CHILD HEALTH SERVICES

BIRTH TO SCHOOL ENTRY

UNIVERSAL CONTACT SCHEDULE:
EARLY DETECTION AND PREVENTION

POLICY RATIONALE
AND
SUMMARY OF THE CHANGES TO THE SCHEDULE

Related to Policy Number CH001

2006
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1.0 Introduction

Recent scientific evidence has confirmed the significant influence of early childhood experience on brain development and on the development of disease in later life. Research has identified critical periods in a child’s early years of life, including the antenatal period, that impact on later physical, social and emotional wellbeing. This knowledge has added more weight to evidence about the importance of the early years, an issue which has long been recognised by parents, child health nurses and early childhood educators. Children need to be given opportunities and firm foundations in order to reach their full potential.

Families have the biggest influence on the ways in which children grow and develop. The capacity of families to support their children in reaching their potential is affected by their immediate physical and social environment as well as by broader factors in society. Increasing evidence has emphasised the importance of effective health interventions that involve health providers working collaboratively with families and carers at critical points along the developmental pathways.

Health service interventions which are most effective take a population health approach which provides both universal and targeted strategies. That is, universally available services are offered within which the needs of particular at risk population groups and individuals can be specifically addressed. Interventions for families and children are most effective when they are family centred, responsive to key protective and risk factors and are accessible through a range of settings.

The development of new policies for Child Health Services is being carried out in the context of the new evidence about early childhood. This document will outline the changes in the approach to service delivery and the rationale for the changed approach, together with a summary of the revised schedule of contact times for child health nurses and their recommended content. (See Tables 1 & 2).

This policy rationale supports the policy statement relating to the Child Health Services Universal Contact Schedule: Early Detection and Prevention.

2.0 A new approach to Child Health

For many years, the child health service has been highly valued and widely accepted by the community. Community child health nurses are exceptionally well positioned to implement the kinds of practices indicated by the new evidence. Community child health nurses are acceptable to parents, non-stigmatising and ideally placed to provide the necessary supports to families and identify those at risk who may require extra assistance from services. Supporting families with babies and young children has been a major element of the community child health nursing role for many decades. However community child health nurse support for parents has largely been undervalued and unrecognised because of a lack of adequate measures and the intangible nature of practice.

A major impetus for reviewing the current child health schedule has been the publication by the National Health and Medical Research Council (NHMRC) of a detailed review of the evidence relating to twenty child health screening tests. The proposed changes to the
screening schedule have been informed by the findings of this review and, in cases where the
evidence was insufficient to make a recommendation for or against child health screening,
policy has also been informed by consultation with experts in the field.

The provision of screening services has been an important part of the work of community
child health nurses for many years. It is proposed to shift the focus gradually from an
emphasis on screening towards a more holistic approach to working with families with babies
and young children, whilst acknowledging the importance of early detection.

The universal schedule of contacts offers a unique opportunity for community child health
nurses to work with families to promote health and wellbeing and deliver prevention
strategies which are well timed and appropriate to the needs of the families. Community child
health nurses provide information and support relevant to child development and family
circumstances, as well as appropriate screening. These regular contacts provide an
opportunity to address key issues including infant feeding, child development, maternal
physical and emotional wellbeing, injury prevention and safety, child abuse, and
immunisation.

There will be an emphasis on innovative and flexible service delivery to improve access for
families who under-utilise the service.

The changes to the Child Health Service aim to:

- Improve access to community health services by enabling a more flexible approach to
  service delivery. For example, the scheduled contact within the first 10 days after birth
  will be delivered as a home visit wherever possible, and visits at other times may be
  offered at venues other than the child health centre.

- Promote opportunities for families to have contact with their child health service in the
  first 12 months at the critical points in the child’s development. A universal contact at
  3-4 months of age has been included and parenting groups will be commenced prior to
  the 6-8 week scheduled contact where appropriate.

- Shift the content and emphasis of contacts to concentrate on building partnerships
  between the community child health nurses and the family. The contacts will focus
  more holistically on the child’s physical and psychosocial development and address
  specific concerns of the family.

- Improve the responsiveness of the service to the needs of the family through a family
centred approach.
2.1 Changes to the schedule

In recognition of the importance of critical periods in the first year of life, community child health nurses will continue to focus most of their time and effort in the early months after birth. The changes to the schedule are minimal. The major differences from the previous schedule of contacts are the introduction of a universal contact in the first 10 days after birth (as a home visit wherever possible), an additional universal contact at 3-4 months, and earlier commencement of parenting groups, ideally before 6 weeks. The universal post-natal first contact (UPFC) will take the place of the 1-2 week scheduled centre visit and will be delivered in the home wherever possible. The changes to the schedule are shown in Table 1.

2.2 Summary of schedule (Table 1)

<table>
<thead>
<tr>
<th>AGE</th>
<th>Type of Contact</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth &lt; 10days</td>
<td>Universal postnatal first contact (home visit where possible)</td>
<td>New contact</td>
</tr>
<tr>
<td>1-2 weeks</td>
<td>No longer included</td>
<td></td>
</tr>
<tr>
<td>6 – 8 weeks</td>
<td>Individual face to face: home or child health centre</td>
<td>Exists in old schedule</td>
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<tr>
<td></td>
<td></td>
<td>Continue as centre or home visit</td>
</tr>
<tr>
<td>3 – 4 months</td>
<td>Individual face to face: Home or child health centre</td>
<td>New contact</td>
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<tr>
<td>8 months</td>
<td>Individual face to face: Home or child health centre</td>
<td>Exists in old schedule as 7-9 month contact</td>
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<td></td>
<td></td>
<td>Continue as centre visit or home-visit</td>
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<tr>
<td>18 months</td>
<td>Individual or group: Flexible delivery – home, mail, phone, child health centre or community venue</td>
<td>Exists in old schedule as 18-21 month contact</td>
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<td>Consider flexible service delivery</td>
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<tr>
<td>3 – 3.5 years</td>
<td>Individual or group: Flexible delivery – home, mail, phone, child health centre or community venue</td>
<td>Exists in old schedule</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider flexible service delivery</td>
</tr>
</tbody>
</table>
2.3 Changes in content and emphasis

As noted above, while some screening tests will be maintained, there will be a greater emphasis on family support, together with identification of families at particular risk who need extra support.

Consistent with “New Vision for Community Health Services” framework, universal prevention and early detection programs will be offered.

Prevention programs focusing on support for parents and the provision of information on age appropriate child development, injury prevention, immunisation and nutrition will be delivered either in a group format or on an individual basis. The provision of translated materials will assist in bridging communication barriers for culturally and linguistically diverse (CALD) groups whose English may not be proficient. It may be necessary to deliver the service in a primary language through an interpreter.

There is a focus on developing partnerships with families and communities and this will be reflected in the family centred orientation of the service and partnership between service providers.

2.4 Family partnership approach

Health professionals will complement their current practice by using a family partnership approach, allowing service providers to engage and relate to parents in a facilitative manner and develop genuine and respectful partnerships with families. This results in more effective support for parents, greater emphasis on psychosocial and emotional aspects affecting families and a focus on building strengths, with ongoing benefits for parents and children. The family partnership approach recognises the integral role of parents and family in the lives of children as being a central tenet on which to build service provision.

Multidisciplinary family partnership training will provide staff with the foundations to work in a family centred manner and a basis for collaboration, service integration and community partnerships.

2.5 Growth monitoring

Growth monitoring of infants and young children is a contentious issue. While the routine monitoring of growth by measuring weight and length/height is a traditional component of child health services in both developing and developed countries, there is remarkably little scientific evidence in developed countries about the benefits and potential harm.
**Weight monitoring**

The main arguments given for routine weighing of all infants and young children and plotting the weights on a percentile chart are as follows:

- Regular weighing allows for identification of feeding difficulties
- ‘Healthy growth is a sign of a healthy child’: monitoring weight on a chart allows for identification of failure to thrive due to chronic disease (e.g. renal or heart disease)
- Monitoring of weight trends gives early warning of inappropriate diets and the beginning of obesity
- If a child develops diarrhoea and vomiting, knowledge of the recent weight gives a guide to the degree of dehydration
- Knowing that the child will be weighed gives an incentive for the mother to bring the child to the child health centre and an opportunity for raising other concerns.
- Undressing the child to weigh it may reveal other problems which would not have been otherwise noticed.

These arguments assume that the weighing will be accurate, using comparable scales, and that the weights are accurately plotted on an appropriate growth chart for the population.

The arguments against routine weight monitoring are as follows:

- Parents or health professionals do not always understand the wide range of patterns of normal growth. Weight monitoring, especially if done frequently, can lead to parent anxiety if a baby is seen not to be gaining weight fast enough, especially if the parents do not understand that child growth occurs in spurts. Concern about failure to gain the expected amount of weight (particularly from mothers and grandmothers) can lead to feelings of failure on the part of the mother and premature cessation of breast feeding. For bottle fed babies or those already on solids, anxiety about insufficient weight gain can lead to overfeeding of infants with the consequent risk of development of obesity.

- Focussing on the weight of the baby may distract the community child health nurse from facilitating and supporting the parent-child relationship and developing a strong partnership with the family in the postnatal period.

- Healthy weight gain in the child is only one indicator of a healthy child. While growth monitoring may be a clue to diagnosis of certain specific chronic conditions, almost all of these have characteristic signs and symptoms which more accurately lead to diagnosis. In the case of feeding difficulties, other signs and symptoms are likely to give clues that the intake is inadequate and prompt the community child health nurse to weigh the baby.
Weight monitoring to detect obesity is unnecessary as obesity can readily be detected by a health professional without recourse to a weight chart.

Two NHMRC resources on this topic give conflicting advice. The Literature Review on Child Health Screening and Surveillance commissioned by the NHMRC (2002) notes that there is insufficient evidence to make a recommendation for or against screening for failure to thrive or for obesity, but recommends routine weight monitoring at birth, at 6-8 weeks and 8-12 months as part of routine clinical care. No evidence is presented for this schedule. The NHMRC Infant Feeding Guidelines for Health Workers (incorporated in the Dietary Guidelines for Children and Adolescents in Australia, released in 2003) recommend a four weekly assessment of weight in breast fed infants, with the weights plotted on an appropriate chart. Once again, no evidence is presented for this schedule.

As noted earlier, there is little scientific evidence on either side of this argument. A balanced approach is needed to maximise the benefits and minimise the potential harm. This schedule includes routine weighing at each of the scheduled centre contacts in the first year of life. It should be noted that there is nothing in these recommendations to prevent weighing of a baby when it is indicated either by parent concern, professional judgement or where health conditions that may cause poor growth are suspected or under investigation. Having weighing scales in the child health centre for parents to use can satisfy parental interest in the baby’s weight, or they may be able to use scales at the local pharmacy. Community child health nurses should demonstrate the appropriate weighing technique for parents to help reduce measurement error which may lead to further parental concern.

**Height monitoring**

The NHMRC Literature Review stated that there is insufficient evidence to make a recommendation for or against routine length/height measurement. There are considerable errors of measurement, particularly in length measurement before a child can stand. The evidence suggests that routine measurement of height leads to over referral for short stature. Height monitoring by Community Health is not needed to identify very short children as these children are adequately identified and referred. Prior measurements of height are not utilised by specialists who diagnose growth failure.

**Universal schedule for growth monitoring**

The recommended schedule for weighing babies is at each of the routine visits, at 6-8 weeks, 3-4 months and 8 months. The weights should be plotted on the growth charts in the health record. Babies do not need to be weighed between these times unless there are particular concerns. Routine measurement of length/height at each of the visits is not recommended. It should be noted that there is nothing in these recommendations to prevent growth monitoring of a baby when it is indicated either by parent concern, professional judgement or where health conditions that may cause poor growth are suspected or under investigation.

It is not recommended that the baby be weighed at the postnatal home visit, unless there are particular indications such as preterm birth. This visit occurs shortly after discharge from hospital where the baby would have been weighed. Experience has shown that minor
variations from the weight in hospital, although to be expected, given different scales and
different circumstances, are likely to produce undue anxiety in the mother and adversely
affect her confidence in breastfeeding.

**Targeted schedule for growth monitoring**

Weight and length/height should be measured more frequently if the infant is likely to be at
risk of under nourishment. This includes routine measurement for all infants in high risk
groups including Indigenous infants. Weight and length should be measured for infants
referred because of feeding difficulties and when health conditions that may cause poor
growth are suspected or under investigation. Weight should also be measured if, in the
community child health nurse’s judgment, there are clinical indications to do so.

### 2.6 Developmental assessment

The NHMRC review of the evidence relating to child health screening and surveillance stated
that developmental delay is present when a child does not reach the developmental milestones
at an expected age (with adequate flexibility to allow for the broad variation among normal
children). It is estimated that approximately 17% of children have developmental delay.
Many are not detected before school age other than the small proportion who have severe
delay and these children are usually identified by methods other than screening.

It is recommended that the identification of children who would benefit from early
intervention should not be based solely on the use of developmental screening tests, or limited
to inquiry at one point of time.6

Studies show that practitioners use a variety of methods when attempting to detect
developmental problems. Methods include checklists, milestones, taking developmental
histories from parents, clinical observations and informal testing using a variety of ad hoc
items. There is very limited information about the performance of these methodologies.

There are a variety of developmental screening tests. The NHMRC review recommends that
the tools used as part of a community program of developmental screening should have
adequate psychometric properties of >70% sensitivity and specificity.7

The NHMRC review outlines a number of tests that meet these psychometric properties,
including the:
- Ages and Stages Questionnaires (ASQ) and Ages and Stages Questionnaires: Social
  Emotional (ASQ: SE)8,9
- Parent’s Evaluation of Developmental Status (PEDS)
- Brigance Screens
- Child Development Inventories screening versions

The recommended schedule for developmental assessment is at the 3-4 months, 8 months, 18
months and 3 years contact.

For those children considered at risk, a more regular program of developmental assessment
should be offered as appropriate and where resources are available.
For developmental screening and surveillance to be effective, at risk children should receive a more detailed assessment, parents should receive appropriate information and counselling and effective early intervention programs must be offered.

It is recognised that the evidence around cost effectiveness of developmental screening has been focussed on those interventions which are highly intensive. These early intervention programs are resource intensive; however they have demonstrated the economic benefits of early intervention for disadvantaged children and their families.

There is good evidence that intervention should be available both for children who meet criteria for developmental delay and for children who are “at risk” of developmental delay, including those at the lower range of normal development.

2.7 Postnatal depression

The Edinburgh Postnatal Depression Scale (EPDS) should be offered to all mothers on at least two occasions (preferably three) after the birth of the baby: at 6-8 weeks, 3-4 months and 8 months.\(^{10}\)

The EPDS is a 10 item self report scale developed to screen for postnatal depression in the community setting.\(^{11}\) The EPDS is easy to administer and score; since it was developed specifically to screen for Postnatal Depression (PND) it avoids assessing normal postpartum changes as symptoms. Administering the scale sometimes encourages women to talk about their problems.

The EPDS has demonstrated high reliability and specificity as an indicator of significant depressive symptoms. The recommended cut-off scores are 14 during pregnancy\(^ {12}\) and 12 in the postnatal period\(^ {13}\).

The scale is a useful indicator of those who may be suffering from depression. The EPDS scores should not be interpreted as indicating a definite diagnosis of PND, but like any screening test, the tool identifies those who need to be referred for further assessment. Women should not be told they have PND solely on the basis of an elevated score. Area Health Services need to develop different referral policies, dependent on available resources, for those who score above the threshold on the EPDS. The EPDS is available in a number of different languages which will assist health professionals when working with CALD clients.

2.8 Flexible service delivery

Child health service delivery needs to reflect and respond to the changes in the way contemporary Western Australian families live and work, therefore taking into account its diverse population.

Social and economic changes since the 1960s have profoundly affected the structure and function of families in Western Australia. Lone parent families are increasing, there are more step and blended families, families are smaller, first time mothers are older\(^ {14}\). Economic
disadvantage, cultural diversity, the changing nature of work, single parenthood, family stability, extended family support and child care, challenge the health system to reorient and redesign health services for families and children. There have been dramatic changes in work and family life. Women’s workforce participation rate is increasing; there has been an increase in the number of families where both partners are employed, with an increase in combined working hours for employed parents.

Service delivery will need to be more flexible to the demands of parenting and working life. In addition to face to face meetings in child health centres, contact with families may involve alternatives such as phone calls, email, groups and meeting parents outside the home in alternative community venues. Placing greater emphasis on group work will help to build parent support systems and community networking. Other aspects of flexible service delivery could include extended hours, delivery of service in other settings such as childcare, Aboriginal community controlled health organisations or other service locations such as shopping centres.

Community child health nurses provide services to families in diverse and complex family situations. There is a high participation rate in the service in the first year of the child’s life; but much lower participation for the 18 month and 3 year visits. Data received from three Area Health Services in 2004 showed that the rate of attendance ranged from 33- 58% for the 18 month visit and 21 – 42% for the 3 year visit. A more flexible service delivery should increase accessibility for families with children in these age groups.

Local knowledge and data will help to identify specific groups that are under-represented in utilisation of the service. Efforts need to be made to provide services in a way which allow for inclusion of Aboriginal families, disadvantaged families, families from CALD backgrounds and children in out of home care. It is recognised that many health services already have effective prevention programs which address identified need in their communities.

### 3.0 The new schedule

#### 3.1 Universal postnatal first contact (UPFC)

**Rationale**

Accessing mothers in the early days after delivery enables community child health nurses to support and encourage breastfeeding, initiate and establish a helping relationship with the family and promote positive parent-infant interaction. This early contact can also help identify those families at risk and who may require extra services or supports. Visiting in the home environment facilitates the establishment and building of a helping relationship between the community child health nurse and the family, however if home visiting is not possible then alternative service delivery may need to be provided to mothers in the early days after delivery.

Supporting and encouraging breastfeeding is a key role for community child health nurses at this early stage. Breastfeeding rates within Australia and Western Australia are below the current World Health Organisation goals and targets. In WA, although 87 percent of...
mothers are breastfeeding at discharge from hospital, only 63 percent are still fully breastfeeding at 3 months and 22 percent of babies are exclusively breastfed at 6 months. These figures are slightly higher than the national rates.\textsuperscript{19}

\textit{Implications for Practice}

Some health services have been offering universal postnatal home visits for the last few years, whereas others have targeted home-visiting programs to high risk families only. It is recommended that all parents be offered a home visit, to take place within the first 10 days after birth. If a home visit is not possible, the first postnatal contact can take place in a child health centre or as a last resort by telephone.

During the universal first contact community child health nurses conduct an assessment of risk and protective factors to identify family resources, home environments and areas of concern. An Indicators of Need guide has been developed to assist and validate the decision making process and professional judgement of the community child health nurse. Assessment of risk and protective factors occurs from the first contact with the family. Once an assessment is made, the community child health nurse, together with the parent, will then develop a plan outlining frequency of visits, venue, and referral needs. Many Aboriginal and CALD family structures have an extended family type, whereby the grandparents, aunts or uncles play a significant role in child rearing practices. In these cases it is appropriate to include other family members in developing the plan.

During this first contact with the parent it is important to promote the parent-infant relationship, assess maternal physical and emotional wellbeing and provide information on infant feeding. A visual inspection of the infant will be carried out, but the infant will not be weighed at this visit unless there are identified concerns. The rationale for not weighing routinely at this visit has been outlined previously. (Experience has shown that minor variations from the weight as measured in hospital may lead, despite reassurance, to concerns on the part of the mother about the adequacy of breastfeeding and premature cessation. Undue emphasis on the weight of the baby detracts from other important aspects of this first visit).

For those families considered at risk, a more intensive home visiting program should be offered as appropriate and where resources are available. Community child health nurses working in a multidisciplinary team in targeted home visiting programs should receive extra training in enhancing parent-infant interaction.

\subsection*{3.2 Group contacts in first six weeks}

\textit{Rationale}

The literature consistently identifies peak crying times for babies between 6 – 8 weeks and 3 – 4 months.\textsuperscript{20} The incidence of child abuse has also been found to increase at these times. Parents need to be offered information and strategies for comforting and settling crying babies prior to 6 weeks, in order to promote safe handling of infants and reduce some of the frustrations experienced by parents.
There is evidence of better outcomes for parents when information is delivered as part of a support group format; such groups can reduce isolation and help in building community support networks.\(^{21}\)

**Implications for Practice**

In addition to providing a universal schedule of contacts, the child health service provides a platform that can be utilised to bring families together, support social networks and strengthen local community connections. Parents will be offered contact with other parents through groups prior to the 6 – 8 week contact where appropriate. Information about breastfeeding issues and comforting and settling strategies, for example, have been identified through local parent focus groups as priorities at this time.

### 3.3 6-8 weeks contact

**Rationale**

Children’s physical development and learning ability requires good vision. Proper development of the visual centres in the brain requires equal input from both eyes. When equal input is lacking and the visual image transmitted to the brain is unclear, permanent loss of vision may occur.\(^{22}\) Both eyes compete with each other to make connections to the brain with the critical period for development of vision occurring between birth and eight years of age.\(^{23,24}\)

In relation to developmental dysplasia of the hips, the NHMRC review of the evidence noted that there is insufficient evidence to make recommendation for or against screening by clinical examination and fair evidence to recommend against screening by ultrasound. The review did recommend continuation of newborn and 6 week examination using the Ortolani and Barlow manoeuvres provided it is in the context of an adequate early detection program or system. The system should include clear pathways for communication between health professionals in maternity settings and those in the community.\(^{25}\)

The review of the evidence for screening for undescended testes recommended continuation of specific examination of the genitalia at the newborn and 6 week checks only and opportunistic examination of children not examined in the newborn period.

**Implications for Practice**

The 6–8 week visit is an existing scheduled contact. Community child health nurses will complete the 6-8 week assessment including the physical examination as per the Personal Health Record (PHR) and assess the infant’s early motor development using a checklist as a guide. A new Early Motor Development guide has been developed to assist community child health nurses in their assessment of babies’ posture, body tone and movement. The guide can also be used when providing anticipatory guidance to parents on their child’s development.
A vision assessment will be carried out which includes the Bruckner Red Reflex Test. The Bruckner Red Reflex Test is used to detect mild cataract, small angle strabismus and unequal refractive errors.

Measurement of head circumference and length is no longer included at this contact unless there are special concerns from the history or inspection of the infant, or expressed professional/parental concern.

### 3.4 3-4 month contact

**Rationale**

The latest Australian Dietary Guidelines for Children and Adolescents recommend introduction of solids at about 6 months. The 3 – 4 month contact provides an opportunity for parents to discuss the nutritional needs of their infant and to be supported in the continuation of breastfeeding. The inclusion of a weight assessment during this contact can complement the nutritional advice given to parents.

**Implications for Practice**

The 3 – 4 month visit is a new universal scheduled contact. At this time, many parents contact the community child health nurse for information on changing breastfeeding patterns, introduction of solid food, child development or for maternal health reasons. During this contact the community child health nurse will carry out the Bruckner Red Reflex Test and discuss parent responses to the questions in the PHR related to the infant’s developmental status, hearing and vision.

### 3.5 8 month contact

**Rationale**

The NHMRC review of the evidence relating to screening for permanent childhood hearing impairment concluded that there was good evidence to recommend against hearing distraction testing (HDT). The test is difficult to carry out effectively and to interpret correctly. It is also not particularly accurate; there are significant numbers of both false positives and false negatives. A large Victorian population-based study found a positive predictive value (PPV) of 0.5%, indicating that of 100 children referred for further testing, 95 were false positives.

It is recognised, however, that early detection of hearing difficulties is critical to child development. In order to address this important area, parent questions at each contact time will be used to elicit concerns about possible hearing difficulties. The parent questions about hearing and language in the Personal Health Record (PHR) have been updated and improved, following consultations with audiologists and other professional groups and review of the relevant literature. There are age-appropriate questions for each community child health nurse contact.
Implications for Practice

The 8 month visit is an existing scheduled contact. Community child health nurses will complete the 8 month assessment as per the PHR. In addition, the community child health nurse will check the list of risk factors for hearing loss and vision problems and discuss responses to the parent questions in the PHR related to the infant’s developmental status.

The infant distraction hearing test, assessment of undescended testes, examination for developmental dysplasia of hips, measurement of head circumference and length are no longer included at this contact.

3.6 18 month and 3 year contact

Rationale

The 18 month and 3 year visits are part of the existing scheduled contacts with the parent. At this time, many parents contact the community child health nurse for information on nutrition, child development/behaviour and injury prevention. The emphasis of these contacts is to provide information to parents on childhood behaviours and development.

The emerging evidence indicates that the optimum age group for vision screening is 4 to 4 ½ years, and most children will complete this assessment in Kindergarten or pre-primary.

All children are offered a universal assessment for hearing loss at school entry or soon after.

Implications for Practice

A flexible service delivery should be considered, such as using group settings or making a phone call to parents. The community child health nurse will discuss with the parents the questions related to the child’s development, behaviour, hearing and vision.

Assessment of undescended testes, examination for developmental dysplasia of hips, measurement of length and weight are no longer included at these contacts. At the 3 year contact, vision and hearing assessments are no longer included unless indicated from the history, or expressed professional/parental concern.

Individual centre based visits may be necessary for those parents who have specific concerns about their child’s growth and development.

Child health services may need to consider alternative methods of accessing parents of toddlers and young children who might otherwise not access the service.
### 4.0 Changes to content and emphasis of Community Child Health Nurse contact (Table 2)

At all times, community child health nurses are expected to exercise their professional judgement within the Scope of Nursing Practice Decision Making Framework that is supported by the evidence and with consideration of a range of factors that impact on families. Further advice and consultation with a more experienced colleague should be sought as needed to assist with the decision making process.

<table>
<thead>
<tr>
<th>Age</th>
<th>Focus/emphasis of contact</th>
<th>Changes to content</th>
<th>Testing protocols</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Postnatal First Contact</td>
<td>Identify risk and protective factors using Indicators of Need</td>
<td>Family assessment-genogram</td>
<td></td>
<td>Indicators of Need - CHS 560</td>
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<tr>
<td></td>
<td>Parent support and child development</td>
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<td>Guidelines for responding to child abuse, neglect and the impact of family and domestic violence (2005)</td>
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<tr>
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<td>Injury prevention and safety</td>
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<td>Shaken Baby Syndrome Prevention Program</td>
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<td>Prevention</td>
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<td>Infant feeding guidelines</td>
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<td>Personal Health Record</td>
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<td>Measurement of head circumference, length and weight is no longer included</td>
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<td>Community Child Health Resource Book – Resource for Child Health Practice &lt;sup&gt;2&lt;/sup&gt;nd Edition 1996&lt;br&gt;Indicators of Need - CHS 560&lt;br&gt;Personal Health Record&lt;br&gt;Infant feeding guidelines&lt;br&gt;Guidelines for responding to child abuse, neglect and the impact of family and domestic violence (2005)&lt;br&gt;Shaken Baby Syndrome Prevention Program&lt;br&gt;Health Information Resources</td>
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References


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15 Australian Social Trends 2003 Family and Community – Family function: Balancing family and work


