# GUIDELINES FOR MANAGEMENT, COORDINATION AND CLINICAL LEADERSHIP OF THE BEFORE SCHOOL CHECK PROGRAMME

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Acknowledgements

Developed by the Ministry of Health, in partnership with District Heath Boards and B4SC providers.

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# 1 INTRODUCTION

These guidelines are intended as a resource for Before School Check (B4SC) programme Coordinators, administrators and clinical leaders. They will also be useful for all involved in delivering the services.

The guidelines build on the requirements set out in the B4SC service specification. They provide further detail for management, coordination and clinical leadership of a high quality and nationally consistent B4SC programme.

Under the B4SC service specification, the B4SC Service Providers (those delivering the service) are required to:

- *Provide a universal service that maintains a strong focus on serving high deprivation populations*
- *Ensure that delivery of a high quality and nationally consistent service is in accordance with the service requirements set out in the service specification*
- *Ensure the minimum data requirements of all B4SCs provided are entered into the National B4SC Information System*
- *Monitor the appropriateness and timeliness of referrals, the impact on referral pathways, and the availability of referral services*
- *Provide the B4SC service to children/tamariki and families free of charge. This includes the process of referring children/tamariki and their families for further assessment and/ or intervention*
- *Deliver the B4SC in a clinically, culturally and socially appropriate manner and setting that respects the privacy and developmental needs of the children/tamariki and their families*
- *Employ a Coordinator who is accountable and responsible for managing and coordinating the B4SC, and any resulting referrals, in the DHB's area*
- *Refer children/tamariki to appropriate health, education and / or social services where the B4SC has identified a need for further assessment and / or interventions.* (Ministry of Health 2011)

The DHB is responsible for ensuring that the service is delivered according to the specifications; these guidelines are intended to assist the DHB and their service providers to meet the specifications. They set minimum standards for the service. In addition, exemplars of good practice are included, which may assist providers to address specific problems, enhance their services and meet the Ministry of Health ("the Ministry") targets.

The guidelines do not cover detail on actually performing the B4SC assessment. This detail is provided in the *Well Child/Tamariki Ora Programme Practitioner Handbook* developed by the Ministry and available on its website (Ministry of Health 2014a).

The *National Vision and Hearing Screening Protocols* describe the best practice requirements for vision hearing technicians (VHTs) who are delivering the National Vision and Hearing Screening Programme, including for the B4SC (Ministry of Health 2014b). This is an essential resource document for VHTs and nurses undertaking the B4SC.

The Ministry commissioned the development of the guidelines following a review of the B4SC programme. The review found few mechanisms for ensuring B4SC programme providers were aware of the requirements for management, coordination and clinical leadership, and for ensuring a high quality and nationally consistent B4SC programme. This has led to variability in the coverage, delivery and referral decisions in different components of the B4SC, within the programme and across the country. The programme is complex to administer due to the need to coordinate the inputs of a range of providers and also the difficulties in identifying and accessing families.

## 1.1 Background

The B4SC programme was established in 2008 by the Ministry.

It is a universal, comprehensive and free health and development screening and health education opportunity for four year old children/tamariki and their parents/guardians throughout New Zealand. Its purpose is to promote health and wellbeing in preschool children/tamariki; and identify and address any behavioural, developmental or other health concerns that could affect a child/tamaiti's ability to learn in the school environment. It also promotes early childhood development and supports parents/guardians in supporting their child/tamaiti's health and development. It is undertaken to allow time for further assessment and/or intervention, if required, to occur before the child/tamaiti starts school.

The B4SC programme exists within a continuum of linked Well Child services including immunisations, Well Child/Tamariki Ora (WCTO) programmes and related services including early education and social services for children/tamariki. It has a particular focus on the provision of services to high deprivation populations and to high need, Māori, Pasifika and new migrant children/tamariki with the expectation that it will contribute to the reduction of health inequalities particularly for Māori and Pasifika children/tamariki.

The Ministry increased the national target for children/tamariki receiving the B4SC from 80 to 90 percent of all children/tamariki for 2013/2014. While many district health boards (DHBs) have met or exceeded past targets, wide variation remains in B4SC delivery, coverage and quality, including the delivery of the B4SC to identified vulnerable priority groups.

## 1.2 Objectives

The objectives of the B4SC programme are to:

- Promote health and wellbeing in preschool children/tamariki
- Ensure that children/tamariki are prepared for school
- Identify any health, behavioural, or developmental concerns that may adversely affect a child/tamaiti's ability to learn in the school environment
- Make appropriate and timely referrals to improve child health and education outcomes, and reduce inequalities (Ministry of Health, Service Specification, July 2011).

## 1.3 Components

The B4SC includes:

- assessment
- opportunity for discussions on family health and wellbeing and health education, including nutrition and physical activity, immunisation, child/tamaiti safety, injury prevention, recognition of childhood illnesses, parenting for child/tamaiti age and stage, development, oral health and preparing for school (Ministry of Health, 2014)
- referral to appropriate health, education and/or social services where the B4SC has identified a need for further assessment or intervention
- entry of data into a national database.

The assessments and tools to support the consistent delivery of the assessment are as follows:

**Child health assessment and access to services (including immunisation status)** is supported by use of a *Child Health Questionnaire (CHQ).*

**Vision screening** involves distance visual acuity using Parr letter-matching vision charts or Sheridan Gardner charts.

**Hearing screening** involves screening audiometry followed by tympanometry, if indicated.

**Oral health screening** involves the *lift the lip* oral health check and oral health promotion.

**Growth surveillance** involves measuring and recording a child/tamaiti's height and weight and providing advice to parents about healthy eating and exercise within the framework of WCTO services.

**Assessing psychosocial attributes (positive and negative behaviours): emotional attributes, conduct, hyperactivity, peer relations and prosocial behaviour** is achieved using the *Strengths and Difficulties Questionnaire (SDQ)*, a, a tool the parent and early childhood teacher both complete in discussion with health professionals.

**Assessing developmental issues** is assisted through the use of the *Parents' Evaluation of Developmental Status (PEDS)* a tool that ascertains parents' concerns about their child/tamaiti's development.

Full details on the B4SC can be obtained from the *Well Child/Tamariki Ora Programme Practitioner Handbook* (Ministry of Health 2014), "the Handbook".
Proposals to add health and developments assessments to the B4SC that are outside of what is currently described in the Handbook must come through the Ministry's Technical Advisory Group.

## 1.4 Service delivery models

To meet the requirements for coverage of 90 percent of their population of four year olds, and 90 percent of their high-deprivation population of four year olds, each DHB plans and implements the B4SC using a service model that suits the needs of its local population and its health workforce, to ensure the success of the programme. There are several service delivery models.

*Single lead provider service model*

The DHB engages a single lead provider who is accountable to the DHB and responsible for management, coordination and clinical leadership and the delivery of the B4SC programme in the DHB's area.

There is a range of lead providers including:

- Primary Health Organisations (PHO) or groups of PHOs
- Royal New Zealand Plunket Society (Plunket)
- DHBs' public health nursing (PHN) services.

*Hybrid models*

There are also hybrid models with a lead provider who is accountable to the DHB and responsible for management, coordination and clinical leadership of the B4SC programme in the DHB's area; with delivery of the B4SC by other sub-contracted providers, including Māori and Pacific-led providers. Some examples of hybrid models include:

- A Plunket lead provider sub-contracts with iwi providers that deliver WCTO services to provide the B4SC to its enrolled population.
- A PHO lead provider uses its practice nurses to deliver B4Scs; public health nurses (PHNs) deliver B4SCs to populations enrolled with general practices that opt out of delivering the B4SC (around 30 percent of practices); and a mobile outreach team is contracted to locate and deliver B4SCs to families not enrolled with a general practice or early child education (ECE) provider.

## 1.5 Service inputs

The delivery of a high quality and nationally consistent B4SC involves a range of service inputs and personnel, with components of the B4SC being delivered by different disciplines/personnel. Management, coordination and clinical leadership of the service inputs and personnel is a key feature of the successful delivery of the service.

**The Coordinator**

DHBs are required to engage a Coordinator. The Coordinator may be employed by the DHB, when the DHB is the lead provider, or may be employed by a lead provider. Depending on the size of a DHB the management, coordination and clinical leadership functions may be split across several people. However for smaller DHBs the management, coordination and clinical leadership functions of the role may reside with one person, who may have some additional administrative support. Numbers of personnel required to provide management, coordination and clinical leadership also vary considerably depending on the population and area to be covered.

These guidelines use the term 'Coordinator' to encompass the breadth of the management, coordination and clinical leadership functions of the B4SC programme. , except where specifically discussing the **Clinical nurse leaders role** in B4SC nurse clinical leadership, professional supervision and oversight.

See Section 2 for an overview of the Coordinator Role.

**Personnel who deliver components of the B4SC**

**Registered health professionals, usually registered nurses** undertake the majority of the assessment and are also responsible for maintaining clinical oversight of the whole B4SC. Under the Service Specifications, the B4SC may be delivered by other registered health professionals, such as a GP, but it is predominantly delivered by nurses so the guidelines focus on nurses.

**Vision and hearing technicians (VHTs)** perform the vision and hearing screening components of the B4SC. There will sometimes be a joint care approach with the nurse, for example where the VHT and the nurse are employed within the same service. Where VHTs are not available to deliver the vision and hearing screening component of the service, this component can be delivered by registered health professionals with training and competency requirements equivalent to that of a VHT.

**Early childhood teachers** provide their observations of the child/tamaiti's strengths and difficulties against the *Strengths and Difficulties Questionnaire for Teachers (SDQ-T)*, as well as sharing other relevant information with parental informed consent.

**Kaiāwhina or community support workers** may be employed to assist with locating families that are hard to reach and for arranging appointments. Ideally, they come from local iwi/community and have strong local connections and networks. They may also provide cultural support during the actual appointment, and follow up referrals with families.

**Parents/caregivers** participate in the assessment of the strengths and difficulties, using the SDQ for Parents (SDQ-P), and also evaluate their child/tamaiti's development with the *Parents' Evaluation of Developmental Status (PEDS)* tool (although research has supported this being done face-to-face with the nurse).

# 2 Overview of the coordinator role

The Coordinator should ensure that **systems and processes are established and maintained** for ensuring that the B4SC are offered to all 4 year olds (meeting the Ministry of Health's target of 90 percent), and that the users receive services that are safe, effective, consumer-centred and of high quality and delivered by appropriately qualified and experienced staff.

Systems and processes need to cover:

A. Stakeholder engagement and publicity (Section 3), such as:
   - raising awareness of the programme
   - establishing and maintaining good relationships with key stakeholders in the education and health sectors.

B. Identifying and accessing the target group (all children/tamariki of the age of 4 years)(Section 4), such as:
   - allocating children/tamariki to the relevant providers (nurses, VHTs etc)

- management of the informed consent process (refer section 5.3)
- contacting parents/guardians/ family/whanau
- scheduling appointments and clinics at a time/place convenient to the family/whanau.

C. Coordination of components (Section 5), such as:
   - coordinating and monitoring the progress of children/tamariki through the components of the B4SC to ensure efficiency, effectiveness, quality and completeness of the B4SC
   - ensuring that the B4SC is completed when all components of the B4SC consented to have been delivered
   - ensuring the B4SC is closed i.e. when the requirements for closing have been met (refer to sections 6.4 and 8.2)
   - ensuring the GP involved in the care of the child/tamariki is informed of the results of the B4SC.

D. Documentation and reporting (Section 6), such as:
   - ensuring that the documentation of the B4SC is thorough, complete, accurate and entered in the B4SC Information System
   - reporting regularly to the DHB in a way that meets the contracted requirements and timeframes.

E. Ensuring quality of the B4SC assessments (Section 7), such as:
   - ongoing quality improvement through monitoring the quality of all aspects of the B4SC, identifying local quality improvement priorities and implementing improvements to the B4SC programme delivery
   - ensuring that all personnel involved with delivering components of the B4SC are appropriately qualified and experienced
   - providing and supporting the training and professional development of the registered health professionals delivering the B4SC. **Clinical nurse leaders** are responsible for providing clinical leadership, professional supervision and oversight to the registered nurses undertaking the assessments.

F. Managing referrals (Section 8), such as:
   - ensuring that any issues identified during the B4SCs are discussed with parents and referred to the appropriate specialist service for follow-up with sufficient, well documented information
   - monitoring the progress and outcomes of referrals.

# 3 STAKEHOLDER ENGAGEMENT AND PUBLICITY

***The Coordinator should:***

- ***Ensure that methods for raising community awareness of the B4SC are developed and implemented, including the production and distribution of relevant publicity material***
- ***Establish and maintain effective systems for collaboration and coordination with all health and education sector parties involved with the provision of services to children/tamariki***

- ***Establish and maintain effective systems for engaging with the community served by the programme.***

## 3.1 Raising awareness of the programme

The Coordinator should develop a promotion strategy. The publicity material should include information on:

- The components of the B4SC
- The benefits of participation in the programme, including the importance of completing the B4SC
- How to access the service.

The refreshed national publicity material for the B4SC was made available to Coordinators in April 2015.

The Coordinator should ensure that the production and distribution of relevant publicity material is undertaken in such a way as to reach the target families, for example:

- Distributing leaflets and pamphlets and putting up posters in relevant places in the community visited by families with pre-school children/tamariki, including:
  - PHOs and general practices
  - Early childhood education centres, including kōhanga reo and Pasifika language nests
  - WCTO services, such as Plunket clinics
  - Shops, particularly those selling toys, or children/tamariki's books
  - Libraries.
- Setting up stalls at fairs/gala days and community events
- Presenting at relevant events attended by parents of pre-schoolers, such as pre-school parents' meetings.

The Coordinator should regularly evaluate their promotion strategy.

> ***Exemplar 3.1:*** *One district commissions the manufacture of children's backpacks that can be used for pre-school or school and distributes them free of charge once the B4SC has been completed. The backpacks are brightly coloured and have a B4SC logo on them.*

## 3.2 Service Linkages

***The Coordinator/clinical nurse lead should ensure that effective relationships are established and maintained with all key stakeholders, particularly those in the primary health care and early childhood education (ECE) sectors.***

Critical success factors include ensuring that all health professionals and educators involved with providing services to families with pre-school children/tamariki are knowledgeable about the programme and the importance of assisting families to access the service. A schedule of key linkages with other agencies can be found in Appendix One.

The purposes for such links with services include:

- Maintaining wider awareness of the B4SC programme to ensure the ongoing co-operation of the sectors in:
  - Promoting the B4SC programme to families/whānau with whom they work and encouraging families that have not yet completed their B4SC to contact the service
  - Obtaining contact information from families/whānau with whom they work to assist the Coordinator to locate children/tamariki and update the B4SC Information System.
  - Ensuring that parents are encouraged to register with a general practice and/or ECE provider, if they are not already, and that all aspects of the programme are co-ordinated.
- Ensuring good information flow about changes in all sectors including:
  - changes in specialist personnel who receive referrals
  - changes in B4SC personnel or administration
  - management or organisational changes in other relevant health and special education services, such as early childhood education (ECE) providers
  - any new evidence related to early childhood development or health (clinical nurse lead role)
  - changes in contact details.
- Coordinating the range of inputs to ensure completeness of the B4SC. For example:
  - Early childhood teachers provide useful observations of a child/tamaiti's as part of completing the SDQ-T and may have other observations to share
- Sharing information with relevant health care providers, for example, information to a child's general practice on concerns identified and referrals made.

> ***Exemplar 3.2:*** *In one district, the coordinator (who is also the clinical lead) meets fortnightly with relevant health and education stakeholders (Clinical leader from DHB child health services, SES manager, MoE, SES, and key NGOs) to discuss current issues and triage referrals.*

The Coordinator/clinical nurse lead should maintain a list of contacts at all early childhood centres, including kōhanga reo and Pasifika language nests, and ensure they or their associated groups are engaged with regularly (phone or visits), to:

- obtain support for the administration of the SDQ-T and discuss any issues related to these and the sharing of information in general
- assess the potential use of the facilities as a venue for delivering B4SC assessments and vision and hearing screenings
- obtain support for assistance in display of publicity material and distribution of publicity material, forms and letters for their enrolled populations
- discuss any management or personnel changes to relevant processes and systems, including changes in contact details.

## 3.3 Engagement with the community

The Coordinator/clinical nurse leader should establish and maintain links with key community groups or organisations to ensure that they maintain awareness of the B4SC programme, share information on any changes in administration and personnel, and keep updated on issues or changes within the wider community of interest.

While a key role for the Coordinator/clinical nurse leader, it is important that nurses also maintain these relationships.

The Coordinator/clinical nurse lead should liaise regularly with key community representatives, such as

- Kaumātua and kuia of local iwi
- Pasifika community leaders
- Community groups, such as the Kindergarten Association, Playcentre.

## 3.4 Ensuring Māori participation

***All parts of the B4SC programme should ensure that services contribute to reducing health inequities and meet the health needs of Māori tamariki.***

The B4SC programme must facilitate Māori access to the services and ensure that the service is accessible and acceptable to Māori. Actions include:

- Ensuring Māori participation in decision-making about the design and delivery of the services (e.g. governance structures)
- Developing effective models of service delivery, for example,
  - Conducting B4SC assessments in marae and kōhanga reo (if privacy can be assured)
  - Involving wider whānau in the assessment
  - Employing kaiāwhina from the local iwi and with good networks to work with Māori families
  - Integrating the B4SC with other iwi or Whānau Ora health or education services
- Recognising the cultural values and beliefs that influence the effectiveness of services for Māori and ensuring that staff delivering the various components of the B4SC have the competence to tailor their delivery to meet the cultural values and beliefs of Māori
- Establishing and maintaining regular positive interactions with iwi leaders such as kaumātua and kuia, and other Māori leaders involved in pre-school health and education.

> ***Exemplar 3.4.1****: One district contracts an outreach Māori public health nurse, who is a member of the local iwi and also a qualified teacher, previously running a kōhanga reo, to contact and conduct the B4SC assessments with Māori families.*

> ***Exemplar 3.4.2****: Several districts employ kaiāwhina who visit outlying and rural areas to follow up and access whānau, arrange appointments, and pick them up and take them to clinics if transport is an issue. The kaiāwhina maintains contact with the whānau and facilitates appointments with other agencies to which the whānau is referred.*

# 4 IDENTIFYING AND ACCESSING CHILDREN/TAMARIKI

***The Coordinator must establish and maintain good systems and processes for:***

- ***Identifying and locating all children/tamariki in the target area, with special attention to those in communities that are hard to reach or high deprivation (defined as quintile 5), as soon as possible after they turn four years of age***
- ***Offering the B4SC to all families with 4 year old children/tamariki and that the Ministry of Health's targets of 90 percent of all four olds receiving the completed B4SC are met***
- ***Allocating cases to providers in an efficient and effective way that ensures coverage***.
- ***monitoring the progress of all children/tamariki through the programme.***

## 4.1 Locating children/tamariki

Coordinators will need to use a range of systems to obtain updated addresses and contact details of all families/whānau. The particular service model of the programme may dictate the most effective method to identify and access families/whanau, using other sources of information for identifying these children/tamariki. .

The main ways to identify updated contact details, including phone numbers, of the children/tamariki include:

1. **Community publicity**: Encouraging families to make initial contact with the service is very useful. Distribution of relevant publicity material (Ref. section 3.1) with the contact details of the service will assist with this.

2. **The B4SC information system:** Coordinators have access to the B4SC information system. See section 6.1 for more information on the B4SC information system. The B4SC information system may not accurately identify children/tamariki who have never been enrolled with a PHO. This database is updated quarterly and provides addresses. The information on itinerant children/tamariki may not accurately reflect at the time of turning four years old the address of the child/tamaiti. The absence of listed phone numbers in the B4SC information system also complicates the ability to make initial contact to arrange appointments.

3. **WCTO providers:** WCTO providers may have up to date details for families, and also may be aware of children and families who are not registered with a general practice.

4. **Primary care providers**: Individual general practices are a good direct source of up-to-date information on the children/tamariki enrolled with the practice. Their information may include parents/guardians' names and phone numbers. Where the service is delivered by practice nurses, four year old children/tamariki may be identified directly by the practice nurse from the general practice in which they are enrolled and for which the nurse is responsible, leaving only those children/tamariki not enrolled in a participating practice to be identified through other means. This source of information is not available to all programmes, however, as not all general practices are

prepared to share this information. It also does not provide information on those children/tamariki who are not registered with a general practice.

5. **Early childhood education centres:** Individual ECE providers can assist with lists of names and contact details of children/tamariki enrolled in their centres. The Ministry of Education Early Learning Information (ELI) database may also be useful if the service has access to it.
6. **Other health databases:** Matching the information from the B4SC IS with information from other databases such as the National Immunisation Register (NIR) or National Health Information database (NHI) if the Coordinator has access to these.[1]
7. **Vision and hearing screening service:** Cross-referencing with data held by the vision and hearing screening service.
8. **Family Start providers**: Identifying children/tamariki through close collaboration between services.
9. **Community networks:** Using networks in the community or from professional networks (identified in section 3.2).

> ***Exemplar 4.2.1:*** *A well-publicised 0800 number that enables parents to contact the B4SC service with no cost has been found to be useful, especially those living in high deprivation areas and who may not have the money to answer voicemails, return texts or ring the B4SC service.*

There are particular challenges in locating and contacting families/whānau that are mobile or not engaged with other relevant health and education services such as ECE providers or primary care. These families/whānau also tend to live in high deprivation areas.

It is recommended that the task of initially locating the family/whānau, often extremely time-consuming, is undertaken by non-clinical personnel, leaving the nurse to focus on the assessment.

> ***Exemplar 4.2.2****: Several districts employ kaiāwhina or community support workers who visit outlying and rural areas to follow up and access families/whānau, and arrange appointments.*

[1] It is important that any use of other databases does not contravene the Privacy Act 1993 or the Health Information Privacy Code, 1994 (HIPC). The HIPC and the Privacy Act 1993 can be accessed from the Office of the Privacy Commissioner's website (www.privacy.org.nz)

It is important that if the Coordinator learns that a child/tamaiti has left the district prior to the completion of the assessment, they notify the Coordinator in the recipient district by email. This enables the recipient district to undertake or complete the assessment.

Each Coordinator should take responsibility for maintaining the national integrity of the B4SC information system by ensuring that the names and addresses of children/tamariki are updated as soon as possible (or within a week) after discovering changes.

## 4.2 Allocating children/tamariki

***The Coordinator should establish and maintain allocation systems that ensure that all children/tamariki are allocated to the appropriate nurse.***

The systems used to allocate children/tamariki vary according to the specific area or the way the service is designed to meet the needs in the area which it serves. Systems include:

- Allocating by geographic area with nurses having their own coverage region
- Allocating by clinics with the Coordinator or administrator scheduling clinics and appointments then rostering nurses to the clinic
- Allocating by general practice with practice nurses being responsible for undertaking the assessments to all the registered families/whānau with that particular practice
- Using outreach services who may be working with the same population.

Sometimes the allocation includes the requirement to locate a family/whānau that may not be found at the initial address. It is recommended that this function is done by administrators or kaiāwhina.

## 4.3 Scheduling appointments for assessments

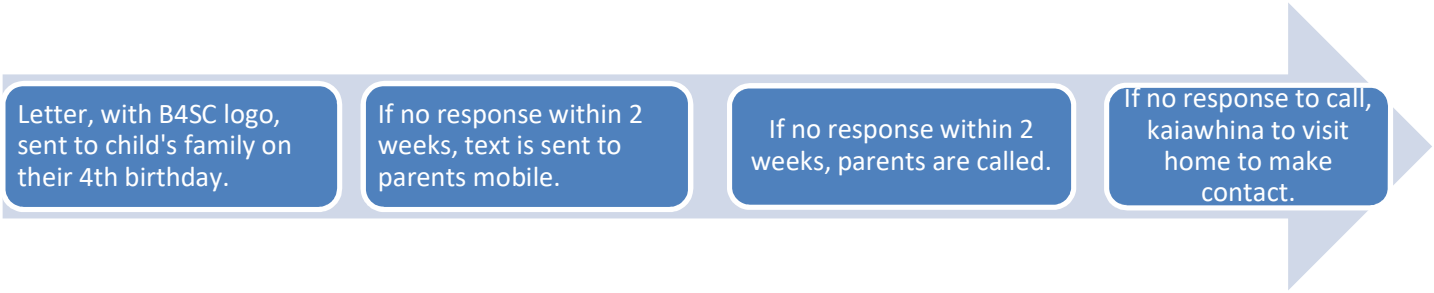
It is important that appointments for assessment are made in an efficient and effective way. An appointment that does not suit the recipient family/whānau is likely not to be kept, resulting in further work re-scheduling in order to ensure that the assessment is completed. The timing of making the appointment is important. The appointment needs to be made enough time in advance to enable the parent to make arrangements to attend but sending it out too early increases the likelihood of it being overlooked.

> ***Exemplar 4.4.1****: One district has found that sending out the appointments two weeks ahead of time is the most effective. They also send a reminder two days before the appointment.*

Making contact with the family/whānau in order to schedule an appointment can be done by letter (if the address is known), phone call (if the phone number is known) or email (if the email address is known). The invitation and appointment needs to include information about the B4SC assessment and its various components and copies of the SDQ-P and PEDS forms with explanations to the parent/guardian on how to complete these prior to the assessment. The approach needs to be flexible enough to be responsive to different populations/communities with regard to speakers of languages other than English, literacy and learning levels, and specific needs of families.

The time and date should be negotiated with the family/whānau to ensure that it suits them. It is important to provide an option for families/whānau to undertake the assessment at flexible times to suit the needs of working families/whānau. As well as scheduled appointments, it is often useful to allow opportunities for families to 'drop in' to clinics in outlying areas or at pre-arranged venues. This includes having clinics or home visiting in early evenings and weekends, as well as during the day.

The refreshed B4SC promotional material is likely to see a greater call to action on the part of parents/caregivers. The following figure shows a suggested process for making contact with families/whanau, but should be adapted to local needs.




**Venues**

***The Coordinator should maintain a list of appropriate venues that are quiet, ensure privacy and are accessible to the targeted population.***

Setting up clinics is an efficient way of scheduling assessments to ensure the maximum number of assessments in the time allocated. The particular venue used for a clinic must ensure privacy and accessibility for the family. Clinics can be held in WCTO clinics, community health facilities, general practices, pharmacies, community halls, marae, church halls, schools, including ECE centres, etc. If the vision and hearing screening is to be done at the same time it is important to ensure that the premises used have enough space for vision screening and are quiet enough to ensure that hearing screening is not compromised.

In outlying or rural areas where there are low volumes of B4SCs or for populations that are hard to reach and who are difficult to get to attend a clinic, it is may be more effective to use the family home. In these cases, it is important to choose a room that is private and not too noisy.

Where assessments are done by practice nurses, appointments can be scheduled individually at the practice as part of the regular primary care service.

***Exemplar 4.4.2:*** *Use of text messages to contact parents has been found to be useful, as it enables the parent to respond with minimal cost.*

***Exemplar 4.4.3****: A brightly coloured or clearly identifiable envelope with a logo for a posted appointment will help to ensure that it is opened.*

# 5 COORDINATION OF COMPONENTS

***The Coordinator is responsible for ensuring that the various components of the B4SC are coordinated in a way that ensures the programme delivers comprehensive assessments of consistent quality.***

***To achieve this, the Coordinator should:***

- ***Liaise regularly with all organisations involved in delivering components of the programme***
- ***Maintain systems and processes for continuous monitoring of children's/tamariki progress through the components***
- ***Maintain processes for following up delays or deficiencies in components to ensure that the whole B4SC is completed well before the child/tamaiti turns five.***

The B4SC is dependent on early childhood educators (for the SDQ-T component and other relevant information to be shared), parents (particularly for SDQ-P, and PEDS), and the DHB public health service (for the vision and hearing screening component). The nurse conducting the B4SC assessment carries professional responsibility for the assessment. Ideally, all components should be completed before the nurse does their B4SC assessment so that they can use the results of the other assessments and discussions to direct the content of health education and inform the need for referral.

## 5.1 Regular liaison

A discussion on service linkages is presented in section 3.2. This section is relevant for ensuring coordination and is not repeated here. Regular engagement with all health professionals and educators involved with providing components of the B4SC service is critical for ensuring success.

The Coordinator should maintain an updated list with contact details of all the personnel contributing to the B4SC programme, including early childhood centres. This list should be available to each nurse involved with the programme. Nurses should be encouraged to contact VHTs or ECE teachers if necessary regarding a specific issue uncovered during an assessment to obtain more information and ensure that any referral includes all the relevant information.

> ***Exemplar 5.1.1:*** 'The ECE teachers use their staff meetings as a time to fill in the SDQT as a team as this then provides a collective view on a child. The B4SC clinical lead will contact an ECE when she receives an SDQ-T with concerns. She finds the conversation very useful, both to provide further context for a child and their family, but also as an opportunity to discuss, and provide advice where appropriate. These processes are well embedded and now ECE teachers More often than not contact the clinical lead if they have concerns for a child and particularly if the SDQT has not been delivered by the parent. Occasionally the clinical lead will deliver in-service training at professional development days for ECE and at other whānau hui events. She notes that ECE can do a lot to model behaviour to parents to adopt at home; and to encourage uptake of services such as Incredible Years.

The Coordinator should ensure that there is a good information flow on changes in all sectors that will impact on the programme, particularly:

- Changes in B4SC personnel or administration
- Management or organisational changes in other relevant providers that will impact on the delivery of the B4SC programme
- Changes in contact details.

## 5.2 Parents/whānau/guardians/caregivers

Active parental participation is an important part of the B4Sc, both in the assessment and in the exchange of information and advice, where necessary. The Coordinator and nurses conducting the assessment need to encourage the parent/whānau/guardian/caregiver ( "the parent") to participate in the assessment and the vision and hearing screening. They can do this by:

- Negotiating appointments for vision and hearing screenings and the nursing assessment with the relevant parent so that they are scheduled for a time and venue that is suitable for them to attend, including:
    - Involving the parent in the scheduling of the appointment
    - Providing sufficient notice of the appointment with clear instructions on how to contact the service to change the time, and sending a reminder a couple of days prior to the appointment
    - Making flexible times available, if necessary, including after working hours and weekends, to enable parents to attend
    - Facilitating ways to assist the parent to access the service including arranging transport or conducting the assessment at the home, if necessary.
- Providing the SDQ-P questionnaire to the parent with full explanations as to how to complete it prior to the appointment, if possible, otherwise its completion becomes part of the nurse's assessment
- Ensuring that the parent gives informed consent for the assessment, any immunisations being given, and any referrals (refer to the Practitioner Handbook for information on informed consent)
- Ensuring the parent has the opportunity to contribute their knowledge, and
- Ensuring that the parent fully understands reasons for referral for further investigation or treatment.

## 5.3 Vision and hearing screening

The Coordinator should work closely with the public health service to ensure that the VHT component of the B4SC is scheduled as soon as possible after the child/tamaiti's 4th birthday and prior to the nurse undertaking the assessment. Ideally, the vision and hearing screenings and SDQ-T components are

completed before the nurse does the B4SC so that they can use the results of the other assessments to direct the content of health education and inform the need for referral.

The B4SC and VHT services need to work together to ensure the completion and integrity of the B4SC. It is recommended that the Coordinator meets regularly with the manager of the VHT service to discuss issues of mutual concern and scheduling, including sharing the names and contact details of children/tamariki and information on which components have been completed and which components are outstanding.

It is also important that liaison and communication occurs at individual practitioner level. The Coordinator should establish processes for communication and relationship building between nurses and VHTs. This mutual involvement is important to facilitate the development of a shared understanding of the B4SC as a whole, a clear understanding of the roles and responsibilities in relation to each component, and a shared commitment to ensuring completion.

Both nurses and VHTs should work collaboratively to ensure that the results are complete and comprehensive. Several strategies can be employed to facilitate this collaboration, including:

- Providing access to the B4SC information system to nurses and VHTs so that they can each check on which components have been completed and the results of the other B4SC assessments.
- Ensuring that nurses and VHTs know how to contact each other to discuss specific issues, including:
    - checking whether the other party has completed their part of the B4SC, if this is not identified in the B4SC information system
    - when it is likely to be scheduled if not completed
    - relevant findings that might impact on referral decisions.[2]
- Holding joint meetings or study sessions on issues of mutual relevance, such as speech and language, at least once a year
- Holding joint clinics attended by both nurses and VHTs where the child/tamaiti completes both components on the same day – 'one-stop-shop'[3]
- Undertaking joint home visits to conduct both parts of the assessment together with home visits being done after hours or at weekends if necessary.

Where VHTs are not available to deliver the vision and hearing screening component of the service, this can be delivered by registered nurses who have received the appropriate training. This option may provide an effective alternative solution for rural or isolated areas or to enable completion of the B4SC for families who have been unable to attend an appointment or where the child/tamaiti does not attend ECE centres.

[2] For example, speech and language delays could indicate hearing problems or developmental delays could indicate vision or hearing problems.

[3] Where joint clinics are held, the scheduling of appointments and rostering is usually done by the coordinator.

***Exemplar 5.3.1:*** *In several districts, the B4SC coordinator undertakes the scheduling of the VHTs for B4SC, including drawing up rosters for clinics. This ensures coordination and timeliness of the checks.*

***Exemplar 5.3.2:*** *One district employs a nurse who is also a qualified VHT who completes both components of the assessment. This provides a flexible way of completing B4SC for families who require home visits.*

***Exemplar 5.3.3****: One iwi provider, which provides B4SCs to its enrolled population, employs a qualified VHT who works with the nurses to provide the full service.*

## 5.4 Early childhood education

The SDQ-T is an important component of the B4SC in terms of assessing whether there are any behavioural issues that should be addressed before the child/tamaiti commences school. Early childhood teachers provide useful observations of a child/tamaiti's as part of completing the SDQ-T but also may have other observations they consider important to share.

Completion of the SDQ-T and making it available to the nurse prior to the B4SC assessment is ideal. This enables the nurse to discuss it with the parent/guardian/caregiver in relation to the SDQ-P and other findings of the assessment and inform any decision for referral for further investigation or follow-up. The Coordinator should strongly encourage early childhood teachers to participate in the B4SC programme and complete the SDQ-Ts for all their enrolled children/tamariki.

It is important that ECE teachers understand the B4SC programme and its various components and the importance of their contribution. The Coordinator may facilitate co-operation of ECE by:

- Building relationships with all the early childhood teachers in the area
- Engaging regularly with key stakeholders in the education sector, including Ministry of Education, ECE associations and kōhanga reo associations
- Participation/presentation at education day.

The Coordinator should maintain a list of contacts at all early childhood centres, including kōhanga reo and Pasifika language nests, and provide updated lists to the nurses carrying out the assessments. The Coordinator or delegate should also liaise regularly with ECE centres where possible regarding linkages between the B4SC programme and Early Child Education providers.

The purpose of liaison includes but is not limited to:

- Obtaining lists and updated contact details of enrolled 4 year olds

- Sharing information on the children/tamariki who have completed their assessments and those who have not
- Coordinating VHT visits, where necessary
- Obtaining support for the administration of the SDQ-T and discussing any issues related to these
- Assessing the potential use of the facility as a venue for delivering B4SC assessments and vision and hearing screenings
- Obtaining support for assistance in display of publicity material and distribution of publicity material, forms and letters for their enrolled populations
- Discussing any management or personnel changes to relevant processes and systems, including changes in contact details.

The Coordinator should also establish and maintain processes for communication between nurses and ECE teachers, for example, joint meetings or training on issues relevant to both such as child development, normal behaviour and learning patterns, speech and language development.

> ***Exemplar 5.4:*** *Conducting joint VHT and nurse B4SC clinics in ECE centres is a good way of completing the components together and also engaging with the teacher at the same time.*

# 6 DOCUMENTATION AND REPORTING

***The Coordinator should***

- ***Ensure that the B4SC information system is kept updated and accurate and timely reports are forwarded to the DHB***
- ***Ensure that all staff who have access to the B4SC information system are familiar with the Ministry's policy for its use (Access, Use and Disclosure Policy for B4 School Check Information System Users)[4] and abide by its conditions***
- ***Establish and maintain effective systems and processes for meeting the Ministry of Health's objectives.***

This includes:

- Maintaining systems of data entry that ensure that the recording of the assessment into the B4SC information system is complete and accurate
- Ensuring that all B4SCs are entered and completed in the B4SC information system no later than seven days after the child/tamaiti's 5th birthday
- Ensuring that the B4SC is not recorded as completed until all minimum requirements have been fulfilled (refer section 6.4)
- Ensuring that all B4SCs are recorded as closed in the B4SC information system when the requirements for closing have been met (refer to sections 6.4 and 8.2).

## 6.1 The B4SC Information System

The B4SC information system is a Ministry purpose-designed and built database specifically for the management and reporting of the B4SC programme, using information related to the child/tamaiti that is collected through the B4SC . This database is intended to include all children/tamariki turning four years old. It is updated quarterly by the Ministry of Health from the PHO register. It also includes those added to the B4SC database by the coordinators. The Ministry uses the B4SC information system as the base for its assessment of target numbers. The B4SC information system records:

- Permissions and consents
- height, weight, vision and hearing screenings, development and behaviour assessments
- Any identified health, developmental or behavioural issues that may limit the child/tamaiti's ability to learn in the school environment
- Any referrals or follow-up required to improve child health and education outcomes.

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[4] Ministry of Health (2010) *Access, use and disclosure policy for B4School Check Information System Users* Ministry of Health, Wellington.http://www.health.govt.nz/publication/access-use-and-disclosure-policy-b4-school-check-information-system-users

Its overall purpose is to track improved health outcomes from the B4SC programme. The creation of a reliable source of B4SC information history for each child/tamaiti at a local and regional level across New Zealand, available to authorised health practitioners, will assist in tracking improved health outcomes and reduced inequalities.

The **objectives** of the B4SC information system are to:

- provide a secure information system that can only be accessed by authorised health practitioners
- accurately record all B4SC results and retain this information throughout the lifespan of that child/tamaiti
- provide a readily available, accurate history for each child/tamaiti to approved health providers (this information must be available to the parent/guardian through their health provider)
- provide B4SC information to assist with the recall and follow-up of individuals by health providers at local and district levels
- provide information to providers that an individual has declined a B4SC and that follow-up is not required
- provide accurate local, district and national B4SC coverage data by age and ethnicity
- identify populations that are not accessing the B4SC so that services and resources can be targeted to assist those people to access the B4SC, and thus improve coverage
- provide accurate information so providers may evaluate and audit their services
- provide an information base to improve programme policy and the delivery of services.

**I**t also provides a database of all children/tamariki which is used for monitoring district and national coverage of the programme and produce reports on health and development trends. The district health board and its agents will use, analyse and monitor the data about their own population to inform their planning and delivery of the B4SC service. (Ministry of Health, 2014. Pp166-167)

An important function of the B4SC information system is the ability it provides for Coordinators and practitioners to access the data generated through other components of the programme, assisting in monitoring of the progress of each individual child/tamaiti through the B4SC.

Because services will be provided by a range of providers working together, the benefit of the *B4SC* information system to a provider is that they will be able to access the data that their colleagues have generated and be able to track frequent movements of the child/tamaiti and respond if necessary.

The use of the B4SC information system to capture and store data is a lawful purpose connected with the Ministry of Health DHBs and their agents' functions of improving individual and population health. On this basis, they each will have authorised access to the information for their populations as per the *Access, use and disclosure policy* for the B4SC information system.

**Health information privacy obligations for users of the B4SC information system, refer to the Practitioner Handbook (**Ministry of Health, 2014a, p 167)**:**

*"The collection, exchange and management of health information about identifiable individuals held on the B4SC IS fall within the provisions of the Health Act 1956, the Privacy Act 1993 and the Health Information Privacy Code 1994 (HIPC). The HIPC and Privacy Act 1993 can be accessed from the Office of the Privacy Commissioner's website (www.privacy.org.nz).*

*B4SC providers must ensure that the child/tamaiti and their parents/guardians are informed about the B4SC IS, the information being collected and what that information may be used for. The overall purpose and objectives behind collecting and storing the information are described above.*

*Those collecting information will collect it in a professional, considerate and respectful manner, sensitive to cultural differences. Users of the B4SC IS must take all reasonable steps to provide accurate information to the system and to check the accuracy of the information with the child/tamaiti and parent/guardian before relaying the information. An individual will also be able to access their (or their child/tamaiti's) information on the B4SC IS and to update and correct their individual details.*

*The Ministry of Health will ensure that storage and security safeguards will prevent unauthorised access to and use of the information contained on the B4SC IS. All employees of the Ministry of Health, district health boards and their agents who have access to the system will be required to show that they understand and will adhere to all privacy requirements.*

*The Access, Use and Disclosure Policy provides further details about information collected as part of the B4SC (Ministry of Health 2010a)."*

## 6.2 Professional documentation and storage of records

All practitioners have a professional responsibility to document each assessment accurately and contemporaneously. Under the *Health (Retention of Health Information) Regulations 1996*, health providers have obligations to retain health information in some form for a minimum period of ten years. The professional record from the B4SC (i.e. case notes) must be separate from that which is recorded in the B4SC information system. The information in the B4SC information system is a Public Record for the purposes of the *Public Record Act 2005*. The B4SC information system is therefore not the provider's record of health information. It is a secondary source of the health information derived from the primary files, which would continue to be held by the provider.

The practitioner's responsibility includes:

- Documenting each assessment accurately and contemporaneously in some form separate from the B4SC information system
- Ensuring that complete and accurate information is available for entry into the B4SC information system
- Storing any hard copy records to prevent unauthorised access

- Providing information to the child/tamaiti's primary health care provider on completion of the B4SC.

## 6.3 Ensuring the integrity of the B4SC Information System

***The Coordinator should ensure that information is correctly entered into the B4SC information system, in accordance with the User Manual. This includes having robust systems to ensure that the information is clearly reported and entered.***

The B4SC information system is not the nurse's record of the assessment, which is documented in a form described above. It is important that accurate information is entered in the relevant parts of the database following the assessment. The requirements are described in more detail in the User Manual (2016 version available on request from the Ministry). Methods of record-keeping and information entry vary depending on the employment setting of the nurse conducting the assessment and the service model used for delivering the programme. There are two main systems:

1. Nurses and/or VHTs have direct access to the B4SC information system and record their own findings and follow-up into the B4SC information system following the assessment
2. Nurses and/or VHTs record their assessments on paper records or, in the case of practice nurses - directly into the practice management system, which are subsequently entered into the B4SC information system by programme administrative staff.

> ***Exemplar 6.3:*** *Providing all nurses working outside their offices with tablet computers with an application specifically designed to enable mobile access to the B4SC information system was strongly supported by stakeholders and would facilitate immediate and accurate data-entry of their B4SC assessments.*

Information recording includes:

- Updating child/tamaiti's contact detail prior to completion of the B4SC
- Recording all contacts with family
- Entering information from all components of the B4SC, including who conducted the B4SC assessments and the date:
    - Vision and hearing screenings and any follow up referral or need for rescreening
    - Nursing health and development assessment, including interpretation and scoring of PEDS, SDQ-T and SDQ-P
    - Advice or education provided to the parent
    - Any referrals for further investigation or remedial action

- Completion of the B4SC and date of completion
- Closing of the B4SC and date of closing.

All entries should be dated and include the name of the person entering the information.

## 6.4 Completion and closing of the B4SC

***The Coordinator must ensure that B4SCs are recorded as completed and closed once all the requirements have been met.***

*Completion of the B4SC*

A B4SC can be recorded as '*completed*' in the B4SC information system once the requirements have been fulfilled. These are:

- The nurse's B4SC assessment is completed (unless declined by the parent/caregiver after an informed consent process)
- Vision and hearing screenings are completed (unless declined by the parent/caregiver after an informed consent process). Vision and hearing screening are not required if the child/tamaiti is currently under the care of a relevant practitioner for an already diagnosed vision or hearing problem. In this case, the reason for omitting the hearing or vision screening should be entered into the information system and the B4SC can be completed.
- If the child/tamaiti attends an ECE service, either the return of a completed SDQ-T or formal notification by the ECE service that they are declining to complete the SDQ-T[5]
- Any referrals are made.

*Closure of the B4SC*

A B4SC can be recorded as *'closed'* in the B4SC information system once it has been completed and all referrals have been accepted and commenced by a referral service. Refer to Section 8.2 for information on following up on referrals, and referral outcomes.

**Declining the B4SC**

If the parent/caregiver has formally declined to have all, or any part of the B4SC, then *'consent given'* should be recorded as *'no'* and the B4SC closed.

If the parent/caregiver declines for their child/tamaiti to have the nurse component of the B4SC but the child/tamaiti does have their vision and hearing screening component completed, this is classified as a '*declined B4SC*'. The vision and hearing screening results should be documented before setting the *'consent given*' to *'no'* and closing the B4SC.

[5] Note: In some cases it is very difficult to obtain such formal notification. In this case, then at least one follow-up attempt should be made with the ECE with parental consent. If it is still not returned after a wait of at least one month, then the check may be completed.

The B4SC can only be recorded as '*declined*' if, after an informed consent process and discussion with the parent/caregiver, the parent/caregiver has notified the provider that they decline for their child/tamaiti to have any part of the B4SC, or all the B4SC.

A '*did not attend*' is **not** a decline. If the child/tamaiti has some of the components of the B4SC completed (e.g. the vision and hearing screenings) but the child/tamaiti does not attend the nurse assessment component (or vice versa), this remains as an uncompleted and open B4SC as there has not been an informed consent process where a decline has occurred.

## 6.5 Reporting

***The Coordinator must:***

- ***Meet all reporting requirements of the Ministry of Health and the DHB, including providing quarterly reports to the DHB which include percentage targets for the population and percentage targets for children/tamariki in high deprivation (quintile 5) populations***
- ***Ensure that the information in the B4SC IS is up to date to enable the Ministry of Health and the DHB to obtain the information and reports that they require for monitoring and quality improvement.***

The B4SC information system can provide a wide range of reports which are very useful for the ongoing management of the programme and quality improvement, including:

- Monitoring progress against targets
- Tracking progress of individual children/tamariki through the various components of the B4SC
- Analysing trends in health and development indictors and referral patterns
- Supporting continuous quality improvement in the delivery of the B4SC.

Information from the B4SC IS also provides a nationally available, unit-level database of non-identifiable information for research, service development and planning purposes.

The Coordinator should ensure that they, and relevant other staff, are familiar with the B4SC information system and able to obtain information pertaining to their particular area or district.

# 7 ENSURING QUALITY OF B4SC ASSESSMENTS

***The DHB:***

- ***Must ensure that users receive services that are safe, effective, consumer centred, culturally appropriate and of high quality, and that services are provided by appropriately qualified and experienced staff***
- ***Should establish and maintain systems and processes for ensuring that all nurses involved in the programme are adequately prepared and competent***
- ***Should ensure all providers involved in the care of each child/tamaiti are effectively communicating and that systems are in place to ensure that this happens.***

## 7.1 Ensuring quality of nursing practice

### *The Clinical nurse leader role*

The Clinical nurse leader role should be undertaken by a senior registered nurse or nurse practitioner, with a special expertise and training in child health and development and experience in the B4SC programme. It is strongly recommended that the clinical nurse leader holds a formal qualification in child health and development such as the *Postgraduate Certificate in Primary Health Care Specialty Nursing (Well Child/Tamariki Ora)* offered by Whitereia Community Polytechnic, and ideally clinical assessment training.

In some cases the Coordinator may take on this role if the Coordinator is a nurse with the appropriate skills and experience.

The role is responsible for providing clinical leadership, professional supervision and oversight to the registered nurses undertaking the assessments, and ensuring the ongoing competence of the nurses. The role is also the most appropriate lead liaison person with other health professionals, such as paediatricians, and the health and education sectors, including representing the nurses in clinical meetings.

The Clinical nurse leader should keep updated records of all nurses who are undertaking B4SC assessments. The record should include the following information on each nurse:

- Qualifications, including initial qualification and any post-registration education and training and current practising certificate with expiry date
- The details of the nurse's orientation programme, including dates, content, the name of the trainer, the number of observed and supervised assessments, any recognition of prior learning[6]
- The target population and geographic area covered

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- Regularly updated information on numbers of completed assessments, numbers declined, numbers not able to be located, numbers and types of referrals
- Records of any competence assessments including date, name of assessor
- Details of study days or sessions attended. Note that this is important, not just for monitoring competence but also may be required for a Nursing Council professional development and recognition programme (PDRP) or competence audit
- Any other relevant information.

Where the lead provider has other organisations contracted to deliver the B4SC, those organisations also have a responsibility for providing clinical leadership, professional supervision and oversight of their nurses undertaking assessments.

## *Initial training/orientation for nurses*

***The Clinical nurse leader must ensure that a robust orientation programme is developed and that all nurses employed to undertake B4SC assessments receive adequate training to do so competently.***

Nurses entering the programme should be registered nurses who have a background or experience in public health, child health (particularly WCTO), or primary health care. The initial training programme should be tailored for the individual nurse. For example, a nurse who has completed the *Postgraduate Certificate in Primary Health Care Specialty Nursing (Well Child/Tamariki Ora)* may not need to complete as much training in child development as a nurse who has previously practised only in paediatric or adult settings.

The initial training programme should be **a minimum of 24 hours** including provision of theoretical and practical information as well as clinical experience in actually conducting assessments, delivered prior to the conduction of any assessments. There needs to be flexibility in its delivery to cater for varying conditions and different service models. For example, the 24 hours may need to be delivered in scheduled shorter sessions spread over a period of a month in order to enable nurses to complete it.

The content should be planned and delivered by the clinical nurse lead or nurses experienced in delivering B4SC assessments. The Clinical nurse lead will have undertaken the B4SC train the trainer programme. Specific aspects, such as speech and language development, oral health, and behavioural issues etc should ideally be delivered by outside specialists in the particular field.

The *Well Child/Tamariki Ora Practitioner Handbook* (Ministry of Health 2014a) provides an evidence based source of information and the orientation programme should familiarise nurses with the relevant contents.

Topics covered should provide an understanding of:

- Normal child development related to four year olds
- All the components and 'tools' of the B4SC, including:
    - Scoring and interpretation of PEDS and SDQs

- Criteria for referral

- Relationship-building and communication of the results of the assessment with parents/whānau/guardians/caregivers
- The referral pathways in the specific district
- The roles of others involved in the B4SC programme, including VHTs, Coordinators, administrators, clinical leaders, and early childhood teachers
- The B4SC information system and the information that needs to documented
- The processes around documentation, storage of information and follow-up
- Profile of the community, including the quintile profile, availability and location of services.

It is important that the nurse is assessed as having the ability to competently complete an assessment, prior to conducting B4SC assessments independently. The nurse should have the opportunity to observe a range of assessments and complete a minimum of **six satisfactory supervised assessments** in order to be approved as competent to provide the service.

> ***Exemplar 6.2:*** *One area has developed an extensive modular training package which is delivered to practice nurses in a series of sessions, followed by a day in a clinic, observing assessments in the morning and undertaking supervised assessments in the afternoon.*

## *Ensuring ongoing competence for registered nurses completing B4SC assessments*

***Clinical nurse leaders should ensure that nurses:***

- ***have ongoing access to specialist advice, including:***
  - A senior child health clinical advisor (e.g. developmental/community paediatricians, general practitioners or experienced registered nurses or nurse practitioners) to provide guidance on clinical issues
  - A range of other multi-disciplinary specialists (e.g. speech language therapists, dentists and child behavioural psychologists) to provide advice and support them on making referrals
- ***participate in recommended professional development***

Each nurse should complete **a minimum of eight hours professional development** per year, relevant to the delivery of the B4SC programme. Professional development can be delivered in a variety of ways, for example, through a series of one hour study sessions/meetings, through two half study days or through one full study day. Professional development would also include participation in any Ministry-led education mechanism such as a conference.

The content of the study sessions will vary from area to area but they should be led by the clinical nurse leader who also designs the programme based on the identified development needs of the nurses in the

area. Sessions may involve invited experts to discuss and present on developments in their fields. Examples of useful topics include:

- Updates or changes to the database or administration of the programme
- Changes to referral pathways – specific criteria or personnel
- Updating on clinical issues, including new evidence, such as
    - Identifying and responding to family violence
    - Speech and language
    - Oral health, including '*lift the lip'*
    - Feeding and nutrition, sleeping and toileting patterns (including identifying normal or delayed development and advice to parents)
    - Demonstrations of assessments for feedback, discussion and commentary
- Any other issues that have arisen from competence assessments or auditing.

- ***complete a minimum number of 24 B4SC assessments per year***

  Nurses involved in conducting assessments should complete **a minimum of 24 B4SC assessments per year** to maintain their competence. The clinical nurse leader must ensure that records of the number of assessments completed are kept for each nurse.

  It is the responsibility of the clinical nurse leader and the Coordinator to put processes in place to ensure that individual nurses can complete 24 assessments. This might involve planning their participation in a clinic set up for the purpose, re-assigning cases in a day clinic in high volume areas, or facilitating commuting to another area to relieve another nurse with a higher case-load.

  It is recognised, however, that some nurses undertake B4SC assessments as only one component of their work and may be challenged in completing this number, particularly if their catchment population is small. If the maximum is not reached, the clinical nurse leader must ensure competency through increased supervision of B4SC assessments and auditing each B4SC and referral to identify and address any competence issues.

- ***have an annual performance appraisal:***

The appraisal should include:

- *A revalidation process and review of their documentation, including referrals.*
- *Clinical observation of a B4SC assessment, at least annually or more frequently if undertaking fewer than 24 assessments per year.*
- *Auditing of nurse assessments and referrals as required/regular*

The annual performance appraisal can be done using the PDRP or Nursing Council Portfolio. The Ministry has prepared a guide for nurses and clinical nurse leaders on the specific B4SC skills required. The guide can be used as an adjunct for preparing a PDRP, and for assessing performance.

The Clinical nurse leader should keep a record of each nurse's ongoing quality assessments, including the results of audits, the performance appraisal and any supervised B4SC assessments, including the feedback

given to the nurse and recommendations for ongoing professional development and professional development plan.

The audit should include a review of the documentation to assess the quality of clinical decision-making and of the recording of the results. If nurses are doing their own referrals, the audit should include a review of the referral letter for quality, including quality of presentation and of comprehensiveness of information provided and an assessment of the documentation leading to the referral to ascertain the appropriateness of the referral, evidence of discussion with parents/guardians/caregivers. It should also include the outcome of the referral (acceptance of the referral by the specialist service to which the referral was made).

The audits form an important part of performance appraisal and professional development plan and discussing the results of the audit with the nurse provides excellent opportunities for professional supervision focusing specifically on any areas of weakness.

## 7.2 Ensuring quality of vision and hearing screening

All practitioners conducting the vision and hearing screening component of the B4SC should meet the competency requirements outlined in the *National Vision and Hearing Screening Protocols* (National Protocols), the *VHT competencies for the B4SC* and other relevant Ministry documents.

The competency requirements in the *National Protocols* are:

> VHTs who provide vision and hearing screening services must have attained or be working towards the *New Zealand Certificate in Health and Wellbeing (Level 3) Vision and Hearing Screening Strand*[7] (see www.careerforce.org.nz).
>
> They must:
>
> 1. be employed for a minimum of 16 hours per week for vision and hearing screening work
> 2. receive ongoing professional development relevant to the screening processes specified in the National Protocols and attend the bienniall Training Seminar
> 3. have a biennial review/assessment of their competence against the *VHT competencies for the B4SC*
> 4. have completed training in the use of the Ministry of Education's ENROL database or the Ministry of Health's B4 School Check database.

Vision and hearing screening is usually delivered by vision hearing technicians (VHTs). VHTs are often but nor exclusively employed by the Public Health Unit of the DHB. As they may not be directly employed by the B4SC programme, the clinical leadership function is limited in ensuring the competence of VHTs. The clinical leadership role needs to work closely with the management of the VHT service to ensure that the specific requirements of B4SC are understood and met by the service, and that the VHTs maintain their competency.

[7] This qualification replaced the National Certificate in Community Support Services (Vision and Hearing Screening) (Level 3).

Where the vision and hearing screening component is delivered by other practitioners such as a nurse or a VHT employed directly by the programme, the clinical leadership role would be responsible for ensuring that the VHT meets the competency requirements.

Where personnel provide either vision screening or hearing screening alone, they still must meet the above requirements for employment, professional development, review and training.

In cases where registered nurses or other health professionals carrying out vision and hearing screening, they do not need to be dedicated to vision and hearing screening for 16 hours per week but must meet all other competency requirements.

**Initial qualification**

All VHTs are required to have completed *New Zealand Certificate in Health and Wellbeing (Level 3) Vision and Hearing Screening Strand*[8] which is delivered by Careerforce. This qualification is designed for people who conduct vision and hearing screening with children/tamariki as specified by the Ministry of Health through the National Vision Hearing Screening programme and the Well Child/Tamariki Ora National schedule. Further details on the 10 months training course can be obtained from the Careerforce website: https://www.careerforce.org.nz/new-zealand-qualifications/new-zealand-certificate-health-wellbeing-level-3-vision-hearing-screening/.

Registered nurses who include the vision and hearing screening component in their delivery of the B4SC must have completed an equivalent initial qualification. Careerforce provides recognition of prior learning to nurses, exempting them from completing three of the unit standards (13 credits):

- Demonstrate knowledge of infection control requirements in a health or disability setting
- Describe and apply culturally safe Māori operating principles and values in a health, disability or community setting, and
- Recognise indicators and describe responses to suspected abuse of people using health or disability services.

**B4SC orientation**

Prior to commencing B4SCs VHTs should be provided with **eight hours of B4SC orientation**. This orientation should include:

- Training on the current B4SC screening protocols and specific requirements[9]
- Familiarisation with the B4SC information system and documentation and reporting requirements
- Information and contact details of other personnel involved in the B4SC programme
- Information on referral pathways in the district, including audiologists, deaf advisors, optometrists and ophthalmologists.

[8] This qualification replaced the National Certificate in Community Support Services (Vision and Hearing Screening) (Level 3).

[9] Note that the protocols have recently been revised and new protocols came into force in 2014.

It is strongly recommended that the orientation includes sessions delivered by an audiologist (hearing) and ophthalmologist or optometrist (vision).

**Requirements before conducting vision and hearing screening independently**

It is important that all personnel are assessed as having the ability to competently complete a B4SC vision and hearing screening assessment, prior to conducting B4SC assessments independently.

The VHT or nurse should have the opportunity to **observe 10 vision and hearing screenings** in a range of settings and **complete a minimum of three satisfactory supervised screenings** in order to be approved as competent to provide the service.

**Ongoing professional development about the B4SC programme**

It is expected that managers will ensure that VHTs are kept updated on any changes to B4SC protocols, and any changes in personnel or requirements or referral pathways. This can be delivered through short regular study sessions, district staff meetings, regional meetings and the national biennial conference.

**Ensuring ongoing competence**

The National Protocols require that VHTs should have a biennial performance appraisal of their competence. It is recommended that the performance appraisal includes:

- assessment against the VHT competencies for the B4SC
- at least three supervised B4SC assessments in a B4SC venue or school setting. This supervised visit should also be discussed, recorded and form part of the performance appraisal.

Where nurses are conducting vision and hearing screening, clinical nurse leaders need to include equivalent provisions in their ongoing professional development and need to include an assessment against the VHT competencies in their annual performance appraisal.

VHT competency should also be ensured through the auditing of vision and hearing screenings and referrals. Establishing and maintaining processes for auditing is the responsibility of the VHT manager, but clinical nurse leaders need to ensure that this requirement is met.

# 8 MANAGING REFERRALS

***The Coordinator/clinical nurse leader should ensure that all issues identified in the assessment are promptly and effectively referred to the appropriate specialist service.***

***The clinical nurse leader should manage ongoing relationships with all referral services and follow up problems with referrals with the relevant authorities.[10]***

Managing referrals is a key function for ensuring that the B4SC meets its purpose – promoting health and wellbeing in preschool children/tamariki; identifying behavioural, developmental or other health concerns that may adversely affect the child's/tamaiti's ability to learn in the school environment; and making appropriate and timely referrals when problems are identified to enable remedial action to be taken prior to school entry.

## 8.1 Referral pathways and processes

***The Coordinator/clinical nurse leader should ensure that information on area-specific referral pathways and processes is kept updated and is available to all VHTs and nurses involved in the B4SC programme.***

The information required at district level includes the:

- Names and contact details of all relevant referral service provider,
- Processes and procedures for referral
- Criteria for referral to each referral service provider
- Details to be included in the referral letter.

This information is obtained from the referral service providers s themselves, each of which will set their own thresholds and requirements for referral. It can also be obtained from feedback from referral letters which should be sought at least annually from each service so that it can inform quality improvement of the programme.

**Quality of referral letters**

It is recommended that a process is set up for ensuring quality control of referral letters. Such a process may include

- Seeking feedback from referral service providers on the quality of the information in the letters and appropriateness of the referrals through such measures as a biennial survey, annual meeting with specialist services to whom referrals are made etc
- Providing ongoing feedback to the person making the referral when it is received

[10] For example, in one area a ten month waiting list for audiometry follow up has been reduced to one month through the intervention of the DHB on the advice of the clinical nurse leader.

- Summarising information and presenting it to nurses and VHTs at study days and/or annual appraisals.

> ***Exemplar 7.1:*** *One DHB has commissioned the development of an extensive and detailed IT platform that presents, regularly updated, clinical referral pathways for a wide range of services including early childhood services and is available to all primary care practices and DHB services.*

Clinical guidelines for referral for the components of the B4SC are well documented elsewhere and are not repeated here. For example:

- Protocols for referral (and rescreen) from the vision and hearing screening are presented in the National Vision and Hearing Protocols (Ministry of Health, 2014) (hearing: p12; and vision: p25) and in the *Well Child/Tamariki Ora Programme Practitioner Handbook* (Ministry of Health, 2014) (hearing: pp.175-176; vision: pp 186-187)
- Clinical referral pathways for SDQ-P and SDQ-T, and PEDS are also presented in *Well Child/Tamariki Ora Programme Practitioner Handbook* (Ministry of Health, 2014) (SDQ-P: p.198; and SDQ-T: p199; and PEDS:p.79)

## 8.2 Following up referrals

***The Coordinator/clinical nurse lead should establish and maintain clear documented systems and processes for following up referrals, ensuring that the referral has been received and accepted by the specialist service to which it is referred or, if not accepted, referred on to an alternative provider and notifying the practitioner of the outcome.***

Referrals should all be done as soon as possible after the assessment to enable the B4SC to be completed and closed, and also to ensure that any issues can be remediated prior to a child/tamaiti starting school.

The individual nurse undertaking the B4SC assessment is professionally responsible for ensuring the appropriate follow up for the problems identified in the assessment. This clarifies accountability for the whole service, increases the nurse's professional satisfaction and, through providing a sense of responsibility, should ensure that each case is followed up appropriately.

The practice for each district should to be tailored to suit the requirements and service delivery model of the B4SC programme in that area. In each case, the person responsible for making the referral should also take responsibility for following through to ensure either that the referral is accepted and appointments made, or if it is not accepted, an alternative course of action is followed. In some areas individual nurses each manage their own referrals and the follow up while, in others, the process is managed centrally with all referrals being undertaken by the clinical nurse leader. In the latter case, the

individual nurse is responsible for ensuring that their recommendation and record of the assessment contains enough information to lead to the appropriate clinical decision.

A selection of systems for managing referrals include:

1 In several areas the clinical nurse leader writes and makes all of the referrals, after each nurse has made the recommendation and discussed it with the parents.

2 One area has a triage system for referrals where the nurse makes the recommendation and the Coordinator presents the information at fortnightly meetings between the Coordinator, Ministry of Education representatives (SES and ECE), clinical advisor from DHB Child Health Services and a range of NGOs. Referral decisions are agreed by the group. The Coordinator writes the referral letters of those which have been agreed will go forward.

3 In other areas, individual nurses do referrals, sending copies to the parent and the general practitioner (GP). The coordination team is responsible for following up the referral and closing the B4SC when process is completed.

4 In other areas, nurses are responsible both for the referral and following it up.

**Outcomes of referrals**

Regardless of the system used, individual nurses responsible for the B4SC that resulted in a referral should always be notified of the outcome of the referral. This feedback is important to provide ongoing information on the quality of their service delivery.

A B4SC can be recorded as *'closed'* in the B4SC information system when the requirements for closing have been met (refer to sections 6.4 for these requirements).

If the referral is declined, then it must be reviewed and, in discussion with the provider, either further information is supplied to support the referral or an alternative provider is sought. Acceptance of the referral completes the B4SC and the record is then closed.

The referral outcome must be stored and entered into the information system.

Any further follow-up of the child/tamaiti becomes the responsibility of the family's primary care provider. It is the responsibility of the Coordinator to have processes in place for informing the child/tamaiti's primary health care provider both of the referral and of the outcome of the referral in order that such follow up can occur.

## GLOSSARY OF TERMS

| | |
|---|---|
| Administrator | Person employed to provide administration services to the B4SC programme. This role may be combined with that of Coordinator, and may not be a full-time role. |
| Assessment | *Assessment* refers to the clinical assessment carried out as a component of the overall B4SC. |
| B4SC | Before School Check |
| B4SC IS | Before School Check Information System |
| CHQ | Child Health Questionnaire |
| Clinical nurse leader | The senior registered nurse, with a special expertise and training in child health and development and experience in the B4SC programme. This role is responsible for providing clinical leadership, professional supervision and oversight to the registered nurses undertaking the assessments, including ensuring the ongoing competence of the nurses administering the assessments. This role may be combined with that of Coordinator. |
| Coordinator | The person responsible for overseeing and managing the B4SC programme. The role may be combined with that of clinical nurse lead or administrator. |
| DHB | District Health Board |
| ECE | Early childhood education |
| Kaiāwhina | Health assistant employed mainly to use their community networks to locate families that are hard to reach and ensure that they can access B4SC services and immunisation etc. |
| Lead provider | Coordinates the B4SC process for the DHB region and to ensure the success of the programme |
| MoE | Ministry of Education |
| MOH | Ministry of Health |
| NGO | Non-governmental organisations |
| NHI | National Health Information |
| NIR | National Immunisation Register |

| | |
|---|---|
| PDRP | Professional development and recognition programme |
| PEDS | Parents Evaluation of Developmental Status (questionnaire) |
| PHO | Primary Health Organisation |
| PHN | Public health nurse |
| Plunket | Royal New Zealand Plunket Society |
| Nurse | Means nurse registered with the Nursing Council of New Zealand in the registered nurse or nurse practitioner scopes of practice. |
| Nurse Practitioner | Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. |
| SDQ-T | Strengths and Difficulties Questionnaire for teachers |
| SDQ-P | Strengths and Difficulties Questionnaire for parents |
| SES | Special Education Services |
| VHT | Vision and hearing technician |
| WCTO | Well Child/Tamariki Ora |

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## APPENDIX ONE: SERVICE LINKAGES

Table 1: Service linkages (Ministry of Health, July 2011, p.8)

| Service Provider | Nature of Linkage | Accountabilities |
|---|---|---|
| DHB Management – Managers of Planning and Funding, Nursing Services, VHT Service | Share information<br>Ensure linkages across child health direction and services within the DHB<br>Assistance with maintaining service quality | To ensure continuity and quality of care for the child/tamaiti and their family and whānau.<br>To ensure joined up care for the child/tamaiti and their family and whānau. |
| General Practice Team (GPT) | Share information.<br>Liaise and work with the relevant GPT whenever there are client concerns or issues. | To ensure continuity of primary care for the child/tamaiti and their family and whānau. |
| Family Start (FS) | Liaise and work with the relevant FS worker. | To ensure continuity of care for the child/tamaiti and their family and whānau. |
| Child, Youth and Family (CYF) | Liaise and work with CYF whenever there are growth or developmental concerns for a child/tamaiti referred to, or under, CYF supervision.<br>Participate in Family Group Conference (FGC) as required.<br>Refer to CYF where a child/tamaiti's safety is at risk from abuse or neglect. | To ensure continuity and quality of care for the child/tamaiti and their family and whānau.<br>The child/tamaiti's safety is paramount. |
| Interagency Co-ordination (Strengthening Families) | Attend or instigate Interagency Co-ordination meetings as appropriate. | To ensure continuity and quality of care for the client. |
| Other Well Child /Tamariki Ora providers (WCTO Providers) | Share information.<br>Liaise and work with the relevant WCTO Providers. | To ensure seamless WCTO care delivery for all families. |
| Public Health Nursing Services<br>Hospital services<br>Specialist Medical Services | Refer to relevant hospital service when a child/tamaiti's health or development is of concern.<br>Liaise and work with relevant professional whenever there are concerns relating to the health or development of a particular child/tamaiti. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti.<br>General practice team is first point of referral, where appropriate, and is kept informed of child/tamaiti's progress/discharge plan. |
| Community /General Paediatrician | Share information. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |

| Service Provider | Nature of Linkage | Accountabilities |
|---|---|---|
| | Refer or liaise re individual children/tamariki as appropriate. | |
| Pre-school Vision and Hearing Screening Services | Refer individual children/tamariki at 4 years. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |
| Community Agencies/NGOs | Refer or liaise re individual children/tamariki as appropriate. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |
| Whakarongo Mai Ear Health Service | Refer individual children/tamariki with suspected otitis media with effusion for screening and ear care management. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |
| Pre-school Dental Services | Refer or liaise re individual children/tamariki as appropriate. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |
| MSD programs – HIPPY, SKIP, PAFT | Refer or liaise re individual children/tamariki as appropriate. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |
| Early Childhood Education Centres<br>Special Education (general services as well as Incredible Years) | Provision of the SDQT<br>Refer or liaise re individual children/tamariki as appropriate. | To ensure timely intervention occurs and provide continuity of care for the child/tamaiti. |