# Children & Young People’s Directorate

## Health Visiting and School Nursing

### Supervision Procedure

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<thead>
<tr>
<th>Author</th>
<th>Mairead Donnelly and Bronagh Shields</th>
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<tr>
<td>Directorate responsible for this Document</td>
<td>Children and Young Peoples Services</td>
</tr>
<tr>
<td>Date of Implementation</td>
<td>1st September 2010</td>
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<td>Date of Review</td>
<td>1st September 2013</td>
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<td>Screened by</td>
<td>Mairead Donnelly and Bronagh Shields</td>
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Approved by (Signature)

August 2010
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<th>Name of Procedure/Guidelines/Protocol:</th>
<th>Health Visiting &amp; School Nursing Supervision Procedure</th>
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<td>2</td>
<td>Purpose of Procedure/ Guidelines/ Protocol:</td>
<td>These procedures, developed within Health Visiting and School Nursing, are aimed at facilitating the implementation of the Trust’s Nursing Supervision Policy (2008) within the service.</td>
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<td>Applicable to which staff:</td>
<td>All Health Visiting &amp; School Nursing Staff</td>
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<td>4</td>
<td>Name &amp; Title of Author:</td>
<td>Health Visiting &amp; School Nurse Team Managers</td>
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<td>Equality Screened by: Note any issues</td>
<td>Mairead Donnelly &amp; Bronagh Shields No equality issues</td>
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<td>Proposals for dissemination:</td>
<td>Julie McConville via the Team Manager Forum and CYPS PNF Governance Forum</td>
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<td>Upload to Trust Intranet:</td>
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<td>Proposals for implementation:</td>
<td>With immediate and full effect in Teams</td>
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<td>8</td>
<td>Training Implications:</td>
<td>All new staff will be sent on Supervisee Awareness Raising Sessions</td>
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<td>9</td>
<td>Date Procedure/Guideline/Protocol submitted to Procedures Committee:</td>
<td>26 May 2010</td>
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<td>10</td>
<td>Outcome: Approved</td>
<td>Approved on 26 May 2010 subject to minor amendments</td>
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<td>14</td>
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### Appendices

1. Record of 1:1 Supervision
2. My issue for supervision
3. Questions to consider at each stage of the Gibbs Cycle
4. School Nursing and Health Visiting Record Audit Tool
5. Health Visiting / School Nursing Case Discussion Record
6. Health Visiting / School Nursing Supervision Record
7. Explanation of Standard for School Nursing / Health Visiting Record Audit and documentation for supervision.
Health Visiting and School Nursing Supervision Procedure

1.0 Introduction

Nursing supervision is essential in promoting the delivery of safe and effective care within the Trust and plays an important part in protecting the public. It supports the development of nursing knowledge and skills and ensures the delivery of safe and effective care. Nursing supervision provides nurses with an opportunity to discuss professional issues and facilitates personal and professional development. Johns (1994) states, that practitioner’s are active and reflective creators of their own practice. In developing and maintaining reflective ability, supervision is an essential approach for optimising and nurturing it.

Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety (NIPEC 2007).

1.1 Purpose

These procedures, developed within Health Visiting and School Nursing, are aimed at facilitating the implementation of the Trust’s Nursing Supervision Policy (2008) within the service. Supervision facilitates reflection of nursing practice by:
- Increasing knowledge and skills
- Improving standards of patient/client care
- Identifying solutions to nursing problems / issues
- Increasing understanding of professional issues
- Enhancing understanding of professional and personal accountability and responsibility for nursing practice
- Contributing to continuous development.

All records of supervision sessions will remain confidential except where issues arise which require escalation. The practitioner will be informed of the intention to disclose issues before any confidential information will be shared.
1.2 Scope

For all Health Visitors and School Nurses working in Children and Young People’s Directorate.

2.0 Roles & Responsibilities

2.1 Supervision is a key component of safe and effective care and for the development of all health visitors and school nurses; therefore it is essential that arranged supervision sessions are upheld. Supervision sessions should only be cancelled in exceptional circumstances, and re-arranged to take place within 4 weeks of initial cancelled date. Repeated cancellation of sessions should be avoided and may invoke disciplinary proceedings.

2.2 Supervisors are required:

1. To meet the SHSST requirements on becoming a supervisor;
2. To identify and discuss supervisee roles and responsibilities at induction of new staff and team meetings;
3. To keep written records of all supervision sessions (Appendix 1), and
4. Adhere to the principles and ground rules for supervision.

2.3 Supervisees are required:

1. To be aware of the Trusts supervision policy and information leaflet;
2. Adhere to the principles and ground rules for supervision as set out in the above documents;
3. Prepare for the supervision sessions (Appendix 2) and complete and retain written records of these sessions, and
4. When supervision is cancelled it is the responsibility of the health visitor /school nurse to ensure another suitable date is arranged.

3.0 Procedure

3.1 Band 7 staff will supervise Band 6. Band 5 staff will be supervised by Band 6 or Band 7 staff. Band 5 may supervise health care assistants. Generally managers will provide supervision for team members but can delegate this to other team members.

3.2 Staff will be supervised every four months i.e. 3 times per year. Two of these sessions will be facilitated by the line manager or their nominee on a 1:1 basis. The third session may be in the form of group supervision, facilitated by a supervisor not necessarily the line manager.
3.3 Group supervision will be of duration no longer than two hours, with a maximum of six supervisees. 1:1 supervision will last a maximum of three hours, however ideally it should range from 1 to 2 hours (Appendix 1). 3.4 Supervision sessions will provide the practitioner the opportunity to reflect on practice using a model such as Gibbs. The questions in Appendix 3 may help the practitioner prepare for this process

Gibbs’ model of reflection (1988)

3.5 An audit of records will be undertaken with the documentation in Appendix 4. Records will be reviewed at the 1:1 sessions with line managers or their nominee. Records will be selected at random by the manager / nominee. Supervision of records can be undertaken either before, during or after the session, findings must be discussed with supervisees and both parties need to be clear on any future action plan (if applicable). The supervisor will document in the health visiting / school nursing records when they have been reviewed and this will be recorded in the main body of the child’s record. Appendix 7 provides an explanation of the standard for audit of records process.

3.6 Caseload management will also be included in the 1:1 sessions using the documentation in Appendix 5.

3.7 Professional and practice issues will be recorded using the documentation in Appendix 6. This will include details of any training required, supervision attended with CPNS, attendance at team meetings etc.

3.8 Supervision especially group supervision may also follow significant events or case management reviews to explore critical events and the learning from them.
3.9 The Head of Service will ensure the completion of an annual report to monitor general compliance with Trust Policies and procedures and to review the quality of supervision being carried out.

4.0 Frequency of supervision sessions for newly qualified, staff new to post and bank Staff

4.1 These members of the team will be supervised monthly for the first two months, then bi-monthly, up to six months, moving to four monthly (as existing staff and if practice dictates it to be appropriate). Bank staff if new to team will receive this same level of supervision.

4.2 This supervision will be on a 1:1 with the line manager or their nominee. The duration of each session will be determined by both parties, however should not exceed the time specified in 3.3.

4.3 Supervision arrangements for staff working in more than one team in the Trust will be negotiated between relevant team managers.

4.4 When staff re-locate within the Trust area the supervision files will be transferred, if appropriate, to relevant team manager.

5.0 Long term absences (six months or longer)

When staff return from long periods of leave e.g. sick leave or maternity leave a meeting will take place with the staff member and team manager within the first 2 weeks. A further supervision will take place within six weeks of their return to work in order to re-establish supervision arrangements. Supervisors in consultation with the supervisees will agree the frequency and model of supervision required thereafter.

6.0 Unscheduled supervision sessions

Managers will continue to provide unscheduled supervision for staff. These sessions will be supported by the documentation in Appendix 5 & 6.

7.0 Retention of supervision records

Supervision records will be retained in staffs’ supervision files which will be securely stored by the Team Manager. Supervisees will make their own arrangements to retain their copy of the supervision records.
8.0 Equality and Human Rights Considerations

This procedure/guideline/protocol has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Using the Equality Commission’s screening criteria, no significant equality implications have been identified/the following implications have been identified and action taken. Similarly, this procedure has been considered under the terms of the Human Rights act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

9.0 Related Policies

This procedure should be read in conjunction with the following policies:

- Southern Health and Social Care Trust (2008) Nursing Supervision Policy

10.0 References


Northern Ireland Practice and Education Council (2007) The Review of Clinical Supervision for Nursing in the HPSS 2006 on Behalf of the DHSSPS. Belfast, NIPEC.
# RECORD of 1:1 SUPERVISION

| Date _____/_____/_____ | Venue ___________________ | Time from _____ to ______ |

## SUPERVISOR

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<th>PRINT NAME</th>
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## PRINT NAME

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### Review of Action Points from Previous Supervision Session

### Issues / Topics for Discussion

### Key Points from Discussion

### Agreed Action Plan for Supervisee
### Actions

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### Agreed Action Plan for Supervisor (if applicable)

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If a significant issue requires onward reporting, record below outline of issues for onward reporting, to whom and when it will be reported.

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<th>Report to</th>
<th>Timescale</th>
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### Issues / areas of disagreement

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### Date and Time of Next Session

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<th>Time</th>
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### Session Evaluation

Copy to supervisee Date _____/_____/_____
### MY ISSUE FOR SUPERVISION

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<th>The issue</th>
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<tbody>
<tr>
<td>Why it is significant</td>
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<td>What is the worst aspect</td>
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<td>What is the best aspect</td>
</tr>
<tr>
<td>What would I do in the same way</td>
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<tr>
<td>What would I do differently</td>
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<tr>
<td>What have I learnt</td>
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<tr>
<td>The action I am going to take</td>
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**Health Visitor/School Nurse**  ____________________________  
Date____________________________________

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Health Visiting and School Nursing Supervision Policy  
August 2010
Questions to consider at each stage of Gibbs’ Cycle.

**Description**
- What happened? Give a concise, factual account
- Provide relevant details

**Feelings**
Identify and examine reactions, feelings and thoughts at the time. It is important, although often difficult, to be honest about these.
- How can you explain your feelings? What was affecting them? Did they change? Why?
- How did they affect your actions and thoughts at the time?
- Looking back, have your views on this changed?

**Evaluation**
Look at the judgements you made at the time about how things were going.
- What was positive? Negative? What made you think this?
- Try to stand back from the experience to gain a sense of how it went.
- What made you think something was good or bad?
- Examine your own judgements and what contributed to them. How do you feel about them now?

**Analysis**
In this section of the reflection, you need to examine the experience in depth, and start to theorise about key aspects. Try to identify an overarching issue, or key aspect of the experience that affected it profoundly, which needs to be examined for the future. For example, an aspect of communication or time management might have played a central part in the outcome.
- How was it flawed this time? In what way? Why? How should it work in this situation?
- What ideas or theories are you aware of which look at this? Does theory about this aspect help you make more sense of what happened?
- Could you use theory to improve this aspect in the future?

In this section, you need to fully examine and make sense of factors affecting the situation, and exploring ways to change and develop these.

**Conclusion**
Summing up the key things learned through using the reflective process, the main factors affecting the situation, and what to improve. This section might include naming specific skills that need developing, or aspects of organisation to improve. You might identify new knowledge or training which is needed.

**Action plan**
- What could you do differently next time and how could you prepare for this?
- What areas need developing or planning? What resources do you need, and where would they be found?
- What steps will be taken first?


Health Visiting and School Nursing Supervision Procedure August 2010
## SCHOOL NURSE’S RECORD’S AUDIT TOOL

School Nurse: ___________________
Base: _______________________
Date: _______________________

**Record Categories**

Three School Nursing records will be selected from the following criteria:-

- a) P1 / Year 8 Health Appraisal
- b) Targeted School nursing intervention (care plan in place)
- c) Nurse Review
- d) Family with a child with Child Protection concerns or/ at Case Planning level or/ a Looked After Child.

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<th>Record No.</th>
<th>CHS NO.</th>
<th>Consent recorded for SN Service</th>
<th>CHS form completed to standard</th>
<th>Centile Chart recorded as per standard</th>
<th>Referral made as required</th>
<th>Appropriate School Nurse Intervention</th>
<th>Current Health Care Plans</th>
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<th>Appropriate follow up of DNA’s</th>
<th>A&amp;E attendances follow up as per guidance</th>
<th>Current FNA Y/N N/A</th>
<th>Chronology of Significant Events</th>
<th>NMC guidelines on record keeping</th>
<th>Category of Record</th>
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School Nurse Signature _________________________________
Team Manager Signature_________________________________
Date_______________        Date of Next Review ______________
HEALTH VISITOR RECORD’S AUDIT TOOL

Health Visitor: _____________________  Base: ____________________________  Date: ____________________________

**Record Categories**

Three Health Visiting records will be selected from the following criteria:-

a) Family with a child aged 0-4 months.

b) Family with a child with Child Protection concerns or/ at Case Planning level or/ a Looked After Child.

c) Vulnerable family who requires targeted health visiting intervention (care plan in place).

d) Family with a child aged fifteen months to four years.

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<th>Chronology Sig Events</th>
<th>Current FHA</th>
<th>Summary/Action Plan Completed</th>
<th>Ante Natal Contact</th>
<th>Primary Visit</th>
<th>Discussion on Maternal Health</th>
<th>Evidence of Domestic Violence Enquiry</th>
<th>Jaundice Procedure</th>
<th>Contact in first 8 weeks</th>
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<th>EPDS Y/N</th>
<th>Appropriate Intervention</th>
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<th>Centile Charts recorded as per standard</th>
<th>Current Health Care Plans</th>
<th>A&amp;E attendances follow up as per guidance</th>
<th>Referral made as required</th>
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Health Visitor Signature _________________________________

Team Manager Signature_________________________________

Date_______________        Date of Next Review _____________
Health Visiting/School Nursing Case Discussion Record

Health Visitor/School Nurse

Date

Family Details

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<th>Issues/Concerns</th>
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Discussion

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Advice/Action

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Signed _____________________       Signed ______________________
Health Visitor/School Nurse                           Health Visitor Team Manager

THIS FORM TO BE FILED IN HEALTH VISITING/SCHOOL NURSING RECORDS

Health Visiting & School Nursing Supervision Procedure     August 2010
## Health Visiting/School Nursing Supervision Record

<table>
<thead>
<tr>
<th>Professional/Practice Issues</th>
<th>Discussion</th>
<th>Action Required (By Whom)</th>
<th>Review Date</th>
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Signed __________________________
Signed __________________________

Health Visitor/School Nurse                                                Team Manager

THIS FORM TO BE FILED IN PRACTITIONERS SUPERVISION FILE
STANDARD FOR SCHOOL NURSING RECORD AUDIT

Record of Consent
Written consent must be obtained for each child, each school year for any school nurse intervention e.g.: immunisation, vision, nurse check, health appraisal. There are times when parents or children will refuse or withdraw consent for a school nurse intervention, this must recorded appropriately on the relevant CHS forms. When consent for P1 health appraisal is refused by parent the school nurse should liaise with the family HV and the outcome recorded within the child’s records.

Centile Charts
Centile charts will be audited to examine that all measurements are appropriately plotted and recorded on the child’s growth chart. The index section of the centile chart must be dated and signed by the School Nurse. Appropriate follow up action should be taken as per Child Growth Foundation guidelines.

Referrals
The records will be audited for evidence of appropriate referrals when concerns are identified and mechanisms in place to record the referral made. A copy of referral letter to GP, Speech Therapy, vision referral and behaviour management should be filed within the child’s record.

Appropriate School Nurse Intervention
Records will be reviewed for evidence of appropriate intervention by the school nurse. This will include evidence of appropriate assessment and intervention to families who require a targeted school nursing service. It will also include assessment and intervention for families in the universal programme.
This will include recording of;
- Follow up of concerns previously identified
- Any new concerns
- Action taken as a result of concerns identified
- If no action is required
- Analyses of information recorded
- Rationale for action taken / not taken
- Plans for further contact

Current Health Care Plans
When records are being reviewed that identify a targeted school nursing Intervention to be carried out, relevant care plans should be in place. The content of the care plans will be audited and should clearly reflect reason for targeted intervention. Care plans should be amended as needs change. When care within the care plan has been achieved this should be recorded appropriately. If new interventions are planned then the care plan should be updated.

Appropriate Follow up DNA’S
The records will be reviewed to ensure that all DNA’S are followed up as per trust procedure and recorded in a chronology of significant events where appropriate.
A&E Attendances
The records will be reviewed to ensure that all A&E attendances are processed and followed up as per trust procedure and recorded in a Chronology of Significant Events where appropriate.

Current Family Health Assessment (FHA)
When the school nurse is providing a targeted service to a family (e.g. child protection plans) school nurse must complete a FHA. If an existing FHA has been commenced within the child’s record this should be updated as required and clearly signed and dated by the School Nurse.

Chronology of Significant Events
A chronology should be commenced / updated, recording significant events as the school nurse becomes aware of them. Significant events are those as outlined in the regional record keeping guidelines. Source of information should be clearly recorded and each entry signed, timed and dated by the School Nurse.

NMC guidelines on Record Keeping
Each entry should be in chronological order and include;

- Time and date of contact
- Place of contact
- Time and date of recording
- Signature of recording practitioner
- Name and designation should be printed when recording the first entry
- Written in black ink
- Contemporaneous recording
- All writing should be legible
- Errors should be made by scoring out with a single line, followed by initials and date.
- Clients name and D.O.B on every contact sheet
- A separate contact sheet should be used for each individual family member.
EXPLANATION OF STANDARD FOR HEALTH VISITING RECORD AUDIT AND DOCUMENTATION FOR HV SUPERVISION

As part of HV supervision, an audit of records will be carried out to ensure adherence to all Trust Policies and Procedures. The record audit will include the following;

Record of Consent
Standard statement of consent should be recorded on first entry of 4yr+ maternal contact sheet. The statement should read e.g. ‘Health visiting service discussed, role of the health visitor explained and consent for service obtained’. There are times when clients will withdraw consent for health visitor intervention e.g. an offer of listening visits refused, this should be clearly documented.

Chronology of Significant Events
All records should have a chronology of significant events form. Significant events should be recorded as per regional record keeping guidelines. Where a chronology has been commenced the family details should be recorded on the form.

Current Family Health Assessment (FHA)
All families should have a current FHA. When there are significant changes to family circumstances this should be reflected in the FHA. Initial FHA should be completed by the four month contact; it should be reviewed at all subsequent contacts. Updates to the FHA should be clearly dated.

Summary / Action Plan
This section should be completed on all records where the child is over 4 months of age. It should include a summary of strengths and weakness and identify if family are receiving a Universal or Targeted service. This section should be kept updated as family circumstances change or health visiting intervention changes. This summary should be updated at every universal contact; evidence that the FHA has been updated at these regular contacts should be recorded on the summary/action plan form.

Antenatal Contact
A record of antenatal contact should be present for all first time mothers and those identified as requiring a targeted service as per antenatal procedure. If an antenatal visit has not been carried out the reason for this should be recorded.

Primary Visit
Records will be audited to identify that a home visit has been carried out between the 10th and 14th day following the birth of the baby. If the visit has not been completed within the timeframe the reason for this should be clearly recorded.

Discussion on Maternal Health
Evidence of discussion of maternal health should be recorded in the FHA. Ongoing discussion and assessment should be recorded in the maternal record. Where there have been changes or significant information has become available, the FHA should be updated.
Evidence of Domestic Violence Enquiry
The records will be reviewed for evidence of routine domestic violence enquiry and direct questioning. The outcome of this enquiry should be recorded in the Family Health Assessment.

Jaundice Procedure
At a primary visit, an assessment should be carried out to identify if a baby has any evidence of jaundice. When jaundice has been identified, either at the primary visit or on the Infants Discharge on the Hospital Neonatal Discharge form (CHS3b), records should include a summary of physical assessment of the child for evidence of jaundice, record of advice given to parents about signs and symptoms of jaundice and appropriate action. Where jaundice persists, records should include evidence that appropriate follow up action has been taken as per Jaundice Procedure.

Contact in First 8 Weeks
Records will be reviewed for evidence of appropriate intervention in the first 8 weeks following the birth of a baby. Planned follow up contacts should be dependant on identified need and the reason should be clearly recorded. Alternative methods of communication should be clearly recorded e.g. contact telephone number given mother to contact if necessary.

Neonatal Bloodspot Screening Result Filed
The records will be reviewed to ensure that every child, over four weeks of age, has a neonatal bloodspot screening result filed in the Child Health Record. This is in accordance with current failsafe arrangements. Evidence of appropriate follow up action will also be reviewed e.g. if a repeat bloodspot sample is required in the case of a child born before 36 weeks gestation.

Postnatal Depression Appropriate Intervention
When postnatal depression has been identified the records will be audited to identify if appropriate health visiting intervention has been carried out in line with the Maternal Depression Procedure.

Edinburgh Postnatal Depression Scale (EPDS)
Records will be reviewed to identify if the EPDS has been completed within the timeframe set out in the postnatal depression procedure. When the EPDS has not been carried out the reason for this should be clearly recorded.

Appropriate Health Visitor Intervention
Records will be reviewed for evidence of appropriate intervention by the health visitor. This will include evidence of appropriate assessment and intervention to families who require a targeted health visiting service. It will also include assessment and intervention for families in the universal programme. This will include recording of;

- Follow up of concerns previously identified
- Any new concerns
- Action taken as a result of concerns identified
• A summary of impact of concerns identified
• If no action is required
• Analyses of information recorded
• Rationale for action taken / not taken
• Plans for further contact

Child Health Promotion Contacts
All children should have routine Child Health Promotion contacts, the records will be audited for evidence of these routine contacts. This will include an audit of PCHR contact sheets which should be present and appropriately filed. Concerns identified at routine contacts and subsequent actions and interventions should be appropriately recorded. Records will be audited for evidence that the FNA has been updated following these contacts.

Centile Charts
Centile charts will be audited to examine that all measurements are appropriately plotted and recorded in the index part of the centile chart, dated and signed. When recording a measurement carried out by another practitioner, the source of the information should be recorded e.g. hospital. They will also be audited to ensure appropriate follow up action has been taken when there is a digression from the norm.

Current Health Care Plans
When records are being reviewed that identify a targeted health visiting service is being carried out, relevant care plans should be in place. The content of the care plans will be audited and should detail reason for targeted service, intervention planned and should be up to date. Care plans should be reviewed on a 3 monthly basis as a minimum. When care set out in a care plan has been achieved this should be recorded, if new interventions are planned then a new care plan should be commenced.

A&E Attendances
The records will be reviewed to audit that all A&E attendances are processed as per Trust procedure and are recorded in the Chronology of Significant Events.

Referrals
The records will be audited for evidence of appropriate referrals when concerns are identified and mechanisms in place to record the referral made e.g. copy of referral letter to GP. All referrals should be appropriately filed in chronological order.

NMC guidelines on Record Keeping
Each entry should be in chronological order and include;
• Time and date of contact
• Place of contact
• Time and date of recording
• Signature of recording practitioner
• Name and designation should be printed when recording the first entry
• Written in black ink
• Contemporaneous recording
• All writing should be legible
• Errors should be made by scoring out with a single line, followed by initials and date.
• Clients name and D.O.B on every contact sheet
• A separate contact sheet should be used for each individual family member
• No gaps, spaces between entries.

Professional / Practice Issues
This part of the supervision document should be used to record Professional / Practice matters, e.g.
• Identified training needs
• Attendance at team meetings
• Annual leave plans and arrangements for cover of clinics etc.
• Submission of HV returns
• Any issues impacting on the practitioners ability to carry out their duties
• Adherence to Child Protection Supervision Policy
• Any actions required by the supervisor/supervisee resulting from the supervision session
• Any incidence or accidents in line with Trust Policy
• Evidence of effective caseload management