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| **Workbook 2025** |
| **Registered Public Health Nurse (RPHN) / Registered Midwife(RM)****Child Health Activity Metrics (CHAM) and Definitions 2025** |

This workbook is to be used when entering child health activity metrics. It provides the metric wording and definitions for all child health activity metrics.

Metric returns capture **Caseload Activity** and should include all activity delivered over a seven day service including bank holidays.

The Primary Care metrics software system (PCM) was introduced in 2021 to support the collection of primary care activity metrics. The Child Health Activity Metrics (CHAM) extension was added in 2022 to capture child health activity metrics. Each user is assigned to a designated caseload within PCM and is issued with a unique username and password for that caseload. Activity can be entered using a desktop, laptop or smart phone. Daily activity entry is encouraged. RPHNs or RMs working across several caseloads will have access to all relevant caseloads.

***All nurses (RPHNs and RMs) are responsible to return their own child health activity in the caseload(s). The caseload holders account can be identified on the software system.***

In the event that an area is vacant due to annual leave or long term sick / maternity leave, agreement must be made with line management which caseload holder/s are responsible for entering the activity data into CHAM for the cross cover period.

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| **Metrics and Definitions** | **Page Number** |
| **Total PHN Caseload Size** BirthsDeathsTransfers in (including and excluding those experiencing homelessness)Transfers out (including and excluding those experiencing homelessness) Discharges | Page 1, 2, 3 |
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| **Line** | **Metric**  | **Definition** |
| 1 | Total number of live births notified (including home births) to the PHN caseload | This is a count of the total number of live births notified to the PHN caseload during the reporting month.  Count each live birth once only regardless of the number of notifications received i.e. preliminary notification/36 hours’ notification /CHIS birth sticker/ Final Birth Notification Record the birth notification on the date it is received by the PHNLive birth is the birth of an infant who when delivered shows any definite sign of life such as voluntary movement or heartbeat. * Notification of birth is required by the Notification of Births Act 1907, the notification form is completed by the maternity service staff with the parent(s) with relevant details of the infant and parent(s). It is sent to the Director of Public Health Nursing Office as one or more of the following
* preliminary notification/36 hours’ notification
* Child Health Information System (CHIS) sticker
* Final Birth Notification

Count live births notified to this PHN caseload for this month only. **Include:** * All births discharged to home (including infants born through surrogacy)
* All home births i.e. births that takes place outside of the maternity hospital or unit usually in the mother’s home.
* Live birth notified were the parent has formally declined the primary visit for this infant (the infant remains as notified and on the PHN caseload for the purposes of calculating total PHN caseload size)
* Live birth notified of infants who are still in hospital. If the infant subsequently dies, having never been discharged home the birth is still recorded as a live birth notified to PHN caseload and is also entered in Metric 2 as an infant death

**Exclude:** Live births notified with an incorrect address *Work related to non-caseload notifications can be* *returned as an indirect activity in Metric 56*In order to avoid duplication and double counting see example below:an infant is born in Mullingar Hospital to a mother who has a Mullingar address. The mother is then discharged from the maternity hospital and goes temporarily to Dublin with the infant i.e. to stay with a grandparent. The mother and infant should be seen by the Dublin PHN as a primary visit. This infant is admitted onto the Dublin PHN caseload on the child health activity metrics and in the birth register (where in use). When the infant returns to the Mullingar address the Dublin PHN records this as a transfer out in the child health activity metrics and the birth register (where in use). The receiving PHN in Mullingar will record this infant as a transfer in on the child health activity metrics and birth register (where in use). Similar steps should be taken for the mother on the primary care metrics.   |
| 2 | Total number of infant and child deaths notified to the PHN caseload  | This is a count of the number of infant and child deaths notified to the PHN caseload.Record on the date notification of the transfer is received. |
| 3 | Number of children aged 0 – 5 years (up to 5th birthday) (excludingchildren experiencing homelessness) who **transfer into** the PHN caseload | This is a count of all children that transfer into the PHN caseload area in this reporting month.Include children who are adopted.Exclude children experiencing homelessness.Record on the date notification of the transfer is received.Manage child health record transfer in accordance with National Procedure for the Safe Transfer of Child Health Records (2021) [www.hse.ie/phn](file:///C%3A%5CUsers%5Cvirginia.pye%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5CG8LFH1I0%5Cwww.hse.ie%5Cphn). |
| 4 | Number of children experiencing **homelessness** aged 0 - 5 years (up to 5th birthday) who **transfer into** the PHN caseload | This is a count of all children who are experiencing homelessness that transfer into the PHN caseload in this reporting month. Record on the date notification of the transfer is received.An individual is regarded by a housing authority as being homeless (as per Section 2 of the Housing Act 1988) if: a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and he is, in the opinion of the authority, unable to provide accommodation from his own resources. **Note Children living in International Protection Accommodation Services are considered homeless****Note Families living with relatives do not meet the definition of homelessness.** |
| 5 | Number of children aged 0 – 5 years (up to 5th birthday) (exclude children experiencing homelessness) who **transfer out** of the PHN caseload | This is a count of all children 0 – 5 years (up to 5th birthday) that transfer out of the PHN caseload in this reporting monthExclude children experiencing homelessness that have transferred out. Manage child health record transfer in accordance with National Procedure for the Safe Transfer of Child Health Records (2021) www.hse.ie/phn |
| 6 | Number of children experiencing **homelessness** aged 0 - 5 years (up to 5th birthday) who **transfer out** of the PHN caseload | This is a count of all children 0 – 5 years (up to 5th birthday) experiencing homelessness that transfer out of the PHN caseload in this reporting month. Manage child health record transfer in accordance with National Procedure for the Safe Transfer of Child Health Records (2021) www.hse.ie/phn |
| 7 | Number of children **discharged** from the PHN caseload at 5 years (up to 5th birthday) following completion of the core PHN child health and development assessments  | This is a count of the number of children discharged from the PHN caseload following completion\* of the core PHN child health and development assessments. \*Completion of the programme does not reflect the child having had each of the available assessments or any specific number of assessments. Any child over 5 years of age who has ongoing health issues should be transferred to the primary care metrics (5-17 disability care group). In this event close the child health record and open a clinical nursing record and admit the child to the primary care metrics of the PHN caseload. Ensure all care plan actions are closed off and appropriate referrals made. Include children who reach discharge age and had been filed in the area’s Unknown Address FileChild Health Records are either sent to school PHN service or for archiving when the child is greater than 5 years old or at school commencement age (depending on local policy). |
| 8 | **Total PHN Caseload Size** | This should equal the number of all children on the PHN caseload (not discharged) 0-5 years (up to 5th birthday).  |
| **KPI 72 hours primary visit/PHN Primary Visit** |
| 9 | Number of PHN visits to infants carried out **within 72 hours** of discharge from maternity services | Count visits performed within 72 hours from the infants time of discharge from maternity service (including Domino, SECM, private midwives etc.) Visits for the purpose of undertaking new born bloodspot screening are counted for the purposes of this metric *All subsequent visits to review the infant must be recorded in the section for subsequent child health visits outside core PHN child health and development assessments (metric 16 or 17)*. |
| 10 | Number of PHN visits to infants carried out **after 72 hours** of discharge from maternity services  | Count visits performed after 72 hours from the time of discharge from maternity services (including Domino, SECM, private midwives etc.)(not a KPI as it is outside of the time frame)*All subsequent visits to review the infant must be recorded in the section for subsequent child health visits outside core PHN child health and development assessments (metric 16 or 17)* |
| 11 | **% of Public Health Nurse (PHN) visits to infants carried out within 72 hours of discharge from maternity services** | This is calculated by the software. |
| **Primary Visit Breastfeeding KPI** |
| 12 | Number of infants seen at the PHN primary (first) visit that are **exclusively** breastfed | Exclusive breastfeeding: the infant has received only breast milk from his/her mother, or expressed breast milk and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines. |
| 13 | Number of infants seen at the PHN primary (first) visit that are **partially** (not exclusively) breastfed  | Partial (not exclusive) breastfeeding: the infant received some breastfeeds some artificial feeds, either milk or cereal or other foods. |
| 14 | **KPI name: % of infants breastfed exclusively at the Public Health Nurse (PHN) primary (first) visit**  | This is calculated by the software. |
| 15 | **KPI name: % of infants breastfed (exclusively and partially (not exclusively)at the Public Health Nurse (PHN) primary (first) visit** | This is calculated by the software. |
| **Subsequent child health visits (outside core PHN child health and development assessments** |
| 16 | Number of subsequent child health visits (face to face) for review of the infant/child in the home or clinic  | Count face to face visits to the home or clinic where the infant/child is reviewed by the PHN/RM for follow up or care plan review. Include visits for / to:* sticky eyes, sticky cords, jaundice reviews and weight checks.
* reviews of CFHNA care plan/ Tusla child protection care plan actions or a Supervision Order (see metrics 51 to 54 for administration work connected to child welfare and protection cases)
* children that receive a ‘late visit’ as per National Healthy Childhood Programme (NHCP) definitions.

Exclude visits for: * breastfeeding support as they are counted in metric 17
* routine core PHN child health and development assessments
* late PHN primary (first) visits as they are counted in metric number 10
* clinical care contacts / visits for the mother.
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| 17 | Number of one – to –one breastfeeding support visits (face to face) in the home or clinic | Count visits to the home or clinic when the purpose of the visit is specifically or primarily for breastfeeding support provided by the RPHN/RM, one to one, to an individual mother. Visit should only be counted once e.g. if the RPHN/RM visits to support breastfeeding and review an umbilical cord – the visit is recorded under the primary reason only i.e. if included in metric 16 do not include in metric 17 |
| **3 month Child health and Development Assessment and Breastfeeding KPI** |
| 18 | Number of infants who **have had** a 3-month Public Health Nurse(PHN) child health and development assessment in the home or clinic | This is a count of the number of infants **who have had** their 3 month PHN child health and development assessment in the home/clinic Use corrected age for all infants born between 32 - 37 weeks’ gestation up until their first birthday when planning their child health and development assessment.Use corrected age for all infants born before 32 weeks’ gestation up until their second birthday when planning their child health and development assessment.This metric is only recorded in the calendar month the child health and development assessment took place. |
| 19 | Total number of infants who have reached 4 months of age **in this reporting month**  | This is a count of the number of infants who have reached 4 months of age at the end of this reporting month.Include infants whose corrected age is 4 months Only count this number at the end of each month i.e. At the end of the calendar month e.g. Dec 2022, please count the total number of children on the caseload who were born in August 2022.  |
| 20 | Total number of infants who have reached 4 months of age **in this reporting month** and **have had** a 3-month Public Health Nurse (PHN) child health and development assessment in the home or clinic  | Count the number of infants who have reached 4 months of age in this reporting month who have had their 3 month PHN child health and development assessment in the home or clinic Include infants whose corrected age is 4 months |
| 21 | Total number of infants who have reached 4 months of age **in this reporting month** and **have not had** a 3-month Public Health Nurse (PHN) child health and development assessment (i.e the PHN service has not offered an appointment for this assessment)   | Count the number of infants who have reached 4 months of age who **have not** had a 3 month PHN child health development assessment. Exclude infants * Who were not brought (WNB) for the 3 month PHN child health and assessment (previously known as DNA)
* Where the PHN has made a No access visit
* Whose parent/guardian have formally opted out/declined the 3 month PHN child health and development assessment

**Was not brought** Is defined as an infant who had a scheduled PHN child health and development assessment appointment at the health/primary care centre, who, without notification to the service, was not brought/did not attend for the appointment. **No Access Visit**Is defined as an infant with a scheduled PHN child health and development assessment visit at their home, and when the RPHN/RM attends their place of residence at the pre-arranged time, they are not available, without having provided notification to the service.**Opt Out**Infant whose parent/ guardian has formally declined the 3 month PHN child health and development assessment.   |
| **22** | **% of infants reaching 4 months within the reporting period who have had their 3 month Public Health Nurse (PHN) child health and development assessment on time or before reaching 4 months of age**  |  |
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| 23 | Total number of infants:**Was Not Brought/ No Access/Opt outs** of the 3 month PHN child health and development assessment in this reporting month  |  |
| 24 | The number of infants seen at the 3-month Public Health Nurse(PHN) child health and development assessment visit that are **exclusively breastfed**  | Exclusive breastfeeding: the infant has received only breast milk from his/her mother, or expressed breast milk and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines |
| 25 | **KPI name: % of infants breastfed exclusively at the Public Health Nurse (PHN) 3-month child health and development assessment visit**  |  |
| 26 | The number of infants seen at the 3-month Public Health Nurse(PHN) child health and development assessment visit who are **breastfed partially** (not exclusively)  |  Partial (not exclusive) breastfeeding: the infant receives some breastfeeds and some artificial feeds, either milk or cereal or other foods**.**  |
| 27 | **KPI name: % of infants breastfed (exclusively and partially (not exclusively)) at the 3-month** **Public Health Nurse (PHN) child health and development assessment visit** |  |
| **9 - 11 months Child Health and Development Assessment and KPI** |
| 28 | Number of infants who **have had** a 9 -11-month Public Health Nurse (PHN) child health and development assessment in the home or clinic   | Count number of infants who have had their 9-11 month PHN child health and development assessment in the home/clinic Use corrected age for all infants born between 32 - 37 weeks’ gestation up until their first birthday when planning their child health and development assessment.Use corrected age for all infants born before 32 weeks’ gestation up until their second birthday when planning their child health and development assessment.This metric is only recorded in the calendar month the child health and development assessment took place. |
| 29 | Total number of infants who have reached 12 months of age **in this reporting month** | Count the number of infants who have reached twelve months of age in this reporting month Include infants whose corrected age is 12 monthsOnly count this number at the end of the month i.e. at the end of the calendar month e.g. June 2022, count the number of children on the caseload who were born in June 2021. |
| 30 | Total number of infants who have reached 12 months of age **in this reporting month** and have **had** a 9 – 11 month~~s~~ Public Health Nurse (PHN) child health and development assessment in the home or clinic   | Count the number of infants who have reached 12 months of age who have had their 9-11 month child health and development assessment in the home/clinic Include infants whose corrected age is 12 monthsOnly count this number at the end of the month i.e. At the end of the calendar month e.g. June 2022, please count the number of children on the caseload who were born in June 2021 and have received their 9 – 11 month child health and development assessment (when they received it is not counted in this metric). |
| 31 | **% of children reaching 12 months within the reporting period who have had their 9 – 11 month Public Health Nurse (PHN) child health and development assessment on time or before reaching 12 months of age**  |  |
| 32 | Total number of infants who have reached 12 months of age **in this reporting month** who **have not** had a 9-11 month PHN child health and development assessment (i.e the PHN service has not offered an appointment for this assessment) | Count the number of infants who have reached 12 months of age in this reporting month who **have not** had a 9 - 11 month PHN child health and development assessment. Exclude infants  * Who were not brought (WNB) for the 9- 11 month PHN child health and development assessment (previously known as DNA)
* Where the PHN has made a No access visit.
* Whose parent/guardian have formally opted out/declined the 9- 11 month PHN child health and development assessment

**Was not brought** Is defined as an infant who had a scheduled PHN child health and development assessment appointment at the health/primary care centre, who, without notification to the service, was not brought/did not attend for the appointment. **No Access Visit**Is defined as an infant with a scheduled PHN child health and development assessment visit at their home, and when the RPHN/RM attends their place of residence at the pre-arranged time, they are not available, without having provided notification to the service.**Opt Out**Infant whose parent/ guardian has formally declined the 9 – 11 month PHN child health and development assessment.  |
| **33** | Total number of infants:**Was Not Brought/No Access/Opt outs** of the 9 -11 PHN child health and assessment in this reporting month  |  |
| **21 – 24 months Child Health and Development Assessment** |
| 34 | Number of children who **have had** a 21-24 month Public Health Nurse (PHN) child health and development assessment in the home or clinicDAILY ENTRY | Count the number of children who have had their 21 - 24 month PHN child health and development assessment in the home/clinic Use corrected age for all infants born between 32 - 37 weeks’ gestation up until their first birthday when planning their child health and development assessment.Use corrected age for all infants born before 32 weeks’ gestation up until their second birthday when planning their child health and development assessment.This metric is only counted in the calendar month the PHN child health and development assessment took place.  |
| 35 | Total number of children who have reached 26 months of age **in this reporting month** | Count the number of children who have reached 26 months of age at the end of this reporting month (26 months is in line with the Parent Health Record) Only count this number at the end of the month i.e. At the end of the calendar month e.g. Dec 2022, please count the number of children on the caseload who were born in October 2020. |
| 36 | Total number of children who have reached 26 months of age **in this reporting month** who **have had** a 21 – 24-month Public Health Nurse (PHN) child health and development assessment in the home or clinic  | Count the number of children who have reached 26 months of age in this reporting month who have had their 21-24 month PHN child health and development assessment in the home or clinic At the end of the calendar month e.g. Dec 2022, please count the number of children on the caseload who were born in October 2020 and have received a 21 – 24 month development assessment. |
| 37 | **% of children reaching 26 months within the reporting period who have had their 21-24 month Public Health Nurse (PHN) child health and development assessment on time or before reaching 26 months of age**  |  |
| 38 | Total number of children who have reached 26 months of age **in this reporting month** who **have** **not** had a 21 – 24 months Public Health Nurse (PHN) child health and development assessment in the home or clinic (i.e the PHN service has not offered an appointment for this assessment) | Count the number of children who have reached 26 months of age who have **not** had a 21 – 24 month PHN child health and development assessmentExclude Children * Who were not brought (WNB) for the 21 – 24 month PHN child health and development assessment (previously known as DNA)
* Where the PHN has made a No access visit
* Whose parent/guardian have formally opted out/declined the 21 – 24 month PHN child health and development assessment

**Was not brought** Is defined as an infant who had a scheduled PHN child health and development assessment appointment at the health/primary care centre, who, without notification to the service, was not brought/did not attend for the appointment. **No Access Visit**Is defined as an infant with a scheduled PHN child health and development assessment visit at their home, and when the RPHN/RM attends their place of residence at the pre-arranged time, they are not available, without having provided notification to the service.**Opt Out**Infant whose parent/ guardian has formally declined the 21- 24 month PHN child health and development assessment.   |
| 39 | Total number of children:**Was Not Brought/ No Access/ Opt outs** of the 21-24 month PHN child health and development assessment in this reporting month |  |
| **ASQ** |
| 40 | Number of children who have had a 21-24 month Public Health Nurse (PHN) child health and development assessment in the home or clinic for whom the Ages and Stages Questionnaire- 3 (**ASQ-3**) has been **completed**.  | For areas with ASQ-3 implementation Count the number of children who received their 21 – 24 month PHN child health and development assessment and have had an Ages and Stages Questionnaire- 3 (ASQ-3) Screening tool completed.  |
| 41 | % of children who have had their 21 – 24 month PHN child health and development assessment and had an ASQ-3 completed |  |
| **46 – 48 months Child Health and Development Assessment** |
| 42 | Number of children who **have had** a 46-48 month Public Health Nurse (PHN) child health and development assessment in the home or clinic | This is a count of the number of children who have had their 46-48 month PHN child health and development assessment in the home/clinic.This metric is only recorded in the calendar month the PHN child health and development assessment took place. |
| 43 | Total number of children who have reached 50 months of age **in this reporting month** | This is a count of the number of children who have reached 50 months of age in this reporting month. Include those discharged from the PHN caseload with the 46 – 48 month PHN child health and development assessment completed. Only count this number at the end of the month At the end of the calendar month e.g. Dec 2022, please count the number of children on the caseload who were born in September 2018 |
| 44 | Total number of children who have reached 50 months of age **in this reporting month** who **have had** a 46-48 month PHN child health and development assessment in the home or clinic  | This is a count of the number of children who have reached 50 months of age in this reporting month who have had their 46 -48 month PHN child health and development assessment. Include those discharged from the PHN caseload with the 46 – 48 month PHN child health and development assessment completed.Only count this number at the end of the month i.e. At the end of the calendar month e.g. Dec 2022, please count the number of children who were previously and are currently on the caseload and who were born in September 2018 and have had a 46-48 month PHN child health and development assessment. |
| 45 | **% of children reaching 50 months within the reporting period who have had their 46-48 month Public Health Nurse (PHN) child health and development assessment on time or before reaching 50 months of age**  |  |
| 46 | Total number of children who have reached 50 months of age who **have** **not had** a 46 – 48 month PHN child health and development assessment (i.e the PHN service has not offered an appointment for this assessment) | This is a count of the number of children who have reached 50 months of age in this reporting month who have **not** had a 46 – 48 month PHN child health and development assessment. (50 months is in line with the Parent Held Record)**Only count this number at the end of the month** Exclude Children * Who were not brought (WNB) for their 46 – 48 month PHN child health and development assessment (previously known as DNA)
* Where the PHN has made a No access visit
* Whose parent/guardian have formally opted out/declined the 46 – 48 month PHN child health and development assessment

**Was not brought** Is defined as an infant who had a scheduled PHN child health and development assessment appointment at the health/primary care centre, who, without notification to the service, was not brought/did not attend for the appointment. **No Access Visit**Is defined as an infant with a scheduled PHN child health and development assessment visit at their home, and when the RPHN/RM attends their place of residence at the pre-arranged time, they are not available, without having provided notification to the service.**Opt Out**Infant whose parent/ guardian has formally declined the 46 - 48 month PHN child health and development assessment.  |
| 47 | Total of children:**Was Not Brought/No Access/ Opt outs** of the 46 – 48 month PHN child health and development assessment in this reporting month |  |
| **Number of child health indirect interventions** |
| 48 | Number of child health indirect interventions | Count the number of **indirect interventions** relating to children and families (caseload and non-caseload)**Indirect interventions:** * Can be non-face to face in nature i.e. via telephone, video, e-mail, written, etc.
* Can be face to face with parent/guardian
* are **meaningful** interventions i.e. **requiring recording in the child health record**
* should be at least 15 **minutes duration**

Include: * phone/video call discussions relating to a named child/family with team members / other professionals / family member etc.
* report writing e.g. preparation for court reports
* liaison with voluntary and statutory agencies
* liaison with hospital pre and post discharge case discussions
* contacts by parents/guardians attending at primary care centers / health centers for information / advice relating to child health on e.g. immunisation,
* non-caseload children
* tracking of defaulters
* no access for planned domiciliary visits
* ASQ-3 tool administration for children outside of those captured in metric 40

**Exclude:** * casual conversations / discussions with colleagues about a parent/guardian/child
* care planning
* arranging clinic appointments by phone / mail
* To ensure accuracy, the number of indirect interventions should be captured daily in a desk diary or directly into the software system
 |
| **PHN Led Breastfeeding Support groups** |
| 49 | Number of women who attended PHN led breast feeding support groups  | This is a count of the number of women who attended PHN facilitated breastfeeding support group in the reporting month. If the group is facilitated by two PHN’s, divide numbers attending for the purposes of PHN caseload activity returns. This return is completed by the area PHN/s facilitating the breastfeeding group. See metric 56 if the intervention took place by virtual means. |
| **Group health promotion /education interventions** |
| 50 | Number of parents/adults who attended PHN led group health promotion / education interventions  | This is a count of the number of parents/adults that attended at each session. If two PHNs facilitate group divide numbers attending for the purposes of PHN caseload activity returns. If the PHN is facilitating with another health professional the PHN should not divide the number. Enter the attendance on the date the group took place. See metric 56 if the intervention took place by virtual means. |
| **Child Welfare/Protection** |
| 51 | Number of individual Child and Family Health Needs Assessments (CFHNA) completed by the PHN this month | Count the number of CFHNA completed in this month, count one for each child in a family for whom a CFHNA was completed |
| 52 | Total number of children with an open Child and Family Health Needs Assessment (CFHNA) care plan in place at the end of the reporting month | This is a count of the total number of children with a CFHNA who have an open care plan in place at the end of the reporting month. Children with open CFHNA care plans in place will need to be included every month until such time as the CFHNA care plan is closed off. Count children whose CFHNA care plan was newly opened in this month and children whose CFHNA care plan was opened in previous months and remains open. |
| 53 | Number of Child Protection and Welfare report forms submitted to Tusla by PHN  | Count the number of completed Child Protection and Welfare report forms submitted to Tusla  |
| 54 | Number of child protection conferences/child protection reviews/strategy meetings attended by PHN  | Count child protection conference/reviews/strategy meetings attended by area PHN.Exclude meetings attended by PHN management or Student PHN. *If a case conference is attended by a cross cover PHN then the cross cover PHN returns meeting attendance in own primary care activity metrics.*  |
| 55 | Number of court preparation meetings attended / court attendances by PHN  | Count court preparation meetings attended by area PHN with HSE legal team or area PHN attendance at court.Exclude those attended by PHN managementEach individual day’s attendance is counted |
| 56 |  Number of PHN child health contacts by phone, video or audio conferencein the reporting month  | Number of PHN/RM contacts with parents/adults by phone, video or audio conference carried out in the reporting month (e.g. Attend Anywhere, WebEx,)**Include**1. contacts for the purpose of undertaking assessments/intervention or follow up actions of newly referred children
2. contacts for the purpose of undertaking re-assessment, interventions or follow up actions for existing children on the PHN caseload
3. Initial phone calls to parents/guardian in advance of a face to face visit to gather information and provide health promotion
4. Virtual group contacts – i.e. breastfeeding support group, weaning education, count as a contact for each parent /adult who attended

**Exclude**1. Phone call discussions with team members / other professionals / family member
2. Any face to face contacts
3. Liaison with other agencies
4. Liaison with hospital pre and post discharge.
5. Report writing e.g. written report for Tusla

 **(return all above as indirect interventions)**1. Contacts by telephone, video or audio conferencing with the parent/guardian and other team member solely for the purposes of arranging appointments
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| 57 | % **Was Not Brought/No Access and Opt** outs for all core PHN child health and development assessments (except primary visit) in this reporting month |   |
| 58 | % of transfers in and out of the PHN caseload of children experiencing homelessness  |   |