Clinical Guideline

Child and Family Health Nursing Services Model of Care

Sites where Clinical Guideline applies	All Child and Family Health Nursing Services in HNELHD
This Clinical Guideline applies to:	
1. Adults	Yes
2. Children up to 16 years	Yes
3. Neonates – less than 29 days	Yes
	Approval gained from the Women's Health and Maternity Clinical Network on 8 December 2021
Target audience	All HNELHD staff working in Child and Family Health Nursing Services and partnering services.
Description	Hunter New England LHD Child and Family Health Nursing Services Model of Care.

Go to Guideline

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Registration number and dates of superseded documents	Comprehensive assessment, additional care and documentation for universal child and family health nurses HNELHD GandP 20_09 from 8 March 2020; (Note: Child and Family Health Nursing - Universal Health Home Visiting (UHHV) Procedure PD2010_017:PCP 1 was rescinded on 17 September 2021)

Related Legislation, Australian Standard, NSW Ministry of Health Policy Directive or Guideline, National Safety and Quality Health Service Standard (NSQHSS) and/or other, HNE Health Document, Professional Guideline, Code of Practice or Ethics:

- National Standards: One, Two, Three, Four, Five, Six and Eight
- First 2000 Days Framework (PD2019_008)
- NSW Health Policy Directive: Maternal & Child Health Primary Health Care Policy (PD2010_017)
- Review of health services for children, young people and families within the NSW Health system 2019
- See Reference Section on page

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GLOSSARY

Acronym or Term	Definition
ACHP (BSF, ND)	Aboriginal Child Health Programs (Building Strong Foundations, New Directions)
AHP - Aboriginal Health Practitioner	This role is an advance practitioner role with extra training and expertise, AHP are registered with AHPRA and can provide independent clinical care within the individual AHP scope of practice. Managers in conjunction with the AHP will develop an individualised scope of practice appropriate to the expertise and skills of the AHP.
AHW - Aboriginal Health Worker	Holds or aspires to hold a minimum Certificate III qualification in Aboriginal Primary Health Care or a minimum Certificate III health qualification in the area of care in which the Aboriginal Health Worker works.
AMIHS	Aboriginal Maternal and Infant Health Service (AMIHS) is delivered through a continuity-of-care model, where midwives and AHW collaborate to provide a high-quality maternity service that is culturally safe, women-centered, based on primary healthcare principles and provided in partnership with Aboriginal people.
Assessment	Assessment is an ongoing process beginning with first contact and continuing throughout all involvement with the family. Assessment is based on a range of information sources. It looks at physical, psychological, emotional and social aspects of health and identifies both vulnerabilities and strengths of the family.
CAP	The Clinical Applications Portal or CAP as it is commonly known, is a web based application which displays patient documents, demographics and episode information. Clinical Documentation can also be created in CAP.
CFHN - Child and Family Health Nurse	A Registered Nurse holding recognised qualifications in Child and Family Health.
Child and Family Health Nursing services	Programs of services offered by Child and Family Health Nurses providing health surveillance, health promotion, education and support to families with children aged 0-5 years
CHIME	Community Health Information Management Enterprise is a software program that is used by community health staff as the primary client health record for the purpose of recording client clinical records and for data collection.
Eligible clients (Universal CFHN services)	Families living in Hunter New England Local Health District with children from birth and until they go to school (0-5 years)
Family	A family can be made up of anyone a person considers to be their family. A family shares emotional bonds, common values, goals and responsibilities. Family members contribute significantly to the wellbeing of each other. When a family includes children, one or more adults may take on an involved role in the child's life and become a parent or carer. Parents and carers may not necessarily be biologically related to the child or even live with the child all the time. A child may have one or several parents or carers. In addition to their biological parents, this could include grandparents, stepparents, aunts and uncles, foster parents, adoptive parents, and any other person who fulfils a significant portion of the parenting and caregiving for the child.
Family Partnership approach	Effective communication skills used to develop a relationship based on partnership with the family enabling the family to identify their issues, strengths and capabilities used in setting goals and strategies. Family's needs and strengths will direct care provided.
Family Vulnerabilities	Factors or criteria that may influence and impact on the family's ability to provide care and protection for their children.
First 2000 Days Framework	The First 2000 Days Framework is a strategic policy document which outlines the importance of the first 2000 days of a child's life (from conception to age 5) and what action people within the NSW health system need to take to ensure that all children have the best possible start in life. The framework incorporates a range of policies, programs, services and models of care to make sure that the right health services are available for everyone. The policy is supported by an Implementation Strategy document.
Health Home Visiting	Health Home Visiting is defined as the delivery of health services within a client's home, to parents/carers who are expecting or caring for a baby, in order to enhance health and social functioning by responding to the specific need of that family within the family's own environment
IBCLC	International Board Certified Lactation Consultant

i.PM(PAS)	i.PM(PAS) is the core clinical computer system for HNELHD. It is used to store and maintain patient information including, Medical Record Numbers and patient demographics
Levels of Care:	Service response based on the family's strengthens and vulnerabilities identified as part of a psychosocial screen defined in the NSW Health PD2010_017 - Maternal and Child Health Primary Health Care Policy as: Level 1 – Universal services Level 2 – Early intervention and prevention Level 3 – Complex parenting needs
NGO	Non-Government Organisation
Parent/carer	Parent/carer is any person, or persons, with primary responsibility for the care and welfare of the child.
Perinatal	The NSW Ministry of Health GL2010_004 - SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants defines this period from conception to 2 years. Within the mental health context, it is defined as encompassing pregnancy and the first 12 months postpartum.
Postnatal period	Defined by the World Health Organisation (WHO) as the period that starts about an hour after the delivery of the placenta and includes the following six weeks.
Primary Health Care	NSW Health defines the meaning of Primary Health Care by adopting the definition used by the Australian Health Ministers Council (1998): *Primary Health Care seeks to extend the first level of the health system from sick care to the development of health. It seeks to protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology.*
Safe Start	A collaborative initiative across NSW health and related services in the context of Families NSW. It involves universal psychosocial risk assessment as part of a comprehensive assessment in the antenatal and postnatal period.
Secondary (service)	A service provided by health professionals who generally do not have the first contact with the family. Some secondary services will require a referral.
Strengths-based approach	Views a family as resourceful and skilled, setting the agenda and actively engaging in the process of addressing their issues and solving their own problems. The focus is on the available resources and skills within the family and community to use those assets in building resilience. The aim is to facilitate families in the process of identifying their own strengths.
Sustained Health Home Visiting (SHHV) (Sustaining NSW Families (SNF) is the name of the SHHV program in HNELHD)	A structured program of funded health home visiting over a sustained period of time, beginning in pregnancy and continuing until the infant is two (2) years old. The aim of this program is to provide a range of support around health and other bio-psychosocial areas of risk and vulnerability.
Targeted (service)	A targeted service is one that offers 'additional' care and support to eligible clients where there are identified health, social or cultural needs.
Universal (service)	A Universal service that is one that is offered to all eligible clients regardless of identified need.
Universal Clinic Visit	The term used when the UHHV cannot be provided in the home or the home visit has been refused by the family and is delivered in a clinic.
Universal Health Home Visiting (UHHV)	Includes at least one universal contact in the client's home within two weeks of birth and may also include further home visiting. The child and family health nurse from the early childhood service conducts the UHHV. A home visit can be classified as a UHHV if it has occurred up to four weeks and six days from the birth of the baby. NSW Ministry of Health PD2010_017 - Maternal and Child Health Primary Health Care Policy.

PURPOSE AND RISKS

The First 2000 days of life, from conception to around the time a child starts school, is a critical time for physical, cognitive, social and emotional health. What happens in the first 2000 days of life has been shown to have an impact throughout a person's entire life, across all phases of life and between generations.

Child and Family Health Nursing Services contribute to the First 2000 Days of a Child's life by supporting parents and their children's health and development so they can start school ready to learn. NSW CFHN services are based on a strong strategic policy and evidence base, and it is essential that families living in Hunter New England are offered and provided with a minimum standard of clinical care. A District Model of Care for CFHN Services supports this and reduces the risk of unwarranted clinical variation in care within the various funded programs. Early contact by CFHN services in the setting families choose, has been identified as improving engagement with families.

Not offering families their choice of home visiting early in their parenting experience increases the risks of poor engagement in the service; this in turn increases the risk for children not being developmentally on track when going to school.

These risks are minimised by:

1. Offering the initial visit to all families, with newborn infants, in the home, ideally within the first 2 weeks: Providing families with this visit in the setting of their choice as early as possible in the first 4 weeks
2. Booking the 6–8-week assessment for infants and parent/carer where possible and encouraging families to access the range of developmental checks provided by CFHN services.
3. Working within the Scope of Practice of a Child and Family Health Nursing Service to meet the needs of families we provide service to. This includes providing a culturally appropriate and safe service to First Nations people and to Culturally and Linguistically Diverse families.

Risk Category*: Clinical Care & Patient Safety.*

GUIDELINE

While not requiring mandatory compliance, staff must have sound reasons for not implementing standards or practices set out within guidelines issued by HNE Health, or for measuring consistent variance in practice.

Staff Preparation

It is mandatory for staff to follow relevant: "Five moments for hand hygiene", infection control, moving safely/safe manual handling, documentation practices and to use HAIDET for patient/carer communication: **H**and hygiene, **A**cknowledge, **I**ntroduce, **D**uration, **E**xplanation, **T**hank you or closing comment.

Introduction to CFHN services

Child and Family Health Nurses (CFHNs) are registered nurses with specialised training and expertise who play a key role in promoting the health and well-being of children and their families in the First 2000 days.

CFHNs function in accordance with government legislation, local policy directives and professional and ethical standards to fulfil their obligations as health professionals for the provision of optimal standards of care.

CFHNs are uniquely placed to provide early contact and effective Primary Health Care for Families with a child/children aged 0-5 years.

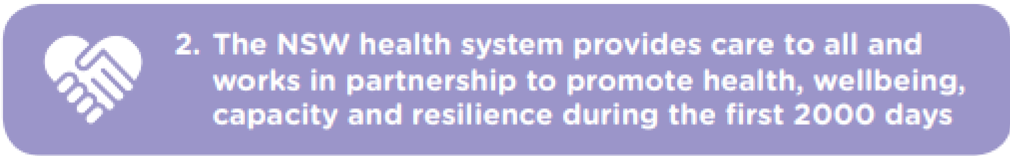
The CFHN recognises a child's family as the most significant influence on their child's lives. The foundation of a CFHN's practice is to work in partnership with families. Using a strengths based and family centred approach, the CFHN aims to provide health screening and surveillance and early identification of concerns with timely interventions. Providing anticipatory guidance which builds a family's resilience and capacity to strengthen the family's relationship with the child.

CFHNs address the broader determinants of health through the comprehensive assessment of the physical, developmental, psychological, socio-economic health and well-being of the child and family. The

CFHN utilises evidence-based tools and strategies to facilitate the early identification of and intervention for, the identified child and family needs.

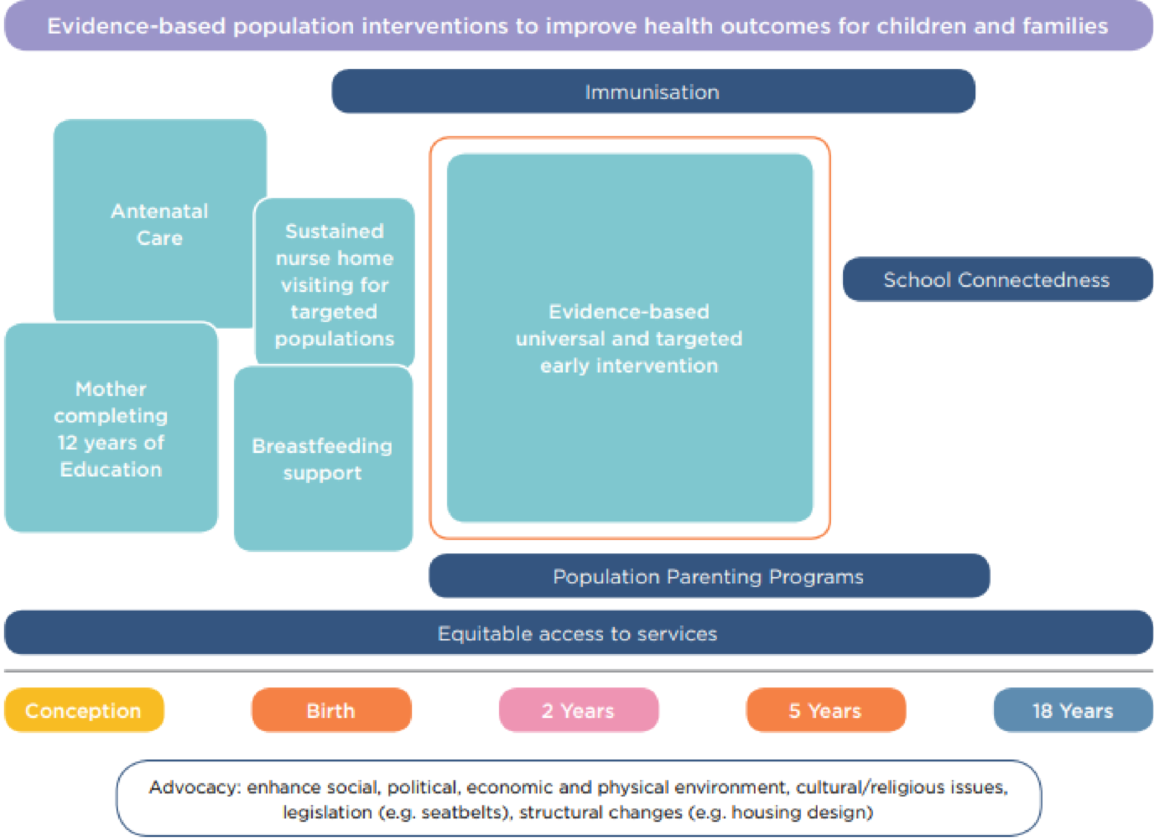
The CFHN recognises the diverse cultural and linguistic backgrounds of the families with which they work and work in partnership respecting their culture, values, beliefs and capacity to support them in making decisions regarding identified health needs.

CFHNs work with other professionals from a range of disciplines to provide care, collaborate and communicate together for the interests and needs of the child and family.



Universal, evidence-based, seamless care and services improves health and development for all children from pregnancy to school entry, and provides a way for opening pathways to extra care for those who need it.

CFHN Services in NSW operate within the NSW Health First 2000 Days Strategic Framework



Source: Lisa Altman, Sara Burrett and Susan Woolfenden, Sydney Children's Hospital Network (adapted from Alperstein and Nossar)

As outlined in the Framework, families will be offered the appropriate level of CFHN care that they need

The right level of health care for each family's needs

More intensive services for those needing specialised help

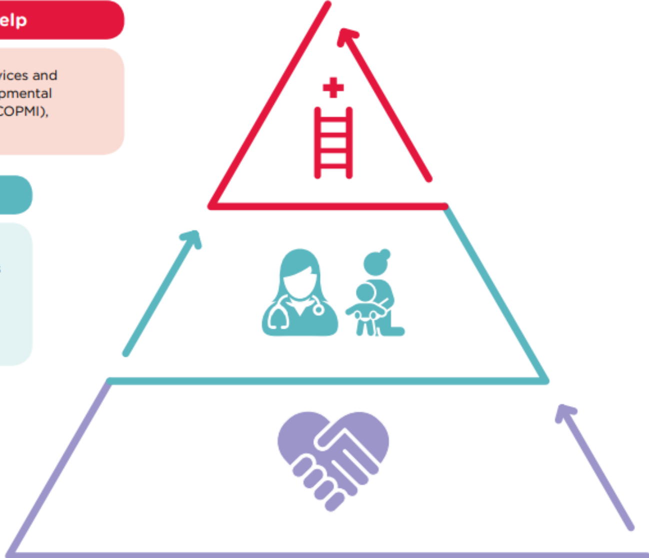
For example: Child Protection Counselling Services, Domestic Violence Services and Sexual Assault Services, Tresillian and Karitane Residential Services, Developmental Diagnostic Assessment Services, Children of Parents with a Mental Illness (COPMI), Out-of-Home-Care (OOHC)

Extra care for those who need it

For example: Sustaining NSW Families (sustained health home visiting), Family Care Centre Services, child and family health multidisciplinary teams (paediatricians, nurses, allied health), Perinatal and Infant Mental Health Services (PIMHS), Child and Adolescent Mental Health Services (CAMHS), Aboriginal Maternal and Infant Health Service (AMIHS), Building Strong Foundations for Aboriginal children, families and communities (BSF)

Care and services for everyone

For example: Maternity services, Statewide Infant Screening Hearing Program (SWIS-H), Universal Health Home Visiting (UHHV), Child and Family Health Services (Personal Health Record or Blue Book), General Practice, Statewide Eyesight Preschooler Screening (StEPS), immunisation programs



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Universal CFHN Services – Care and services for everyone

Access to the universal service

- Access is universal for families living in HNELHD with children 0-5 years. (Secondary or SNF services have different process which are outlined later in this document)
- Infants and their parents/carers are offered a service once the local CFHNS is notified of their birth or their creation in the iPM system in the first 5 weeks. This information is available to services via a variety of sources (sources of notification can include Babies under 40 days Created on CHIME' daily email; self-referral, maternity units, community referrals, GPs and other clinicians). Infants created in iPM, address updated in iPM or duplicated in the system are also available in a real time Families NSW RAP Report. Accessing this list weekly can reduce late offers of service where there are changes in iPM.

Process for initiating contact

• Review discharge information and previous service contact to assess priority or additional needs (sources may include maternity discharge papers, CHIME, CAP, e-maternity)

• Review /explore any known risks for Home Visiting

• Create CFHN CHIME service request for mother/carer and Infant

• Determine eligibility for UHHV services (see UHHV Flowchart Appendix 1)

• Client Assessed as Ineligible / Excluded – contact family, offer appropriate CFHN service (not recorded as UHHV), complete the Families NSW Tool and document the reason they are ineligible/excluded

• Client Assessed as Eligible – contact family, offer UHHV service

Where the service is available Central intake will make the offer of UHHV.

UHHV Offer Accepted

- Negotiate with parent/carer date and time for visit
- Discuss expectations of visit
- Complete Home /Facility Risk Assessment (if this is completed more than 24 hours prior to the planned visit, the home/facility risk assessment will need to be reviewed prior to the visit)
- Enter planned appointment in CHIME diary
- Document any clinical discussion in Clinical Notes

UHHV Declined

- Explore and document reasons for decline and offer clinic visit (UCV)

UCV Accepted

- Negotiate with parent/carer date and time for visit
- Discuss expectations of visit
- Enter planned appointment in CHIME diary
- Document any clinical discussion in Clinical Notes

UCV or CFHN Service Declined

- Explore reason for decline (i.e. other services involved AMS/ GP)
- Document reason for decline in CHIME clinical notes
- If there are any known vulnerabilities escalate any Child Protection concerns as per policy; consider making a Safe Start MCD referral and informing the GP.
- Complete Families NSW Tool
- Close Service Request

Unable to Contact Family

A CFHN service request is required to enable appropriate documentation of these steps

- Leave phone message for client (if this facility is available) with contact details for service
- Make a second attempt by phone to contact ideally after a minimum of 24 hours
- Send Generic Feedback Letter to available address offering UHHV and CFHN services
- Document all attempts to offer UHHV in CHIME clinical notes
- If there are any known vulnerabilities escalate any Child Protection concerns as per policy; consider making a Safe Start MCD referral and informing the GP.
- Complete Families NSW tool with ‘No response/Family could not be contacted’
- Close the CHIME service request

NOTE: Where there are known vulnerabilities or a client of the ACHP a more assertive attempt to contact the family to offer the service should be made and documented.

Child and Family Health Nursing Services (CFHNS) in HNELD offer and provide a ‘universal’ service to all families with children 0-5 years living in the Local Health District (LHD). Universal means every family is offered the CFHN service following notification of birth; when another service/clinician refers a family/child; and when a family contacts the CFHNS. The initial contact, within the infant’s first 5 weeks, should be offered as a home visit when assessed as safe for the clinician. The reason for not offering a home visit must always be documented in the clinical notes.

In HNELHD there are some specifically funded universal child and family health services to Aboriginal families (Aboriginal Child Health Programs/ACHP). Services provide targeted responses including referral and active follow up to families with identified needs for additional support and/or services.

Comprehensive Primary Health Care Assessment (Universal service provision)

Infant/child assessment includes age-appropriate developmental assessments (PHR checks) i.e., 1-4 week to 4 years. It is recommended that the CFHN completes the 1–4-week assessment at the initial contact in the post-natal period when possible.

Maternal/carer assessment includes a number of screening assessments tools that have an advised timeframe but are not required to be completed at the first contact unless clinically indicated. If no previous assessment is available to review in CAP please attempt assessments as soon as clinically able or practical.

These CFHNS assessments in CHIME include:

- Domestic Violence Screening (DVRS) (CHIME Tool) – This should be considered at every CFHNS contact for the safety and wellbeing of women and children. The minimum policy requirement is to attempt to screen at each contact in the first 12 weeks until successfully screened, then at least every 12 months after that.
- Edinburgh Postnatal Depression Screening (EPDS) (CHIME Tool) – this is ideally completed at the 6–8-week PHR check unless there is not a previous depression screen available e.g. Private Hospital Births. It should also be reviewed at the 6-month PHR check or at any time the CFHN is concerned about the parent's mood/wellbeing.
- CFHN Psychosocial Assessment (CHIME Tool) – this assessment can be undertaken in stages between the initial contact and completed around the 6–8-week PHR check. The tool can be copied and updated at each contact until completed or as completed as possible.

The outcome of all assessments/screening must be documented in the client's clinical notes. This includes documenting what still needs to be completed and any plan or advice provided relating to the assessments.

Additional documentation requirements

If unable to offer a home visit/complete any assessment/screening tool the reason must be clearly documented in the clinical note.

CHIME CFHN Clinical Note templates are agreed by clinical leads and managers outlining best practice assessment and documentation, although these may vary depending on the service they are a mandatory requirement for documenting CFHN and AHW/AHP assessment summaries and care.

- Where initial or follow up appointments are provided via different modalities in the same working day the one Clinical note template should be completed for all appointments.
- If the initial or follow up appointments happen on different days the clinical note templates need to be completed separately.
- Any part of the initial or follow up assessment not completed in the first day's appointment should be documented for completion in the next appointment.

When families are being provided additional targeted contact the following documentation is a requirement for all mainstream and ACHP.

1. The identified health need or psychosocial risks and strengths and protective factors for the family.
2. What other supports and/or services the family are engaging with currently.
3. The CFHN's plan and agreed goals for the family e.g. increased weight gain of infant, improved breastfeeding duration or parent's mood improves.
4. The additional care setting, (Home visiting should only be offered when safe for the clinician, see note below on steps for consideration of home visiting risks).
5. Each appointment should have the correct CHIME activity code based on the location of the contact (see Flow Chart for mainstream CFHN services) as well as when the next appointment is planned.

When additional care is no longer required, mainstream services will offer the family universal (PHR) CFHN service.

Comprehensive Primary Health Care Assessment (Targeted service provision) - extra care for those who need it

Additional targeted appointments (Home or clinic) are available for families with additional needs. Identification of these needs should be guided by the documented CFHN's clinical assessment and judgement; be within the scope of CFHNS practice and reflective of the client's needs and goals. Documentation should outline the assessed need, agreed plan, any interventions being provided and evaluated against agreed goals in subsequent appointments.

When concerns persist after short-term interventions provided by CFHNS or the desired intervention or outcome is outside of the scope of CFHNS practice, the CFHN should offer a referral to the family for an appropriate service. This may include secondary CFHN services provided within HNELHD, including Tresillian.

HNELHD Aboriginal Child Health Programs (ACHP) – extra care for those who need it

The HNELHD ACHP is a Child and Family Health Service provided by teams of Aboriginal Health Workers/Practitioners and Child and Family Health Nurses, working in close partnership with Aboriginal parents, families and communities to provide a flexible, culturally safe and appropriate Child and Family Health Nursing service using a family centred approach to build strong relationships and ongoing engagement.

The service is provided in the family home, at the local community health centre/clinic, or in a place where families, parents, carers and children feel safe and comfortable. ACHP teams work with parents, carers, and the local community to support families in providing the optimal physical, social, emotional and cultural wellbeing of the children. Aboriginal Health Workers/Practitioners are key to ensuring the relationship is culturally safe, flexible and meets the needs of the individual child, families and communities.

Service includes:

- Monitoring the normal growth and development of infants and children.
- Working collaboratively with parents to identify needs early, and referring to other health professionals, NGO's and community organisations to promote optimal child development and support children's transition to school.
- Promoting the importance of health and wellbeing, including health promotion, anticipatory guidance, brief interventions, education and support for parents and families to enhance parenting capacity and enable parental change.
- Promoting parental social and emotional wellbeing by screening to detect social and emotional distress and form a comprehensive picture of the family, with the child at the centre of the family's physical and emotional wellbeing.
- Supporting families to link purposefully with their local Aboriginal community to sustain the family connectedness and self-efficacy.

Eligibility

Any Aboriginal child from birth to school age who resides within the catchment area of a HNELHD ACHP is eligible to be referred to the voluntary service. Smooth transition of care of the newborn and family from maternity services such as AMIHS, to the ACHP ensures continuity of care for the child up until school age.

All staff that manage and work in the HNELHD ACHP recognise and strives to attain New South Wales Ministry of Health (NSW MoH) AMIHS & Building Strong Foundations (BSF) service values:

- **Cultural Respect** – recognising the unique place that Aboriginal and Torres Strait Islander people have in Australian society.
- **Social Justice** – enabling Aboriginal people to have their physical, social, emotional and spiritual needs met and have greater control over the decision-making processes which affect their lives.
- **Participation** – facilitating involvement by people in the issues which affect their lives based on

autonomy, shared power, skills, knowledge and experience.

- **Equality** – challenging the attitudes of individuals, and the practices of institutions and society, which discriminate against and marginalise people.
- **Access** – facilitating access to services by Aboriginal people and working towards ensuring that those services are culturally respectful and appropriate.
- **Learning** – recognising the skills, knowledge and expertise that people contribute and develop by taking action to tackle issues that impact on the wider social determinates of health.
- **Collaboration** – working together to identify and implement action, based on mutual respect of diverse cultures and contributions.

Standard equipment needed for all CFHN services

Growth Measuring equipment as per Growth Surveillance of Infants and Children in Primary Health Care HNELHD GandP 19_17

- High Quality Electronic Digital or Beam Balance pan scales. Infant scales can be portable or 'fixed' (0-2 years)
- High quality Electronic scales or Beam Balance scales with movable weights that can be easily tared / 'zeroed' (2 years and above). A wipe able measure board /mat specifically designed for measurement of infants with a fixed headboard and a movable foot-board
- Flexible, non-stretchable measuring tape or disposable paper measuring tape. (Note: If using a non-disposable tape measure ensure that it is cleaned after each use. Plastic tapes are required to be replaced annually or more often if needed)
- A wipe able Pen torch or equivalent
- Paperwork (Assessments and resources), pen, and access to CHIME
- HNELHD identification badge
- Appropriate Personal Protection Equipment as per Infection Prevention and Control advice (Masks, gloves, aprons or gowns, eye protection, shoe covers)
- Hand sanitiser and clinical wipes for equipment cleaning
- Other equipment for different modalities, motor vehicle, mobile phone, audio visual equipment for telehealth

Secondary CFHN Services – extra care for those who need it

Hunter New England Local Health District services

HNEKidshealth First Steps Parenting Centre

First Steps Parenting Centre (FSPC) is a secondary community health service providing parenting interventions for families with children under school age in the Newcastle and Lake Macquarie local government areas (LGAs). The staffing profile includes Social Workers, Child and Family health nurses, Clinical nurse specialists, a Paediatrician, and direct access to speech pathology service. Individual clinician services include working on parent-child attachment; behaviour management; post-natal depression (PND), anxiety, and adjustment to parenting counselling, complex sleep and settling support, and developmental assessments. Group services include Circle of Security parenting education, Self-Compassion, PND, and a drop-in clinic at Dale School for young parents. There are two satellite services – Young Parent Network (YPN) for parents under the age of 25 in the Maitland and Port Stephens council areas, and the Program of Initial Parenting Support (PIPS) for vulnerable, first-time parents in the Newcastle and Lake Macquarie LGAs. FSPC is a voluntary service where parenting support is the primary reason for referral. Referrals come from a health service provider or community service and as the service is secondary, all referrals must be linked to a primary health care provider such as a GP or Child and Family health nurse. Parents/carers cannot directly refer unless they are young parents at the Dale school or meet the YPN criteria.

Maitland Family Care Cottage

The Family Care Cottage (FCC) is a secondary level, community based, referral service managed through the Division of Maternal and Child Health Services, The Maitland Hospital. The FCC co-ordinates a range of early childhood services and incorporates the Maitland Child and Family Health Nursing Service. Referrals are required for complex parenting issues that have not been able to be resolved at the primary care level. Free service by appointment only. Monday – Friday. The service provides centre-based appointments including day stay, home visits and group programs to expectant parents and families with babies and young children aged 0 – 3 yrs. Referrals received from CFHN's from Upper and Lower Hunter including Maitland and surrounding areas, Singleton, Muswellbrook, Cessnock and Kurri Kurri. Referrals are also received from other health professionals, including GP's, Paediatricians, also government and non-government agencies that work with families with young children. FCC is staffed with a clinical NUM (Nursing Unit Manager), CFHNs, Social Workers and an Administration officer. The service supports families with a range of issues including Sleep and settling; Lactation and feeding difficulties; Anxiety and Depression; pre and postnatal mood disorder; postnatal depression; Parent-infant relationships issues; Grief and loss issues; Child behaviour management as well as Counselling and group work Circle of Security.

Tamworth Family Care Cottage

Tamworth Family Care Cottage is a free service providing support, counselling and education to parents and families with children aged 0-3 years living in the Peel, Mehi and Tablelands Sectors. Referrals are accepted from Child & Family Health Nurses, other Health Professionals and Self-referral from families. There is limited Outreach Service for referrals from either Safe Start MCD meetings or Child & Family Health Nurses for very vulnerable families. The service is day stay with CFHNs and Social Worker providing a range of services including outreach for vulnerable families one day a week. One CFHN is a lactation consultant offering limited appointments for breastfeeding support and both CFHNs provide sleep and settling support. Social Worker provides short term counselling support for families at risk of post-natal depression.

Tresillian Family Care Cottages

Tresillian in Manning is a Secondary level early parenting support service offering Day Services through their Family Care centre at Taree. The service provides centre-based appointments including day stay, home visits, Extended Home visiting service and group programs to expectant parents and families with babies and young children aged 0 – 3 yrs. Home visiting is offered to a limited geographical area (approx. 30min drive). Referrals can be provided by CFHN, GPs, Paediatricians and NGOS or Clients can self-refer themselves either directly to the centre or Via Parent helpline. The service is free and available Monday-Friday. There is no geographical limit for clients but clients out of area may be directed to a nearer service if available. Clients who are willing to travel to the centre can be seen for face-to-face appointments. Clients unable or unwilling to travel can access Day services by Virtual Consult by Video-link.

Families can be seen for a range of issues including Sleep and settling; Breast feeding; Infant Nutrition; Adjustment to parenting; Infant care; Emotional & Psychological health and Wellbeing; Multiple Babies and Toddler behaviour. Clinicians work with families collaboratively focusing on achievable goals set by the parents. Referrals can be made to other support agencies including Health, NGOs and Community support services such as playgroups. A number of groups are also offered; Getting to Know You is a 6 week group for families with Infants up to 8 weeks of age which helps families learn to recognise and understand their Infants Communication skills. Supporting Sleep is a single session group providing information for families with babies 0-3 months of age around Sleep and Settling.

Tresillian are also rolling out Family Care Cottages in Armidale, and Muswellbrook. A mobile2U centre is being rolled out in Inverell.

Sustained Home Visiting Service - extra care for those who need it

Sustaining NSW Families (SNF) program is a structured program of nurse-led, sustained health home visiting for children and families. It is an evidence-based intervention to help strengthen relationships between children and their family to build parenting capacity and enhance child development, well-being and health in vulnerable families. Program staff employ a strengths-based partnership approach to develop a therapeutic relationship with the family. The program is designed to actively help parents identify and meet their child's needs as well as anticipate and prepare for the future needs. The program is based at Kurri Kurri Community Health Centre and provide care for up to 150 families living in the Lower Hunter, Singleton, Raymond Terrace and Newcastle LGA areas.

The Sustaining NSW Families program seeks to engage parents initially in a relationship with their unborn child. The program then continues to support the transition to parenting in the early newborn period through to toddlerhood (2 years of age) when transfer of care is made to universal CFHN services. Families are identified as potentially eligible for the program through the primary health care pathways described in the Supporting Families Early Package Maternal and Child health Primary Care Policy. This generally occurs through the psychosocial assessment at the first antenatal visit. Families with moderate (level 2 and some level 3) vulnerabilities and mothers-to-be with an Edinburgh Postnatal Depression Scale (EPDS) of 10 or more may be referred from the Safe Start MCD to the Sustaining NSW Families program.

If the family is assessed as eligible and agrees to participate in the program a SNF nurse is allocated to the family and commences providing the program. The specially trained nurse home visitor is part of a team including a full-time nurse clinical coordinator; a full time Social Worker position and funded part-time allied health professional including speech pathologist, occupational therapist, dietician, physiotherapist and psychiatrist/psychologist. Within the program they have a consultant/liaison role, providing specialist consultation and expertise to the nurse to support them in their interaction with the families.

Service delivery modalities

Hunter New England Child and Family Health Services are provided to families through different modalities depending on the wishes of the client, the location of staff/service and any infection prevention control measures currently in place. Services may also be provided in a combination of these modalities:

- Face to face individual appointments (Domestic or Clinic Setting)
- Face to face group appointments
- Telephone individual appointments
- Telehealth (Video) individual appointments
- Telehealth (video) group appointments
- SMS service for communication or information provision
- Email

Parenting Groups

Early Parenting Groups (EPGs) are an evidenced based service provided by many Child and Family Health Nursing Services (CFHNS). The aim for the CFHNS Early Parenting Group is to provide the opportunity for eligible parents to establish a support network through the meeting of other new parents residing in a close geographical area.

These groups are designed to increase parental support and confidence in parenting through informal sessions that are facilitated by a Child and Family Health Nurse (CFHN) or Aboriginal Health Worker/Practitioner (AHW/P). Evidence shows benefits of such groups include increased duration of breastfeeding and less postpartum depression and anxiety. It also suggests groups should be a peer supported model and should be parent led, facilitated by the nurse. Consumer surveys identified the need for both a peer support group with some educational content. In a peer supported group, the agenda is to be set at the beginning of each session by the participants. Mentoring and support for newer group facilitators and for those who wish to develop their skills, observation of a CFHN or AHW/P skilled in group facilitation, is recommended.

Lactation Services/Breastfeeding Support

In some CFHN services there are additional supports for families' breast feeding their infants/children. CFHNs who have certification as IBCLC may offer individual breastfeeding support focused appointment. CFHN also liaise with midwives certified IBCLC within local hospitals who can do collaborative work or provide a referral pathway. Referrals can come from families, hospital or CFHN service staff.

Audiometry Services

In some areas CFHN teams contain trained Audiometry Nurses who can offer audiometry assessments to school aged children 3 ½-18yrs still at school.

IMPLEMENTATION, MONITORING AND AUDIT

1. the document will be communicated and implemented through the HNELHD CFHN Managers and Clinical Leads group
2. Resources, education or training will be provided by the same group as required.
3. The document will be monitored for effectiveness and compliance. An initial survey with staff will assess understanding of the Model of Care and this will be repeated 12 months later. Ongoing surveys and feedback from Families accessing the survey will be undertaken. The annual District CFHN Clinical Practice Audit will assess Universal services including the ACHP programs. Key performance Indicators, reports through the CFHN Managers group

In relation to the model of care it is ensuring that its principles and actions are actually occurring and sustained in the clinical environment. This can be done effectively through monitoring Key Performance Indicators, auditing, review of staff-completed checklists and using inbuilt quality data from Information Technology Programs.

CONSULTATION WITH KEY STAKEHOLDERS

Targeted consultation

This District Model of care has been developed as an action from the 2020 District CFHN Planning day. The Model of care was developed though a District Working Group that included Managers, Clinical Leads, CFHNs, Aboriginal Health Staff, a consumer, and Population Health Staff.

Consultation with Aboriginal Health staff and consumers was guided by an Aboriginal Health Impact Statement. Aboriginal Health staff were consulted with, and they developed a survey specifically for Aboriginal families. Consumers were consulted with through the HNEKidshealth Family Advisory Council who also helped to develop an online survey for consumers.

The Multi-cultural Health Unit provided translations of surveys in a number of our most common languages used by CFHNS clients, Indian languages, Arabic, Mandarin, Thai, and Vietnamese for online surveys. All except the Indian languages were able to go into online surveys for our culturally and linguistically diverse clients.

All CFHNs staff were consulted with through online survey developed by the working party. In addition to this the Nursing and Midwifery Office supported staff feedback sessions with a member of the Essentials of Care Team Helen Baines.

The first draft of the Model of Care was presented to the District CFHN Manager meeting and from there distributed to the whole CFHN workforce for consultation.

It has also been shared with Newborn Services, Maternity Services for further consultations

APPENDICES

- Families NSW Flowchart
- Flowchart – CFHN additional care decision making and documentation process

REFERENCES

- NSW Health Policy Directive Breastfeeding in NSW: Promotion, Protection and Support PD2018_034
- Building Strong Foundations (BSF) Program Service Standards PD2016_013
- Growth Surveillance of Infants and Children in Primary Health Care HNELHD GandP 19_17
- Child Developmental Monitoring and Screening for CFHN HNELHD GandP 18_19
- Providing Telehealth (Video) Appointments in Child and Family Health Nurse Services

- Maternal & Child Health Primary Health Care Policy PD2010_017
- NSW Health Guide to the Role Delineation of Clinical Services.

Useful Links

Plums & Hats

The PLUM (Parent-evaluated Listening & Understanding Measure) screens for hearing and listening problems in young children. The HATS (Hearing and Talking Scale) screens for communication problems. They are designed for use by people who provide services to families with young children, who may not be trained to perform hearing or language assessments. Primary health workers and early educators are well positioned to use the checklists with parents to detect children who need referral.

The checklists use a pictorial format to engage parents or carers to talk about their children's listening and talking activities in real-life situations. The checklists are validated for use with parents of Aboriginal and Torres Strait Islander children below 6 years of age in urban, rural and remote communities. Both checklists have accuracy levels of >80%. That is, 8 of 10 children whose scores require referral have a hearing or communication problem when they receive professional assessments.

Maternal, Child and Family Health Ministry of Health website

Safe Sleeping for Babies Ministry of Health

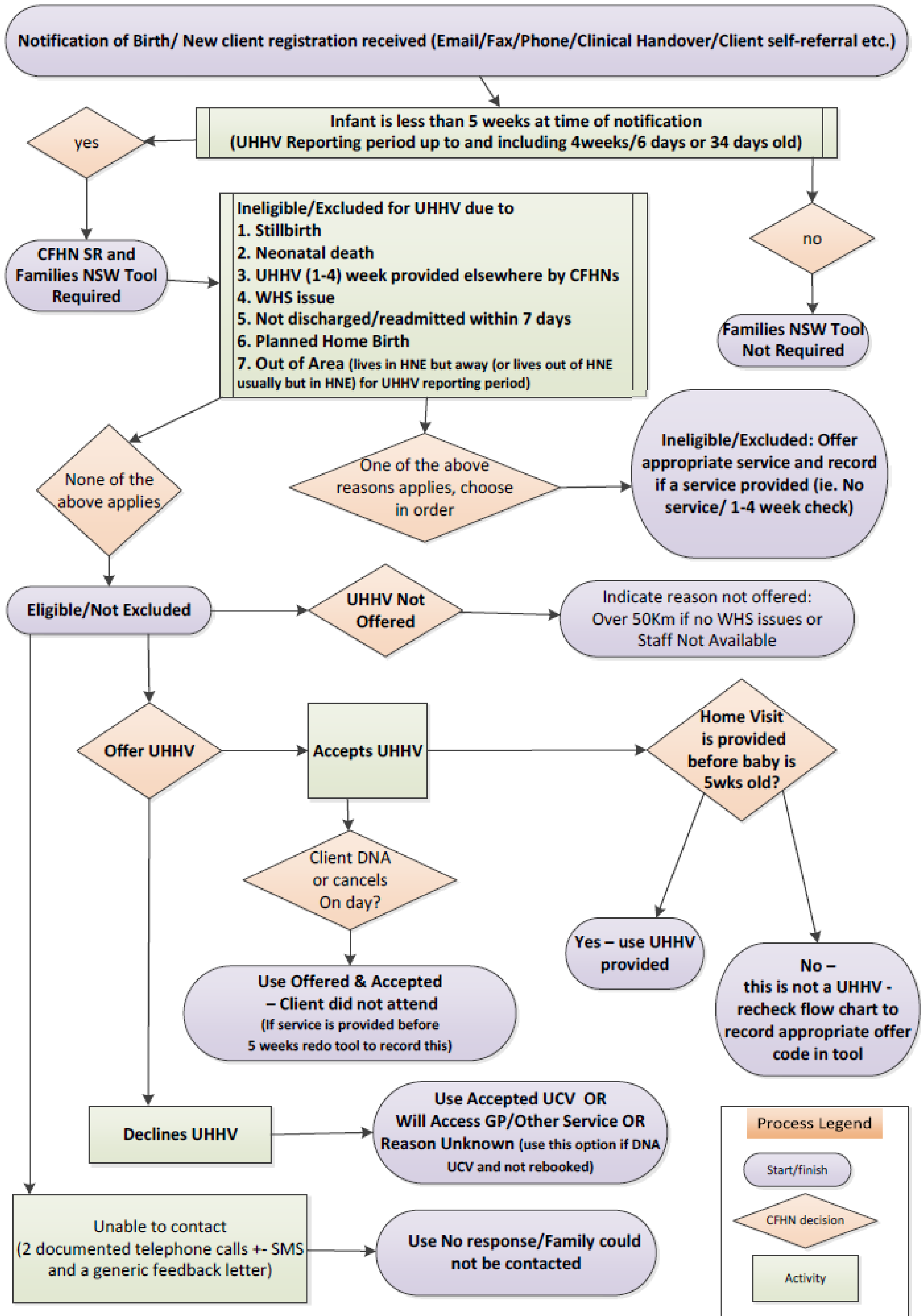
My Personal Health Record (the Blue Book)

Child health and development Resources

FEEDBACK

Any feedback on this document should be sent to the Contact Officer listed on the front page.

APPENDIX ONE Families NSW flowchart



APPENDIX TWO Flowchart – for Mainstream CFHN additional care decision making and documentation process