas of development.<br>1. Walking – level ground.<br>2. Walks on tip toes.<br>3. Gait – normal – heel-toe<br>Variant=in-toeing/out-toeing, limp,diplegic gait.<br>4. Stands on each foot for 5 – 10 seconds.<br>5. Hops on each foot (can hop 2/3 yards forwards on each foot).<br>6. Posture.<br>7. Further information (to see Mary Sheriden chart and scoliosis information leaflets in the pack).</td></tr>
<tr><td>REASONS FOR ASSESSING POSTURE AND LARGE MOVEMENTS<br>▪ A systematic holistic assessment of a child’s health status taking into account his or her age, development and ability.<br>▪ Early detection of delayed development including posture and large movements<br>▪ Thinking of:-<br>- Dyspraxia<br>- Hypotonia<br>- Hypermobile joint<br>- Muscular Dystrophy<br>- Hemiparesis<br>- Scoliosis</td><td>BIBLIOGRAPHY<br>Illingworth, R The Development of the Infant and Young Child – Abnormal or Normal<br><br>Sheridan, M Child Development Birth – Five Years.<br><br>Hall, D., Hill, P., Elliman, D. The Child Surveillance Hand Book<br><br>Lissaueer, T., Clayden, G., Illustrated Textbook of Paediatrics</td></tr>
</table>

**GUIDELINE** **Review Date:**

| | |
|---|---|
| **FINE MOTOR DEVELOPMENT (EYE AND HAND CO-ORDINATION)** | |
| **INDICATIONS** | |
| **To assess the Fine Motor Development** | |
| **GENERAL REQUIREMENTS**<br>1. An understanding of normal fine motor development and its variations.<br>2. Training available for new staff.<br>3. Record the assessments on the School Entry Health Assessment Form, Parent Held record book and 10M as appropriate.<br>4. Refer to the Clinical Medical Officer or GP when:<br>- School Health Advisor has concerns.<br>- Parental concerns.<br>- Any abnormalities identified.<br>- If in doubt, review and/or refer. | **MATERIALS REQUIRED**<br>1. A quiet room with minimal disturbance.<br>2. School Health Assessment Form.<br>3. Child's 10M (Record card). |
| **SPECIFIC OUTCOME MEASURES**<br>1. Procedure carried out with minimum embarrassment to the child, confidently and competently.<br>2. To maintain child's interest and carry out each test quickly.<br>3. It is strongly recommended that parent/guardian attends the assessment. | **PROCESS GUIDE**<br>1. Check identity of child.<br>2. Inform the child of procedure.<br>3. The child should be assessed in the following areas of development:-<br>- Ability to copy shapes.<br>- Draw a man test. (Draw recognisable man with head, trunk, legs and features).<br>- Look out for hand preference, fine precision and tremor.<br>- Further information (to see Mary Sheriden chart and information leaflets in the pack) |
| **REASONS FOR ASSESSING VISUAL AND FINE MOTOR**<br>▪ A systematic holistic assessment of a child's health status taking into account his or her age, development and ability.<br>▪ Early detection of delayed development.<br>▪ A better guide to the level of intelligence than gross motor development.<br>Looking out for :-<br>▪ Dyslexia (Difficulty in learning to read in spite of adequate intelligence).<br>▪ Attention span.<br>▪ Hyperactivity<br>▪ Neurological Disorders. | **BIBLIOGRAPHY**<br>Illingworth, R., The development of the Infant and young Child – Abnormal or Normal.<br><br>Sheriden, M., Child Development Birth – Five Years.<br><br>Hall, D., Hill, P., Elliman, D., The Child Surveillance Hand Book.<br><br>Lissauer, T., Clayden, G., Illustrated Textbook of Paediatrics. |

**GUIDELINE** **Review Date:**

<table>
<tr><td colspan="2">SOCIAL BEHAVIOUR AND PLAY</td></tr>
<tr><td>NDICATIONS</td><td></td></tr>
<tr><td colspan="2">To monitor behaviour and play development</td></tr>
<tr><td>ENERAL REQUIREMENTS<br>1. An understanding of the behaviour development and its variations.<br>2. Training available to new staff.<br>3. Record the clinical evaluation on the School Health Assessment Form, Parent Held Record book and 10M as appropriate.<br>4. Refer to Clinical Medical Officer or other professionals when:-<br>- School Health Advisor’s concerns.<br>- Parents/Guardian concerns.<br>- Any major behaviour problems reported by parents or teacher.</td><td>MATERIALS REQUIRED<br>1. A quiet room with minimal disturbance.<br>2. School Health Assessment form.<br>3. Child’s 10M (Record Card).</td></tr>
<tr><td>PECIFIC OUTCOME MEASURES<br>1. Procedure carried out with minimum embarrassment to the child, confidently and competently.</td><td>PROCESS GUIDE<br>1. Check identity of child.<br>2. Observe all aspects of child behaviour from the moment you introduce yourself to the parent and the child.<br>3. The child should be assessed in the following areas of development:-<br>- Attention span, distractibility, interests, alertness and co-operation.<br>- Discuss with parent any behaviour problems which may include – sleep, eating problems, anxiety, aggression, enuresis and faecal soiling.<br>- Further information of the norm (to see Mary Sheriden chart and information leaflets in the pack).</td></tr>
<tr><td>REASONS FOR MONITORING BEHAVIOUR AND PLAY<br>1. A systematic holistic assessment of a child’s health status taking into account his or her age, development and ability.<br>2. Early detection of delayed development and social behaviour disorders.<br><br>Looking out for:<br>▪ Hyperactivity<br>▪ Attention deficit-Hyperactive Disorder<br>▪ Autistic Spectrum Disorder</td><td>BIBLIOGRAPHY<br>Illingworth,R., The Development of the Infant and Young Child – Abnormal or Normal.<br><br>Sheriden, M., Child Development Birth – Five Years.<br><br>Hall, D., Hill, P., Elliman, D., The Child Surveillance Hand Book.<br><br>Lissauer, T., Clayden, G. Illustrated Textbook of Paediatrics</td></tr>
</table>

**Appendix 1 (a)**

**SCHOOL HEALTH DEPARTMENT**
**(Clinic/address and**
**telephone details)**

SCH 7A

Date:

**To the parents of:**

Dear Parent / Guardian

Now your child has started school, the School Health Advisor is a key person to contact if you have any concerns regarding your child's health and development.

Your School Health Advisor is ……. She can be contacted on …….. or at the 'drop in' which is available in school for children, parents and teaching staff and is held on …….

During this term your child will have his / her height, weight, and hearing checked by the school health team as part of health promotion in school.

The School Health Advisor will send you a copy of the results. If you do not wish your child to be seen please contact your School Health Advisor on the above number.

Please could you complete the enclosed confidential health questionnaire and return it to school within the next 3 days in the enclosed envelope. The results of the height, weight and hearing checks, health questionnaire and any concerns highlighted by yourself, Health Visitor or Teacher will enable the School Health Advisor, if required, to offer you an appointment to discuss any concerns regarding your child's health, development or behaviour.

Yours faithfully

Fiona Santicchia
**School Health Secretary**

**appendix 1**

Dudley NHS
Primary Care Trust

**CONFIDENTIAL**

## CHILD HEALTH SERVICE

**PLEASE RETURN THIS QUESTIONNAIRE TO SCHOOL FOR THE ATTENTION OF THE SCHOOL HEALTH ADVISOR WITHIN THE NEXT 3 DAYS**

School.....…….....

Child's Name (in full) .....

Address .....

.....Postcode.....…..... Tel. Number .....

Date of Birth ..... Name of Family GP .....

If your child attended Nursery School please state name.....

Please answer the following questions and give details below each question if the answer is **YES.**

1 Do you have any concerns regarding any of the following:

(a) Hearing? **YES/NO**

.....

(b) Speech or language problems? **YES/NO**

.....

(c) Co-ordination? **YES/NO**

.....

(d) Growth? **YES/NO**

……..

2 Does your child have a cough / wheeze at night **YES/NO**

.....

3 Does your child have a cough / wheeze after exercise **YES/NO**

.....

4 Are there any smokers living in your child's household? **YES/NO**

If yes would you like to receive a smoke free home pack? **YES/NO**

**p**

5 Does your child have any allergies? If “yes” what to **YES/NO**

.....

6 Does your child have a tendency to skin complaints such as eczema? **YES/NO**

.....

7 Is your child clean and dry during the day and night? **YES/NO**

.....

8 Are you worried about his/her behaviour? **YES/NO**

.....

9 Does your child have any problems sleeping? **YES/NO**

.....

10 Does your child have any long-term medical problems? If yes, pleas give details **YES/NO**

.....

11 Does your child attend the hospital or out-patients? **YES/NO**

…….

12 Does your child take any regular medication, if so please give details? **YES/NO**

…….

13 Has your child received all immunisations due to her/him? **YES/NO**

…….

14 Is there any other condition you are worried about? **YES/NO**

……

……

15 Would you like to discuss any concerns about your child’s health with the school nurse? **YES/NO**
If yes, please give details.

……..

……

……..

Finally it would help us in planning and offering the right care to your child if you would let us know the ethnic group of y
child.

**PLEASE SEE NEXT PAGE**

What is your child's ethnic group? Choose one section from A – E, then ✓ the appropriate box to indicate your child's cultural background.

A) WHITE

- ☐ British
- ☐ Irish
- ☐ Any other White background, *please write in*

_____

B) MIXED

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background, *please write in*

_____

C) ASIAN OR ASIAN BRITISH

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background, *please write in*

_____

D) BLACK OR BLACK BRITISH

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background, *please write in*

_____

E) CHINESE OR OTHER ETHNIC GROUP

- ☐ Chinese
- ☐ Any other, *please write in*

_____

**Signed:** …… **Parent / Guardian** **Date:** ……..

SCH 8A

**SCHOOL HEALTH DEPARTMENT**
**WESTHILL CLINIC,**
**HAGLEY ROAD,**
**STOURBRIDGE,**
**WEST MIDLANDS.**
DY8 1RD
**TEL: 01384 366569**

**Fiona.Santicchia@dudley.nhs.uk**

Date:

**To the Parent / Guardian of:**

Dear Parent / Guardian

Your child was seen today in school for the following:

| | ***Observation*** | ***Review Needed and Reason*** |
|---|---|---|
| **Height** | | |
| **Weight** | | |
| **Hearing** | | |

I would like to refer your child to:

Please contact me within 3 days if you do not wish this referral to be made.

All School Health Advisors / School Staff Nurses hold regular **"Drop In"** sessions at the school where you can access any health related advice. Please see posters in school or ask the school receptionist for dates/times of the drop in sessions.

It is recommended that the following checks are carried out as a routine:

- Annual visit to the **Optician** for vision check
- Six monthly visit to the dentist for teeth checks

**Comments:**
……

**……**

**……**
Signature ……(**SHA name**)
SCH 7B

**SCHOOL HEALTH DEPARTMENT**
**WESTHILL CLINIC,**
**HAGLEY ROAD,**
**STOURBRIDGE,**
**WEST MIDLANDS.**
**DY8 1RD**
**TEL: 01384 366569**

**Fiona.Santicchia@dudley.nhs.uk**

SCH 7C

To the Parents of:

Dear Parent

Your child has been selected for a health assessment with the School Health Advisor.

You are invited to be present at

on at

Please could you complete the enclosed confidential health questionnaire and consent form and return it to school within the next 3 days in the enclosed envelope

During the assessment there will be the opportunity for you to discuss any health concerns you have regarding your child.

It would be helpful if you could bring along your child's personal child health record book (red book) so that any information can be recorded and kept for your future reference.

If you wish to cancel this appointment, or make further enquiries, please contact the School Health Secretary on the number given, at your earliest convenience.

Yours faithfully

Fiona Santicchia / Debbie Smith
**SCHOOL HEALTH SECRETARIES**

Encl.

**SCHOOL HEALTH DEPARTMENT**
**WESTHILL CLINIC,**
**HAGLEY ROAD,**
**STOURBRIDGE,**
**WEST MIDLANDS.**
**DY8 1RD**
**TEL: 01384 366569**

**Fiona.Santicchia@dudley.nhs.uk**

SCH 7D

## CONSENT FORM FOR SELECTIVE HEALTH ASSESSMENT

**Child's Name:** …….

**Date of Birth:** ……

**Address:** …….

**School:** …….

I consent to my child been seen by the School Health Advisor for a selective health assessment.

**Signed:** ……(Parent / Guardian)

**Date:** ……

Dudley NHS
Primary Care Trust

**CONSENTED – BUT DID NOT ATTEND**

Date:

Dear Parent/Guardian

I am sorry you were not able to attend your child's Initial School Health Assessment today. Please find a summary below of the checks carried out today.

Unless indicated below your child will not be seen again routinely, however a drop-in session is held on a regular basis in your school. This will give you and your child the opportunity to discuss any health related issues.

My contact number is……

| | Observation | Review Needed, and Reason |
|---|---|---|
| **Height** | | |
| **Weight** | | |
| **Oral Hygiene** | | |
| **Feet** | | |
| **Posture** | | |
| **Balance and Co-ordination** | | |
| **Speech** | | |
| **Hearing** | | |

Signature……
(SHA name)

SCH 8B

**SCHOOL HEALTH DEPARTMENT**
**WESTHILL CLINIC,**
**HAGLEY ROAD,**
**STOURBRIDGE,**
**WEST MIDLANDS.**
**DY8 1RD**
**TEL: 01384 366569**

**Fiona.Santicchia@dudley.nhs.uk**

Date:

To The Parent / Guardian of:

Dear Parent / Guardian

Following your child's initial school health contact concerns were highlighted regarding: ……

……..

Please could you contact me on: ……..…….

Mobile No:……..……..…….. if you wish to discuss this matter further.

Yours faithfully

Angela Nunn
**School Health Advisor**

**Appendix 2**

**STANDARDISED EQUIPMENT**

**Height and Weight Surveillance**

- Leicester Height Measure
- Self calibrating electronic scale

**Vision Testing**

- Stereo Lang
- 3 metre chart
- Ishihara Colour Vision Book
- Reduced Snellen
- Sheridan Gardner Test for children with learning difficulties.

**Hearing Test in School**

- Screening Audiometer (Kamplex)

**Appendix 3**

**GUIDELINES FOR SCHOOL HEALTH ADVISORS**
**CARRYING OUT VISION TESTS**

## SELECTIVE SCHOOL HEALTH ASSESSMENT

Essential Tests :- Visual Acuity with and without glasses – distance and Near.

Stereotests:- Lang Test or Wirt Fly Test

## Tips for Accurate Vision Testing

1. Test at the correct distance. It is useful to carry a 6m piece of string to accurately measure the testing distance.

2. Make the test area as light as possible, good illumination is vital.

3. Test VA using the Snellen chart if possible. If a child is unsure of the letters, a Snellen chart and Sheridan Gardner Key Card can be used together.

4. To occlude one eye for vision use a pair of children's sunglasses, with the lenses removed, place a patch or piece of opaque sticky tape over one eye.

## Tips for Accurate Assessment of Steropsis

1. Lang Test – The test should be held at 40cms from the child, at eye level, perpendicular to the child's face. Do not move or wiggle the card, and encourage the child to keep his/her head still.

2. Good illumination is necessary, but light shining directly on the test will cause reflections that obscure the child's view of the test.

3. Record results as follows :

    a) All answers correct.
    b) Shapes seen but not recognised.
    c) Negative response.

4. Wirt Fly Test – hold at 33 cms and proceed as for Lang, record result as pass or fail.

## Optional Tests :

Colour Vision Test – Ishihara Test is not always easy for children in this age group.

**REFERRAL CRITERIA**

For referral to optician

1. Unequal vision, e.g. L 6/9 R 6/9 or worse, tested with glasses (if worn).
2. Squint observed.
3. Ocular symptoms/parental concern noted.
4. Markedly reduced vision.

**Appendix 4**

## PROTOCOL FOR SCHOOL HEALTH ADVISORS HEARING SCREENING IN DUDLEY SCHOOLS

Children are to receive a hearing screening test at age 5. The hearing test will be carried out individually on each child as part of the routine medical appointment which parents invited to attend.

The consent letter to carry out the medical will include the hearing screening information.

If a parent states that the child is already under the care of an ENT Specialist, or regularly seen by the Audiology Service, there is no need to carry out the screening test. This information must be written on the 10M form.

If a hearing aid wearer is part of the age 5 medical checks there is no need to carry out hearing screening. However, you can make a referral for us to see the child if the parents indicate that they have some concerns, especially if our routine hearing assessment is not yet due.

If a teacher has a concern regarding a child who is not due to be routinely screened, the School Health Advisor can carry out a screening test after making contact with the parents by telephone or by consent letter. These parents must be informed of the results gained. This information must also be documented in the 10M.

If the child fails the screening an appointment will be sent in due course for them to attend an Audiology hearing test locally.

Parents may contact the School Health Advisor with concerns regarding a child's hearing. The School Health Advisor may make a referral straight away to Audiology without testing first if the information clearly indicates a problem or the child can be screened to either reassure or to aid the decision to refer.

Drop-in sessions in senior schools: If pupils have concerns regarding their hearing the School Health Advisor can carry out a screening test in the appropriate quiet conditions. If the child fails this screen the parents must be informed that the test was carried out, the results gained and that an appointment will be sent in due course to them. This information must be documented in the 10M.

## TEST REQUIREMENTS

The test must take place in a quiet room. Consider the traffic, noise outside as well as the noise from classrooms, corridors and toilets etc. Work with the School Secretary on the timetable of activities going on each day, ie. PE, music etc.

The room will need to have a desk or table and a chair for the child to be tested and one for the tester. If the parent/s are present, arrange their chair/s so that there is not direct eye contact between parent and child during testing which may cause loss of concentration.

The position of the Audiometer is important, angle this to not be on full view to the child. Keep the presentation button covered by cupping your hand around it.

Make sure that the child's chair is a little way back from the table but able to reach the table to tap when responding to a sound and that the table headphones reach easily. The child may use a wooden stick or pencil to tap with.

For training purposes only a group of 5 or 6 children can be seen together. Show the group the audiometer and explain how the test is done. Then chose the most capable child to have a practice run in front of the others first, before continuing to test properly.

# PROTOCOL FOR SCHOOL HEALTH ADVISORS

## HEARING SCREENING IN DUDLEY SCHOOLS

## HEALTH AND SAFETY

Carry out the subjective calibration and check for damaged wires and connections prior to each session the audiometer is used.

Do not have the trailing wire from the headphones or the mains lead in a position to cause a trip or fall etc.

To clean the headphones use alcohol wipes. This can be before or at the end of a session, and as necessary in-between.

The audiometer must be calibrated once a year by a recognised Calibration service.

The Audiology Service will arrange the annual calibration of all the School Health Advisors audiometers.

Contact the Audiology Service regarding any problems with the audiometers.

**ONCE A DAY CALIBRATION CHECK:**
**Test on yourself**
**Frequencies – are the different sounds**
**Decibel (dB) – is the intensity level of the sound tested.**

Subjectively calibrate the audiometer by listening to all the frequencies you are going to test. This is only done at the beginning of a screening session to check that both headphones are working and that the sounds are clear and not distorted.

60dB - 1000hz, 2000Hz, 4000Hz, 8000Hz, 500 Hz and 250Hz Right (red) and Left (blue) ears, and

20dB - 1000Hz, 2000Hz, 4000Hz , and

30dB - 8000Hz, 500Hz and 250Hz Right (red) and Left (blue) ears.

There are three 'rocker switches.' Leave the two on "manual" and "pure tone."

Alter the "right and left" ear rocker switch as you check each ear.

Have a system you use regularly when choosing which ear you start with i.e. always start with the right ear for each child.

To clean the headphones use alcohol wipes. This can be before or at the end of a session, and as necessary in-between.

Check the wires and the connections for any damage.

# PROTOCOL FOR SCHOOL HEALTH ADVISORS

## HEARING SCREENING IN DUDLEY SCHOOLS

## HE TEST PROCEDURE

Conditioning the child to perform the test :-

Leaving the headphones on the table, present 1000Hz at 100dB.

Instruct the child to tap on the table with the stick when they hear the sound.
Remind them that they must do this every time.

Practice until the child is confident, reducing the dB slightly to indicate that the sounds will be quiet when listening with the headphones on.

When the child is confident, immediately reduce the intensity to 40dB to prevent damaging level of sound accidentally being presented directly into the ears.

Put the headphones on the child, Red on the right ear, Blue on the left ear. (Remember when a child looks at you the headphones need to be in your opposite hands when placing them on i.e. left headphone in right hand.

Red = Right ear  Blue = Left ear

Frequencies to conduct for hearing screening on a child

| | 1000Hz | 2000Hz | 4000Hz | 8000Hz | 500Hz | 250Hz |
|---|---|---|---|---|---|---|
| Right | 40dB | | | | | |
| | 30dB | | | | | |
| | 20dB repeat | 20dB repeat | 20dB repeat | 30dB repeat | 30dB repeat | 30dB repeat |
| | | | | | | |
| Left | 20dB repeat | 20dB repeat | 20dB repeat | 30dB repeat | 30dB repeat | 30dB repeat |

The sound must be heard twice at 20dB to pass at each frequency.

If the child only responds once out of the two presentations, (possible concentration lapse) you may present the sound a third time.

To pass there must be two out of three clear responses.

Start with 1000Hz, this is an easy sound to hear.

On the first ear only, present the sound at 40dB, this is an easy intensity to hear whilst becoming familiar with the sounds.

If the child hears the sound, decrease the level in 10dB steps until you reach 20dB.

(Only start at 40dB and reduce the steps for the first ear, first frequency on each child, as it helps to gain their concentration and promotes the understanding of how quiet the sounds are).

For all the other frequencies (inc 1000Hz on the other ear) follow the pass criteria still gaining two responses at each frequency.

It is not heard on two out of three presentations of the sound, this is a “fail” at that frequency.

# PROTOCOL FOR SCHOOL HEALTH ADVISORS
## HEARING SCREENING IN DUDLEY SCHOOLS

### CONSIDERATION WHEN TESTING CHILDREN

**Syndromes**

Some have associated hearing loss. See attached list. The Audiology Service should already have tested these children but still make a referral or a phone call to check.

**High Frequency Loss**

This can be a congenital hearing loss. It may be apparent in one twin, or it can be a temporary loss associated with a runny cold.

**Low Frequency Loss**

This loss can be associated with congestion and catarrh.

### RESULTS

Record the results of the hearing screening test on the 10M.

Referral to the Audiology Service should be made on an identified form and sent directly to the Department.

If the child only fails at one frequency – this may be repeated in 3 to 4 months in school. It may only be due to a cold, congestion etc.

Talk this through with the parents, they may be concerned that the child has had earaches, infections, glue ear etc., and there may wish the child to be referred for a full diagnostic test with the Audiology Service.

If a child fails on two or more frequencies – refer to Audiology. Discuss this with the parent if they are present, or write to them indicating that they will be sent an appointment to have a full hearing test in due course.

If the child passes the screening test but parents are concerned – refer to Audiology with all the relevant information.

Indicate on the referral form to Audiology if the child should be treated 'routinely' or 'as soon as' or 'urgently.' This decision can be aided by identifying the number of frequencies below normal limits and by talking with the parents regarding the child's history.

i.e. 1 ear affected across all frequencies = 'as soon as'
2 ears affected across all frequencies = 'urgent.'

Inform the Audiology Service by referral giving name, dob, address including postcode, GP, telephone number (home, work, mobile etc.) and if they are willing to travel to another clinic within the borough especially if you consider this to be urgent. If very urgent, please telephone the Audiology Service, there may be some cancellations available.

Ring the Audiology Service for any advice you require.  Good liaison is encouraged and welcomed.

Audiology Service
Cottage Street Hearing Centre
Cottage Street
Brierley Hill
West Midlands
DY5 1RE.

01384 366890
Internal number 6890
Fax 01384 366891
Internal Fax 6891

Revised 12/09/2002

**SYNDROMES**

The majority of the physical malformation syndromes which have been associated with hearing loss have a genetic basis, but not all do. The most common syndromes associated with hearing loss are as follows:-

1. **Hearing loss associated with pigmentory change :**
   - Ushers Syndrome - retina – retinitis pigmentos
   - Waardenburgs Syndrome - hair and iris

2. **Hearing loss associated with abnormal metabolism**
   - Pendreds Syndrome - abnormal metabolism of iodine.
   - Hurlers Syndrome - abnormal metabolism of Mucopolysaccharides
   - Taysachs Syndrome - abnormal metabolism of Lipids
   - Wilsons Syndrome - abnormal metabolism of Copper

3. **Hearing loss associated with renal problems**
   Alports Syndrome

4. **Hearing loss associated with skeletal problems**
   - Treacher Collins Syndrome - conductive or mixed hearing loss.
   - Klippel Feil syndrome - Cervico – oculo – acoustic dysplasia
   - Cleft Palate and Lip - conductive deafness – serious otitis media. Secondary myoplalatal anomalies
   - Aperts Syndrome - acrocephalo syndactyly.
   - Crouzons Syndrome - mixed hearing loss.
   - Holt-oram Syndrome - absent thumbs and other limb deformation. Mixed hearing loss.
   - Pierre-Robin Syndrome - conductive and sensory neural loss.

5. **Hearing loss associated with Neurological Disorders.**
   Cerebral Palsy – Brain injury during foetal or early infantile life which may lead to an associated deafness – usually mild to moderate sensory neural.

   Severe Infantile Muscular Dystrophy – mild to moderate high tone loss.

6. **Hearing loss associated with Chromosomal Abnormalities**
   Downs Syndrome – high incidence of unremitting serious otitis media. Additional sensory neural loss not uncommon.

**Sensory-Neural Hearing Loss**
The incidence of sensory-neural hearing loss is approximately 3 per 1,000 live births with 1 per 2,000 being severely affected. Those children can be considered as belonging to three main groups.

1. Hereditary group – due to genetic influence

   a) sole defect.
   b) Associated with other abnormalities

2. Pre-natal group – due to noxious influences on the developing embryo.

3. Peri-natal group – due to accidents shortly before birth, at birth, or in the immediate neonatal period.

There are a number of pre-natal causes of congenital hearing loss that are a direct result of maternal infections or the toxic effect of drugs taken during pregnancy. The maternal infections are :-

| | | |
|---|---|---|
| Rubella | Cytomegalovirus | Toxoplasmosis |
| Measles | Influenza | Chickenpox |
| Mumps | Herpes simplex | Syphilis (deafness rarely present at birth). |

Drugs taken during pregnancy which can have a toxic effect on the foetus, are Thalidomide, Quinine, Streptomycin and Chloroquin.

Peri-natal causes of hearing loss are jaundice, anoxia, toxaemia and low birth weight. In low birth weight babies, the sensory neural deafness results from a combination of factors such as traumatic delivery, neonatal asphyxia and respiratory distress syndrome.

Postnatal or acquired causes of sensory neural hearing loss can be subdivided into two groups :-

Genetic

1. Late onset of familial sensory neural deafness.
2. Genetic deafness syndrome with delayed onset of hearing loss e.g. Alport's syndrome.

Non Genetic

1. Virus infections – Meningitis, Mumps (often unilateral), Measles, Encephalitic Influenza.
2. Bacterial Infections – Typhoid Fever, Diphtheria, Meningitis.
3. Ototoxic Drugs - Neomycin, Streptomycin, Kananycin, Quinine, Aspirin
4. Trauma – Fractures at the base of the skull.
5. Tumours.

The treatment of sensory neural hearing loss is usually by the prescription of appropriate hearing aids and the provision of educational support for the child's family.

**Cochlear Implants**
Recent work in the field of cochlear implants is showing encouraging signs but at the present time the teams working within this country are only treating children with no measurable residual hearing and who have acquired deafness. Within the next ten years however, it is felt that the technology and the skill level of the practitioners will have advanced so far as to offer hope to a wider range of children with sensory neural loss.

**Appendix 5**

## SPEECH AND LANGUAGE

### WHEN TO REFER :

- If there is parental concern.
- If the child responds inappropriately.
- If the Child repeats what you say.
- If the child is not using complete sentences.
- If the child's sentences sound 'odd.'
- If the child seems to be struggling to find the words.
- If the child is unclear.
- If the child stammers.
- If the child's voice has poor quality.

### CHECK WITH THE PARENTS AND/OR TEACHER FIRST

**Appendix 6**

## SCOLIOSIS

Children in Dudley schools are screened by School Health Advisors during routine assessments at the Initial School Health Assessment and Drop-in sessions (at parents request) and are referred to their G.P. or C.M.O. if there are any abnormal signs.

Definition:

Scoliosis is defined as a lateral curve of the spine, the presence of which is abnormal.

Scoliosis can be disfiguring because of the spine curves to one side, the vertebrae become twisted and pull the ribs round with them. This can cause a bulge (rib bump) to appear on the one side of the back and/or cause the scapula to protrude:-

Abnormal signs are :

1. Uneven shoulder level.
2. Uneven scapula prominence
3. Arms hanging uneven
4. A difference in hip prominence
5. The head not symmetrically
   Positioned over the pelvis.

## SCOLOIOSIS

### What is it?

Scoliosis is not a disease. It just means that in an otherwise healthy child the spine is curved or twisted. There is no weakness of the back. Scoliosis is not infectious or contagious and it does not develop as a result of anything the child or its parents did or failed to do.

It usually appears during the fast growth of the early teens, though it can also affect younger children. There are many types of scoliosis, varying from slight to severe curvature. It can sometimes remain mild, but four children in every thousand will need treatment.

### How to recognise it

Children should be examined bare backed for scoliosis from time to time. This is easily done by getting the child to bend over from the waist while keeping the legs and arms straight and the palms together. From the rear a clear rib bulge (as in the picture) will be visible if the child has scoliosis. A common sign of the problems is one shoulder blade being more prominent than the other, with the child tending to lean a little to one side. The hips may also be uneven. The condition will not go away as the child gets older, and the earlier the scoliosis is detected and treated the better for the patient.

### What to do about it

Successful treatment is available nowadays. Go first to your family doctor. If a curvature is confirmed the doctor will refer the child to an orthopaedic consultant who specialises in the treatment of scoliosis and who will best be able to decide on the most suitable treatment for your child. Further information from: The Scoliosis Association UK, 2 Ivebury Court, 323-327 Latimer Road, London, W10 6RA.

Helpline 020 8964 1166. General Enquiries 020 8964 5343. Fax 020 8964 5343. Email info@sauk.org.uk

**Appendix 7**

## REFERRAL GUIDELINES FOR CHIROPODY

After looking at some of the latest thoughts and research within the chiropody field we feel that the following give a helpful set of treatment criteria for us to follow. The treatment can be justified and outcomes easier to achieve by following the general guidelines written here.

In general the following patients should be referred to Chiropody :-

1. Children experiencing any kind of symptoms within their legs or feet even if these symptoms are mild. Usually, the symptom will get worse the more walking they do, or following exertion, however, if you are unsure then refer them and we can usually see if the foot function may be contributing to the problem. If the child is in pain then refer them whatever the foot looks like, i.e. either high or low arched.

2. Secondary problems – If the child has what we would term secondary problems i.e. bunions, curly feet (where the forefoot is deviated inwards), curly toes (appearing to get worse), corns, callus, inflammation or rubbing on part of the foot etc.).

3. Excess shoe wear – If the child wears their shoes out very quickly or they wear them out in an uneven nature i.e. a massive amount on one side of the heel. N.B. It is normal for shoes to wear slightly on the outside of the heel. If the inside of the shoe around the arch area is very pushed over, these would all indicate need for referral.

4. Family history – If the child does appear to have flat foot or other foot problem and along with this there is a history of people in the family having problems with their feet or legs then a referral may be indicated. NB the family should have a problem i.e. symptom and not just a-symptomatic flat feet which are often inherited, however see point 7.

5. Gait Deviations – e.g. out toeing, in toeing. The normal angle of feet during gait is 5 – 1 (as in a clock face). If the feet deviate greatly from this then it could have an effect on the feet if not being caused by the foot itself. On referral we can assess if there is likely to be a problem and treat or monitor as required.

6. Parental concern – If the parent seems very concerned about the child's feet even though they may not fall into any other category for treatment a referral may be relevant.

7. Unsure – If you are unsure whether a referral is necessary. We do not want to stop you referring patients to us for a second opinion and anything you see, if you think something is not quite right then please refer them.

## GENERAL HELPFUL INFORMATION

The a-symptomatic flat foot. On its own it does not necessarily indicate a referral. After 6-7 years of age it is likely the foot may always 'rock' over too much and nothing will cure this. Insoles in the shoes have not proved beneficial in long-term treatment of a-symptomatic flat foot. We do know that insoles help in the short term and can prove this if symptoms are present.

Therefore we now commonly say to patients return if you get any problems even if they are quite mild.

Often we see patients who are quite elderly with flat feet and they don't get any problem whatsoever and only require nail care. This underlines the thought that insoles and extra support are not necessary every time a foot is seen to 'rock' in.

Although this list may seem to limit those who you can refer. Please realise point 7 is there for anyone who you feel unsure of. We hope that this helps you as much as it helps us and ultimately we hope that more patients benefit from more appropriate care.

For any queries on our Children's Service please feel free to contact Linda Crook in our office at Cranham House 01384 361348 Extension 1348.

**Appendix 8**

## ENURESIS

### Routine

1. Encourage drinking during the daytime.

2. Avoid brightly coloured and fizzy drinks.

3. Tea, coffee, and squash are permitted, but only before 5.00 p.m. After 5.00 p.m. milk and water only.

4. Last drink one hour before sleep.

5. Remember to use the toilet twice before settling at night.

6. Be positive – remember your bedtime chat “If you keep it in your head you won’t wet the bed.”

7. No nappies.

8. No lifting. (Wake the child and walk to the toilet).

**REFERRAL GUIDELINES TO THE CONSTIPATION AND SOILING CLINIC**

| From: | To: | Date: |
|---|---|---|
| **Concerning:**<br>**Name**<br><br>**Address** | | |
| **Date of Birth:** | **General Practitioner:** | |
| **Reason for Referral** | | |
| **Additional Information** | | |

**Signature…….Post…….**

**The following section is to be completed by designated medical from the Constipation and Soiling Clinic**

| Action Required |
|---|
| |

**Please return to : Dr I Chandra, Senior Clinical Medical Officer, Cross Street Health Centre, Cross Street, Dudley, DY1 1RN.**

**Appendix 9**

| | 4 years | 5 years |
|---|---|---|
| **Posture and Large Movements** | - Turns sharp corners running, pushing and pulling.<br>- Walks alone up and downstairs, one foot per step.<br>- Climbs ladders and trees.<br>- Can run on tiptoe.<br>- Expert rider of tricycle.<br>- Hops on one foot.<br>- Stands on one foot 3/5 seconds.<br>- Arranges or picks up objects from floor by bending from waist with knees extended. | - Runs lightly on toes.<br>- Active and skilful in climbing, sliding, swinging, digging and various 'stunts.'<br>- Skips on alternative feet.<br>- Dances to music<br>- Can stand on one foot 3 – 10 seconds.<br>- Can hop 2-3 yards forwards on each foot separately.<br>- Grips strongly with either hand. |
| **Vision and Fine Movements** | - Picks up pins, thread, crumbs, etc. with each eye covered separately.<br>- Builds tower of 10 or more cubes and several 'bridges' of three on request.<br>- Builds three steps with six cubes after demonstration.<br>- Imitates spreading of hand and bringing thumb into opposition with each finger in turn – R and L.<br>-<br>- Copies cross (also V.H.T. and O).<br>- Draws man with head, legs, features, trunk and (often) arms.<br>- Draws very simple house.<br>- Matches and names four primary colours correctly.<br>- (Single letter vision test at 10 feet, seven letters: also near chart to bottom). | - Picks up minute objects when each eye is covered separately.<br>- Builds three steps with six cubes from model.<br>- Copies square and triangle (also letters:V.T.H.O.X.L.A.C.U.Y).<br>- Writes a few letters spontaneously.<br>- Draws recognisable man with head, trunk, legs, arms and features.<br>- Draws simple house with door, windows, roof and chimney.<br>- Counts fingers on one hand with index finger of other.<br>- Names four primary colours and matches 10 to 12 colours.<br>- (Full nine letter vision chart at 20 feet and near test to bottom). |
| **Hearing and Speech** | - Speech completely intelligible.<br>- Shows only a few infantile substitutions usually k/t/th/fs and r/l/w/y groups.<br>- Gives connected account of recent events and experiences.<br>- Gives name, sex, home address and (usually) age.<br>- Eternally asking questions 'Why?' 'When?' 'How?' and meanings of words.<br>- Listens to and tells long stories sometimes confusing fact and fantasy.<br>- (7 toy test, 1st picture vocabulary test, 2nd cube test. | - Speech fluent and grammatical.<br>- Articulation correct except for residual confusions of s/f/th and r/l/w/y groups.<br>- Loves stories and acts them out in detail later.<br>- Gives full name, age and home address. Gives age and (usually) birthday. Defines concrete nouns by use.<br>- Asks meaning of abstract words.<br>- (12 high frequency picture vocabulary or word lists. 3rd cube test, 6 sentences). |

| | | |
|---|---|---|
| | 6 high frequency word pictures). | |
| **Social Behaviour and Play** | - Eats skilfully with spoon and fork.<br>- Washes and dries hands. Brushes teeth.<br>- Can undress and dress except for back buttons, laces and ties.<br>- General behaviour markedly self-willed.<br>- Inclined to verbal impertinence when wishes crossed but can be affectionate and compliant.<br>- Strongly dramatic play and dressing up favoured.<br>- Constructive out of doors building with any large material to hand.<br>- Needs other children to play with and is alternately co-operative and aggressive with them as with adults.<br>- Understands taking turns.<br>- Shows concern for younger siblings and sympathy for playmates in distress.<br>- Appreciates past, present and future. | - Uses knife and fork<br>- Washes and dries face and hands but needs help and supervision for rest.<br>- Undresses and dresses alone.<br>- General behaviour more sensible, controlled and responsibly independent.<br>- Domestic and dramatic play continued from day to day.<br>- Plans and builds constructively.<br>- Floor games very complicated.<br>- Chooses own friends.<br>- Co-operative with companions and understands need for rules and fair play.<br>- Appreciates meaning of clocktime in relation to daily programme.<br>- Tender and protective towards younger children and pets. Comforts playmates in distress. |

(Reprinted from Reports on Public Health and Medical Subjects No 102 HMSO 1960 revised 1975)

## CHILD DEVELOPMENT

All children follow the same development pattern. However there is a great deal of variety in individual performance.

Children also develop at different rates in different circumstances.

## FACTORS INFLUENCING DEVELOPMENT

### Genetic
Genetic factors are what the child is born with and they are inherited from the parents, for example eye colour.

### Environmental
This includes social conditions, appropriate stimulation and a well-rounded education.

### Child Development is divided into four sections

- Physical
- Intellectual
- Emotional
- Social

These are commonly referred to as PIES.

Physical Development
This is dependent on healthy diet and exercise. Children today are generally taller and stronger than their parents' generation. This is due to improved diet, health services and living conditions.

Intellectual Development
For a child to develop intellectually they require plenty of stimulation from birth onwards. For speech and language to develop, the child should be exposed to wide vocabulary and encouraged to participate in conversation.

### Emotional Development
A child's emotional needs are :-

1. Affection
   The feeling of being loved.

2. Belonging
   The feeling of being wanted either in the home environment or at school.

3. Independence
   The feeling of managing and directing their own life.

4. Achievement
   The satisfaction gained from making and doing things.

5. Social Approval
   The feeling that others approve of their efforts and achievements.

6. Self Esteem
   Appreciation of their good qualities by family and friends.

**Social Development**
**This is the development from total dependence on the carer to egocentrism – thinking the world revolves around them – to a state of socialisation where he accepts the pattern of behaviour expected by society. He also learns to share and consider the needs of others.**

**NHSP Mission Statement:**

- Enable high quality parent - child interaction for all newborn children through early identification of children at risk of poor interactions attributable to unidentified hearing problems
- Empower parents of hearing impaired children so they can make informed choices about early communication and support options to facilitate high quality parent - child interactions in the first few months of life
- Establish a learning and evaluative culture of NHS service provision and partnership, for children 0-36 months of age, through training and Quality Assurance in:
  - Hearing Screening and Assessment
  - Diagnosis and Medical Management
  - Habilitation for these children that includes ongoing high quality paediatric audiology and a range of options for communication, education, social and family care support, backed with Early Support competence resources

**(Mission Statement updated on 4 February 2006)**

**Quality Standards for the NHSP**

The purpose of the quality standards is to outline the minimum family friendly standards expected to ensure that:

- Families are able to make informed choices about screening uptake
- Screening and diagnostic services are effective and carried out to a high standard
- Results are communicated to parents/guardians effectively
- Families are given comprehensive support post-diagnosis
- Responsibilities for recording and reporting performance are clear

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| Throughout journey | 1) Appropriately trained interpreters available when required | All | Information should be accessible to mother and family | Availability of interpreter services is the responsibility of the provider organisation (Trust). The Team Leader (TL) is responsible for informing the Trust if interpreting resources are inadequate. The screener[1] is responsible for determining if an interpreter is required and recording on eSP. The Local Co-ordinator (LC) should be aware of |

[1] Whenever we use the term 'screener' it refers to the person who carries out the screen (e.g. hospital-based screener, Health Visitor, Special Care Nurse etc). It is the Local Co-ordinators responsibility to ensure that this person has been trained and had their competencies assessed according to the NHSP guidelines found on the website www.nhsp.info

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| | | | | issues relating to the availability of interpreting staff for the service. |
| During third trimester of pregnancy | 2) Parents to have written and verbal[2]information on hearing screening | All | All parents to be aware of hearing screen | The TL is responsible for ensuring that there is an agreed mechanism in place to provide information about the screen in the antenatal period. This activity is not currently recorded on eSP but the LC is responsible for putting a mechanism in place to enable local audit. |
| At birth | 3) Maternity notification to eSP | 90% within 6hr | Notify who to screen and enable mother and baby demographics | Notification to eSP is electronic. The local maternity and IT services, or in exceptional cases the Child Health Department, is responsible for entering high quality, timely data into the NHS number registration system/Patient Demographic System. |
| Before and during screening | 4) Mother[3] to have written and verbal information about the screen and data storage at the appropriate stages throughout the screening care pathway and confirm understanding | All | Ensure all mothers are aware that screen will be offered and understand the advantages and risks and action to be taken | The screener is responsible for giving the information. This activity is not currently recorded on eSP but the LC should put a mechanisms in place to enable local audit |
| | 5) Mother to be offered Newborn Screen | 99% of eligible[4] babies | Ensure high coverage | The screener is responsible for identifying eligible babies and offering the screen (appropriate protocol) and recording on eSP.[5] |
| Screen | 6) Screen started | 98% of eligible babies | Ensure high coverage at start | The screener is responsible for starting the screen (appropriate protocol) and recording on eSP. |
| | 7) Screen completed | 95% of eligible babies | Ensure high coverage | The screener is responsible for completing the screen and |

[2] Whenever we use verbal we mean to include use of appropriate interpreters where required
[3] The term 'mother' is used to indicate any person(s) with parental responsibility
[4] All babies are candidates for the screen unless there is unequivocal evidence of hearing impairment as in babies with atresia in one or both ears. These babies should not be screened but referred directly for audiological assessment within 4 weeks. Babies that start the screen but then develop meningitis should be referred directly for audiological assessment. Referral of babies for audiological assessment following the administration of ototoxic drugs is at the discretion of the responsible clinician (usually a paediatrician).
[5] The TL (unless clearly devolved to another named person) has clinical responsibility for the programme and for ensuring that systems are in place so that the screening programme is able to perform.

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| | by 4 weeks of age (hospital model) or 5 weeks of age (community model) in Well babies or 4 weeks corrected age in NICU babies | | at end | recording on eSP[6]. The LC is responsible for monitoring the quality of patient journeys and accuracy of data on eSP. |
| | 8) Decline screen | <0.1% (guide figure) | High population coverage | The screener is responsible for recording screen declines, providing the checklist in such cases and recording on eSP. The LC is responsible for monitoring screen decline rates and reviewing systems if the rate becomes too high. |
| | 9) No clear response rate | See table 1 below | Ensure referral rate is within programme limits and potential training issues are alerted to | The screener is responsible for ensuring that screening conditions are suitable, equipment checks are carried out and recording results on eSP. The LC is responsible for ensuring that equipment is calibrated and in working order and calibration information is recorded. |
| | 10) Screening Outcomes set | 99%[7] within 3 months of age | Ensure timely screen and follow up where required | The screener is responsible for setting the outcomes in hospital sites. In community sites another nominated person should set outcomes (usually the LC). In both modes the LC has overall responsibility for monitoring the accuracy of the data and acting upon identified errors. |
| | 11) Archiving screening data | All screening data should be archived onto a secure network location at a maximum interval of every 6 weeks | Ensure screening data is available for interrogation if required | The LC is responsible for ensuring adequate archiving procedures are in place and adhered to. |
| | 12) Screening data accuracy | Hospital sites 98% of data to be entered electronically Community sites all equipment data to be | Ensure that the correct results have been communicated to parents and acted upon | Hospital sites: screeners to carry out the electronic upload of data from equipment to eSP and seek approval from LC for manual data entry and any changes to data in eSP. LC to record all manual data entry requests and any data manipulations in eSP and reconcile these with the data |

[6] In community-based programmes the screener may not necessarily complete the screen or enter data in eSP but is responsible for ensuring the appropriate information about babies in process is past to the person responsible (clearly identified by the LC) in a timely and accurate manner.

[7] There may be exceptional circumstances in which babies may still be part of the screening journey at this time e.g. NICU babies.

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| | | checked against the result in eSP | | quality national reports from the programme centre. Community Sites: Data from equipment to be cross checked with eSP/PCHR/Log Sheet following data download every 4-6 weeks. |
| Surveillance | 13) Checklists for appropriate language and auditory behaviour development | All parents given checklists when screening completed with CR / CR, declined or at discharge from assessment | Promote awareness of need to be watchful for possible hearing problems as child develops | Screener or Audiologist |
| Referral | 14) Referral for audiological assessment and targeted follow up | All babies with unilateral and bilateral no clear response outcomes and incomplete baby equipment reason outcome should be referred for audiological assessment at the time of the screen refer or within 3 working days in exceptional circumstances. Babies requiring targeted follow up at 7-9 months should also be referred directly to audiology | Ensure timely referral for audiological assessment | It is the responsibility of the LC to put a mechanism in place for direct referral to audiology and monitor this process. |
| | 15) Follow up of referrals with initial audiological assessment (with exceptions for diagnostic reasons) | All parents of babies that refer from the screen and wish to continue should be offered an appointment that is within 4 weeks of screen completion.<br>All parents whose baby required targeted follow | Swift assessment following screen refer | It is the responsibility of the head of paediatric audiology to ensure that assessment appointments can be set at the time of screen discharge, that assessment appointments for immediate referrals are within 4 weeks of screen completion, that targeted referrals are seen by 9 months and that a system is in place to record accurate and comprehensive session data and outcomes into eSP. The LC is responsible for checking that all babies referred for assessment (immediately or targeted) have an outcome |

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| | | up should be offered an assessment before the baby is 9 months of age. | | set in eSP. |
| | 16) Follow up of referrals with full audiological assessment (with exceptions for diagnostic reasons) | 75% of babies requiring further assessment should be seen by 2 months of age and 100% by 3 months of age. | Swift assessment following screen refer | The head of paediatric audiology has the responsibility to ensure that appropriate assessments are carried out by competent staff in a timely manner and that comprehensive session data and outcomes are entered into eSP. |
| | 17a) True state of hearing[8] confirmed and entered into eSP | 80% of babies to have true state of hearing confirmed by 6 months of age and 98% by 12 months of age[9]. | Ensure timely diagnostic assessment and management of all babies with a significant hearing loss | The head of paediatric audiology has the responsibility to ensure that appropriate assessments are carried out by competent staff in a timely manner and that comprehensive session data and outcomes are entered into eSP. |
| | 17b) Permanent Childhood Hearing Impairment (PCHI) cases confirmed and entered into eSP | 75% of babies with PCHI to have true state of hearing confirmed by 6 months of age and 90% by 12 months of age[9]. | Ensure timely diagnostic assessment and management of babies with PCHI | The head of paediatric audiology has the responsibility to ensure that appropriate assessments are carried out by competent staff in a timely manner and that comprehensive session data and outcomes are entered into eSP. |
| | 18) Explanation of assessment and result | All parents of those assessed to get appropriate verbal and written explanation of the assessment results on the same day that the assessment is carried out. | Enable understanding of child's hearing status | The lead audiological clinician responsible for the assessment care pathway of children that refer from the newborn hearing screening programme to give information and results to the family. |
| Post Identification of deafness | 19) Explanation of deafness and support mechanisms | All parents of babies with a confirmed hearing loss[10] to be given an | Enable understanding of the child's hearing status and support | The lead audiological clinician responsible for the assessment care pathway of children that refer from the newborn hearing screening programme to give information |

[8] True state of hearing is defined as the level of hearing and whether there is likely to be a significant permanent hearing loss present
[9] In all cases the true state of hearing and dates should be entered into eSP within one month of outcome or true state being known.
[10] Confirmed hearing loss is defined as the date when the results of the audiological assessment indicate a degree of permanent hearing loss with sufficient certainty for the clinician to inform the parents

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| | | appropriate explanation of deafness, its implications, early support available and contact details or introduction to parents of a deaf child (at an appropriate time). Mild and unilateral losses to be provided with the appropriate NDCS leaflet. | available | to the family along with other members of the multidisciplinary team as appropriate |
| Education support | 20) Informing Education | Education serviced must be informed of all babies with a confirmed hearing loss within 1 working day of the confirmation. The family must be contacted within 1 day after this and visited within 2 days after initial contact | To give families immediate support | Lead audiological clinician to inform Education services and enter Professional Contacts on eSP. The head of education services is responsible for ensuring that families are contacted and that a service is available on a 52 week basis. |
| | 21) Early support and common assessment | All families of babies with confirmed hearing loss given explanation about early support and offered common assessment | To make early support available and make a common assessment of need | The Teacher of the Deaf is responsible for offering support for the family with information and working with the family to use assessment tools. |
| | 22) Key worker | All families of babies with confirmed hearing loss to be offered a key worker by 10 working days post confirmation of hearing loss and agreed in consultation with the family | Enable seamless service for parents and family | There should be a local mechanism in place to offer parents a key worker. Either the Children's services to take a lead for co-ordinating this or the Children's Hearing Services Working Group should agree a mechanism. |

| Stage | Criteria | Target performance indicator | Objective | Responsibility to deliver, record and monitor |
|---|---|---|---|---|
| Hearing aid provision | 23) Hearing aid fitting offered for confirmed cases of hearing loss where appropriate | All appropriate cases offered hearing aid fitting within 4 weeks of confirmation of hearing loss, unless delayed for management reasons | Enable access to audition at earliest possible age | The lead audiological clinician and the Teacher of the Deaf, with other key worker if appropriate or other members of the multidisciplinary team should work with the family to make a decision. |
| Communication | 24) Parents to be informed and supported with respect to developing early communication with their child | All parents of babies with a confirmed hearing loss to be given the opportunity to consider wide range of communication approaches from 2 weeks of confirming of hearing loss | Promote ability to make informed choices about communication | The lead audiological clinician, Teacher of the Deaf and/or Speech and Language Therapist, with other key worker if appropriate or other members of the multidisciplinary team should work with the family to make a decision. |
| Social care | 25) Family care assessment (as part of a single assessment) and support offered | All babies with confirmed hearing loss | Promote social inclusion and cohesion | The Social Worker or Teacher of the Deaf, with other key worker if appropriate or other members of the multidisciplinary team should work with the family. |
| Additional needs | 26) Confirmation of additional needs | Additional needs noted within working week of confirmed hearing loss and to be reviewed thereafter | To ensure seamless service | The Social Worker or Teacher of the Deaf, with other key worker if appropriate or other members of the multidisciplinary team. |

**Table 1 Referral Rates**

| No clear response targets (%) as a function of stage in screen protocol and conformity with protocol targets | | | | | | | |
|---|---|---|---|---|---|---|---|
| Screen context | AOAE 1 | | AOAE 2 | | AABR | | % Conform to protocol |
| | Bilateral | Unilateral | Bilateral | Unilateral | Bilateral | Unilateral | |
| | | | | | | | |
| Hospital | 10% | 20% | 2% | 4% | 1% | 2% | 100% |
| | | | | | | | |
| Community | 5% | 10% | 2% | 4% | 1% | 2% | 100% |
| | | | | | | | |
| NICU | 3% | 6% | - | - | 3% | 6% | 100% |
| | | | | | | | |
| Overall | | | | | 1% | 2% | |

**System and Capacity**

| System | Capacity | Quality indicators | Self assessment | Responsibility |
|---|---|---|---|---|
| SHA | In JD of senior official | Awareness of national priority and local needs | By DPH | DPH to ensure the quality and performance of the screening programmes in area; ensure appropriate collaboration and robust commissioning arrangements are in place |
| PCT | In JD of senior official | Awareness of national priority and local needs; sign up to SLA with national NHSP | By DPH and partnership assessment e.g. through Early support self assessment such as Service Audit Tool as appropriate | CE / DPH to ensure that appropriate NHSP services are commissioned for population registered to GPs in area and to non-registered people resident in the PCT ; to ensure that follow up services in health, education and Family care are available |
| Community midwifery | To promote information about hearing screen | - | Not available | To ensure information on hearing screen given and explained where necessary |
| Maternity services | Need to enter birth information into the Maternity birth notification system accurately and in timely fashion | Correctness of record | Not available | Enter birth information accurately and in timely fashion to prime eSP |
| NHSP local | Recommended Min 1 f.t.e. screener per 1.25k births; Min 1 f.t.e. Local coordinator per 10k births; 1.0 admin per 10k births; Team leader named and activity in JD | | Using NHSP Best Practice Guidelines | Provide operational screening programme appropriate to local community that meets or exceeds NHSP targets |
| Paediatric audiology assessment | Sufficient staff to assess all NHSP (and other) referrals – currently 3% of births | Trained and competent; good infrastructure, equipment, critical mass of cases | Early support self assessment such as Service Audit Tool as appropriate; NHSP Audiology Service Profile (ASP) pro forma | Assess all children referred from NHSP |

| | | | | |
|---|---|---|---|---|
| Paediatric audiology habilitation | Sufficient staff to carry out appropriate hearing aid assessment and fitting on 2 per thousand births | Trained and competent; good infrastructure, equipment, critical mass of cases | Early support self assessment such as Service Audit Tool as appropriate; NHSP ASP pro forma | Select hearing aids and fit according to advanced assessment of hearing needs as specified in the MCHAS protocols |
| Cochlear implant services | Sufficient staff to assess and implant children as soon as appropriate | Trained and competent; good infrastructure, equipment, critical mass of cases | Early support self assessment such as Service Audit Tool as appropriate | Cochlear implant assessment and implantation + habilitation |
| Medical services (paediatrics and aetiological investigations) | Sufficient staff to assess all the children confirmed to have deafness or hearing impairment | Trained and competent; good infrastructure, equipment, critical mass of cases | Early support self assessment such as Service Audit Tool as appropriate | Carry out a range of diagnostic assessments as per NHSP protocols |
| Education services | Sufficient staff to support all children confirmed with hearing loss, 52 weeks a year | Trained and competent; good infrastructure, equipment, critical mass of cases | Early support self assessment such as Service Audit Tool as appropriate; NHSP Deaf Early Education Service Profile (DEESP) pro forma | Provide support for parents and agree and implement educational plan with parents |
| Social care services | Sufficient staff to support all children confirmed with hearing loss, and contribute to their assessment of need | Trained and competent; critical mass of cases | Early support self assessment such as Service Audit Tool as appropriate; NHSP DEESP pro forma | Provide input to single assessment, provide preventive Family care and social worker for the deaf facility where required |
| Children's Hearing Services Working Groups | All stakeholders known and attend most meetings | Representation and training of parents on group; range of professionals actively engaged | Early support self assessment such as Service Audit Tool as appropriate / ASP / DEESP /NDCS | NDCS and all stakeholders to plan and monitor local NHSP programmes |
| Programme centre for NHSP | Implement, support, maintain, train, Quality Assure all major activities for NHSP | Stakeholders satisfied with services | Risk, clinical operations and IT operations management groups. | Working within and exceeding SLA |

**APPENDIX 9**
**GLOSSARY OF TERMS**

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|---|---|
| B.M.I. | Body Mass Index |
| C.M.O. | Community Medical Officer |
| C.P.N | Community Psychiatric Nurse |
| D.O.H. | Department of Health |
| DDH | Developmental Dysplasia of Hips |
| DGOH | Dudley Group of Hospitals |
| G.P. | General Practitioner |
| H.C | Head Circumference |
| H.V. | Health Visitor |
| HES | Hospital Eye Service |
| N.H.S. | National Health Service |
| N.N.U | Neonatal Unit |
| NICE | National Institute for Clinical Excellence |
| O.O.A | Out of Area |
| OAE | Otto Acoustic Emissions |
| P.C.H.R | Personal Child Health Record |
| P.C.T | Primary Care Trust |
| RGN | Registered General Nurse |
| RSCN | Registered Sick Children's Nurse |
| S.C.B.U. | Special Care Baby Unit |
| S.CPHN | Specialist Community Public Health Nurse |
| S.H.A | School Health Advisor |
| S.H.O. | Senior House Officer |
| SID | Sudden Infant Death Research |
| SIFCRAT | Sandwell Incontinence Following Childbirth Assessment Tool |
| SOGS | Schedule of Growing Skills |