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| **FAMILY NURSE PARTNERSHIP SCOTLAND** |
| **DATA COLLECTION GUIDANCE** |
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| **Scottish Government April 2022** |
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# Introduction

**Family Nurse Partnership (FNP)** is a client-centred preventive intervention, nurturing self-efficacy and health across five targeted domains of functioning. FNP nurses follow Visit-to-Visit Guidelines that focus on the client’s personal health, Family and Friends, quality of care-giving, environmental health, and life-course development. Family Nurses (FN) involve the client’s support system including family members and friends, and assist in assessing clients’ need for other health and social services. Women voluntarily enrol as early in their pregnancy as possible with nurse home visits beginning ideally by the 16th week of pregnancy, and continuing through the first two years of the child’s life.

FNP is a licensed, evidence based programme, developed over the past 40+ years. It has been successfully delivered and received in Scotland since 2010. As part of the license, the programme must be delivered in line with the Core Model Elements (CME’s – see embedded document), which include the staffing model, the programme materials and tools, the visit schedules, data collection and education and training. Failure to fully comply with the licensing conditions can lead to the programme licence being revoked. Annual reports are required to University of Colorado (UCD), the licence holders.

Collection and subsequent analysis of data by FNs and FNP Supervisors (SV) is an integral part of the FNP programme. CME 13 states “FNP teams, implementing agencies, and national units collect/and utilise data to: guide programme implementation, inform continuous quality improvement, demonstrate programme fidelity, assess indicative client outcomes, and guide clinical practice/reflective supervision.”

The FNP programme and the environment in which it is delivered is very complex; the use of qualitative and quantitative data sets in combination is fundamental to developing understanding, to achieve successful programme implementation and beneficial outcomes for clients and their children. As we progress in our international FNP collaboration, this data will allow us to monitor, evaluate, and further refine the implementation of FNP both in Scotland and internationally.

Crucially however, the data collected in FNP Scotland is predominately for clinical use. The use of data in nursing practice is not new and forms an integral component of care. The NMC[[1]](#footnote-1) states that nurses “must use a range of information and data to assess the needs of people, groups, communities and populations, and work to improve health, wellbeing and experiences of healthcare; secure equal access to health screening, health promotion and healthcare; and promote social inclusion” and “must contribute to the collection of local and national data and formulation of policy on risks, hazards and adverse outcomes”. Each question in the data forms has a foundation in clinical practice to aid the FNs and SVs in their clinical assessment, analysis, planning and evaluation of care.

The FNP Education team in NHS Education for Scotland (NES) have produced a learning pack which is intended to support FN’s and SV’s understanding and approach to data as a key aspect of professional practice. Completion of this pack will enable practitioners to be able to:

“Undertake assessment, data collection and critical analysis of data pertaining to the autonomous practice of self as a Family Nurse”.

The Data Learning pack will be included in the Core Education programme for new Family Nurses and Supervisors and can also be used at any time to support team learning.

The link to the Data Learning Pack can be found [HERE](https://learn.nes.nhs.scot/24381/family-nurse-partnership/education-programme/learning-packs)



## Data Quality

General Data Protection Regulations[[2]](#footnote-2) (GDPR, 2018) sets out as a requirement that best data quality practices must be followed.

NHS Digital states “When data is collected using effective data standards, every subsequent step in the lifecycle (assembly, analysis and interpretation, distribution and change) is made easier for each system and organisation involved. This helps improve patient outcomes with better quality data for primary and secondary uses.

Effective data standards benefit the health and care system in various ways:

* vital information can be shared consistently within and across health and care settings to support delivery of high-quality care
* comprehensive and high-quality information supports clinical decision making - it can support more extensive clinical audit and research to enhance the evidence base
* reducing the risk of misinterpretation of records in different care settings leads to improved patient safety and care.”[[3]](#footnote-3)

Concepts of Data Quality include:

* Is it fit for purpose
* Does it portray the actual phenomena
* Completeness
* Validity
* Consistency
* Timely

Therefore, it is essential that we have a standardised national approach to data collection, input, storage, analysis, learning and improvements. FNP Scotland uses a data collection system designed specifically to record and report participating family characteristics, needs, services provided and progress toward accomplishing programme goals. Data is collected by FNP nurses using a set of structured data forms and entered on to the Turas FNP system. This guidance is provided to assist with the completion of each form.

Data quality improvements are driven by the ticket process which is laid out in these embedded documents.



## Discussion with clients about Data Collection and Processing

NHS Scotland consists of 14 regional NHS Boards, 7 Special NHS Boards and 1 public health body who support the regional NHS Boards by providing a range of important specialist and national services.[[4]](#footnote-4) Under the National Health Service (Scotland) Act 1978[[5]](#footnote-5); NHS Boards are responsible for the protection and the improvement of their population’s health and for the delivery of frontline healthcare services in the public interest. In order to deliver FNP and process data about clients’ formal written consent is not required from clients as there is a legal basis for processing this data for the provision of health services in the public interest.

That said, a key element of the Data Protection Laws[[6]](#footnote-6) is the right to be informed about the collection and use of personal information. It is necessary for FNP to use personal information to enable us to perform tasks and functions to provide healthcare services for clients. However, it is essential to discuss the collection and processing of data with each client using the FNP information leaflet “How we use your Information”.



Further information is also provided on the NHS Inform website[[7]](#footnote-7).

Documentation of the discussion and understanding of the client about the processing of their and their child’s personal data should form part of your clinical record-keeping in line with local and national policy documents.

**NOTE:** It is essential that FNs and SVs have had training in relation to data protection and information governance in accordance with local and national policy

## Data Management Flow Chart

Data collection by the Family Nurse using the data collection Form as per the Data Collection Guidance document

Data Collection form reviewed by Data Manager for accuracy

Return to FN for amendment

Inaccurate

Accurate

Data Collection form reviewed by FNP Supervisor for accuracy and notes areas for discussion in Supervision

Inaccurate

Accurate

Data entered on to the Turas FNP system

System validation highlights inaccuracy

Accurate

Reports run

* To support and guide clinical practice
* To assess and guide programme implementation through documentation of the FNP services received by clients
* To measure achievement of programme goals
* To inform clinical supervision and support quality improvements
* To support the quality assurance, learning and quality improvement process

## Data Collection Schedule

The time of collection of data relates to the age of the child. The visit number is related to the content of the programme that is due to be delivered at that stage. Due to a number of factors such as holidays this may not be the number of visits completed i.e. the first ASQ:3 is due at 4 months – which relates to delivery of programme content from Infancy 11.

**NOTE:** ASQ is required to be gestational age corrected if more than 3 weeks premature until the child is 2 years.

|  |  |  |  |
| --- | --- | --- | --- |
| **DATA Collection Form** | | **When to complete** | |
| Home Visit Encounter (V) | | Every visit | |
| Referral - Child (RC) | | As required | |
| Referral - Client (RM) | | As required | |
| Change of Status – Client (SM) | | As required | |
| Change of Status – Child (SC) | | As required | |
| Declined Service – (DS) | | As required | |
| **Pregnancy** | | **Visit by Age** | **Visit No - content** |
| Pregnancy Intake (P) | | Pregnancy | 1 |
| Demographics Intake (DI) | | Pregnancy | 2 |
| Maternal Health Pregnancy (MH) | | Pregnancy | 3 |
| Intimate Partner Violence (IPV) – Previous Disclosure (PD) | | Pregnancy | 5 - 7 |
| Intimate Partner Violence (IPV) – Record of Assessment and Disclosure (AD) | | Pregnancy | 5 - 7 |
| Edinburgh Postnatal Depression Scale (EPDS) | | Pregnancy 36 weeks | 11 |
| Maternal Health Pregnancy (MH) | | Pregnancy 36 weeks | 12 |
| **Infancy** | | **Visit by Age** | **Visit No - content** |
| Infant Birth (IB) | | 1 week | 1 |
| Infant Health 6 weeks (IH) | | 6 weeks | 6 |
| Maternal Health Post-Birth (HH) | | 6 weeks | 6 |
| Edinburgh Postnatal Depression Scale (EPDS) | | 6 weeks | 6 |
| Intimate Partner Violence (IPV) – Previous Disclosure (PD) | | 2 – 3 months | 7 – 19 |
| Intimate Partner Violence (IPV) – Record of Assessment and Disclosure (AD) | | 2 – 3 months | 7 – 19 |
| Edinburgh Postnatal Depression Scale (EPDS) | | 4 months | 11 |
| Ages and Stages Questionnaire (ASQ 3™) | | 4 months | 11 |
| Demographics Update (DU) | | 6 months | 15 |
| Maternal Health Post-Birth (HH) | | 6 months | 15 |
| Infant Health 6 – 24 months (CH) | | 6 months | 16 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | | 6 months | 16 |
| Ages and Stages Questionnaire (ASQ 3™) | | 8 months | 20 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | | 12 months | 28 |
| Infant Health 6 – 24 months (CH) | | 12 months | 28 |
| **Toddler** | | **Visit by Age** | **Visit No - content** |
| Demographics Update (DU) | | 12 months | 29 |
| Edinburgh Postnatal Depression Scale (EPDS) | | 12 months | 30 |
| Maternal Health Post-Birth (HH) | | 12 months | 30 |
| Ages and Stages Questionnaire (ASQ 3™) | | 14 months | 33 |
| Intimate Partner Violence (IPV)– Previous Disclosure (PD) | | 16 months | 37 |
| Intimate Partner Violence (IPV)– Record of Assessment and Disclosure (AD) | | 16 months | 37 |
| Edinburgh Postnatal Depression Scale (EPDS) | | 18 months | 40 |
| Maternal Health Post-Birth (HH) | | 18 months | 40 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | | 18 months | 41 |
| Demographics Update (DU) | | 18 months | 41 |
| Infant Health 6 – 24 months (CH) | | 18 months | 42 |
| Ages and Stages Questionnaire (ASQ 3™) | | 20 months | 46 |
| Maternal Health Post-Birth (HH) | | 22 months | 48 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | | 23 months | 49 |
| Infant Health 6 – 24 months (CH) | | 24 months | 50 |
| Demographics Update (DU) | | 24 months | 50 |
| Change of Status – Client (SM) | | 24 months | 50 |
|  | | | |
| IPV | Completed at the specific times and other times as needed, based on FNP nurse’s professional judgment | | |
| GAD-7 | Completed at the specific times (included in Maternal Health Forms - MH and HH) and other times as needed, based on FNP nurse’s professional judgment | | |
| EPDS | Completed at the specific times and other times as needed, based on FNP nurse’s professional judgment | | |
| ASQ | Completed at the specific times and other times as needed, based on FNP nurse’s professional judgment | | |
| Supervision | See related section for details | | |
| Fathers forms | See section “Father main Carer” | | |

## Colour coding of forms

Data managers have stated a wish for the forms to have a colour coding (print on coloured paper) to assist with processing and ease of vocalising which form is being discussed.

|  |  |
| --- | --- |
| **Data Form** | **Colour of paper** |
| Home Visit Encounter (V) | White |
| Referrals Child (RC) | Salmon |
| Referrals Client (RM) | Salmon |
| Change of Status – Client (SM) | Light blue |
| Change of Status – Child (SC) | Light blue |
| Demographics Intake (DI) | Yellow |
| Demographics Update (DU) | Yellow |
| Pregnancy Intake (P) | Pink |
| Maternal Health Pregnancy (MH) | Pink |
| Maternal Health Post-Birth (HH) | Pink |
| Infant Birth (IB) | Cream |
| Infant Health 6 weeks (IH) | Cream |
| Infant Health 6 – 24 months (CH) | Cream |
| Ages and Stages Questionnaire (ASQ) | Lilac |
| Intimate Partner Violence – Previous Disclosure (PD) | Light green |
| Intimate Partner Violence – Record of Assessment and Disclosure (AD) | Light green |

## Time frames for completing forms

Many of the forms are used at a number of different intervals throughout the programme; it is important to select the appropriate box in the stage option.

* All forms should be completed by FN’s within 24 hours of a visit (or as determined by NHS Board policy and/or professional nursing documentation standards[[8]](#footnote-8)).
* The forms should be entered onto the Turas FNP system within 1 week of the visit.
* The exception is the Infant Birth (IB) form which must be completed within 1 week of the designated time frame.
* Data forms should be completed as close as possible to the scheduled timeframe. In exceptional circumstances only, such as a client is out of the country, forms can be completed a maximum of 60 days from the scheduled due date. This should not be standard practice.
* If more than 60 days has elapsed, the FN should skip the missing forms and begin with the form that is appropriate for the client's phase. See section relating to missing or incomplete forms for guidance on how these should be managed.
* Graduations cannot be completed earlier than 2 weeks prior to the child’s 2nd birthday.
* Graduations should be completed no later than 2 weeks after the child’s 2nd birthday.
* Forms can be completed a maximum of 2 weeks prior to the scheduled due date. The exceptions to this are:

* + Infant Health (IH) 6 weeks – for full term babies, can be completed a **maximum** of 5 days prior to the scheduled due date
  + Infant Health (IH) 6 weeks – for premature babies, cannot be completed prior to 6 weeks
  + Infant Health (CH) 24 months – can be completed a **maximum** of 4 weeks prior to the scheduled date
  + Demographics Update (DU) 24 months – can be completed a **maximum** of 4 weeks prior to the scheduled due date

For clients that transfer to a different NHS Board area within Scotland, all forms that were scheduled are required to be completed prior to transfer to the new FNP Team.

### Premature births

Critical data may be missed when services to clients are disrupted due to preterm births. If a client gives birth to their baby prematurely every endeavour must be made to collect all pregnancy data forms. These forms must be completed.

* Pregnancy Intake (P)
* Demographics Intake (DI)
* Maternal Health Pregnancy (MH) – scheduled at visit 3

If the client gives birth after 33 weeks gestation the Maternal Health Pregnancy (MH) form scheduled for 36 weeks gestation should be completed at the earliest point possible. This form contains important questions that contribute to the overall programme outcomes. The form should automatically move to an early Infancy Visit, alongside other relevant forms, the nurse will need to ask…”just before your baby was born…..”

FNs should use their clinical judgment to determine what assessments to complete and when during this period of catch-up. Screening for EPDS might be skipped/passed over until the 1-8 weeks Infancy timeframe. It is not recommended that the FN undertakes the screening for EPDS twice during the “1-8” week’s timeframe unless repeat screening is clinically indicated within the short time interval. It may be helpful to discuss this in supervision.

If the client gives birth before 33 weeks gestation the maternal Health Pregnancy (MH) form scheduled for completion at 36 weeks gestation should be marked as missing by the SV via option “Premature birth before 33 weeks gestation” from the drop selection.

### Missing or incomplete forms

Missing or incomplete data creates huge challenges for analysis, can lead to a lack of validity and can often mean data is unable to be used. Every effort should be made to complete all data forms, each question has a significant clinical application and helps support the client’s journey to achieve their goals. There can be some mitigating circumstances that prevent a section or whole form from being completed. It is important to understand why there is incomplete or missing data therefore, supervisors are required to enter a reason for the form being incomplete or missing on the Turas FNP system. Clients will not be able to be graduated on the system until all data is accounted for. It is recommended that incomplete or missing form reasons are captured once a client has completed each phase.

### Core Model Element 4 exception form completion

With the introduction of CME 4 exceptions a small number of clients are now enrolled beyond 28+6 weeks gestation some even in the early post-natal period. There have also been a number of clients enrolled onto the programme over 28+6 weeks gestation as an accepted breach of licence for a number of different reasons (A RICE log must be completed prior to engagement of client – see embedded document). This creates challenges for data collection and analysis in the antenatal period. Observation and analysis of the client journey and outcomes are essential for programme implementation, quality assurance and improvement. Therefore, pregnancy data forms must be completed whenever possible. In clinical situations there is always the need to ensure reflection, sound clinical judgement and a degree of flexibility through the supervision process however, in relation to data quality there must be some standardisation and consistency built into the system.

* For clients that enrol before 33 weeks gestation every endeavour must be made to collect all pregnancy data forms.
* For clients that enrol beyond 33 but prior to the birth these forms are expected to be completed:
* Pregnancy Intake (P)
* Demographics Intake (DI)
* Maternal Health Pregnancy (MH) – scheduled at visit 3
* IPV
* EPDS

The EPDS score is to be entered on the Maternal Health Pregnancy (MH) scheduled for 36 weeks, the rest of the form can be marked as complete by the SV on the Turas FNP system with CME 4 exception given as the reason.

* For clients that enrol following the birth of the baby but prior to transfer from maternity to Health Visiting
* The only antenatal form that requires completion in full is the Demographics Intake (DI)
* The Pregnancy Intake (P) form requires the Estimated Date Delivery to be added – This may not be known however, midwifery, obstetric or neonatal professionals should be able to give an approximate
* The Pregnancy Intake (P) form requires the gestation at birth to be entered as the gestation at enrolment - This may not be known however, midwifery, obstetric or neonatal professionals should be able to give an approximate
* The rest of the Pregnancy Intake (P) form should be marked as completed by the SV with the reason of CME 4 exception as the reason
* Infant birth (IB) form

The rest of the pregnancy forms should then be marked as missing with CME 4 as the reason given.

### Form completion for clients transferred from an FNP Site out-with Scotland following birth

There are a number of fields on forms that require completion on the system as analysis of much of the data is then not possible without these:

* The Pregnancy Intake (P) form requires the Estimated Date Delivery and gestation at enrolment – this should be obtained from the FN transferring the client as part of the handover
* Demographics intake (DI) form is required to be completed in full. The FN should ask the client “thinking back to when you were still pregnant…..”
* Infant birth (IB) form should be completed as much as possible. Most of the information should be obtained from the client and the transferring FN

## General Guidance for all Forms

Data will continue to be collected on paper forms unless electronic forms are available in your local area. This may change in the future depending on national and local eHealth strategies and policies.

The instruction pages relating to each form provide information on:

* Completion of the form with the client during the visit or by the FN following the visit
* The purpose and background of the form
* General guidelines on completing the form for FNs
* **Where necessary**, instructions on how to complete individual questions

Information required on all forms relating to the client:

* **Client ID** - Client identification number is required on all forms.
* **Client CHI -** Community Health Index[[9]](#footnote-9).
* **Client Name** – The client’s name should be completed using the first and last name of the client.
* **Date** - This refers to the date the information was gathered.
* **Nurse ID** – Please speak to your Data Manager/Administrator if you do not know your nurse ID.
* **Nurse Name** - Full name of the FN conducting the visit.

Information required on all forms relating to the child:

* **Client ID** – FNP Client identification number is required on all forms.
* **Child ID –** FNP Child identification number.
* **Client CHI -** Community Health Index.
* **Child’s Name** – The child’s name should be completed using the first and last name of the child.
* **Date** - This refers to the date the information was gathered.
* **Nurse ID** – Please speak to your Data Manager/Administrator if you do not know your nurse ID.
* **Nurse Name** - Full name of the FN conducting the visit.

Please be aware that a number of the forms have questions that direct the client and/or the FN to the next part of the form based on the previous answer; it is important to either ***“go to”*** or ***“skip to”*** when asked.

In the case of any answer being followed by an arrow 🡪 this is a prompt to give details for how long in weeks and days this practice was continued.

Each form is embedded into this guidance document at the end of the section relating to that form.

**NOTE:** It is important that national and local policies are adhered to regarding referral or coordination of care for clients who, based on the FN’s clinical judgement, require further assessment and/or support when completing data forms i.e. Child Protection, Mental Health etc. This document has useful links to support learning and development, however it is essential that FNs and SVs ensure that they have the necessary level of understanding and competence to fulfil all aspects of the role. Where there is reference to FNP guidance documents these can be found on the FNP page of the TURAS platform.

**NOTE:** There are a number of assessment tools that require scores to be added and completed on the data form; this is a crucial aspect to support clinical decision making. It is important that all additions are completed by the FN or SV prior to the form being inputted on to the Turas FNP system.

# 

# Data Forms and Guidance

|  |
| --- |
| Visit Encounter (V) **(completed by FN following the visit)** |

**Purpose and Background**

This form provides information about each visit that a client receives, including the duration and location of the visit, the participant’s level of engagement, the content covered, and whether any referrals were made. This helps demonstrate what services are being provided and how consistently they are being provided (across Scottish sites and internationally), and it allows FNP sites to track the service they are providing. This form supports programme documentation and reporting on fidelity requirements and Core Model Elements.

**General Guidelines**

Complete this form every time:

* FN meets with a client
* FN attempts to meet with a client
* A pre-arranged meeting with the client is cancelled within 24 hr (by either FN or client).

If two FNs do a visit together the FN to whom the client is assigned should complete this form.

If a FN completes a home visit for another FN’s client, the FN doing the visit should complete this form.

**Directions for Completing the Form**

**V1. Visit status**

A completed visit is defined as:

* Any direct face-to-face contact in which the FN is interacting with the client that contributes to the achievement of programme goals. Most of these will be usual programme visits; however, these may also include contacts such as: attendance at case conferences, accompanying a client to services such as housing or sexual health clinics if the contact contributes to programme goals.
* The contact lasts at least 15 minutes

An attempted visit is defined as:

* When a FN attempts to meet with a client (usually at home) and the client is not at home/does not answer the door/does not attend.
* A visit is shorter than 15 minutes

A cancelled visit by Nurse is defined as:

* If the FN cancels the visit within 24 hours of the scheduled time.

A cancelled visit by client is defined as:

* If the client cancels the visit within 24 hours of the scheduled time.

**V2. Did this visit form part of a multiagency meeting?**

This section should be completed for every visit status.

For a multiagency meeting to be considered a visit then certain conditions must be meet:

* Client must be present
* FNP programme materials and content will have been used for a minimum of 15 minutes
* The FN will have deployed the theories and models of FNP with a focus on outcomes for a minimum of 15 minutes
* Only the time spent on FNP programme materials and content using the theories and models with a focus on outcomes should be documented on this form

**V3. Location of Visit**

This section should be completed for every visit status.

“Client home” refers to the place that the client spends at least four nights per week. If a client is living at a homeless shelter, group facility or in a prison mark "Client’s home" on the Home Visit Encounter form as this is where they sleep at least 4 nights per week.

Visits completed over the telephone or by video call i.e. Near Me should:

* be used in exceptional circumstances only; please refer to the FNP Core Model Elements for guidance (see embedded document)
* be discussed and agreed by the Supervisor
* last a minimum of 15 minutes.
* contribute to the achievement of programme goals.

**NOTE:** the selection indicates where most time was spent with the client.

**V4. Was this visit accompanied by a supervisor?**

It is a licence requirement for a SV to carry out a minimum of one home visit every four months with each FN.

**V5. Did this visit deliver any part of the Child Health Surveillance Programme (CHSP)?**

It is important to capture the data on all aspects of the FN’s role. As this is an essential component of the role; identify if this visit involved any aspects of the CHSP[[10]](#footnote-10).

**V7. Others than the child was anyone else involved in visit?**

“Involvement” is defined as engaging in some or the entire visit e.g. staying in the room and actively listening or taking part in some or the entire visit.

**NOTE:** If there is an interpreter present they are not included in others involved in the visit.

**V8. Client engagement**

Use the following scale to indicate how involved the client was in the visit. Rate each element from 1-5 (where 1 is low and 5 is high), according to the following criteria:

***Involvement rating scale***

Rate 1 if:

The client has little interaction other than being present. Greetings with the FN and eye contact is minimal. This person has no involvement in the session, seems to not be listening and may even be engaging in an independent activity (such as watching TV, texting or reading). Attempts at conversation come to a dead end. They may tolerate the FN’s presence, but show few signs of interest in the session.

Rate 2 or 3 if:

The client shows some involvement in the visit, keeping eye contact, listening most of the time, and speaking up. They may make it through a good part of the planned content, but may fade out towards the end of the visit, or they may be "slow to warm up", becoming more engaged towards the end. The FN may feel that s/he has to jump-start activities or conversations but then the client follows along and there is some two-way interaction. The client is willing to engage in some of the programme (that is, their attention to the FN is not just social or superficial).

Rate 4 or 5 if:

The client is involved in the entire visit. They are very interested in the content, even if they do not fully understand it. They take a very active role in agenda matching and the content of the session, fully maintaining a two-way conversation with the FN. They are fully invested in spending time with the FN, whether that means that they are eager and glad to be with the FN or that they strongly disagree or are in conflict with the FN. Their enthusiasm or involvement is apparent and contagious.

***Conflict with material rating scale***

Rate 1 if:

The client has absolutely no conflict with the material and is supportive of the ideas and suggestions presented.

Rate 2 or 3 if:

The client has reservations about what was talked about or the materials presented. There may not have been active disagreement, but either (a) the person minimally voiced some concern or (b) the FN could feel that the person was not accepting through their silence and/or a passive attitude toward the FN in this visit (the FN may feel that the client is agreeing just so they won't have to deal with the material). This score can also be used if (a) the person had moderate conflict with a small portion of the material presented or (b) if the person expressed some conflict initially but their opinion changed during the course of the visit.

Rate 4 or 5 if:

The client was vocal in their opposition to a significant portion of the material or viewpoint presented. The client lets the FN know definitely that they had problems with it. This does not necessarily mean the client was angry or hostile regarding the material, but they did have strong beliefs about it. The client’s opinions changed very little during the course of the visit. For a score of ‘5’, a client should be quite up-front in telling the FN of their disagreement.

***Understanding of material rating scale***

Rate 1 if:

The client seemed very confused with a large portion of the material presented. There was difficulty in conveying even relatively basic points to them and this difficulty forced considerable changes in the planned visit.

Rate 2 or 3 if:

The client had mild problems understanding the material. Some points had to be repeated, rephrased or simplified before the client showed any comprehension of the material. Therefore, there is little change from the planned visit. This score can also be given if the person showed confusion over only small portions of the material, but this does not detract from an overall understanding of the ‘bigger picture’.

Rate 4 or 5 if:

The client seemed to have an almost intuitive understanding of the material presented in the visit, so little additional explanation was necessary. The FN may have felt as though the client and the nurse ‘are on the same wavelength’. The person gives multiple signs of demonstrating understanding, such as rephrasing points in different ways or bringing up aspects related to the material that had not been initially covered.

**V9. Percentage of time spent on each domain**

Estimate the relative proportion of time (0 – 100%) spent covering each of the five content domains listed. Make sure that the total amount of time adds up to 100%. If the FN spends no time in a domain, score it ‘0’ (zero).

Given that the emphasis on a particular content domain within the home visit guidelines varies from visit to visit, it is not expected that the FN consistently records an equal amount of time spent on each programme area.

**NOTE:** Generally, any discussion of health and social services arises because of a need identified in one of the other content domains, so a separate category for time spent discussing community resources is not included. For example, a client’s interest in completing education may lead to a discussion about educational support for young mothers available to the client and the agencies they should contact for more information; interest in completing education falls within the ‘Life Course Development’ domain. Apply discussions about community resources to one of the applicable content domains specified below.

The five content domains are:

* **Personal Health:** refers to client’s health both pre and post-natal, e.g., nutrition and exercise requirements, fatigue and loss of sleep, physical or emotional symptoms, birth control, pre-term labour, substance abuse, mental health etc.
* **Environmental Health**: refers to factors within the home, work, school, neighbourhood or community which have the potential to impact on the client or child’s health/safety, e.g., domestic violence, inadequate heating, gangs etc.
* **Life Course Development:** client’s plans for the future related to education, job training, employment, and decisions about planning further children etc.
* **Maternal Role:** client’s adjustment to the responsibilities of the maternal role, facilitation of infant attachment, child care, immunisations and well-child care, discipline, promotion of child development, physical, behavioural and emotional care of child etc. **NOTE:** When completing with “Father as Main Carer” discussion will relate to paternal role.
* **Friends and Family**: client’s development of social networks and other support systems, changes in relationships, assistance with childcare etc.

**V10. Percentage of planned content delivered**

Estimate the total proportion of the planned content covered during this visit – **this planning would have occurred prior to the visit.**

The purpose of this item is to help determine whether the FN is able to cover all the programme material that the FN and client had jointly agreed they would cover at this visit. This enables nurses and supervisors to see how much of the planned content for each visit is undertaken, and how nurses are managing the ’creative tension’ between planned content and flexibility in response to client’s needs and current challenges.

The FN has the flexibility to move topics included in the home visit guidelines from one visit to another, especially for clients who enter the programme later in pregnancy (e.g. 26 weeks gestation). The FN may need to rearrange visit content in order to cover the essentials for a given client prior to the birth.

When planned in advance of the visit, reapportioning visit content or covering a topic at a time other than when it appears in the Visit to Visit Guidelines because a client expresses interest in the topic need not be viewed as not following the programme plan.

During many visits, the FN may not cover all the planned material. In particular, you may find that on some visits, clients are so distracted by an immediate crisis that you have to set aside much of the planned content in order to help the client decide how to handle the crisis. However, the goal is that planned content does not take a back seat to crisis the majority of the time, since the planned content is expected to provide the long-term benefits of the programme.

It is important to remember that some clients will often have crises and this may detract from undertaking any of the programme content. One of the aims of FNP is to help clients with problem-solving. You will need to decide when to respond to regular crisis and when to encourage the client with some of the established programme which will help the client deal with crises in the longer term. In these circumstances, nurses will estimate the percentage of planned content against their original plans and will indicate that less than 100% of the planned material was covered.

Planning visits with clients, instead of for them, is central to FNP. When clients feel they are making an investment in the programme through actively planning visits and agenda matching, it may have a positive effect on the number of completed visits and client retention.

**V11. Referrals made**

If a referral was made for either the client or child, complete the relevant Referrals form.

If a change of status for either the client or child was disclosed, complete the relevant “Change of Status” form.

**V12. If client requires an interpreter was there one present for this visit:**

This question should only be answered if it has already been identified that the client requires an interpreter.

**NOTE:**  Indication for requirement of interpreter is initially noted on the Demographics intake (DI) form and can also be updated on the change of status (SM) form.



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| Referrals– Client (RM) **(Completed by FN following the visit)** |

**Purpose and Background**

This form provides information about each referral the FN makes on behalf of a client. This helps FNP sites track services for clients and allows a demonstration of the use of services being provided to families, and how the team and clients are working with other professionals.

To comply with the EU’s General Data Protection Regulations (GDPR) which came into force in May 2018, there are separate referral forms for the client and the child. If a single referral is made for both the client and child (e.g. Family Centre Placement), fill out two separate forms, one for the child and one for the client.

**General Guidelines**

**Definition of a referral for a client:**

A referral to services may be made directly by the FN who calls an agency requesting services for the client or indirectly when the FN gives the client a list of resources to call for assistance themselves. Indicate that a referral has been made if any of the following apply:

* Any request made by the FN for use of a service on a client’s behalf.
* Any instance in which the FN has advised/encouraged the client to contact a specific service themself (excluding universal services such as a GP or midwife).
* When the FN wishes to re-refer the client back to a service (e.g. if social care has closed the case, and the FN would like further social care input).

**Directions for Completing the Form**

**RM1. Referral made**

Complete this form whenever the FN makes a referral for the client. If the FN makes more than one referral for the client arising from one home visit, select as many as appropriate on a single form.

**NOTE: The option of other is for use under exceptional circumstance and only when the referral cannot be categorised in one of the broader headings.**



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| Referrals – Child (RC) **(Completed by FN following the visit)** |

**Purpose and Background**

This form provides information about each referral the FN makes for the child. This helps FNP sites track services for children and allows a demonstration of the use of services being provided to families, and how the team and clients are working with other professionals.

To comply with the EU’s General Data Protection Regulations (GDPR) which came into force in May 2018, there are separate referrals forms for the client and the child. If a single referral is made for both the client and child (e.g. Family Centre Placement), fill out two separate forms, one for the child and one for the client.

**General Guidelines**

**Definition of a referral for a child:**

A referral to services may be made directly by the FN who calls an agency requesting services for the child or indirectly when the FN gives the client a list of resources to call for assistance for the child. Indicate that a referral has been made if any of the following apply:

* Any request made by the FN for use of a service on a client’s behalf for the child
* Any instance in which the FN has advised/encouraged the client to contact a specific service for their child (excluding universal services such as a GP or midwife)
* When the FN wishes to re-refer the child back to a service (e.g. if social care has closed the case, and the FN would like further social care input)

**Directions for Completing the Form**

**RC1. Referral made (select all that apply)**

Complete this form whenever the FN makes a referral for the child. If the FN makes more than one referral for the child arising from one home visit, tick as many referrals as appropriate on a single form.

**NOTE:** The option of other is for use under exceptional circumstance and only when the referral cannot be categorised in one of the broader headings.

**NOTE:** In the case of multiple children i.e. twins, a separate form may be required for each child that a referral takes place for.



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| Change of Status – Client (SM) (Completed by FN following the visit) |

**Purpose and Background**

This form records any change of status of an FNP client. It is also used to track the number of clients who leave or return to the programme.

**General Guidelines**

When to complete this form:

* Every time there is a change of status for the client
* When a client completes the programme at 2 years (visit T50)
* Each time a client leaves the programme
* Each time a client returns to the programme after leaving
* When a client transfers out to a different FNP site
* Where a change of status relates to the unborn baby (e.g. the unborn baby’s name is placed on the child protection register)

If a single change of status affects both the client and the child (e.g. the client moves to a new house with the child), fill out two separate forms, one for the client and a Change of Status – Child (SC) form.

If the child is subject to change of status complete a Change of Status – Child (SC) form.

**Directions for Completing the Form**

**SM2. Change of Estimated Delivery Date (EDD)**

Some clients may not initially have an established EDD, and for others a new accepted EDD may apply following clinical decision i.e. due to ultra-sound scan findings. If this occurs, this option will need to be selected on the form, and the new EDD entered.

**NOTE:** This is for a change in EDD following completion of the information captured at P1 on the “Pregnancy Intake” form.

**SM3. Change of address within site area**

If the client moves home within the site area complete this section giving full address details including post code. If the client moves out of the site, complete **SM7**.

If the child also moves then a Change of Status – Child (SC) form is required to be completed.

**SM4. Change of need for interpreter status:**

The requirement for interpreter should be captured on the Demographics Intake (DI) form. Occasionally the need for interpreter changes and should be indicated here.

**SM5. Client/unborn child subject to a specific social work intervention**

Complete this section if a client or unborn child becomes subject to specific social work intervention. Tick as many as is appropriate. For further information in relation to Detention under the Mental Health Act[[11]](#footnote-11).

**SM6. Client/unborn child no longer subject to a specific social work intervention**

When a client or unborn child ceases to be subject to a social work intervention, record this by ticking as many options as appropriate.

**SM7. Multiple pregnancy – loss of one or more fetus but ongoing pregnancy**

There are occasions when a client with a multiple pregnancy may suffer the loss of one or more fetus but there remains an ongoing pregnancy. The client will remain on the programme, but it is important to capture this information.

**SM8. Client transferred/left/completed the programme**

Choose the most appropriate reason for the client leaving the programme

Child reached second birthday

Select once completed the final visit to the client after the child reaches second birthday and client graduates from the programme.

Client moved out of FNP service area

The client moves to an area outside of the current service area and is no longer receiving the FNP programme.

Maternal death

In the event of a client death, the FN should select this option of the form.

If the father wishes to continue with the programme, then “Father becomes main carer” should also be marked (see section in relation to this for further guidance).

Miscarriage, Termination or Still Birth[[12]](#footnote-12)

In the event of a foetal death (including miscarriage, termination or stillbirth) the FN will select the relevant option of the form. The FN will still undertake some bereavement visits. These visits are not recorded on the Turas FNP System, no data forms are required. However, documentation of these visits are required on local record keeping systems.

If the client becomes pregnant again and continues to meet the eligibility criteria; they can be offered the programme. There would be another episode of care opened on the system with a different client ID.

Neonatal death or Infant death

In the event of a child’s death, the FN will need to select the relevant option of the form. Then, depending on the circumstances, it may be appropriate for the FN to undertake a number of bereavement visits. These visits are not recorded on the Turas FNP System, no data forms are required. However, documentation of these visits are required on local record keeping systems.

Strong family/friend support

Select if the client has chosen not to continue with the programme because they are satisfied that they have a strong enough support network from family and friends.

Transferred to FNP site outside Scotland

To be completed if the client moves out of Scotland but continues to receive FNP in another country or elsewhere in the UK. With an increasing number of countries delivering FNP, it is important to capture data on clients who transfer out of Scotland but continue to receive FNP.

Transferred to a different FNP Scotland site

To be completed if a client transfers to another Scottish FNP site and continues to receive the programme. Name of the receiving site and team is required to be recorded. The Turas FNP system will automatically transfer the client on to the caseload of the new site and team.

Child into long-term care

Select if the child has been taken into long-term care and there are no plans for the child to be placed back with the mother/father in the foreseeable future.

Parental rights terminated

Select if parental responsibility has been terminated because the child is placed for adoption.

No contact for 6 months

Select if attempts to re-engage those clients who have disengaged have failed after six months. Do not complete this form until six months have fully passed since the client last completed visit with a FN.

Too much commitment

Select if the client leaves the programme because they feel that the commitment (whether time commitment, psychological commitment or other) is unmanageable.

Father main carer

Occasionally the father may become the main carer permanently and there are no plans for the child to be placed back with the client. Please see guidance section regarding Father as main carer.

**NOTE:** this is **not** selectable reason on Turas FNP for a client to leave the programme (as yet) but is chosen to show the programme will continue to be delivered. Therefore, it would be chosen in addition to the primary reason a client has left. Also, as this has not been built on the system (as yet) the change of status should not be completed on the Turas FNP system as this would render it impossible for the child forms to be completed.

Did not meet eligibility criteria for exceptions when attempted to transfer to new FNP site in Scotland

As FNP has expanded across Scotland a number of sites have tested different eligibility criteria for clients i.e. 20-24 year olds. If a client has enrolled in FNP due to meeting an exception criteria moves to a different health board area with a different eligibility criteria in most instances the client should continue to receive the programme (please see FNP Guidance for the transfer of clients aged between 20-24 years). In the rare event that this cannot happen please indicate this here.

Did not accept change of family nurse

Select if the client has chosen not to continue with the programme following the change of their FN.

Other (specify other)

The option of other is for use under exceptional circumstances and only when the leaving reason cannot be categorised in one of the broader headings.

**NOTE:** Transfer to health visiting services is the destination not the reason for leaving; please indicate in the broader headings why the client has chosen to transfer to health visiting services.

**SM9. Client returned to the programme**

Re-engaged with the programme

Select this if a client who previously left and has subsequently returned i.e. moved out of area and not received FNP but then returned to area.



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| Change of Status – Child (SC) (Completed by FN following the visit) |

**Purpose and Background**

This form records any change of status of a child in the FNP programme.

**General Guidelines**

Complete this form every time there is a change of status for a specific child on the FNP programme.

To comply with the EU’s General Data Protection Regulations (GDPR) which came into force in May 2018, there are separate Change of Status forms for the client and the child. If a single change of status affects both the client and the child (e.g. the client moves house with the baby), fill out two separate forms, one for the child and one for the client.

**Directions for Completing the Form**

**SC2. Change of Address**

If the child moves home complete this section giving full address details including post code. If the client also moves then a Change of Status – Client(SM) form is required to be completed.

**SC5. Father becomes main carer and remains on the FNP Programme**

Please see section under father as main carer for further details.

**NOTE:** The option of other is for use under exceptional circumstance and only when the referral cannot be categorised under one of the broader headings.

**NOTE:** In the case of multiple children i.e. twins, a separate form may be required for each child that a change takes place for.



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| Demographics: Intake (DI) (Completed with the client during the visit) |

**Purpose and Background**

This form is used to compile information on social, economic, family and educational situation. This enables the FN to enhance assessments and interventions in this area. While the extent to which the client is able to impact their own life situation may not be generally regarded as an indicator of health per se, a client’s sense of mastery or self-efficacy has a strong influence on how they are able to use health information in caring for themselves and their child. It is important to collect some baseline data that will be re-collected at later points in the programme to help assess change over the course of the programme.

**General Guidelines**

Complete this form on the second home visit (P2).

**Directions for Completing the Form**

**DI1. What is your current full address?**

Complete section giving full address details including full post code.

For the purposes of this form the client address refers to the place that the client spends at least four nights per week this may include a homeless shelter or prison.

**DI2. What is your primary language?**

This is the language that the client is most comfortable speaking (usually, but not always, this will be the language that the client speaks at home).

If the client is bi-lingual and equally comfortable and fluent speaking two languages, select both languages (for example, if the client was raised in a bilingual household).

However, if a client is bi-lingual but speaks one of these languages more fluently than the other (e.g. if they speak Polish in the home and Polish is their “go-to” language whenever they have a choice, but they also speak English as a second language), please select only their dominant language.

**DI3. Does this client require an interpreter?**

Refer to the FNP Guidance Document - “The use of interpreters within the FNP programme”.

**DI4. How well can you speak English?**

Select the option that most closely represents the client’s self-reported ability to speak English.

**DI9. How often, if at all, do you see or communicate with your child’s biological father?**

Seeing/communicating with the father of the child includes in-person contact as well as contact on social media/texting/phone calls etc.

**NOTE:** If the child’s biological father is unknown select never.

If child’s biological father is deceased select option Not Applicable.

**DI10. Are you currently registered homeless?**

“Registered homeless” means that the client (or their partner/parents if they live with them) has made a homelessness application to the local council and has been deemed eligible for assistance[[13]](#footnote-13).

**DI12. If you are not registered homeless; do you consider yourself to be homeless?**

If directed to answer from previous question: Select yes if the client deems them self to be homeless for any reason but has not applied for homelessness assistance to the council or has applied for homelessness assistance and the application was rejected.

**DI14. Who do you live with?**

Select the box/boxes that most closely represents the client’s self-defined status in relation to this question. It is important to be mindful of client’s understanding of the terminology in this question; some may require support to understand the definitions of the terms.

**DI17. Which, if any, of the following qualifications have you ever been awarded?**

Select all qualifications that the client has already been awarded at any point in their life (i.e. the client has sat the exams and had confirmation that they have passed the qualification). If the client isn’t sure or can’t remember, the FN should probe a little further. If the client still isn’t sure, select “don’t know”.

**DI20. Which of the following best describes your current situation? If currently on maternity leave, what was your situation immediately prior to that? (select all that apply)**

Full-time carer/part-time carer – select only if the client has unpaid caring responsibilities (e.g. for family member). If the client is employed as a carer, this should be registered under “working full-time” or “working part-time”

**DI21. Does your household currently receive any income from public funds/benefits (excluding child benefit)?**

Examples for how to fill out this question:

1. If the client receives no income at all but lives with her parents/partner who receive all their income through benefits, then select “yes, this accounts for all my income”.

2. If the client receives all their income through paid work, but their parents/partner receive income through benefits, select “yes, this accounts for some of my income”

3. If the only benefit the household receives is child benefit, select “no”.

**DI22. If you do not receive any income from public funds/benefits, is there a specific reason for this?**

If directed to answer from previous question:

Select “Not eligible due to level of income” if household income is too high to be eligible for benefits

Select “Sanctioned from benefits” if the client/client’s parents/client’s partner cannot claim any benefits due to sanctions

Select “No recourse to public funds” if the client/client’s parents/client’s partner are ineligible for benefits due to immigration status etc.

**DI23. As far as you are aware, have any of the following ever applied to you? Each option is required to be answered.**

Often clients will not know the answer to some of these questions, particularly those about their past. If the client says they do not know the answer to any of the questions, try and gently probe a little further. If they still do not know, select “don’t know”, and if further information comes to light at a later date, this question can be updated.

**DI24. Thinking about your current situation, can you tell me how much you agree or disagree with the following statements**

These are positive statements in relation to life course development statements; support the client to tick the box which represents how much they agree or disagree with each statement.

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| Demographics: Update (DU) (Completed with the client during the visit) |

**Purpose and Background**

This form is used to update the demographic information collected early in pregnancy, and to update information on mental wellbeing, self-efficacy and loneliness/social isolation, which was initially collected in the Pregnancy (P) form. The information gathered in this form can help to better understand how FNP works with clients with different social and economic characteristics, and how clients’ situations change over the course of the programme.

**General Guidelines**

This form is to be completed four times across the course of the programme:

* Infancy 6 months (Visit I15)
* Toddler 12 months (Visit T29)
* Toddlerhood 18 months (Visit T41)
* Toddlerhood 24 months (Visit T50)

Select the relevant time point/age of child; it is important that FN’s collect this data at all four of these points in time to accurately demonstrate the changes in clients’ social, economic and health behaviours and circumstances.

**Directions for Completing the Form**

**DU1. What is your current full address?**

Complete section giving full address details including full post code.

For the purposes of this form the client address refers to the place that the client spends at least four nights per week this may include a homeless shelter or prison.

**NOTE:** If this differs from the current address on Turas FNP system please complete a change of Status form for client (SM) and if appropriate for the child (SC).

**DU2. Does this client require an interpreter?**

Please refer to the FNP Guidance Document - “The use of interpreters within the FNP programme”.

**DU3. How well can you speak English?**

Select the box that most closely represents the client’s self-reported ability to speak English

**DU6. How often, if at all, do you see or communicate with your child’s biological father?**

Seeing/communicating with the father of the child includes in-person contact as well contact on social media/texting/phone calls etc.

**DU8. Are you currently registered homeless?**

“Registered homeless” means that the client (or their partner/parents if they lives with them) has made a homelessness application to the local council, and has been deemed eligible for assistance.

**DU9. If you are not registered homeless; do you consider yourself to be homeless?**

Select yes if the client deems them self to be homeless for any reason, but has not applied for homelessness assistance to the council, or has applied for homelessness assistance and the application was rejected.

**DU12. Who do you live with?**

Select the box/boxes that most closely represents the client’s self-defined status in relation to this question. It is important to be mindful of client’s understanding of the terminology in this question; some may require support to understand the definitions of the terms.

**DU15. Which, if any, of the following qualifications have you been awarded since you began the FNP programme?**

Select all qualifications that the client has been awarded since joining FNP (i.e. the client has sat the exams and had confirmation that they have passed the qualification). If the client isn’t sure or can’t remember, the FN should probe a little further. If the client still isn’t sure, select “don’t know” The form can be updated later on if the correct information is later available.

**DU18 Which of the following best describes your situation?**

If the client is on maternity leave from a job, select “working full-time” or “working part-time” depending on whether she was part-time or full-time before having her baby

Full-time carer/part-time carer – select only if the client has unpaid caring responsibilities (e.g. for family member excluding her own baby). If the client is employed as a carer, this should be registered under “working full-time” or “working part-time”.

If the client looks after her own child full-time, this should be registered as “full-time parent”

**DU19. Does your household currently receive any income from public funds/benefits (excluding child benefit)?**

Examples for how to fill out this question:

1. If the client receives no income at all but lives with their parents/partner who receive all their income through benefits, then select “yes, this accounts for all my income”.

2. If the client receives all their income through paid work, but their parents/partner receive income through benefits, select “yes, this accounts for some of my income”.

If the only benefit the household receives is child benefit, select “no”.

**DU20. If you do not receive any income from public funds/benefits, is there a specific reason for this?**

Select “Not eligible due to level of income” if household income is too high to be eligible for benefits

Select “sanctioned from benefits” if the client/client’s parents/client’s partner cannot claim any benefits due to sanctions

Select “no recourse to public funds” if the client/client’s parents/client’s partner are ineligible for benefits due to immigration status etc.

**DU21. Thinking about your current situation, can you tell me how much you agree or disagree with the following statements:**

These are positive statements in relation to life course development statements; support the client to tick the box which represents how much they agree or disagree with each statement.

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| Pregnancy Intake (P) **(Completed with the client during the visit)** |

**Purpose and Background**

Breastfeeding intention, and baseline data on key FNP outcomes such as mental wellbeing, self-efficacy and social isolation/loneliness. Assessments and analysis of in-depth clinical information can enhance interventions and programme delivery.

**General Guidelines**

This form is to be completed on the first home visit (Visit P1). Completion of this form indicates that the client has been recruited on to the programme.

Prior to completion of the form please ensure a discussion regarding consent has taken place.

**Directions for Completing the form**

**P1. How many engagement visits took place before client enrolled onto FNP**

This is to be completed by the FN.

A completed engagement visit is defined as:

* Any direct face-to-face contact in which the FN is interacting with the young woman with goal of enrolling on to the FNP Programme.

**NOTE:** In the rare event that a client is enrolled on to the programme at the first face to face visit where Pregnancy Intake (PI) and Visit Encounter (V) forms are completed no engagement visits will have taken place this should be marked as 0.

**P2. Gestation at referral to FNP**

This is to be completed by the FN.

Enter weeks and days of gestation of pregnancy on the day first known to the FNP service. This information enables learning and development in relation to the engagement process.

**P3. Gestation at enrolment**

Enter weeks and days of gestation of pregnancy at the first home visit (visit P1). This information is required to calculate the number of visits expected in the pregnancy phase. This will assist with agenda matching programme materials and to support the reporting of licence requirements for core model elements.

**P5. When is your baby due?**

Provide information in day, month, year format. Some clients will not initially have an established EDD in this instance provide estimated date.

**P6. Do you plan to breastfeed your baby?**

FNP has worked closely with Unicef and there is an understanding that data collection helps track progress and trends and is an integral part of the programme. When Unicef released guidance about not asking a woman their intention to breast feed it was because this could be asked in a closed way and then the conversation is shut down. However, Unicef understands the work of FNs and that questions in relation to intention to breast feeding are asked in an open, curious and interested way. It has therefore been agreed with Unicef that these questions can be discussed as part of a detailed and holistic assessment.

**P8. SWEMWBS**[[14]](#footnote-14)**.**

This set of questions, from the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), provides a measure of mental wellbeing among clients that can be tracked regularly from enrolment to graduation. The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**P9. GSE**

The General Self-Efficacy Scale[[15]](#footnote-15) is used nationally and internationally to provide a measure of self-efficacy among clients. This can indicate how well a client copes with daily activities, stressful events and adversity and can measure changes in quality of life that can be tracked regularly from enrolment to graduation.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**P10. Social-Iso**

This set of questions is taken from an amended version of the UCLA Social Isolation and Loneliness Scale, which was adapted for use in Nurse Family Partnership (NFP) International. It aims to measure subjective feelings of loneliness and social isolation, and can be used to highlight those clients who are at risk.

The client should answer the questions in relation to how they have felt over the last 2 weeks

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**P11. Do you have any physical or mental health condition or illness lasting or expected to last 12 months or more?**

The answers to this question provides important information to aid the understanding of the clinical needs of clients and helps determine some of the complexities within the lives of the client group. These questions support understanding of a wide range of long term mental and physical health conditions that is in line with the definition of disability in the Disability Discrimination Act 2005 and is used as part of the Scottish Surveys Core Questions (SSCQ) therefore can be compared to other national surveys.

**P12. SWEMWBS Total**

FN should complete this section. Tally up the total score of the 7 questions answered in P8, using the following scoring mechanism:

1 = none of the time

2 = rarely

3 = some of the time

4 = often

5 = all of the time

The overall score should fall between 7 and 35.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

**P13. GSE Total**

FN should complete this section. Tally up the total score of the 10 questions answered in P9, using the following scoring mechanism:

1 = Not at all true

2 = Hardly true

3 = Moderately true

4 = Exactly true

The overall score should fall between 10 and 40.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

**P14. Social-Iso Total**

FN should complete this section. Tally up the score of the 3 questions answered in P10, using the following scoring mechanism:

1 = Hardly ever

2 = Sometimes

3 = Often

The overall score should fall between 3 and 9.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

A total score less than 4 indicates low risk

A total score of 4-5 indicates moderate risk

A total score of 6-9 indicates high risk

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| --- |
| Maternal Health: Pregnancy (MH) **(Completed with the client during the visit)** |

**Purpose and Background**

This form provides FNs with important clinical information needed to support delivery of the programme materials and to guide the client in the direction of positive change. Along with the form Maternal Health: Post Birth (HH) it allows the tracking of health behaviours over time to demonstrate progress and provide information regarding some of the programme’s intended outcomes.

**General Guidelines**

This form is to be completed twice:

* On the 3rd home visit (visit P3)
* At 36 weeks gestation (approx. visit P12) or Post Natally if birth before 36 weeks see guidelines in Introduction section.

**Directions for Completing the form**

**MH2. Do you smoke cigarettes or e-cigarettes nowadays[[16]](#footnote-16)?**

Answer if directed to from previous question. If clients smoke either cigarettes or e-cigarettes occasionally, this should be recorded as “yes”.

**MH3. How many cigarettes do you usually smoke in a day?**

Answer if directed to from previous question. Definition of “in a day” is within a 24 hour period.

**MH4. Have you been offered a referral for a smoking cessation service since you found out you were pregnant?**

This is a probing question that can help open a discussion regarding the client’s state of readiness regarding smoking cessation and can help track progress regarding behaviour change outcomes.

**MH5. Have you consumed alcohol during your pregnancy, including before you knew that you were pregnant?**

This question can help open discussions in relation to the client’s use and understanding of the implications of alcohol consumption[[17]](#footnote-17).

**MH6. Roughly how many units of alcohol have you consumed in the last 7 days?**

Units should be calculated as accurately as possible according to the NHS alcohol units guide:

|  |  |
| --- | --- |
| **Type of drink** | **Number of alcohol units** |
| Single small shot of spirits \* (25ml, ABV 40%) | 1 unit |
| Alcopop (275ml, ABV 5.5%) | 1.5 units |
| Small glass of red/white/rosé wine (125ml, ABV 12%) | 1.5 units |
| Bottle of lager/beer/cider (330ml, ABV 5%) | 1.7 units |
| Can of lager/beer/cider (440ml, ABV 5.5%) | 2 units |
| Pint of lower-strength lager/beer/cider (ABV 3.6%) | 2 units |
| Standard glass of red/white/rosé wine (175ml, ABV 12%) | 2.1 units |
| Pint of higher-strength lager/beer/cider (ABV 5.2%) | 3 units |
| Large glass of red/white/rosé wine (250ml, ABV 12%) | 3 units |

\*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

**MH7. Thinking about the last time you were on a night out or at a party, roughly how many units of alcohol did you consume then?**

Units should be calculated as accurately as possible according to the NHS alcohol units guide:

|  |  |
| --- | --- |
| **Type of drink** | **Number of alcohol units** |
| Single small shot of spirits \* (25ml, ABV 40%) | 1 unit |
| Alcopop (275ml, ABV 5.5%) | 1.5 units |
| Small glass of red/white/rosé wine (125ml, ABV 12%) | 1.5 units |
| Bottle of lager/beer/cider (330ml, ABV 5%) | 1.7 units |
| Can of lager/beer/cider (440ml, ABV 5.5%) | 2 units |
| Pint of lower-strength lager/beer/cider (ABV 3.6%) | 2 units |
| Standard glass of red/white/rosé wine (175ml, ABV 12%) | 2.1 units |
| Pint of higher-strength lager/beer/cider (ABV 5.2%) | 3 units |
| Large glass of red/white/rosé wine (250ml, ABV 12%) | 3 units |

\*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

**MH8. Have you ever taken any of the following drugs**[[18]](#footnote-18)**?**

Select all applicable boxes. It is important to have a baseline to understand a client’s use and understanding of drug use.

**MH11. GAD-7[[19]](#footnote-19)**

The client should answer the questions in relation to how she has felt over the last 2 weeks. The scale has been widely used nationally and internationally for monitoring and investigating the determinants of mental wellbeing. This is a valid and reliable tool to assess for Generalized Anxiety Disorder.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**MH12. GAD-7 Total**

FN should complete this section. Tally up the score of the 7 questions answered in MH11, using the following scoring mechanism:

0 = Not at all

1 = Several days

2 = Over than half the days

3 = Nearly every day

The overall score should fall between 0 and 21

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

This is a screening tool; referral to services is never based solely on a client’s score. A full holistic assessment based on history and presentation should be used to inform practice. Each NHS Board area will have policies and protocols that are required to be followed in relation to referral process for clients with Mental Health challenges.

|  |  |  |
| --- | --- | --- |
| **GAD7 score** | **May mean the person has** | **Possible actions** |
| 0-4 | Indicates minimal anxiety (low risk) | Continue to observe |
| 5-10 | Indicates mild anxiety (moderate risk) | Assess need for additional support.  Considering completing questionnaire earlier than normally planned – no greater than 90 days. |
| 11-15 | Indicates moderate anxiety (high risk) | For discussion/referral to GP services.  For assessment of mental health at each visit.  To work with multi-agency partners to plan care. |
| 16-21 | Indicates severe anxiety (high risk) | For referral to GP/Mental Health Services.  For assessment of mental health at each visit.  To work with multi-agency partners to plan care. |

**NOTE: An emergency referral is required for any client who has intentions or plan to harm them self, baby, or someone else.**

**MH13. EPDS[[20]](#footnote-20)**

FN should complete this section. This is a stand-alone document, but the scores are also captured here in the FNP data forms. EPDS is completed in line with local and national policies and procedures[[21]](#footnote-21) also as part of care given by FN’s to deliver the Health Visiting Care Pathway[[22]](#footnote-22).

The Edinburgh Postnatal Depression Scale (EPDS) 10-question self-rating scale is an efficient and effective way of identifying women at risk for perinatal/postnatal depression. Without treatment, perinatal depression affects all aspects of a woman’s health and that of their baby. It can be a factor leading to low birth weight, compromised mother-infant interaction, and behavioural/cognitive impairment in early preschool years. The most tragic consequences of perinatal depression are maternal suicide and infanticide. FN’s may be the first point of contact for women experiencing perinatal depression. The use of a reliable screening instrument is intended to supplement the FN’s clinical judgment and assist with decision making about the client’s care. Its use provides women with the opportunity to discuss their feelings and enables the FN to discreetly raise the issue of potential perinatal depression with the client. The instrument is easy to administer, and most clients complete the scale in less than 5 minutes.

High scores do not themselves confirm a depressive illness, and similarly, some women who score below a set threshold might be depressed. The EPDS does not provide a clinical diagnosis of depression and should not be used as a substitute for full psychiatric/mental health assessment and clinical judgment. The EPDS cannot be used to predict whether or not a respondent will experience depression in the future - it can only be used to determine current mood- within the past seven days. The EPDS will not detect mothers with anxiety neuroses, phobias or personality disorders. The EPDS Score is designed to assist, not replace, clinical/professional judgment.

**NOTE:** EPDS is recorded at 36 weeks only in the antenatal period.

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| Maternal Health: Post Birth (HH) **(Completed with the client during the visit)** |

**Purpose and Background**

This form provides FN’s with important clinical information needed to support delivery of the programme materials to guide the client in the direction of positive change. Along with the forms Maternal Health: Pregnancy (MH) and Pregnancy Intake (P) it allows the tracking of health behaviours over time to demonstrate progress and provide information regarding some of the programme’s intended outcomes.

**General Guidelines**

This form is to be completed at five different stages:

* Infancy 6 weeks (visit I6)
* Infancy 6 months (visit I15)
* Toddlerhood 12 months (visit T30)
* Toddlerhood 18 months (visit T40)
* Toddlerhood 24 months (visit T48)

**Directions for Completing the form**

**HH1. Do you smoke cigarettes or e-cigarettes nowadays[[23]](#footnote-23)?**

If clients smoke either cigarettes or e-cigarettes occasionally, this should be recorded as “yes”.

**HH2. How many cigarettes do you usually smoke in a day?**

Answer if directed to from previous question. Definition of “in a day” is within the last 24 hour period.

**HH4. Roughly how many units of alcohol have you consumed in the last 7 days?**

Units should be calculated as accurately as possible according to the NHS alcohol units guide:

|  |  |
| --- | --- |
| **Type of drink** | **Number of alcohol units** |
| Single small shot of spirits \* (25ml, ABV 40%) | 1 unit |
| Alcopop (275ml, ABV 5.5%) | 1.5 units |
| Small glass of red/white/rosé wine (125ml, ABV 12%) | 1.5 units |
| Bottle of lager/beer/cider (330ml, ABV 5%) | 1.7 units |
| Can of lager/beer/cider (440ml, ABV 5.5%) | 2 units |
| Pint of lower-strength lager/beer/cider (ABV 3.6%) | 2 units |
| Standard glass of red/white/rosé wine (175ml, ABV 12%) | 2.1 units |
| Pint of higher-strength lager/beer/cider (ABV 5.2%) | 3 units |
| Large glass of red/white/rosé wine (250ml, ABV 12%) | 3 units |

\*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

**HH5. Thinking about the last time you were on a night out or at a party, roughly how many units of alcohol did you consume then?**

Units should be calculated as accurately as possible according to the NHS alcohol units guide:

|  |  |
| --- | --- |
| **Type of drink** | **Number of alcohol units** |
| Single small shot of spirits \* (25ml, ABV 40%) | 1 unit |
| Alcopop (275ml, ABV 5.5%) | 1.5 units |
| Small glass of red/white/rosé wine (125ml, ABV 12%) | 1.5 units |
| Bottle of lager/beer/cider (330ml, ABV 5%) | 1.7 units |
| Can of lager/beer/cider (440ml, ABV 5.5%) | 2 units |
| Pint of lower-strength lager/beer/cider (ABV 3.6%) | 2 units |
| Standard glass of red/white/rosé wine (175ml, ABV 12%) | 2.1 units |
| Pint of higher-strength lager/beer/cider (ABV 5.2%) | 3 units |
| Large glass of red/white/rosé wine (250ml, ABV 12%) | 3 units |

\*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

**HH6. Which of the following, if any, have you taken in the last month?**

Select all applicable boxes[[24]](#footnote-24). It is important to have a baseline to understand a client’s use and understanding of drug use.

**HH12. Please select all the different types of birth control you have been using**

The client should indicate all forms of birth control they have used during the last 6 months. This information enhances the FN’s knowledge of the client’s understanding and satisfaction of their choice of contraceptive. This can help the FN to ensure that client has a method of contraception that works for them.

**HH14. Please indicate the outcome of each pregnancy you have had since the birth of your child enrolled on FNP**

If a pregnancy has resulted in a multiple birth the birth date refers the DOB of the first born child.

If the client has had more than three pregnancies since the birth of their first child, provide details of any further pregnancies on a separate piece of paper and hand these to the data manager along with this form.

**HH15. SWEMWBS[[25]](#footnote-25).**

This set of questions, from the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), provides a measure of mental wellbeing among clients that can be tracked regularly from enrolment to graduation. The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**HH16. GSE**

The General Self-Efficacy Scale[[26]](#footnote-26) is used nationally and internationally to provide a measure of self-efficacy among clients. This can indicate how well a client copes with daily activities, stressful events and adversity and can measure changes in quality of life that can be tracked regularly from enrolment to graduation.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**HH17. Social-Iso**

This set of questions is taken from an amended version of the UCLA Social Isolation and Loneliness Scale, which was adapted for use in Nurse Family Partnership (NFP) International. It aims to measure subjective feelings of loneliness and social isolation, and to highlight those clients who are at risk.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**HH18. GAD-7[[27]](#footnote-27)**

The client should answer the questions in relation to how they have felt over the last 2 weeks. The scale has been widely used nationally and internationally for monitoring and investigating the determinants of mental wellbeing. This is a valid and reliable tool to assess for Generalized Anxiety Disorder.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**HH19. EPDS**

This is a stand-alone document, but scoring is also captured here in the FNP data forms. EPDS is completed in line with local and national policies and procedures[[28]](#footnote-28) also as part of care given by FN’s to deliver the Health Visiting Care Pathway[[29]](#footnote-29). EPDS to be completed only at 6 weeks, 6 months (insert 16 week EPDS score), 12 months and 18 months

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-question self-rating scale that has been proven to be an efficient and effective way of identifying women at risk for perinatal/postnatal depression. Without treatment, perinatal depression affects all aspects of a woman’s health and that of their baby. It can be a factor leading to low birth weight, compromised mother-infant interaction, and behavioural/cognitive impairment in early preschool years. The most tragic consequences of perinatal depression are maternal suicide and infanticide. FN’s may be the first point of contact for women experiencing perinatal depression. The use of a reliable screening instrument is intended to supplement the FN’s clinical judgment and assist with decision making about the client’s care. Its use provides women with the opportunity to discuss their feelings and enables the FN to discreetly raise the issue of potential perinatal depression with the client. The instrument is easy to administer, and most clients easily complete the scale in less than 5 minutes.

High scores do not themselves confirm a depressive illness, and similarly, some women who score below a set threshold might be depressed. The EPDS does not provide a clinical diagnosis of depression and should not be used as a substitute for full psychiatric/mental health assessment and clinical judgment. The EPDS cannot be used to predict whether or not a respondent will experience depression in the future - it can only be used to determine current mood- within the past seven days. The EPDS will not detect mothers with anxiety neuroses, phobias or personality disorders. The EPDS Score is designed to assist, not replace, clinical/professional judgment.

**HH20. SWEMWBS Total**

FN should complete this section. Tally up the total score of the 7 questions answered in HH15, using the following scoring mechanism:

1 = none of the time

2 = rarely

3 = some of the time

4 = often

5 = all of the time

The overall score should fall between 7 and 35.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

**HH21. GSE Total**

FN should complete this section. Tally up the total score of the 10 questions answered in HH16, using the following scoring mechanism:

1 = Not at all true

2 = Hardly true

3 = Moderately true

4 = Exactly true

The overall score should fall between 10 and 40.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

**HH22. Social-Iso Total**

FN should complete this section. Tally up the score of the 3 questions answered in HH17, using the following scoring mechanism:

1 = Hardly ever

2 = Sometimes

3 = Often

The overall score should fall between 3 and 9.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

A total score less than 4 indicates low risk

A total score of 4-5 indicates moderate risk

A total score of 6-9 indicates high risk

**HH23. GAD-7 Total**

FN should complete this section. Tally up the score of the 7 questions answered in HH18, using the following scoring mechanism:

0 = Not at all

1 = Several days

2 = Over than half the days

3 = Nearly every day

The overall score should fall between 0 and 21

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

This is a screening tool; referral to services is never based solely on a client’s score. A full holistic assessment based on history and presentation should be used to inform practice. Each NHS Board area will have policies and protocols that are required to be followed in relation to referral process for clients with Mental Health challenges.

|  |  |  |
| --- | --- | --- |
| **GAD7 score** | **May mean the person has** | **Possible actions** |
| 0-4 | Indicates minimal anxiety (low risk) | Continue to observe |
| 5-10 | Indicates mild anxiety (moderate risk) | Assess need for additional support.  Considering completing questionnaire earlier than normally planned – no greater than 90 days. |
| 11-15 | Indicates moderate anxiety (high risk) | For discussion/referral to GP services.  For assessment of mental health at each visit.  To work with multi-agency partners to plan care. |
| 16-21 | Indicates severe anxiety (high risk) | For referral to GP/Mental Health Services.  For assessment of mental health at each visit.  To work with multi-agency partners to plan care. |

**NOTE: An emergency referral is required for any client who has intentions or plan to harm them self, baby, or someone else.**

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| Infant Birth (IB) **(Completed with the client during the visit)** |

**Purpose and Background**

The purpose of this form is to provide basic information regarding the new child. This will provide information from birth to help track the wellbeing of the child and give a baseline from which to observe the outcomes of the programme.

**General Guidelines**

This form should be completed as soon after birth as possible, on the first infancy visit (visit I1)

If a client has twins or triplets, the FN should complete one form per child.

This form is to be used for the index child (or index children in the case of twins/ triplets) only. Information on subsequent children should be entered on the Maternal Health: Post Birth (HH) form only.

**NOTE:** It may be necessary under exceptional circumstances for this form to be completed without the client being present i.e. if the child is looked after and accommodated. It is essential that the person completing the form with the FN has sufficient knowledge of the child to do so. A V form would not be completed.

**Directions for Completing the form**

**IB1. Child’s sex**

In rare cases it may be appropriate to answer this question with “not known” or “unspecified”.

Answer with “not known” if: the sex of the child cannot be determined for physical reasons. If the child is intersex, it should be recorded as “not known”.

Answer with “unspecified” only if: the sex of the child is not known because the personal information of the child is unavailable.

**IB2. Gestation at Birth**

Please complete in weeks and days.

**IB3. Was birth a result of an induced labour?**

Induction of labour is defined by The World Health Organisation (WHO)[[30]](#footnote-30) [[31]](#footnote-31) as “the process of artificially stimulating the uterus to start labour.”

**IB5. Measurements**

The birth weight, OFC and length should be standard information obtained from maternity services i.e. labour ward records or at hand over from the midwife at transfer of care normally at day 10 post natal. This is in order to give a base line from which to base clinical changes to growth centiles. However, in exceptional circumstances if this information has not been available the measurements taken by the FN in the first 12 days could be entered but this needs to be reflected in the clinical record as such.

**IB6. Has your child ever received breast milk?**

Answer yes if the child has received any amount of breast milk, whether through direct breastfeeding, expressed milk, or donated breast milk.

**IB8. Immediately prior to birth, did any of the following apply to your child?**

Immediately prior to birth is defined as the last few minutes prior to birth.

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| Infant Health: 6 Weeks (IH) **(Completed with the client during the visit)** |

**Purpose and Background**

This form gives an update following on from the Infant Birth (IB) form; it provides information on the health, wellbeing and development of the child at 6 weeks of age.

**General Guidelines**

Complete this form when the child is 6 weeks old (visit I6)

**Directions for completing the form**

**IH1. Measurements:**

Please complete this section with a measure, completed by the FN at this visit, of weight, length and head circumference as per the World Health Organisation guidelines[[32]](#footnote-32).

**IH2. Has your child ever received breast milk?**

Answer yes if the child has received any amount of breast milk, whether through direct breastfeeding, expressed milk, or donated breast milk.

**IH4. Did your child ever receive breast milk exclusively?**

Answer yes if the child was/is exclusively breastfeeding.

“Exclusive breastfeeding means that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines”[[33]](#footnote-33).

**IH7. Do you have a smoke-free home?[[34]](#footnote-34)**

Select yes if no one smokes whilst in the family home. Select no if anyone smokes inside the family home even if this is in a separate room.

**IH8. Is your child exposed to second hand smoke outside the family home[[35]](#footnote-35)?**

Please complete if directed to do so based on previous answer. Select the most appropriate answer i.e.

Yes - if the child attends a family member or friends home where someone smokes in the home or in the car.

No - if the child is never in an area where there is anyone smoking.

**IH9. Was your child ever in the neonatal unit or (Special Care Baby Unit) SCBU?**

Select yes even if the child was admitted for a short period of time.

**IH10. Is your child still in hospital?**

If the child is still in the neonatal unit/SCBU at the time of asking this questionnaire, select “yes”, then the total amount of time spent there will be recorded on the Infant Health (6-24 months) form (CH).

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| Infant Health: 6 – 24 months (CH) **(Completed with the client during the visit)** |

**Purpose and Background**

This form provides updates on the health, wellbeing and development of the child throughout infancy and toddlerhood. It aims to monitor many of the key outcomes that FNP seeks to improve, in order that the child’s development can be tracked over time.

**General Guidelines**

This form should be completed four times:

* Infancy 6 months (visit I16)
* Infancy 12 months (visit I28)
* Toddlerhood 18 months (visit T42)
* Toddlerhood 24 months (visit T50)

Please select the correct stage at point of completion of the form.

**Directions for completing the form**

**CH1. Has your child received all scheduled immunisations?**

Clients may require support to understand the time schedule for immunisations[[36]](#footnote-36).

**CH2. Measurements:**

Please complete this section with a measure of weight, length and head circumference as per the World Health Organisation guidelines[[37]](#footnote-37).

**NOTE:** OFC is completed at 6 and 12 months only.

**CH3. Has your child ever received breast milk?**

Answer yes if the child has received any amount of breast milk, whether through direct breastfeeding, expressed milk, or donated breast milk.

**CH5. Did your child ever receive breast milk exclusively?**

Answer yes if the child was/is exclusively breastfeeding.

“Exclusive breastfeeding means that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines”[[38]](#footnote-38).

**CH6. For how long was your child exclusively breastfed?**

Please complete if directed to do so based on previous answer.

**CH9. At what age did your child first receive any food other than milk?**

Please complete, in months and weeks, if directed to do so based on previous answer.

**CH12. Do you have a smoke-free home?**

Select yes if no one smokes whilst in the family home. Select no if anyone smokes inside the family home even if this is in a separate room.

**CH13. Is your child exposed to second hand smoke outside the family home[[39]](#footnote-39)?**

Please complete if directed to do so based on previous answer. Select the most appropriate answer i.e.

Yes - if the child attends a family member or friends home where someone smokes in the home.

No - if the child is never in an area where there anyone smoking.

**CH14. Was your child in the SCBU/neonatal unit?**

Select yes is if the child was admitted even for a short period of time.

**CH15. Was your child in the SCBU/neonatal unit for longer than 6 weeks?**

Complete if directed to do so based on previous answer. Information regarding length of stay under 6 weeks is captured in Infant Health – 6 weeks (IH).

**CH16. Does your child remain in hospital?**

Complete if directed to do so based on previous answer. Answer yes if the child has remained in hospital since the first episode of care.



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| Ages and Stages Questionnaires **(Completed by Family Nurse following the visit)** |

**Purpose and Background**

Screening infants and toddlers is an effective, efficient way to catch problems and intervene when it does the most good - during the crucial early years when the child’s brain and body are developing rapidly. Because developmental and social-emotional delays can be subtle and can occur in children who appear to be developing typically, most children who would benefit from early intervention are not identified until after they start school.

Because of the long-term relationship FN’s establish with the families they serve, they are in a unique position to observe/screen infants and toddlers at risk for developmental problems and refer them for further evaluation when indicated. The developmental screening process empowers families by giving them anticipatory guidance on developmental tasks and allowing them to appreciate their child’s unique way of accomplishing developmental milestones.

**General Guidelines**

See FNP clinical guidance document relating to Ages and Stages Questionnaires.

ASQ 3 is completed

* 4 months
* 8 months
* 14 months
* 20 months

ASQ:SE2 is completed

* 6 months
* 12 months
* 18 months
* 23 months

Although ASQ’s have validity across a wide time scale to ensure data quality and enable consistent analysis it is essential that forms are completed at the age of the child indicated above.

**A1: Scheduled assessment has not taken place, please indicate why**

If circumstances prevent assessment at the scheduled time please indicate why.

**NOTE:** The ASQ questionnaires should not be completed if the *child has already been screened and determined to have a disability requiring special education and/or related services.*

**A3: Unscheduled assessment:**

The FN will be required to use sound clinical judgement for re-establishing an assessment routine for the child. In exceptional circumstances a FN may wish to complete an ASQ questionnaire to assist with the clinical assessment of child development out with the scheduled timeframe. It is important the correct questionnaire is used for the age of the child. If assessment is completed out with the scheduled time please indicate this by selecting unscheduled assessment and enter the child’s age in months at the date of the assessment.

**A4: Please indicate if the questionnaire has been gestational age corrected[[40]](#footnote-40)**

ASQ’s are only required to be gestational age corrected if more than 3 weeks premature until the child is 2 years. Please indicate if the ASQ has been gestational age corrected.

**A5 AND A6**

**. ASQ scores**

To be completed by the FN. To give total score. To assist with data linkage to Community Child Health[[41]](#footnote-41) please also state

* C=Concern newly suspected
* N=No Concern
* P=Previous Concern
* X=Assessment Incomplete

**NOTE:** These tools are copyrighted and must be purchased for use[[42]](#footnote-42). Scottish Government has agreed with the publisher’s national procurement and has a service level agreement with NHS Boards who are required to comply with the licence agreements.

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| Intimate Partner Violence: Record of Assessment and Disclosure (AD) **(Completed by FN following the visit)** |

**Purpose and Background**

The purpose of this form is to record clinical assessment activities and client responses regarding Intimate Partner Violence (IPV) experiences, as well as nurse actions following their assessment. It is designed to collect data on IPV so that collated data can be analysed to identify patterns, trends and impacts over time.

* This form is completed by the FN nurse **FOLLOWING** the visit where the “My Experiences” facilitator is used (a list of questions to guide the completion of an assessment to ascertain the types of IPV a client is currently experiencing, or has experienced in the last 12 months). See embedded facilitator and guidance document.
* This form should NOT be completed with the client.
* The FN should complete section 1 to record the client’s responses to the assessment of their IPV experiences and section 2 to record nurse actions following the assessment

For further information on expectations for clinical assessments, nurses should refer to the national clinical pathway or guidance document.

**General Guidelines**

This form is completed following completion of the IPV Clinical Assessment for all clients unless the nurse had completed this form previously and the client disclosed IPV; in which case an IPV:PD form should be used:

* Pregnancy visit 5-7
* Infancy 8-12 weeks
* Toddlerhood 16 months
* To record first time to FNP client disclosures that occur at time points outside the regular assessment points.

If the client has disclosed IPV, the data form ‘**Intimate Partner Violence (IPV) Previous Disclosure Form** should be completed at the subsequent expected time points in place of this form

NOTE: a client may have disclosed IPV to another professional who have then informed the FN; this form should be completed if this is the first time that this has been assessed in FNP.

**Directions for completing the form**

The form requests that the nurse provides information/ data based on the clinical assessment. Specific instructions relating to this are as follows: Any subsequent disclosures or further assessments should be captured on the IPV:PD form.

**Date of IPV assessment:**

The date inserted into the form should be that when the “My Experiences” facilitator was shared with the client, or the date at which IPV was spontaneously disclosed. The form make take some time to fully complete in order to provide adequate time for the FN to complete the necessary follow-up activities following the initial assessment however, it is expected that this should take no more than 6 weeks.

**Indicates when the form was completed:**

It is important to understand if the completion of the form was scheduled or not and why.

Please ensure the form is completed even when it is not possible to complete the assessment at the scheduled time point.

If scheduled assessment is not completed it is necessary to complete which scheduled assessment should have been completed.

If this is a delayed scheduled assessment please indicate which scheduled assessment it relates to as well as completing the gestation or age of the child.

**Section 1: Documentation of client responses to IPV assessment**

**AD1. Did the client disclose IPV?**

If yes continue to complete the remainder of section 1

If no go to section 2

**Section 2: FNP Nurse activities**

For further information in relation to DASH-9 assessment[[43]](#footnote-43)

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|  |
| --- |
| Intimate Partner Violence: Previous Disclosure (PD) **(Completed by FN following the visit)** |

**Purpose and Background**

This form should be completed by the FN nurse for all clients who have previously disclosed Intimate Partner Violence (IPV). This form is used to record activities regarding ongoing client experiences of IPV, as well as nurse responses and actions. This form will assist the FN nurse to collect data at points subsequent to the initial assessment without a requirement for additional direct, nursing structured assessments. This form is designed to collect data on IPV so that this collated information can be analysed to identify patterns, trends and impacts of the programme in relation to IPV over time.

This should NOT be completed with the client.

**General Guidelines**

This form is competed to provide updates following the completion of the IPV:AD form at the time of initial disclosure to the FN. This form should be completed if previously disclosed at these time points:

* Pregnancy visit 5-7
* Infancy 8-12 weeks
* Toddlerhood 16 months
* To record assessment that occur at time points outside the regular assessment points.

The nurse is NOT expected to repeat the IPV assessment with a client who has previously disclosed IPV but should use their ongoing knowledge of the client’s circumstances, arising from their work with the client, to complete this data form.

**Directions for completing the form**

The data form completion time point should always be ticked to show which routine data collection time point the form relates to.

It is important to understand if the completion of the form was scheduled or not and why.

Please ensure the form is completed even when it has not been possible to complete assessment at the scheduled time point.

If scheduled assessment is not completed it is necessary to complete which scheduled assessment should have been completed.

If this is a delayed scheduled assessment please indicate which scheduled assessment it relates to as well as completing the gestation or age of the child.

**Section 1: Documentation of Client experience**

**PD1. At present, how does your client describe their experiences of IPV as:**

If yes continue to complete the remainder of section 1

If no go to section 2

**Section 2: FNP Nurse activities**

For further information in relation to DASH-9 assessment[[44]](#footnote-44)



|  |
| --- |
| Supervision Record (S) **(completed by the person facilitating the Supervision Session)** |

**Purpose and Background**

The Scottish Government considers supervision to be an essential part of support for nurses[[45]](#footnote-45) and the Nursing and Midwifery Council state that nurses are required to “contribute to supervision and team reflection activities to promote improvements in practice and services”[[46]](#footnote-46). Supervision has been an integral component of FNP from the beginning in Scotland, having been first introduced by Professor Olds following feedback from nurses in the first Randomised Control Trial in Elmira, USA.

This form supports programme documentation and reporting on fidelity requirements relating to Core Model Element 12. The completion of data and analysis from this form, along with the use of the Supervision Guidance document will support the monitoring, evaluation, and further refinement of the supervision processes.

**General Guidelines**

This form is to be completed following any form of FNP supervision which has taken place or should have taken place as laid out in the Family Nurse Partnership Scotland: Supervision Guidelines document.

The form should be completed by the team supervisor directly onto the Turas FNP system. However, in the case of the supervisor being absent the nominated facilitator/deputy who leads the session should complete the form.

This form should be completed when any form of supervision did or should have taken place in accordance with the FNP Supervision Guidance document (August 2021) which can be found on [Turas FNP Learn](https://learn.nes.nhs.scot/56866/family-nurse-partnership/clinical-practice/supervision/reflective-supervision-in-family-nurse-partnership-scotland).

The first section of the form

* Team Name
* Team Supervisor Name
* Date
* Was the Session to be completed by the team supervisor?:

should always be completed even if the team supervisor is absent. On the occasion of more than one team being present, a form should be completed for each team.

S1 to S5 should be completed regardless of the supervision session status.

**Directions for Completing the Form**

**S2. Supervision session status:**

A completed session is defined as:

* As supervision session using the theories and models described in The Family Nurse Partnership Scotland: Supervision Guidelines document that contributes to the achievement of programme goals and should be more than 15 minutes long.

An attempted session is defined as:

* When an attempt is made to convene a session but a person/s does not attend or is less than 15 minutes long.

A cancelled session is defined as:

* If a session should have taken place as laid out in the Family Nurse Partnership Scotland: Supervision Guidelines document and did not take place or a person/s cancel the session.

**S3. Was a family nurse expected to attend?**

Only to be complete if the session status is cancelled or attempted.

**S4. If supervision session did not take place (attempted or cancelled), select why:**

Only to be complete if the session status is cancelled or attempted.

**NOTE:** environmental factors that contribute to a session not taking place may include but are not exclusive of:

* Personal safety challenges relating to the planned sessions location
* Adverse weather conditions
* No private space available

**S6. Focus during supervision session (tick all those that apply):**

FNP supervision is complex and dynamic; there many topics may be touched upon however, the response to this should relate to the focus of the discussion/session.

**S7. Family Nurse(s) in Attendance:**

If relevant, indicate which FN/s were present.

Was there a presenting Supervisor/Nurse?:

* Indicate the presenting nurse/supervisor is completed to indicate the SV/FN presenting a case or information in a session regardless of the type of session.

Name of nurses in attendance:

* Nurses who attended the session that were not presenting a case or information.

**S11. Did a case presentation of a client(s) take place?:**

Was the client presented by a FN in the team that this form relates to?:

* Team meetings should be:- one team facilitated by the team Supervisor.
  + In the exceptional circumstance of multiple teams having to join together for a meeting, as previously noted a form is required for each team.
  + If a client is discussed their name should be added only to one form; that is the form that is related to the team in which the client and presenting nurse is linked.



# Father as Main Carer

## Introduction – Father Main Carer

Eligibility for engagement on to the FNP programme is for first time mothers, under the age of 20 years and under 28+6 weeks gestation. However, there a number of areas where testing is underway extending the criteria for eligibility i.e. 20 – 24 years old and greater than 28+6 weeks gestation at notification.

There have been a few occasions that the father has become the main carer permanently with no plans for the child to be placed back with the mother and the father has continued to receive the FNP programme. There has been no data capture in relation to this, which creates challenges to evaluating outcomes.

Only using sound clinical judgement, through a process of rigorous reflective supervision would a father be deemed suitable to continue to receive the FNP Programme. Consideration should be given to (not exclusively):

* Has he requested to continue on the programme
* Previous availability for visits
* Engagement whilst attending visits

The following steps should then be taken:

* Change of Status – Child (SC) should be completed under option “father becomes main carer and remains on FNP programme”
* The mother’s original episode of care should be closed using Change of Status (CM) section SM7. Client left the programme, Father becomes main carer. (this cannot be entered on the Turas FNP system - please see note below)
* Demographics intake – Father (FDI) form to be completed at first visit following father becoming main carer.

The FN will then complete all forms as below according to stage; maternal health forms will not be completed.

**NOTE:** Currently the Turas FNP system does not have the functionality to store Father as Main Carer data forms and these need to be held by sites. The mother’s episode of care should remain open in order to allow child data forms to be input.

|  |  |  |
| --- | --- | --- |
| **DATA Collection Form** |  | |
| Home Visit Encounter (V) | Every visit | |
| Referral - Child (RC) | As required | |
| Referral - Father main carer (RF) | As required | |
| Change of Status – Father main carer (SF) | As required | |
| Change of Status – Child (SC) | As required | |
| Demographics Intake – Father main carer (FDI) | As required | |
| **Infancy** | **Visit by Age** | **Visit No** |
| Infant Birth (IB) | 1 week | 1 |
| Infant Health 6 weeks (IH) | 6 weeks | 6 |
| Father Health Post Birth (FHH) | 6 weeks | 6 |
| Ages and Stages Questionnaire (ASQ 3™) | 4 months | 11 |
| Demographics Update – Father main carer (FDU) | 6 months | 15 |
| Father Health Post Birth (FHH) | 6 months | 15 |
| Infant Health 6 – 24 months (CH) | 6 months | 16 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | 6 months | 16 |
| Ages and Stages Questionnaire (ASQ 3™) | 8 months | 20 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | 12 months | 28 |
| Infant Health 6 – 24 months (CH) | 12 months | 28 |
| **Toddler** | **Visit by Age** | **Visit No** |
| Demographics Update – Father main carer (FDU) | 12 months | 29 |
| Father Health Post Birth (FHH) | 12 months | 30 |
| Ages and Stages Questionnaire (ASQ 3™) | 14 months | 33 |
| Father Health Post Birth (FHH) | 18 months | 40 |
| Demographics Update – Father main carer (FDU) | 18 months | 41 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | 18 months | 41 |
| Infant Health 6 – 24 months (CH) | 18 months | 42 |
| Ages and Stages Questionnaire (ASQ 3™) | 20 months | 46 |
| Father Health Post Birth (FHH) | 22 months | 48 |
| Ages and Stages Questionnaire: Social and Emotional (ASQ:SE2™) | 23 months | 49 |
| Infant Health 6 – 24 months (CH) | 24 months | 50 |
| Demographics Update – Father main carer (FDU) | 24 months | 50 |
| Change of Status – Father main carer (SF) | 24 months | 50 |

## Colour coding of forms – Father Main Carer

|  |  |
| --- | --- |
| **Data Form** | **Colour of paper** |
| Home Visit Encounter (V) | White |
| Referrals Child (RC) | Salmon |
| Referrals Client (RF) | Intense Green |
| Change of Status – Client (SF) | Intense Green |
| Change of Status – Child (SC) | Light blue |
| Demographics Intake (FDI) | Intense Green |
| Demographics Update (FDU) | Intense Green |
| Infant Birth (IB) | Cream |
| Infant Health 6 weeks (IH) | Cream |
| Infant Health 6 – 24 months (CH) | Cream |

|  |
| --- |
| Referral - Father Main Carer (RF) (Completed by FN following the visit) |

**Purpose and Background**

This form provides information about each referral the FN makes on behalf of a client. This helps FNP sites track services for clients and allows a demonstration of the use of services being provided to families, and how the team and clients are working with other professionals.

To comply with the EU’s General Data Protection Regulations (GDPR) which came into force in May 2018, there are separate referral forms for the client and the child. If a single referral is made for both the client and child (e.g. Family Centre Placement), fill out two separate forms, one for the child and one for the client.

**General Guidelines**

**Definition of a referral:**

A referral to services may be made directly by the FN who calls an agency requesting services for the client or indirectly when the FN gives the client a list of resources to call for assistance themselves. Indicate that a referral has been made if any of the following apply:

* Any request made by the FN for use of a service on a client’s behalf.
* Any instance in which the FN has advised/encouraged the client to contact a specific service herself (excluding universal services such as a GP or midwife).
* When the FN wishes to re-refer the client back to a service (e.g. if social care has closed the case, and the FN would like further social care input).

**Directions for Completing the Form**

**RF1. Referral made**

Complete this form whenever the FN makes a referral for the client. If the FN makes more than one referral for the client arising from one home visit, select as many as appropriate on a single form.

**NOTE:** The option of other is for use under exceptional circumstance and only when the referral cannot be categorised in one of the broader headings.



|  |
| --- |
| Change of Status – Father Main Carer (SF) (Completed by FN following the visit) |

**Purpose and Background**

This form records any change of status of an FNP client. It is also used to track the number of clients who leave the programme, become inactive, or return to the programme.

**General Guidelines**

When to complete this form:

* Every time there is a change of status for the client
* When a client completes the programme at 2 years (visit T50)
* Each time a client leaves the programme
* Each time a client returns to the programme after leaving
* When a client transfers out to a different FNP site
* When a client transfers in from a different FNP site

If a single change of status affects both the client and the child (e.g. the father moves to a new house with the child), fill out two separate forms, one for the client and a Change of Status – Child (SC) form.

If the child is subject to change of status complete a Change of Status – Child (SC) form.

**Directions for Completing the Form**

**SF2. Change of address within site area**

If the client moves home within the site area complete this section giving full address details including post code. If the client moves out of the site, complete **SF5**.

If the child also moves then a Change of Status – Child (SC) form is required to be completed.

**SF3. Client subject to a specific social work intervention**

Complete this section if a client becomes subject to specific social work intervention. Tick as many as is appropriate. For further information in relation to Detention under the Mental Health Act[[47]](#footnote-47).

**SF5. Client transferred/left/completed the programme (please select reason)**

Choose the most appropriate reason for the client leaving the programme

Child has reached second birthday

Select after you have completed the final visit to the client after the child reaches second birthday and graduates from the programme.

Client has moved out of the service area

The client moves to an area outside of the service area and is no longer receiving the FNP programme.

Death of client

In the event of a client death, the FN will need to select this option of the form.

Neonatal death or Infant death

In the event of a child death, the FN will need to select the relevant option of the form. Then, depending on the circumstances, it may be appropriate for the FN to undertake a number of bereavement visits. However these visits are not recorded on the Turas FNP System.

Child into long-term care

Select if the child has been taken into long-term care and there are no plans for the child to be placed back with the mother/father in the foreseeable future.

Parental rights terminated

Select if parental responsibility has been terminated because the child is placed for adoption.

No contact for 6 months

Select if attempts to re-engage those clients who have disengaged have failed after six months. Do not complete this form until six months have fully passed since the client last completed visit with a FN.

Transferred to FNP site outside Scotland

To be completed if the client moves out of Scotland but continues to receive FNP in another country or elsewhere in the UK. With an increasing number of countries delivering FNP, it is important to capture data on clients who transfer out of Scotland but continue to receive FNP.

Transferred to a different FNP Scotland site

To be completed if a client transfers to another Scottish FNP site and continues to receive the programme.

Name of the receiving site and the team to be completed. The Turas FNP System will automatically transfer the client on to the caseload of the new site and team.

Enough family and friend support

Select if the client has chosen not to continue with the programme because they are satisfied that they have a strong enough support network from family and friends.

Too much commitment

Select if the client leaves the programme because they feel that the commitment (whether time commitment, psychological commitment or other) is unmanageable.

Did not meet eligibility criteria for exceptions when attempted to transfer to new FNP site in Scotland

As FNP has expanded across Scotland a number of sites have tested different eligibility criteria for clients i.e. 20-24 year olds. If a client has enrolled in FNP due to meeting an exception criteria moves to a different health board area with a different eligibility criteria in most instances the client should continue to receive the programme (please see FNP Guidance for the transfer of clients aged between 20-24 years). In the rare event that this cannot happen please indicate this here.

Did not accept change of family nurse

Select if the client has chosen not to continue with the programme following the change of their FN.

Other (specify other)

The option of other is for use under exceptional circumstances and only when the leaving reason cannot be categorised in one of the broader headings.

**NOTE:** Transfer to health visiting services is the destination not the reason for leaving; please indicate in the broader headings why the client has chosen to transfer to health visiting services.

**SF6. Client returned to the programme**

Re-engaged with the programme

Select this if a client who previously left but has subsequently returned i.e. moved out of area and not received FNP but then returned to area.



|  |
| --- |
| Demographics Intake - Father Main Carer (FDI) (Completed with the client during the visit) |

**Purpose and Background**

This form is used to compile information on the social, economic, family and educational situation of the father at the point of becoming the main carer. This enables the FN to enhance assessments and interventions in this area. While the extent to which a client is able to impact their own life situation may not be generally regarded as an indicator of health per se, a father’s sense of mastery or self-efficacy has a strong influence on how he is able to use health information in caring for himself and his child. It is important to collect some baseline data that will be re-collected at later points in the programme help assess change over the course of the programme.

**General Guidelines**

Complete this form on the first visit following the decision for the father to remain on the programme when becoming the main carer. Before beginning to ask for information about the client, assure him of the confidentiality of the data. Explain that the information will be useful to you in helping him to have the healthiest child possible and that you and the client jointly will decide how to use the information.

**Directions for Completing the Form**

**FDI1. What is your current full address?**

For the purposes of this form the client address refers to the place that the client spends at least four nights per week this may include a homeless shelter or prison.

**FDI2. What is your primary language?**

This is the language that the client is most comfortable speaking (usually, but not always, this will be the language that the client speaks at home).

If the client is bi-lingual and equally comfortable and fluent speaking two languages, select both languages (for example, if the client was raised in a bilingual household speaking two languages fluently).

However, if a client is bi-lingual but speaks one of these languages more fluently than the other (e.g. if they speak Polish in the home and Polish is their “go-to” language whenever they have a choice, but they also speak English as a second language), please select only their dominant language.

**FDI3. Does this client require an interpreter?**

Refer to the FNP Guidance Document - “The use of interpreters within the FNP programme”.

**FDI4. How well can you speak English?**

Select the box that most closely represents the client’s self-reported ability to speak English.

**FDI8. Who do you live with?**

Select the box/boxes that most closely represents the client’s self-defined status in relation to this question. It is important to be mindful of client’s understanding of the terminology in this question; some may require support to understand the definitions of the terms.

**FDI9. Are you currently registered homeless?**

“Registered homeless” means that the client (or his partner/parents if he lives with them) has made a homelessness application to the local council and has been deemed eligible for assistance[[48]](#footnote-48).

**FDI10. Do you consider yourself to be homeless?**

If directed to answer from previous question: Select yes if the client deems himself to be homeless for any reason but has not applied for homelessness assistance to the council or has applied for homelessness assistance and the application was rejected.

**FDI16. Which, if any, of the following qualifications have you ever been awarded?**

Select all qualifications that the client has already been awarded at any point in his life (i.e. the client has sat the exams and had confirmation that he has passed the qualification). If the client isn’t sure or can’t remember, the FN should probe a little further. If the client still isn’t sure, select “don’t know” The form can be updated later if the correct information becomes available in the future.

**FDI19. Which of the following best describes your situation?**

Full-time carer/part-time carer – select only if the client has unpaid caring responsibilities (e.g. for family member). If the client is employed as a carer, this should be registered under “working full-time” or “working part-time”

**FDI20. Does your household currently receive any income from public funds/benefits (excluding child benefit)?**

Examples for how to fill out this question:

1. If the client receives no income at all but lives with his parents/partner who receive all their income through benefits, then select “yes, this accounts for all my income”.

2. If the client receives all their income through paid work, but his parents/partner receive income through benefits, select “yes, this accounts for some of my income”

3. If the only benefit the household receives is child benefit, select “no”.

**FDI21. If you do not receive any income from public funds/benefits, is there a specific reason for this?**

If directed to answer from previous question:

Select “Not eligible due to level of income” if household income is too high to be eligible for benefits

Select “sanctioned from benefits” if the client/client’s parents/client’s partner cannot claim any benefits due to sanctions

Select “no recourse to public funds” if the client/client’s parents/client’s partner are ineligible for benefits due to immigration status etc.

**FDI22. Do any of the following currently apply to you?**

**Each option is required to be answered.**

Often clients will not know the answer to some of these questions. If the client says they do not know the answer to any of the questions, try and gently probe a little further. If they still do not know, select “don’t know”, and if further information comes to light at a later date, this question can be updated.

**FDI23. As far as you are aware, have any of the following ever applied to you?**

**Each option is required to be answered.**

Select yes to all that has applied to the client at any point in his life. Often clients will not know the answer to some of these questions, particularly those about their past. If the client says they do not know the answer to any of the questions, try and gently probe a little further. If they still do not know, select “don’t know”, and if further information comes to light at a later date, this question can be updated.

**FDI24. Thinking about your current situation, can you tell me how much you agree or disagree with the following statements**

These are positive statements in relation to life course development statements; support the client to tick the box which represents how much they agree or disagree with each statement.



|  |
| --- |
| Demographics Update - Father Main Carer (FDU) (Completed with the client during the visit) |

**Purpose and Background**

This form is used to update the information collected on the DIF form. The information gathered in this form can help to better understand how FNP works with clients with different social and economic characteristics, and how clients’ situations change over the course of the programme.

**General Guidelines**

This form is designed to be completed four times across the course of the programme:

* Infancy 6 months (Visit I15)
* Toddlerhood 12 months (Visit T29)
* Toddlerhood 18 months (Visit T41)
* Toddlerhood 24 months (Visit T50)

Select the relevant time point/age of child. It is important that FNs collect this data at all four of these points in time to accurately demonstrate the changes in clients’ social, economic and health behaviours and circumstances.

However, if the Demographics Intake – Father Main Carer (FDI) form was completed within the last 6 weeks it is recommended that the FN waits until the next form collection point.

**Directions for Completing the Form**

**FDU1.** **What is your current full address?**

For the purposes of this form the client address refers to the place that the client spends at least four nights per week this may include a homeless shelter or prison.

**FDU2. Does this client require an interpreter?**

Please refer to the FNP Guidance Document - “The use of interpreters within the FNP programme”.

**FDU3. How well can you speak English?**

Select the box that most closely represents the client’s self-reported ability to speak English

**FDU5. Who do you live with?**

Select the box/boxes that most closely represents the client’s self-defined status in relation to this question. It is important to be mindful of client’s understanding of the terminology in this question; some may require support to understand the definitions of the terms.

**FDU6. Are you currently registered homeless?**

“Registered homeless” means that the client (or his partner/parents if he lives with them) has made a homelessness application to the local council, and has been deemed eligible for assistance.

**FDU7. Do you consider yourself to be homeless?**

Select yes if the client deems himself to be homeless for any reason, but has not applied for homelessness assistance to the council, or has applied for homelessness assistance and the application was rejected.

**FDU13. Which, if any, of the following qualifications have you been awarded since you began the FNP programme?**

Select all qualifications that the client has been awarded since joining FNP (i.e. the client has sat the exams and had confirmation that he has passed the qualification). If the client isn’t sure or can’t remember, the FN should probe a little further. If the client still isn’t sure, select “don’t know” The form can be updated later on if the correct information is later available.

**FDU16. Which of the following best describes your situation? If currently on paternity leave, what was your situation immediately prior to that**

Full-time carer/part-time carer – select only if the client has unpaid caring responsibilities (e.g. for family member excluding his own baby). If the client is employed as a carer, this should be registered under “working full-time” or “working part-time”.

If the client looks after their own child full-time, this should be registered as “full-time parent”

**FDU17. Does your household currently receive any income from public funds/benefits (excluding child benefit)?**

Examples for how to fill out this question:

1. If the client receives no income at all but lives with his parents/partner who receive all their income through benefits, then select “yes, this accounts for all my income”.

2. If the client receives all their income through paid work, but his parents/partner receive income through benefits, select “yes, this accounts for some of my income”.

If the only benefit the household receives is child benefit, select “no”.

**FDU18. If you do not receive any income from public funds/benefits, is there a specific reason for this?**

Select “Not eligible due to level of income” if household income is too high to be eligible for benefits

Select “sanctioned from benefits” if the client/client’s parents/client’s partner cannot claim any benefits due to sanctions

Select “no recourse to public funds” if the client/client’s parents/client’s partner are ineligible for benefits due to immigration status etc.

**FDU19. Thinking about your current situation, can you tell me how much you agree or disagree with the following statements**

These are positive statements in relation to life course development statements; support the client to tick the box which represents how much they agree or disagree with each statement.



|  |
| --- |
| Father Health: Post Birth (FH) **(Completed with the client during the visit)** |

**Purpose and Background**

This form provides FN’s with important clinical information needed to support delivery of the programme materials to guide the client in the direction of positive change. It allows the tracking of health behaviours over time to demonstrate progress and provide information regarding some of the programme’s intended outcomes.

**General Guidelines**

This form is to be completed at five different stages:

* Infancy 6 weeks (visit I6)
* Infancy 6 months (visit I15)
* Toddlerhood 12 months (visit T30)
* Toddlerhood 18 months (visit T40)
* Toddlerhood 24 months (visit T48)

**Directions for Completing the form**

**FH1. Do you smoke cigarettes or e-cigarettes nowadays?[[49]](#footnote-49)**

If clients smoke either cigarettes or e-cigarettes occasionally, this should be recorded as “yes”.

**FH2. How many cigarettes do you usually smoke in a day?**

Answer if directed to from previous question. Definition of “in a day” is within a 24hour period.

**FH4. Roughly how many units of alcohol have you consumed in the last 7 days?**

Units should be calculated as accurately as possible according to the NHS alcohol units guide:

|  |  |
| --- | --- |
| **Type of drink** | **Number of alcohol units** |
| Single small shot of spirits \* (25ml, ABV 40%) | 1 unit |
| Alcopop (275ml, ABV 5.5%) | 1.5 units |
| Small glass of red/white/rosé wine (125ml, ABV 12%) | 1.5 units |
| Bottle of lager/beer/cider (330ml, ABV 5%) | 1.7 units |
| Can of lager/beer/cider (440ml, ABV 5.5%) | 2 units |
| Pint of lower-strength lager/beer/cider (ABV 3.6%) | 2 units |
| Standard glass of red/white/rosé wine (175ml, ABV 12%) | 2.1 units |
| Pint of higher-strength lager/beer/cider (ABV 5.2%) | 3 units |
| Large glass of red/white/rosé wine (250ml, ABV 12%) | 3 units |

\*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

**FH5. Thinking about the last time you were on a night out or at a party, how many units of alcohol did you consume then?**

Units should be calculated as accurately as possible according to the NHS alcohol units guide:

|  |  |
| --- | --- |
| **Type of drink** | **Number of alcohol units** |
| Single small shot of spirits \* (25ml, ABV 40%) | 1 unit |
| Alcopop (275ml, ABV 5.5%) | 1.5 units |
| Small glass of red/white/rosé wine (125ml, ABV 12%) | 1.5 units |
| Bottle of lager/beer/cider (330ml, ABV 5%) | 1.7 units |
| Can of lager/beer/cider (440ml, ABV 5.5%) | 2 units |
| Pint of lower-strength lager/beer/cider (ABV 3.6%) | 2 units |
| Standard glass of red/white/rosé wine (175ml, ABV 12%) | 2.1 units |
| Pint of higher-strength lager/beer/cider (ABV 5.2%) | 3 units |
| Large glass of red/white/rosé wine (250ml, ABV 12%) | 3 units |

\*Gin, rum, vodka, whisky, tequila, sambuca. Large (35ml) single measures of spirits are 1.4 units.

**FH6. Which of the following, if any, have you taken in the last month?**

Select all applicable boxes[[50]](#footnote-50). It is important to have a baseline to understand a client’s use and understanding of drug use.

**FH8. SWEMWBS[[51]](#footnote-51).**

This set of questions, from the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), provides a measure of mental wellbeing among clients that can be tracked regularly from enrolment to graduation. The scale has been widely used nationally and internationally for monitoring, evaluating projects and programmes and investigating the determinants of mental wellbeing.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**FH9. GSE**

The General Self-Efficacy Scale[[52]](#footnote-52) is used nationally and internationally to provide a measure of self-efficacy among clients. This can indicate how well a client copes with daily activities, stressful events and adversity and can measure changes in quality of life that can be tracked regularly from enrolment to graduation.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**FH10. Social-Iso**

This set of questions is taken from an amended version of the UCLA Social Isolation and Loneliness Scale, which was adapted for use in Nurse Family Partnership (NFP) International. It aims to measure subjective feelings of loneliness and social isolation, and to highlight those clients who are at risk.

The client should answer the questions in relation to how they have felt over the last 2 weeks.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**FH11. GAD-7[[53]](#footnote-53)**

The client should answer the questions in relation to how they have felt over the last 2 weeks. The scale has been widely used nationally and internationally for monitoring and investigating the determinants of mental wellbeing. This is a valid and reliable tool to assess for Generalized Anxiety Disorder.

Try to encourage the client to answer all of the questions, as a total score cannot be calculated if answers are missing.

**FH12. SWEMWBS Total**

FN should complete this section. Tally up the total score of the 7 questions answered in HH15, using the following scoring mechanism:

1 = none of the time

2 = rarely

3 = some of the time

4 = often

5 = all of the time

The overall score should fall between 7 and 35.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

**FH13. GSE Total**

FN should complete this section. Tally up the total score of the 10 questions answered in HH16, using the following scoring mechanism:

1 = Not at all true

2 = Hardly true

3 = Moderately true

4 = Exactly true

The overall score should fall between 10 and 40.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

**FH14. Social-Iso Total**

FN should complete this section. Tally up the score of the 3 questions answered in HH17, using the following scoring mechanism:

1 = Hardly ever

2 = Sometimes

3 = Often

The overall score should fall between 3 and 9.

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

A total score less than 4 indicates low risk

A total score of 4-5 indicates moderate risk

A total score of 6-9 indicates high risk

**FH15. GAD-7 Total**

FN should complete this section. Tally up the score of the 7 questions answered in HH18, using the following scoring mechanism:

0 = Not at all

1 = Several days

2 = Over than half the days

3 = Nearly every day

The overall score should fall between 0 and 21

If any of the questions have not been answered, the score should not be calculated. Insert N/A into the box for the total score.

This is a screening tool; referral to services is never based solely on a client’s score. A full holistic assessment based on history and presentation should be used to inform practice. Each NHS Board area will have policies and protocols that are required to be followed in relation to referral process for clients with Mental Health challenges.

|  |  |  |
| --- | --- | --- |
| **GAD7 score** | **May mean the person has** | **Possible actions** |
| 0-4 | Indicates minimal anxiety (low risk) | Continue to observe |
| 5-10 | Indicates mild anxiety (moderate risk) | Assess need for additional support.  Considering completing questionnaire earlier than normally planned – no greater than 90 days. |
| 11-15 | Indicates moderate anxiety (high risk) | For discussion/referral to GP services.  For assessment of mental health at each visit.  To work with multi-agency partners to plan care. |
| 16-21 | Indicates severe anxiety (high risk) | For referral to GP/Mental Health Services.  For assessment of mental health at each visit.  To work with multi-agency partners to plan care. |

**NOTE: An emergency referral is required for any client who has intentions or plan to harm them self, baby, or someone else.**

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