Child health clinical audit protocol

3 months to <15 years

2015 Release

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Changes to this audit tool and protocol are carefully monitored to ensure that trending over CQI cycles is possible. If you notice discrepancies between what is documented in the protocol, and what is recommended best practice in your jurisdiction, or have any questions, please contact One21seventy by email: one21seventy@menzies.edu.au or phone 1800 082 474. Your feedback is appreciated.

Version control

Record of version updates

Version	Release date	Description
2.2	30/3/2007	ABCD project, eligibility criteria age 3 months <5 years
2.3	19/11/2007	Increased eligibility 3 months <6 years
3.0	1/5/2011	Increased eligibility 3 months<15 years
3.1	2013	Immunisation question 4.1 removed (validation of dates inhibited data entry to the point of stopping audits)
2014 release	01/02/2014	Internal review of content
July 2014 release	16/7/2014	Immunisation section revised to incorporate updated immunisation schedules and data input page
2015 release	22/4/2015	Internal protocol review only CARPA references updated

Introduction

This protocol should be used in conjunction with *Improving the quality of primary health care: A training manual for the One21seventy CQI cycle.*

Child Health clinical audit

A child health audit can be used to audit recorded care at the health service for children aged 3 months to 15 years.

Eligibility of clients

To be eligible for inclusion in the child health clinical audit, a child must:

- be between at least 3 months and <15 years (i.e. up to but not including 15 years) at the audit date
- have been resident in the community for 6 months or more of the past 12 months, or if the child is less than 12 months, they should have been resident in the community for at least half of the time since birth
- have no major health anomaly, such as Down syndrome, cerebral palsy, heart defects or inherited disorders; the reason for excluding children with a major health anomaly from the audit is that they have special needs and therefore receive extraordinary attention from carers and health care providers. The record of their care will therefore not be a reflection of the general care provided to children attending the health centre. It may be useful to assess the quality of the special care provided to these children through a separate exercise.

Sample size and confidence interval

Refer to *Improving the quality of primary health care: A training manual for the One21seventy cycle*, Section 4, for more information on determining appropriate sample size for your population for this audit, and the confidence interval required for the indicators.

The audit tool can be used to audit service delivery to two broad age groups:

- 3 months to <6years
- 6 years to <15 years

The suggested minimum randomised sample (stratified by age and gender) for each of these 2 age groups is 30 children. If there are fewer than 30 children in one or both of these age groups, then we recommend that the audit includes the records of all children in the age group.

Audit of children aged 3 months <6 years: include all children in this group if there are 30 or less, or

- divide the randomised sample into a further 3 groups: 3 months to <12 months; 12 months to <3 years; 3 years to <6 years
- include equal numbers of male and female children in each of these age groups where possible

Audit of children aged 6 years <15 years: include all children in this group if there are 30 or less, or

- divide the randomised sample into a further 3 groups: 6 years to <9 years; 9 years to <12 years; 12 years to <15 years
- include equal numbers of male and female children in each of these age groups where possible

This sample should provide an adequate estimation for quality improvement purposes of the proportion of children receiving specific services. Health services with large service populations should increase the randomised sample size so that the confidence intervals around the sample estimates are not too wide. Health services with smaller service populations (30 children or fewer) should audit all client records. Health services auditing small service populations should be cautious when using and comparing reported data.

Using the child health clinical audit tool and protocol

This protocol provides:

- the rationale behind the questions in the audit tool and how they relate to best practice or current guidelines
- the questions to audit and a description of what to look for in client records, including timeframes around when certain services are scheduled
- explanation of the options available for selection.

The protocol will be valuable for useful interpretation of the reports.

Section 1 General information

This section describes the characteristics of the clients in the sample, including age, sex and Indigenous status.

1.1 Client ID

Assign a unique three-digit identification (ID) number for each client audited. At data input, this three-digit number will be automatically prefixed with the tool and health centre IDs.

To ensure each medical record is only audited once in each cycle, the auditor should refer to the list of clients generated during sampling that includes each client's name, date of birth and client ID number.

Medicare number

The *Medicare Australia Act 1973* states that government-funded health services should be provided to people with a valid Medicare card. People who do not have a Medicare card (for example, overseas visitors) are usually charged for their health care.

Much of the funding for community controlled health services is via Medicare (money is allocated for MBS items). If a client's Medicare number is not on file or has expired, the claim for the service may be delayed or rejected.

1.2 Medicare number recorded

Is the client's current Medicare number recorded in the client's medical record?

Indicate **1-Yes** or **0-No**.

1.3 Date of birth

Record the client's date of birth. Record as dd/mm/yyyy.

1.4 Age at date of audit

Record the child's age at the date the audit is undertaken.

Age is recorded in months for children aged <1 year, and in years for children aged 1 to <15 years. On data entry this is automatically calculated.

1.5 Gender

Indicate gender of client.

Indicate **1-Male** or **2-Female**.

1.6 Indigenous status

Record the client's Indigenous status as stated in the client record. Indicate **one** of the following:

1-Aboriginal

2-Torres Strait Islander

3-Both Aboriginal and Torres Strait Islander

4-Neither Aboriginal nor Torres Strait Islander

5-Not stated if there is no clear record of the client's Indigenous status

1.7 Auditor

Record the name of the person doing the audit. You may want to make a stamp if you are a regular auditor.

1.8 Audit date

You may wish to use a date stamp if using paper audit tool. Record as dd/mm/yyyy.

Note that the audit date will be the same for all clients being audited in this cycle. Even if all auditing cannot be completed on this date, continue to use the same audit date for all clients and audit the medical records retrospectively from this date. All records for this audit must be completed within 3 months of audit date.

Section 2 Attendance at health service

Attendance

By attending a health service, Aboriginal and Torres Strait Islander people can help to ensure they receive primary health care that is matched to their needs, and encourages early detection, diagnosis and intervention for common and treatable conditions such as chronic diseases.

Time since last attendance is a useful indicator of the level of client engagement with the health service. Identifying which staff member was the first point of contact for the client at their last attendance can be used to measure clinic processes and Aboriginal and Torres Strait Islander health professional involvement with program delivery.

Couzos and Murray (2008), suggest studies show that advice from health professionals to Aboriginal clients is often the key reason the clients change their risky behaviours. The health centre is often the major source of health advice, particularly in remote areas.

2.1 Date of last attendance

A record of attendance includes a record that the client was seen by a health care professional (refer to question 2.6 for types of health professionals). Individual care plans will dictate how often a client should be reviewed by a health care professional, and younger children and babies should be seen often. If the client made a visit to the health centre but left without being assessed by a health professional, this should *not* be recorded as having attended the health centre.

It is acknowledged that some clients may never visit the health service itself. If a regular service is provided (e.g. home visits by community nurses to check on child health), this can be included as attendance. It should be recorded in the systems assessment tool (SAT) in the appropriate component or item to show that this service is provided.

Record the **date** the client last attended the health service for care. Record as **dd/mm/yyyy**.

2.3 Reason for last attendance

Table 2.1 Reasons why clients may attend the health service

Reason	Examples
1–Acute care	Infections, trauma
2–Immunisations	Reason is primarily for immunisation (although other things may have been checked as well)
3–Child health check	Well baby check, any routine check
4–Other	Review or treatment by specialist, allied health, social worker, etc

If reason for last attendance is ‘Other’, provide a brief description of reason.

2.2 Unsuccessful follow-up attempt

All clients who have a health check should be followed up and provided with feedback (Queensland Health 2010). Health services may have a system in place to remind staff when a client is due to be seen again. If this system has been activated, or if there is documentation to show that the client (or the carers) have been notified of an appointment but has not presented to the health centre, this is classified as an unsuccessful follow up attempt.

If a client has **not** attended the health centre in the last 12 months, record any documentation of attempts by health centre staff to contact the client for follow up within those 12 months.

Indicate **1-Yes** or **0-No.**

Indicate **9-N/A** if the date last attended is within 12 months of audit date.

Health workers

Aboriginal Health Workers are immensely important to the health and wellbeing of Aboriginal people and communities. For people living in remote areas, Health Workers are often the first health professional they see. More importantly, Aboriginal Health Workers are both critical and integral to ensuring that Aboriginal people and communities receive culturally appropriate, and therefore more effective, health services. They are the gatekeepers of Aboriginal health and the key to Closing the Gap.

Kalunga Research Network, 2010

2.5 First seen by

It is acknowledged that sometimes a health professional will meet more than one criterion, eg an Aboriginal nurse. Correct interpretation of the report is important for usefulness at the health service where the information was collected. Some health services may have a clear policy on which type of health worker should be the first to see clients. This question will help to evaluate implementation of that policy.

When the client last attended the health service, which health professional did the client see **first**?

Table 2.2 Types of health professionals who the client sees first

Type of health worker	Example
1- Aboriginal or Torres Strait Islander health worker or practitioner	Aboriginal and/or Torres Strait Islander health workers working in tertiary institutions, local hospitals, health centres or any primary health care services. Depending on the area of work, health workers may need to obtain a licence or registration. Some Aboriginal and/or Torres Strait Islander health workers may be called Aboriginal and/or Torres Strait Islander Practitioners.
2- Nurse	Registered nurses, enrolled nurses and/or endorsed nurses who are registered/enrolled and/ or endorsed by the Australian Health Practitioner Regulation Agency (AHPRA)
3- General practitioner	Doctors registered with the Royal Australian College of General Practitioners
4- Specialist	A doctor who has specialised in a particular field and is registered with the appropriate specialist college (e.g. an ophthalmologist registered with the Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
5- Allied health professional	Audiologists, chiropractors, dieticians, occupational therapists, podiatrists, psychologists, radiographers, radiation technicians, sonographers, social workers, speech pathologists, physiotherapists, diabetes educators, cardiac rehabilitation therapists, pathologists
6- Other	Any health professional not identified above
7- No record	No record of which health professional the client first saw at the last visit

Section 3 Key information in client record summaries

Child growth and development

Child growth and development are important signs that a child is physically, emotionally, culturally and spiritually healthy (CARPA, 2014).

3.1 Growth chart

A growth chart is a specific record designed to graphically track the progress of the child's physical changes in weight and height, it may also include head circumference. It is important that the growth chart is correct according to the client's sex and age, and that the chart is the standard used by the health centre. Regular recording of growth should be in accordance with local guidelines.

Is there a growth chart present which shows regular recording of the child's weight and height over time?

Indicate **1-Yes** or **0-No**

3.2 Immunisation record

An up to date immunisation record is one that shows signs of being updated each time a client has an immunisation, either at this facility or another. Ideally, an immunisation record shows that immunisations are up to date.

Is there an up to date immunisation record present in the client's record?

Indicate **1-Yes** or **0-No**.

3.3 Recall system

This can be the standard system used in your health centre for recall of recommended child health assessments, immunisations and/or follow-ups. A recall system can be part of a care plan in the electronic health record or a paper record (e.g. a wall chart or appointment book) showing due dates.

Is the client on a recall system for care?

Indicate **1-Yes** or **0-No**.

3.4 Child health check MBS item 715

The child health check needs to be current and completed (and is eligible to be claimed at that location) to be claimable. *If the child is Aboriginal and/or Torres Strait Islander*, is there a record that a general practitioner (GP) has completed an MBS item 715, child health check, in the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is not identified as Aboriginal and/or Torres Strait Islander.

3.5 Alternative child health check

An alternative child health check may be a locally produced and/or locally defined template or careplan that mimics the MBS 715, or it may be the same template completed by a health professional unable to claim a medicare refund. If a MBS item 715 has not been completed, has an alternative child health check been completed in the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if a Child Health Check MBS item 715 is recorded in 3.4.

Section 4 Audit of scheduled immunisations

In recent decades, vaccination has been very successful in eliminating or substantially reducing the rates of many vaccine-preventable diseases (VPDs), such as diphtheria, polio, tetanus, hepatitis B, measles, mumps and rubella, in all Australians, and has made a substantial contribution to improvements in Indigenous child mortality. For some VPDs, control is suboptimal in the general population despite high vaccination coverage (e.g. pertussis). For others, such as invasive pneumococcal disease (IPD), greater burdens of illness still occur in Indigenous persons than in non-Indigenous persons, largely due to the greater prevalence in Indigenous persons of serotypes for which vaccines do not protect, and high exposure levels associated with the environmental issues mentioned above. Timeliness of immunisation can also be a factor. (ATAGI, 2013)

Definition of timeliness

For the purpose One21seventy reporting, the **definition of timeliness** is:

- Immunisations due at **birth** are given within 7 days of birth
- Immunisations due at **2, 4, 6 months** are given within 1 month of due date, however, all immunisations due at 2 months may be given as early as 6 weeks – according to immunisation schedule. (South Australia 2014 schedule recommends immunisation previously due at 2 months of age, now at 6 weeks of age)
- Immunisations due at **12, 18 months** are given within 2 months of due date
- Immunisations due at **4 years** are given within 6 months of due date

If immunisations are received outside the recommended schedule, they will not be counted as timely, even if they are recommended 'catch up' doses.

Timeliness reporting

If immunisation information, including date, is collected, timeliness will be reported for all children under the age of 6 years. Children aged 6 years and over will have only completeness reported.

Additional vaccinations recommended for clients with medical risk factors are not included in this audit.

Data collection

If completing paper based audits, record **all** the immunisations given to the child, and the date given.

Website Data Entry

The data entry page will show all the immunisations that could have been scheduled for the child, according to the child's age and the state immunisation schedule. If the child was not scheduled for an immunisation, it will not show in the data entry page. If the child was given an immunisation that was not scheduled for them, you will not be able to enter this.

Complete the data entry by indicating 1-Yes or 0-No for each immunisation available for the child. To enable timeliness reporting, record the date given.

More than one option for the same immunisation may show, in this case indicate 1-Yes for the immunisation actually given, and 0-No for the immunisation that was not given.

Date of vaccination is not validated on data entry, so care should be taken to accurately record the date immunisations were delivered. It is possible to answer the questions in this section without entering the date given, however, timeliness will not be reported.

No audit of immunisation data

If your health centre does not use One21seventy to report on immunisation status, you can choose **not** to collect immunisation information as part of this child health audit. In this case, enter 'no' for each immunisation, and leave the date field blank.

Table 4.1: Current immunisation schedules (at time of publishing)

State/territory	Effective from	Reference
National (NIPS)	1 July 2013	http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/4CB920F0D49C61F1CA257B2600828523/$File/nips-oct2013.pdf
New South Wales	1 July 2013	http://www.health.nsw.gov.au/immunisation/Pages/schedule.aspx
Victoria	February 2014	http://www.health.vic.gov.au/immunisation/factsheets/schedule-victoria.htm#
Queensland	March 2014	http://www.health.qld.gov.au/immunisation/documents/nips_antigens.pdf
South Australia	October 2014	http://immunisationcalculator.sahealth.sa.gov.au/SAOct2014.pdf
Western Australia	1 November 2014	http://www.public.health.wa.gov.au/2/1714/2/childhood_vaccines.pm
Tasmania	March 2014	http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0017/155312/Aboriginal_and_Torres_Strait_Islander_adult_and_child_immunisation_schedule.pdf http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0018/155313/Immunisation_schedule_2014_for_adult_child.pdf
Northern Territory	1 July 2013	http://www.health.nt.gov.au/Centre_for_Disease_Control/Immunisation/NT_Immunisation_Schedules/index.aspx

Table 4.2: Immunisations and common vaccination brand names

Vaccine abbreviations	Vaccination brand names (examples only — refer to individual state protocols)	Disease, infection or organism
BCG	Bacillus Calmette Guerin	Tuberculosis
DPTa	Boostrix	Diphtheria, tetanus, acellular pertussis (whooping cough)
DPTa IPV	Infanrix Quadracel	Diphtheria, tetanus and acellular pertussis Poliomyelitis
DPTa Hep B OPV	Infanrix Penta	Diphtheria, tetanus, acellular pertussis Hepatitis B Poliomyelitis
DPTa Hib Hep B IPV	Infanrix Hexa	Diphtheria, tetanus and acellular pertussis Haemophilus influenzae type B Hepatitis B Poliomyelitis
Hep A	VAQTA	Hepatitis A
Hep B	H-B-VaxII Energix-B Hexa B	Hepatitis B
Hib/Hep B	Comvax (HepB and Hib)	Haemophilus influenzae type B Hepatitis B
Hib	Hiberix Pedvax	Haemophilus influenzae type B
HPV	Gardasil	Human papillomavirus
MenCCV	NeisVac-C Meningitec	Meningococcal C disease
MMR	Priorix M-M-RII	Measles, mumps and rubella
Hib/MenCCV	Menitorix	Haemophilus influenza type b (Hib) Meningococcal C
Rotavirus	Rotarix Rotateq	Rotavirus
VZV	Varilrix Varivax	Varicella zoster virus (chickenpox)
VZV/MMR	Priorix-Tetra	Varicella zoster virus (chickenpox) Measles, mumps and rubella
Pneumococcal	Prevenar 13	Pneumococcal disease
10vPCV	Synflorix	Pneumococcal disease
23vPPV	Prevenar Pneumovax	Pneumococcal disease

Section 5 Scheduled services

Child health checks

Child health checks are used to plan and track the management of care, through regular checking of risk factors, regularly scheduled services, required pathology tests, immunisations and specialist care.

Additionally, child health checks provide regular opportunities for engaging the child and the family in education about health, and for setting goals aiming at the 'close the gap target' of 'halving the gap in mortality rates for Indigenous children under five by 2018' (Australian Government, 2013).

Many jurisdictions have guidelines for the frequency and composition of health checks. Healthy Under 5 Kids and CARPA (NT), Chronic Disease Guidelines (Qld), Enhanced Aboriginal Child Health schedule (WA) and the National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people are examples of widely used guidelines.

Measurements and results

Measurements and results

State and territory guidelines recommend that **weight** and **length/height** should be checked *at least* every 3 months from birth to 1 year, at 18 months of age, and then at least annually. Weight and length/height measurements are included in routine growth assessment for infants, children and adolescents.

5.1 Weight

Is there a record of a weight measurement *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

If yes, record the **date** and **weight measurement** (kg up to 2 decimal points) of the most recent weight taken at a time when the child was not acutely ill, if available.

5.2 Length or height

Recumbent length measurements should be taken for children for the first 2 years, and standing height measurements from 2 years. Is there a record of a length or height measurement *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No.**

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

If yes, record the **date** (dd/mm/yyyy) and **length/height measurement** (cm up to 2 decimal points) of the most recent length/height.

Head circumference

QH (2010) describes the correct procedure for head circumference measurement: Measure head circumference (to the nearest 0.1cm), over largest part of head just above the eyebrows and above the ears. Repeat measurement twice more and average the measurements, then record.

The head circumference growth curve normally follows that of height and weight. Head circumference should be checked at least every 3 months from birth to 2 years (QH, 2010).

NACCHO/RACGP (2012) recommend that growth monitoring, including head circumference be done at each health visit to coincide with immunisations at 2, 4, 6, 12, 18 and 24 months.

5.3 Head circumference

Head circumference measurements are an indication of how well the brain is growing and is measured using a flexible, non-stretch measuring tape, and is recorded or plotted on a head circumference growth chart by sex (QH, 2010).

If the child is <12 months old, is there a record of a head circumference measurement *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥12 months old, or has not attended within 12 months of audit date.

If yes, record the **date** (dd/mm/yyyy) and **head circumference measurement** (number with up to 2 decimal points) of most recent head circumference. If **9-N/A** is indicated the measurement must be entered as **0**.

BMI

Body mass index (BMI) determines if a client has a healthy weight for their height. BMI is calculated by dividing the weight (in kilograms) by the square of the height (in metres). It is a useful screening tool for identifying underweight, overweight and obesity in children.

$$\frac{\text{Weight (kg)}}{[\text{height (m)} \times \text{height (m)}]}$$

OR kg/m^2.

It is recommended that BMI is plotted for children once a year from 2 years (NACCHO/RACGP 2012). Health services have definitions and protocols for the follow up, monitoring and treatment of abnormal growth in children.

BMI Classification (QH 2010)	
<5th percentile	Underweight
5th-85th percentile	Healthy weight
85th-<95th percentile	Overweight
≥ 95th percentile	Obese

5.4 BMI

If the child is ≥4 years old and resident in the Northern Territory OR if the child is ≥2 years old and resident in any other state or territory, is there a record of a BMI calculation *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <4 years old in the Northern Territory; or is <2 years old in any other state or territory; or has not attended within 12 months of audit date.

If yes, record the **date** (dd/mm/yyyy) and **BMI value** (number with up to 2 decimal points) of the most recent calculation.

Hb

A low haemoglobin (Hb) reading can be a sign of iron deficiency anaemia. Iron gives the body energy and aids blood formation. Anaemia is common in Aboriginal and Torres Strait Islander children, particularly in the 6–30 month age group (QH, 2010).

Hb can be tested in a laboratory as part of blood film, or at point of care, using a capillary sample and a haemocue type facility.

If your health service is in a community with high prevalence of iron deficiency anaemia, there may be a policy on more frequent Hb testing for children.

Individual children who may be at risk include those with a history of low birth weight or pre-term birth, maternal anaemia, twin, failure to thrive, and/or chronic infections (NACCHO/RACGP, 2012). Other reasons for low Hb include starting food later than 6 months old, not enough food, and/or drinking cow's milk before 1 year old (CARPA, 2014)

CARPA (2014) recommend Hb reading every 6 months from 6 months of age to 5 years, then at 5,10 and 15 years of age. NACCHO/RACGP (2012) acknowledge that there are jurisdictional differences in the screening for anaemia, however, they do suggest screening at 6-9 months and 18 months of age in area of high prevalence of iron deficiency anaemia and in children with risk factors.

5.5 Haemoglobin

≥6 months

Where children live in a geographical area of high prevalence of anaemia and parasitic infection the health service protocols or guidelines may indicate haemoglobin as a standard check.

If the child is ≥6 months old and haemoglobin is indicated, is there a record that the child had a haemoglobin measurement *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <6 months old or has not attended within 12 months of audit date or Haemoglobin is not indicated in your area.

If yes, record the **date** (dd/mm/yyyy) and **haemoglobin result** (g/L, up to 2 decimal points).

Urinalysis

Routine urinalysis screening for kidney disease is not a recommended unless there is a clinical indication (NACCHO/RACGP 2012). Examples of this may be suspicion of a urinary tract infection (UTI), sexually transmitted infection (STI) or where children are living in areas with high rates of chronic kidney disease (CARPA, 2014).

Is urinalysis screening for proteinuria indicated in your area?

If your health centre has a policy on urine screening, please follow this policy, because it will provide the justification for including this question in your audit. If your health centre does not have a clear policy on proteinuria screening, the above guidelines (CARPA, 2014) may help you make the decision whether this process would be indicated for your area.

5.6 Urinalysis for proteinuria

If the child is in Queensland and urinalysis is indicated or the child is ≥10 years old and resident in the Northern Territory, is there a record that the child had a urinalysis for proteinuria *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is in Queensland and urinalysis not indicated, or is <10 years old in the Northern Territory, or is in New South Wales, Victoria, South Australia, Western Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Appearance

5.7 Testes check

This is a clinical examination by a qualified health professional in line with the health centre policy on roles within the health team. It involves checking whether both testes have descended and are palpable.

If the child is <12 months old and male, is there a record that the child had his testes checked *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is female or is ≥12 months old, or has not attended within 12 months of audit date.

5.8 Hip examination

<12 months

This should be a clinical examination by a qualified health professional in line with the health centre policy on roles within the health team. It involves assessing hips for evidence of hip dysplasia or unequal abduction.

If the child is <12 months old, is there a record that the child had their hips examined *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥12 months old, or has not attended within 12 months of audit date.

5.9 Gait

Qld ≥12 months

NSW ≥18 months

This is a clinical examination by a qualified health professional in line with the health centre policy on roles within the health team. It includes assessment of limbs, joints and movement, coordination of movement, balanced walking, widely placed walking (bow legged or swagger), knock-knees, in-toeing, out-toeing, limping or flat feet.

If the child is ≥12 months old and resident in Queensland OR ≥18 months old and resident in New South Wales, is there a record that the child had their gait examined *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <12 months old in Queensland, is <18 months old in New South Wales, is in Victoria, South Australia, Western Australia, Tasmania, Northern Territory or the Australian Capital Territory, or the child has not attended within 12 months of audit date.

Skin infections

Staphylococcal ('staph') infections of the skin can cause skin sores with infected tissue under the skin and sepsis (infection of the blood).

Scabies is currently endemic in many remote Aboriginal communities with prevalence up to 50% in children. It underlies 50-70% of streptococcal skin infections (Department of Health and Families NT, 2010). Streptococcal infections, such as Group A, cause strep throat, scarlet fever and rheumatic fever as well as Group B infection in newborn babies.

Scratching the scabies can lead to infected sores, kidney and heart problems (CARPA, 2014; QH, 2010).

Children living in areas with high rates of infectious skin disease (scabies and impetigo) should have skin checked for scabies and impetigo opportunistically, and as part of an annual health assessment (NACCHO/RACGP, 2012)

QH (2010) and CARPA (2014) suggest that skin be checked with each immunisation, and yearly from age 2 years.

5.10 Skin check

This is a clinical examination by a qualified health professional in line with the health centre policy on roles within the health centre, and includes assessment of skin for abscesses, boils, carbuncles, cellulitis, scabies, crusted scabies, eczema, fungal infections, head lice, molluscum contagiosum, tinea, skin sores, rashes, bruises, bites and impetigo.

Is there a record that the child had a skin check *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

Oral hygiene

Compared to the overall Australian population of similar age, Aboriginal and Torres Strait Islander children generally have more than twice the number of dental caries and a greater proportion of untreated caries. Furthermore, poor periodontal health is evident in younger populations (QH, 2010).

Establishing proactive **oral hygiene** practices and healthy food choices is essential for overall physical wellbeing. Oral health influences appearance, diet and speech. Poor oral health has been shown to affect general health, while poor general health can lead to oral health problems (QH, 2010).

Children 0-5 years have opportunistic and/or annual review with a dental health professional. People aged 6-18 years should have an annual dental health review (NACCHO/RACGP, 2012).

5.11 Oral hygiene

≥6 months

This examination is a visit by a dentist, or a teeth and gum examination by a qualified health professional in line with the health centre policy on roles within the health team. The examination includes a visual check of the mouth, teeth and gums, to report the condition of the teeth as healthy, decayed, or maligned. Gums should be reported as being healthy, bleeding or swollen. 'Lift the lip' screening tool may be used, and if recorded, is an indication that a child has had an oral check

If the child is ≥6 months old, is there a record that the child has had an oral hygiene examination *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <6 months old, or has not attended within 12 months of audit date.

Examinations

Cardiac auscultation

Listening to the heart assists in gathering information about the heart rate and rhythm, valve function and anatomical defects. It assists in the detection of rheumatic heart disease. Aboriginal and Torres Strait Islander peoples living in remote areas have among the highest rates of this disease in the world (QH, 2010).

NACCHO/RACGP (2012) recommends all people have cardiac auscultation annually to assess for previously undiagnosed RHD.

5.12 Cardiac auscultation

NT≥12 months

This is a clinical examination by a qualified health practitioner in line with the health centre policy on roles within the health team. A medical officer is required to listen to the child's heart at any presentation and check for unusual sounds or murmurs. Other practitioners are not expected to distinguish heart sounds unless they have been appropriately trained.

If the child is resident in the Northern Territory and ≥12 months, or resident in any other state or territory, is there a record of cardiac auscultation *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <12 months old in the Northern Territory, or has not attended within 12 months of audit date.

Respiratory disease

Respiratory disease is five to six times more common in the Aboriginal and Torres Strait Islander population compared with other Australians, and respiratory infections are the second-most common cause of hospitalisation. Increased tobacco smoking in the child's environment and pneumococcal infection rates are also important contributors to poor respiratory health. Asking children about breathlessness is a good screening question to address these issues (QH, 2010).

NACCHO/RACGP (2012) states that immunisation against pneumococcal disease and influenza is also important in the prevention of lung disease, as is addressing lifestyle, eg tobacco smoking and exposure to tobacco smoke.

5.13 Respiratory examination

This is a clinical examination by qualified health staff in line with the health centre policy on roles within the health team. The examination includes checking respiratory rate, observing for signs of chest recession, noisy breathing, wheezing, breathlessness, asthma or cough.

Is there a record that the child had a respiratory examination *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

Ear Disease

The burden of ear disease and hearing loss is high in Aboriginal and Torres Strait Islander populations. Nine per cent of the Aboriginal population under 15 years reports a hearing problem. Hearing loss is a major contributor to potential language and speech delays, poor education rates and unemployment. A high proportion of Aboriginal and Torres Strait Islander infants and children suffer from chronic suppurative otitis media, and this has a negative effect on the education attainment of Aboriginal and Torres Strait islander school children (Australian Government, 2013).

Screening for otitis media pathology by otoscopy when a child is younger than 4 years should be done by the medical officer, audiologist, registered nurse or health professional trained in otoscopy for very young children, due to the risk of trauma (QH, 2010).

NACCHO/RACGP (2012) recommends yearly (and opportunistic) monitoring for hearing loss for children <15 years. The use of parental questionnaires, otoscopy or typanometry should be used to identify otitis media that can lead to hearing loss.

5.14 Ear examination

For the purpose of the audit, this question is not about a hearing test. For preschool children and infants, this is an otoscopic examination by a qualified health professional in line with the health centre policy on roles within the health team. For school-age children, this may include hearing screening, otoscopic examination with or without audiometry.

It does *not* need to be an ear, nose and throat (ENT) specialist examination or an audiological assessment, unless this is the standard policy for the service. However, for the purpose of this audit, an ear examination by an ENT specialist in the last 12 months does qualify as a 'yes' answer to this question.

In Queensland, children currently under the management of an ENT specialist or audiologist would not have an otoscopic examination or hearing screen as described above. In these cases, look for documentation that the child has been assessed by the ENT or audiologist within the past 12 months.

Is there a record that the child has had their ears examined *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

Eye examination

Infants less than 6 months age should have a general eye examination as part of newborn and 3-6 month health assessment (NACCHO/RACGP, 2012)

5.15 Eye examination

NT≥4 years

This question is not about a visual acuity test. The eye examination should include general eye health, appearance of the eye (normal or abnormal), ability to follow objects (yes or no), red eye reflex (present or not present/absent), equal corneal light reflex (yes or no), cover test at 4 years (movement or no movement).

It should be documented in the client record if a child is wearing glasses.

If the child is resident in the Northern Territory and ≥4 years old or resident in any other state or territory, is there a record that the child had their eyes examined *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <4 years old in the Northern Territory, or has not attended within 12 months of audit date.

Trachoma

Trachoma is an infectious eye disease caused by Chlamydia trachomatis. It is spread through contact with eye or nose discharge of an infected person on flies, fingers, towels and handkerchiefs. After years of repeated infection, the inside of the eyelid may be scarred so severely that the eyelid turns inward and the lashes rub on the eyeball, scarring the cornea. If untreated, this can lead to the formation of irreversible corneal opacities and blindness. Cases of trichiasis require assessment and timely referral to an ophthalmologist (CDNA, 2014).

The prevalence of blindness in Aboriginal and Torres Strait Islander people is 6 times higher than non-Aboriginal people, and trachoma accounts for 9% of this blindness. Australia is the only developed nation in the world to still have endemic trachoma. Although trachoma was eliminated from most parts of Australia by the 1930s, it continues to be a significant public health problem in Aboriginal and Torres Strait Islander communities in many rural and remote areas of the NT, SA and WA (CDNA, 2014).

Children predominantly bear the active infection but pain, scarring and damage to the eye manifests in adulthood. Treatment and control of trachoma has been implemented using the SAFE strategy (surgery, antibiotic treatment, facial cleanliness and environmental improvement), which includes providing access to clean water, to help reduce the activity and spread of the disease.

Is trachoma screening indicated in your area? If your health centre has a policy on trachoma screening, please follow the procedure, because it will provide the justification for including trachoma screening in your audit. The National Guidelines for public health management of trachoma (2014) will provide further information.

NACCHO/RACGP (2012) recommends community screening in trachoma endemic areas.

5.16 Trachoma

NT ≥4 years

All states and territories if indicated

Trachoma is often checked as a school-age community screening program.

A trachoma check should be a clinical examination by a qualified health professional in line with the health centre policy on roles within the health team using World Health Organization (WHO) grading, and include a record of whether the child has a clean face (as part of the National Trachoma Surveillance System)

If the child is ≥4 years old and resident in the Northern Territory or resident in any other state or territory and trachoma check is indicated, is there a record that the child has been checked for trachoma *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <4 years old in the Northern Territory or if trachoma screening is not indicated, or has not attended within 12 months of audit date.

Developmental

Developmental milestones

Developmental milestones are set-specific tasks that most children achieve within a certain age range. Milestones are used to check a child's development, or ability to perform increasingly more complex fine-motor, gross-motor, and cognitive activities as they mature. The age at which a normally developing child attains that milestone can vary. Promoting parent/carer/family and child interaction through play, conversation, and mental and physical stimulation is vital for a child's development.

Note that child 'growth' is different from 'development'; the former refers to the child's physical changes only.

Several resources are available for assessing a child's development:

- The Parent evaluation of developmental status (PEDS) is a method for detecting developmental and behavioural problems in children from birth to 8 years. This methodology involves asking parents to complete a 10-item questionnaire, which takes only a few minutes http://www.rch.org.au/ccch/resources_and_publications/Monitoring_Child_Development
- The Healthy Under 5s kids' guidelines (HU5Ks) http://remotehealthatlas.nt.gov.au/healthy_under_5_kids_program.pdf

5.17 Developmental milestones

Children <4 years

This assessment includes milestones being observed or of discussion with parents regarding developmental milestones. This should be a clinical assessment by a qualified health professional in line with the health centre policy on roles within the health team.

If the child is <4 years old, is there a record that the child has had their developmental milestones checked *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥4 years old, or has not attended within 12 months of audit date.

Vision

Indigenous children are five times less likely to have vision loss than non-Indigenous children. However, by the time they reach adulthood, they are six times more likely to be blind and three times more likely to have low vision (Centre for Eye Research Australia, 2013). Even before a child is old enough to undergo a visual acuity test, eyes should be checked for eye problems that may affect visual acuity.

Visual Acuity

In the >5 years age group, there should be a record of visual acuity checked for long and short-sightedness, and a cover test for both eyes to test near and distant movement. This should be done when the child starts school, and again at about 12 years of age, but it is not a yearly test.

It should be documented in the client record whether the child is wearing glasses.

NACCHO/RACGP (2012) and CARPA (2014) recommend children aged 4-5 years are screened once only for visual acuity. The E test visual acuity chart has been extensively researched as the best suitable tool for this group (QH, 2010).

5.18 Concerns about vision

Qld, NT Children ≥6 months

NSW, WA all children

For the purpose of this audit, this question is **not** about a visual acuity test. For younger children, health professionals should inquire whether the child's carer or family have any reason to believe that the child may not be seeing normally. Symptoms may include sore/watery/itchy eyes, photophobia, double or blurred vision. Signs may include obvious strabismus (squint), tilting head, rubbing eyes excessively, excessive blinking, general clumsiness, recurring blepharitis/conjunctivitis (NTG, 2009).

If the child is ≥6 months old and is resident in Queensland or the Northern Territory OR the child is resident in New South Wales or Western Australia, is there any record of discussion of parental concern around the child's vision *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <6 months old in Queensland or the Northern Territory, or is in Victoria, South Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

5.19 Hearing

NSW, Vic, Qld, SA, WA all children

NT ≥6 months

For the purpose of this audit, this question is not about an audiometry test. Health professionals should inquire whether the child's carer or family have any reason to believe that the child may not be hearing normally, and depending on the child's age, should attempt to distract the child with an appropriate noise.

If the child is resident in New South Wales, Victoria, Queensland, South Australia, Western Australia or ≥6 months old and resident in the Northern Territory, is there any record of discussion of parental concerns around the child's hearing *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <6 months old in Northern Territory, or is in Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Parent–child interaction

Promoting and monitoring infant/child-parent/carer interaction and relationships is important to the socio emotional and cognitive development of the child. There are evidence based tools available for assessment of parenting interactions and child behaviour that can be used as part of the strategies to monitor child socio emotional wellbeing. For example, the Ages and Stages Social and Emotional Questionnaires, Nursing Child Assessment Satellite Training – Parent-Child (AHMC, 2011).

For pre-school children, family support and parenting programs continue to be the most effective method of preventing the onset of emotional and behavioural problems, which predispose to mental illness in later childhood and adolescence (RANZCP, 2010). RANZCP (2010), also suggest that services should provide parenting interventions that enhance the parent infant relationship.

If your health centre is not in Queensland, Western Australia or the Northern Territory, is parent–child interaction assessment indicated in your area?

If your health centre has a policy on assessing parent–child interaction, please follow it, because it will provide the justification for including this question in your audit. If your health centre does not have a clear policy on assessing parent–child interaction, it may be useful to access the report at: http://www.ranzcp.org/Files/ranzcp-attachments/Resources/peips_report-pdf.aspx for guidance.

5.20 Parent–child interaction

QLD, WA <4 years

NT<2 years

This should include an assessment by qualified health staff in line with the health centre policy on roles within the health team. This assessment should include parent or carer concerns, or anxiety about coping, direct or indirect exposure to violence, and the child's general behaviour. The interactive relationship between the parent or carer and the child should also be observed and recorded.

If the child is <4 years old and resident in Queensland or Western Australia; OR <2 years old and resident in the Northern Territory; OR resident in another state or territory and parent–child interaction is indicated, is there a record of parent–child interaction being assessed *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**

Indicate **9-N/A** if child is ≥4 years old in Queensland or Western Australia, or is ≥2 years old in the Northern Territory, or is in New South Wales, Victoria, South Australia, Tasmania or the Australian Capital Territory and not indicated, or has not attended within 12 months of audit date.

Brief intervention

Brief interventions

Brief interventions are important protective or risk-assessment discussions. They may be delivered in a variety of ways as brief interventions, depending on the approach of the clinician and the circumstances of the client. Approaches to recording brief interventions will also vary.

For the purpose of this audit, the record of a brief intervention should indicate either that a brief intervention has been delivered, or that there has been discussion and/or advice given on the issue. For example, if breastfeeding, there should be a record that the parent or carer has been asked about breastfeeding knowledge and their ongoing intentions or interest in breastfeeding if their child is <2 years. This may include developing a care plan to promote breastfeeding.

Nutrition

Nutrition

Infants should be exclusively breastfed until around 6 months of age when solid foods are introduced. Breastfeeding should be continued while solid foods are introduced until 12 months of age and beyond, for as long as the mother and child desire (NHMRC, 2013).

The general Australian dietary guidelines are relevant to Aboriginal and Torres Strait Islander peoples. In particular, increased consumption of vegetables and fruits could be expected to improve the health and nutritional status of Aboriginal and Torres Strait Islander people (p 106 NHMRC, 2013).

Nutrition in utero and during the first 2 years of life is associated with increased risk of chronic disease in adult life. It is important to promote breastfeeding and healthy lifelong eating habits in these early years, and for parents or carers to become healthy role models. Providing positive feedback to parents or carers can reinforce the continuation of good nutrition practices (QH, 2010).

There are well-recognised links between a healthy diet for infants and brain development and cognitive functioning, which flow on to attainment of literacy and numeracy skills, and school retention rates (COAG, 2009). *Poor nutrition is a major risk factor for many of the diseases with higher prevalence among Aboriginal and Torres Strait Islander groups and it has been estimated that 19% of the national Indigenous burden of disease is attributable to poor diet* (p 105 NHMRC, 2013)

5.21 Breastfeeding

<2 years

The optimal mix of interventions to improve breastfeeding practices includes education of mothers, peer support, hospital practices such as rooming-in and early skin-to-skin contact, staff training, development and implementation of hospital policies, media campaigns, and paid maternity leave (NHMRC, 2013)

If the child is <2 years old, is there a record of enquiry or discussion of breast feeding *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥2 years old, or has not attended within 12 months of audit date.

5.22 Nutrition

Children, particularly those under 5 years of age, are especially susceptible to socioeconomic inequalities that lead to marked differentials in health and nutrition (NHMRC, 2013). Discussion with the child and/or carer should revolve around encouraging healthy eating and drinking practices. Asking about the child's food intake in the previous 24 hours may obtain an idea of the child's diet history, for a reference to improving food choices.

Is there a record of enquiry or discussion of nutrition, or introduction of solids if the child is <21 months old, *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

Environmental factors

Tobacco smoke

Passive smoking is breathing the smoke form other people's cigarettes. Passive smoking is a risk factor for sudden infant death syndrome (SIDS), pneumonia, bronchitis, croup, ear infections, asthma, learning difficulties, behavioural problems, heart disease and meningococcal disease. Children of smokers are 4 times more likely to take up smoking in later life (KAMSC and WACHS, 2011)

Explaining to the mother the importance of not exposing her baby to cigarette smoke, suggesting smokers to smoke outside, and making sure nobody else smokes around the baby are positive steps in reducing passive smoke exposure to children (QH, 2010).

5.23 SIDS prevention

<12 months

If the child is <12 months old, is there a record of enquiry or discussion of SIDS prevention *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥12 months old, or has not attended within 12 months of audit date.

5.24 Passive smoking

NT <2 years

If the child is <2 years old and resident in the Northern Territory OR resident in any other state or territory, is there a record of enquiry or discussion of passive smoking risk *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥2 years old in Northern Territory, or has not attended within 12 months of audit date.

Safety, infection prevention and hygiene

Health outcomes relate strongly to social, economic and environmental factors. Health professionals need to advise parents and carers how to alter the environment to allow for safe play, exploration, learning and teach children about safety (QH, 2010).

CARPA (2014), RACGP (2012), QH (2010) and KAMSC and WACHS (2011) suggest regular discussion and guidance about age appropriate safe environments for infants and children.

5.25 Infection prevention and hygiene

NT<3 years

In younger children (0–3 years), this includes washing hands and face, washing the infant, nappy hygiene and toilet training. In older children (≥3 years) this includes washing hands and face, showering, bathing, brushing teeth and blowing the nose.

If the child is resident in Queensland, South Australia or Western Australia OR the child is <3 years old and resident in the Northern Territory, is there a record of enquiry or discussion of infection prevention/ hygiene *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥3 years old in the Northern Territory or is in New South Wales, Victoria, Tasmania or the Australian Capital Territory or has not attended within 12 months of audit date.

Oral health

A healthy mouth enables people to eat, speak and socialise without pain, discomfort or embarrassment. Programs that encourage parents or carers to make appropriate dietary choices, such as choosing foods that are low in sugar and fat, and promoting good oral hygiene practices can assist in addressing oral disease issues. Aboriginal and Torres Strait Islander children generally have more than twice the number of dental caries and a greater proportion of untreated caries (QH, 2010).

NACCHO/RACGP (2012), recommend all people aged 6-18 years have annual review with a dental health professional. Children aged 0-5 years should have opportunistic reviews of the teeth, gums and oral mucosa as part of a health assessment (NACCHO/RACGP, 2012)

5.26 Oral health

NSW, VIC, Qld ≥ 6 months

WA ≥ 8 months

NT ≥6 months and <5 years

'Lift the lip' screening tool may be used, and if recorded, is an indication that a child has had an oral check, with opportunity for brief intervention.

If the child is ≥6 months old and resident in New South Wales, Victoria or Queensland OR the child is ≥8 months old and resident in the Western Australia OR the child is ≥6 months and <5 years old and resident in the Northern Territory, is there a record of enquiry or discussion of oral health *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <6 months old in New South Wales, Victoria or Queensland, is <8 months old in Western Australia, is <6 months old or ≥5 years old in the Northern Territory, is in South Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Injury prevention

RACGP (2012), suggest 'injury prevention' is part of preventive counselling and advice at every age related child health check.

5.27 Injury prevention

NSW ≥18 months

Qld <4

SA ≥6 months

NT <3 years

Injury prevention and safety promotion in children relates to more than just supervision. It should include a discussion and advice to parents or carers on how to alter the environment to allow for safe play, exploration, learning and teaching children about safety (QH, 2010). Injury prevention can also include a discussion around preventing bites, burns, falls, poisoning, drowning and other specific injuries. *If the child is ≥18 months old and resident in New South Wales OR resident in Victoria or Western Australia OR <4 years old and resident in Queensland OR ≥6 months old and resident in South Australia OR <3 years old and resident in the Northern Territory*, is there a record of clear enquiry or discussion of injury prevention *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <18 months old in New South Wales, is ≥4 years old in Queensland, is <6 months old in South Australia, is ≥3 years old in the Northern Territory, is in Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Domestic/ Social/ Environmental factors

Social determinants of health

The health of Aboriginal and Torres Strait Islander people is determined by factors outside the health system. Key social determinants of health include housing, education and employment. Higher proportions of Aboriginal and Torres Strait Islander households live in conditions that do not support good health (Australian Government, 2013). Poorer health status is indisputably linked with poverty and deprivation. Studies show considerable levels of poverty within Aboriginal households. Income inequality is associated with higher population rates of mortality, infant mortality, death from cardiovascular disease and homicide (Western Australian Aboriginal Child Health Survey; http://aboriginal.childhealthresearch.org.au/kulunga-research-network/waachs.aspx).

5.28 Domestic/social environment

WA <5 years

NT <6 years

Discussion should include living conditions generally, as well as exposure to physical and emotional violence, substance misuse and gambling.

If the child is resident in New South Wales, Victoria, Queensland or South Australia OR the child is <5 years old and resident in Western Australia; OR the child is <6 years old and resident in the Northern Territory, is there a record of enquiry or discussion of domestic/social environment *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥5 years old in Western Australia, or is ≥6 years old in the Northern Territory, or is in Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

5.29 Social/family support

Qld <4 years

WA <5 years

NT<6 years

Discussion should include family relationships and the availability and accessibility of support services, community and cultural background.

If the child is resident in New South Wales, Victoria or South Australia OR the child is <4 years old and resident in Queensland OR the child is <5 years old and resident in Western Australia OR the child is <6 years old and resident in the Northern Territory, is there a record of enquiry or discussion of social or family support *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥4 years old in Queensland, or is ≥5 years old in Western Australia, or is ≥6 years old in the Northern Territory, or is in Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

5.30 Financial situation

Only WA, NT <5 years old

Discussion should include employment opportunities, access and availability of support services such as Centrelink, and financial management advice within the area.

If the child is <5 years old and resident in Western Australia or the Northern Territory, is there a record of enquiry or discussion of financial situation *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥5 years old in Western Australia or the Northern Territory, is in New South Wales, Victoria, Queensland, South Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

5.31 Housing condition

WA <5 years

Discussion should include maintenance and safety of housing, clean air and drinking water, suitable food preparation areas and storage facilities, heating and cooling, effective sewerage, safe removal of waste and control of pests, the number of people living in the house and if any major repairs are required.

If the child is <5 years old and resident in Western Australia OR if the child is resident in any other state or territory, is there a record of enquiry or discussion of housing condition *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≥5 years old in Western Australia, or has not attended within 12 months of audit date.

5.32 Food security

Qld all children

WA <5 years

Food security refers to the ability to access safe nutritious, affordable foods and the capacity to obtain them. At an individual or family level, food insecurity can be characterised by running out of food and being unable to afford to buy more (NHMRC, 2013). Discussion should include the availability, affordability, accessibility and attainment and storage of appropriate and nutritious food on a regular and reliable basis.

If the child is resident in Queensland OR the child is <5 years old and resident in Western Australia, is there a record of enquiry or discussion of food security *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is in New South Wales, Victoria, South Australia, Tasmania, the Northern Territory or the Australian Capital Territory, or is ≥5 years old in Western Australia, or has not attended within 12 months of audit date.

Developmental factors

Development

Early childhood is when children develop a range of essential capabilities including social, emotional, language, cognitive and communication skills that provide the foundations for formal learning and relationships in later life. During the middle childhood period (approximately 6-10 years) physical and mental development occurs and learning and social behaviours are established (p 32 Australian Government, 2013).

5.33 Physical and mental stimulation

NSW ≥ 6 months

Qld, WA, NT <5 years

Topics for discussion and advice should include opportunities for children to interact with adults and other children to encourage the social skills of cooperation, helping, caring and sharing. For language and cognitive stimulation, talking with and reading to, encourages development. Children also require a safe and secure place in which to run, jump, climb and play.

If the child is ≥6 months old and resident in New South Wales OR the child is resident in Victoria OR the child is <5 years old and resident in Queensland, Western Australia or the Northern Territory, is there a record of enquiry or discussion of physical and mental stimulation *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <6 months old in New South Wales, is ≥5 years old in Queensland, Western Australia or the Northern Territory, is in South Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Physical Activity

The benefits of being active are well documented. Australian physical activity guidelines recommend activity for specific age groups from under 2 years to 55 years and over. QH (2010) suggest physical activity brief intervention begins at 5 years. NACCHO/RACGP (2012), recommend that the level of physical activity is assessed at least yearly for all people. Advice and referral to appropriate activities should be recorded.

5.34 Physical activity and rest

NSW ≥3 years

Qld >5 years

WA >3 years

NT >2 years

This discussion or enquiry should recognise the importance of physical activity that is balanced with periods of rest. Physical activity includes everyday activities (e.g. active play, walking to school) or organised activities (e.g. team sports). Vigorous physical activity makes you 'huff and puff' and should be balanced with periods of rest or quiet time.

If the child is ≥3 years old and resident in New South Wales OR if the child is >5 years old and resident in Queensland OR if the child is >3 years old and resident in Western Australia OR if the child is >2 years old and resident in the Northern Territory, is there a record of enquiry or discussion of physical activity and rest *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <3 years old in New South Wales, is ≤5 years old in Queensland, is ≤3 years old in Western Australia, is ≤2 years old in the Northern Territory, is in Victoria, South Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Education

Going to school every day is vital to improve levels of general education, which, in turn, is known to improve child health. Hungry, tired or anaemic children, and children with poor hearing and acute or chronic health problems, will find it much more difficult to concentrate and to learn. Addressing health problems at school can improve overall health, classroom behaviour and school attendance. It is important for teachers, health staff and community members to work together to inform children of both the traditional and western ways of looking after health and wellbeing. The school-aged health check (screening) may be the only time some children are seen by health staff. In communities where school attendance is poor, other ways of reaching children are required, such as opportunistic health assessments

(Northern Territory Government, Department of Health and Families, 2007)

5.35 Education progress

≥5 years old

This discussion should include providing information or advice to parents or carers about school-aged children, and emphasise that school attendance, educational achievement and health concerns affect learning. Preferably, the discussion should involve family, clan, skin or community groups and be undertaken at every possible opportunity during contacts in the community or health centre.

If the child is ≥5 years old, is there a record of enquiry or discussion of education progress *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <5 years old, or has not attended within 12 months of audit date.

Social emotional wellbeing

Relationships and the quality of experiences are the way in which babies and young children come to know the world and their place in it. Relationships and experiences also provide the loving context that is necessary to comfort, protect, encourage and offer a buffer against stressful times. Through relationships, young children develop social and emotional wellness. Developing the capacity to experience and regulate emotions, form secure relationships, and explore and learn — as well as to feel wanted, loved and secure — will help children's social and emotional wellbeing. Infants, children and young people whose social and emotional wellbeing is at risk include those experiencing feelings that impact on their social and emotional wellbeing, and those at risk of neglect or abuse and future mental health difficulties (QH, 2010).

NACCHO/RACGP (2012), recommend that all people 12-24 years have a psychosocial assessment to determine risk factors affecting wellbeing.

5.36 Social and emotional wellbeing

NSW, Vic, SA, Tas, ACT, NT >5 years

This discussion should also include providing advice to parents or carers on whether the child has the ability to form satisfying relationships with others, play, communicate, learn, face challenges, and experience emotions. Look for evidence of the child experiencing thoughts or feelings of suicide or self-harm.

If the child is ≥ 5 years old and resident in New South Wales, Victoria, South Australia, Tasmania, the Australian Capital Territory or the Northern Territory; OR all children in Queensland and Western Australia, is there a record of enquiry or discussion of social and emotional wellbeing *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≤5 years old in New South Wales, Victoria, South Australia, Tasmania, the Australian Capital Territory or the Northern Territory, or has not attended within 12 months of audit date.

Sexuality

Establishing relationships with local community elders, Aboriginal staff and health clinic staff is important for understanding what and how children learn about sexuality within their community. Schools working in partnership with the local community can ensure all customs and practices are considered, and programs are modified accordingly, to ensure that the most appropriate and valued program is delivered (Northern Territory Government, 2007)

NACCHO/RACGP (2012) suggest all young people 12 -24 years should be provided tailored anticipatory guidance and sexual health education as part of an annual health assessment and opportunistically.

5.37 Sexual and reproductive health and safe sex advice

WA >3 years

NT ≥5 years

If the child is >3 years old and resident in Western Australia OR the child is ≥5 years old and resident in the Northern Territory, is there a record of enquiry or discussion of sexual and reproductive health or safe sex advice *at least once* within the past 12 months?

This discussion should include providing advice to parents or carers, or the child (as appropriate) about their bodies, reproduction, sexuality and safe sex. The discussion may also include physical, social and emotional development; sexuality and stereotypes; shaping of identity; changing roles, peer pressure, expectations, responsibilities and relationships; understanding the significance of community values; attitudes and acceptable standards of behaviour; and understanding harmful situations and behaviours, and how they can be minimised.

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≤3 years old in Western Australia, is <5 years old in the Northern Territory, is in New South Wales, Victoria, Queensland, South Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

Risk factors

Risk factors

The factors that are associated with ill health, disability, disease or death are known as risk factors. Risk factors may be behavioural, biomedical, environmental, genetic, or demographic. Risk factors often coexist and interact with one another (p 50, Australian Government, 2013).

Lifestyle choices, for example, alcohol, tobacco and drug use, lack of physical activity and poor nutrition are risk factors for chronic disease. QH (2010) suggest annual assessment of alcohol (at 10 years), tobacco (at 5 years) and other drug use (at 8 years).

NACCHO/RACGP (2012), recommend annual assessment of smoking status in all people over 10 years, alcohol use in all people 10-15 years and drug use in young people 12-24 years.

5.38 Smoking

≥5 years old

This discussion should include the child and parent or carer, and focus on lifestyle choices, risk behaviour, and a healthy lifestyle that excludes smoking. Look for evidence of the child smoking, and if so, how many cigarettes per day. If there is evidence of the child smoking, a prompt referral to the appropriate service is required (QH, 2010)

If the child is ≥5 years old, is there a record of enquiry or discussion of smoking *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <5 years old, or has not attended within 12 months of audit date.

5.39 Alcohol use

Qld ≥10 years

NT ≥5 years

Discussion should include the child and parent or carer, and focus on lifestyle choices, risk behaviours, and a healthy lifestyle that excludes alcohol. Look for evidence of the child drinking alcohol, and if so, how often and how many standard drinks per day. During the discussion, help them to understand that there is no safe level of drinking for children.

If the child is ≥10 years old and resident in Queensland OR ≥5 years old and resident in the Northern Territory, is there a record of enquiry or discussion of alcohol use *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is ≤10 years old in Queensland, or is <5 years old in the Northern Territory, or is in New South Wales, Victoria, South Australia, Western Australia, Tasmania or the Australian Capital Territory, or has not attended within 12 months of audit date.

5.40 Drug or substance use

Qld ≥8 years

≥5 years

Discussion should involve the child and their parent or carer, and focus on lifestyle choices, risk behaviour, and a healthy lifestyle that excludes substance use. Drug or substances can include amphetamines, methamphetamines, ganja (cannabis), kava, petrol and other volatile substances. Look for evidence of the child using drugs or any harmful substances, and if so, which substances, how often and how much. Provide advice that there is no safe level of use for children.

If the child is ≥8 years old and resident in Queensland OR the child is ≥5 years old and resident in any other state or territory, is there a record of enquiry or discussion of drug or substance use *at least once* within the past 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child is <8 years in Queensland, or is <5 years old in New South Wales, Victoria, South Australia, Western Australia, Tasmania, the Australian Capital Territory or the Northern Territory, or has not attended within 12 months of audit date.

Section 6 Follow-up of abnormal clinical findings

Growth

For the purpose of this audit, the following definitions apply:

- **Growth faltering** is described as the child's line on the growth chart beginning to *flatten or is flat, or is going down compared to line on growth chart OR weight gain is less than expected over* time (p 161, CARPA 2014).
- **Failure to thrive** 'failure to thrive is recurrent episodes of growth faltering (as defined above) or persistently poor growth with the growth curve rising at a slower rate than the standard centile lines on the growth chart'
- QH and RFDS (2013) define **Failure to thrive (FTT)** as a child whose *weight is less than normal for gestational corrected age / gender and past medical history. Children with genetic short stature, intrauterine growth retardation or prematurity, who have appropriate proportional weight for length and normal growth velocity, are not regarded as FTT*.
- Suggested minimum intervals for recording are 2 monthly for children 4- 6 months, 3 monthly for children 9- 18 months, yearly for children 2 to 5 years (CARPA, 2014).

NACCHO/RACGP (2012), recommend all children have growth monitored at intervals coinciding with health visits for immunisation. If there are concerns, weight should be monitored more frequently and a growth monitoring action plan commenced.

6.1 Growth faltering or failure to thrive

There must be a record of weight and height in questions 5.1 and 5.2 to answer '1-yes' or '0-No' to this question

Is there a diagnosis or evidence of growth faltering or failure to thrive *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if no weight is recorded in 5.1.

6.2 Actions taken: growth faltering

Recommended actions for growth faltering include medications for deworming and zinc supplements. For the purpose of this audit, only indicators of action taken are used.

If there is documentation of growth faltering or failure to thrive, there should be a record of one or more of the following actions:

- clinical assessment by medical officer or paediatrician
- follow-up weights measured
- nutrition advice given
- family meeting arranged
- action plan made
- referral to support services such as social worker, home visiting service, Strong Women, Strong Babies, Strong Culture (SWSBSC) program, nutrition program, child care or other community service
- other appropriate action (according to health service policy).

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of growth faltering or failure to thrive in 6.1.

6.3 Evidence of overweight or obesity

When using the WHO growth charts, overweight is defined as two standard deviations above normal on the weight-for-height chart. The BMI Z-score-for-age chart defines overweight as greater than one standard deviation above normal, obesity as greater than two standard deviations above normal.

When using CDC BMI growth charts, overweight and obesity in childhood is defined as a BMI in the 85–95th percentile (overweight), and >95th percentile (obese), (NHMRC, 2013). **There must be a record of weight and height in questions 5.1 and 5.2 to answer '1-yes' or '0-No' to this question**

Is there evidence of overweight or obesity *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if there is no weight recorded in 5.1.

6.4 Actions taken: overweight or obesity

If there is evidence of overweight or obesity, there should be a record of one or more of the following actions:

- referral to dietician or medical officer
- blood pressure measured
- venous blood glucose measured
- blood lipids measured

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of overweight or obesity in 6.3.

Ears

In some rural and remote Aboriginal communities complications of ear disease are very common. They include hearing loss, tympanic membrane perforations, chronic suppurative otitis media (CSOM), otitis media with effusion (OME) and mastoiditis. This is the reason that higher dose and longer duration antibiotics are recommended in these children, while in low risk populations (non Aboriginal and Torres Strait Islander populations) the advantage of antibiotics is small unless systemic features are present (QH and RFDS, 2013)

Assessment for possible middle ear disease, hearing impairment and speech and language problems should be a routine part of the primary care from an early age (QH and RFDS, 2013). NACCHO/RACGP (2012) recommends opportunistic and annual ear examinations in order to detect unrecognised acute or chronic otitis media.

6.5 Recurrent or chronic ear infections

For the purposes of this audit, *recurrent ear infections* refers to two or more ear infections in the past year; *chronic ear infections* refers to ear infections persisting for two weeks or more in the past year.

Is there evidence of recurrent or chronic ear infections *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if no ear examination is recorded in 5.14.

6.6 Actions taken: recurrent or chronic ear infections

If there is evidence of recurrent or chronic ear infections, there should be a record of one or more of the following actions:

- follow-up examinations completed
- advice on ear care provided
- antibiotics prescribed
- action plan made
- referral for audiology made
- referral to ear, nose and throat specialist made
- other appropriate action (according to health service policy).

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of recurrent or chronic ear disease in 6.5.

Anaemia

Anaemia is common in Aboriginal and Torres Strait Islander children, particularly in the 6 to 30 month age group. Children most at risk of developing anaemia are those of low birth weight, including children born prematurely, or children born to mothers who had low iron or were anaemic during pregnancy (QH and RFDS, 2013). Infants and children between the ages of 6 months and 24 months whose nutrient requirements are very high are susceptible to anaemia, as are adolescent girls (whose iron requirements peak at puberty). Early intervention is required to decrease the risk of poor psychomotor development in infants and young children at a time of rapid brain growth and development, and to decrease the risk of poor outcomes in pregnant adolescent girls with anaemia (QH, 2010).

Table 6.1: Children living in the Northern Territory: diagnosis of anaemia using Hb by age

Age	6–<12 months	1–<5 years	5–<8 years	8–<12 years	12–<15 years (male)	12–<15 years (female)
Hb (g/L)	105	110	115	119	125	118

Hb = haemoglobin
Source: CARPA, 6th edn 2014; p 119.

6.7 Evidence of anaemia

For the purpose of this audit, anaemia is defined as Hb <110 g/L. This ensures all possible anaemic episodes recorded will qualify for follow up.

Qld children aged 6<12 months Hb <105 g/L

Qld children aged ≥12 months Hb <100 g/L

NT children refer to Table 5.

Is there documentation that the most recent Hb (in the past 12 months) indicates **anaemia**?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if no haemoglobin is recorded in 5.5.

6.8 Actions taken: anaemia

Recommended actions may also include a medical review, and/or a folic acid supplement, especially if Hb <90 g/L (CARPA, 2014). For the purpose of this audit, indicators for minimal action are used.

If there is evidence of anaemia, there should be a record of one or more of the following actions:

- dietary or nutrition advice given
- deworming undertaken
- iron supplement prescribed
- follow-up of iron or haemoglobin within 2 months of diagnosis completed.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of anaemia in 6.7

Chronic lung disease

Chronic lung disease is an important contributor to the high rates of chronic illness in Indigenous communities, and recurrent or chronic infections in childhood are recognised contributors to the development of chronic lung disease. A survey of all children younger than 7 years from 8 communities in the Northern Territory showed that 7.5% of children had 3 or more documented episodes of chest infection requiring antibiotics in a 1-year period. While there are currently no generally accepted guidelines on follow-up of children with recurrent or chronic respiratory disease, this information captures a high-risk group of children for whom a more intensive investigation appears to be justified. It also provides a reasonable guideline for audit purposes. Referring children for respiratory paediatric assessment is a reasonable first step, although access to paediatricians can be difficult in some areas (Housing Improvement and Child Health Project, March 2011, unpublished data).

6.9 Recurrent or chronic respiratory disease

For the purposes of this audit, recurrent or chronic respiratory disease is defined as more than three episodes of chest infection requiring antibiotics within the last 12 months. Respiratory disease can include asthma, asthma attacks, frequent coughs, pneumonia and bronchitis.

Is there a record of recurrent or chronic respiratory disease within the last 12 months?

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if no respiratory examination is recorded in 5.13.

6.10 Number of respiratory infections

If there is evidence of recurrent or chronic respiratory disease in 6.9, enter the **number** of chest infections requiring antibiotics within the last 12 months.

Enter a number (4 or above). Enter '**0**' if there is no evidence of recurrent or chronic respiratory disease in 6.9.

6.11 Action taken: recurrent or chronic respiratory disease

If there is evidence of recurrent or chronic respiratory disease, there should be a record of one or more of the following actions:

- referral for paediatric respiratory assessment, for example to paediatrician or other medical officer
- paediatric respiratory assessment report.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of recurrent or chronic respiratory disease in 6.9.

Skin Infections

Early detection and treatment of skin infections can prevent acute post-streptococcal glomerulonephritis and acute rheumatic fever (QH, 2010). Acute post-streptococcal glomerulonephritis (APSGN), is a disorder of the kidneys after infection by Streptococcus, and is strongly associated with skin infection. Some communities regularly experience epidemics that affect large numbers of children.

6.12 Infected skin sores

For the purpose of this audit, infected skin sores refers to yellow–brown crusted sores that are often surrounded by redness and swelling and may include evidence of pus, discharge or bleeding.

Is there evidence of infected skin sores *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if no skin check is recorded in 5.10.

6.13 Action taken: infected skin sores

If there is evidence of infected skin sores, there should be a record of one or more of the following actions:

- cleaning and intramuscular or oral antibiotic treatment has started
- swabs have been taken if the condition is not improving
- effectiveness of treatment has been assessed in a follow-up check.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of infected skin sores in 6.12.

Scabies

Scabies commonly involves the genital areas, buttocks, lower abdomen, wrists, forearms and webs between the fingers. Burrows are often difficult to see, but can most often be seen on the webs between the fingers, around the waist (under the belt line), in the creases of the wrists and elbows, and on the palms and soles of children (QH, 2010).

Treatment of scabies may vary in jurisdictions. QH and RFDS (2013), recommend that a medical officer is consulted if any of the following are present:

- BP or urinalysis abnormal,
- severe crusted scabies,
- infant < 6 months of age,
- secondary dermatitis develops requiring treatment.

Other recommendations include:

•Treat any secondary bacterial infections at the same time

•Permethrin 5% is the treatment of choice and can be used on open lesions.

Although permethrin 5% is not approved for use in children < 6 months of age, this must be balanced against the high morbidity of untreated scabies. If Norwegian (crusted) scabies is present oral ivermectin is recommended (QH and RFDS 2013, NTG, 2010).

CARPA (2014) have introduced grading for severity of crusted scabies, and suggest a chronic care management plan for reinfection.

6.14 Scabies

Is there evidence of scabies *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if no skin check is recorded in 5.13.

6.15 Action taken: scabies

If there is evidence of scabies, there should at least, be a record of one or more of the following actions:

- treatment has commenced
- effectiveness of treatment has been assessed in a follow-up check.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of scabies in 6.14.

Proteinuria

1+ of protein or more on dipstick urinalysis in children indicates the possibility of a urinary tract infection (UTI) or sexually transmitted infection (STI). Urine should be sent for ACR, and BP checked (CARPA, 2014).

6.16 Proteinuria

For the purpose of this audit, proteinuria is defined as 1+ protein on dipstick urinalysis.

If the child is resident in Queensland and urinalysis is indicated OR if the child is resident in the Northern Territory and aged ≥10 years, is there evidence of proteinuria (1+ protein on urinalysis) *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if there is no urinalysis recorded in 5.6.

6.17 Action taken: proteinuria

If there is evidence of proteinuria, there should be a record of one or more of the following actions:

- urine has been sent for albumin:creatine ratio (ACR)
- follow-up by a medical officer has occurred.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of proteinuria in 6.16.

Developmental delay

Biological, psychological and sociocultural factors affect infant and child development. This may include temperament, genetics, quality of the attachment relationship, and the environmental context in which children live. Adverse developmental experiences during infancy can become risk factors for later development, and social and emotional wellbeing.

Developmental delay can occur when milestone-specific tasks are not met. Poor child development can mean a child is unable to do more complex things as they grow older (QH, 2010).

6.18 Developmental delay

Look for evidence of the child not meeting developmental milestones.

Is there evidence of concern regarding developmental delay *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

6.19 Action taken: developmental delay

If there is evidence of developmental delay, there should be a record of one or more of the following actions:

- a record of referral
- evidence of a follow-up report.

Indicate **1-Yes** or **0-No** for each.

Indicate **9-N/A** for each action if there is no evidence of concern regarding developmental delay in 6.18.

Environment

The environment in which children are raised can influence their health and wellbeing. Crowding, availability of clean water, food and shelter are all factors that can influence health outcomes that relate strongly to social, economic and environmental factors (QH, 2010).

Family and domestic violence is a crime, and children who witness violence can suffer long-term effects. Each state and territory has mandatory reporting laws that relate to the reporting of violence against children (CARPA, 2014).

6.20 Domestic environment

Is there evidence of concern regarding domestic environment *within the past 12 months?*

This includes concerns regarding living conditions generally, as well as exposure to physical and emotional violence, substance misuse and gambling.

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

6.21 Action taken: domestic environment

If there is evidence of concern regarding the domestic environment, there should be a record of one or more of the following actions:

- a record of referral
- evidence of a follow-up report.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of concern regarding the domestic environment in 6.20.

6.22 Social/family support and financial situation

Is there evidence of concern regarding social/family support and financial situation *within the past 12 months?*

Look for concern regarding the availability of support from extended family, the community and culture, social relationships and financial resources.

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

6.23 Action taken: family support and financial situation

If there is evidence of concern regarding family support and financial situation, there should be a record of one or more of the following actions:

- a record of referral
- evidence of a follow-up report.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of concern regarding social and financial situation in 6.22.

Food security

Food security is the ability to acquire appropriate and nutritious food on a regular, reliable basis using socially acceptable means. Food security is determined by people's local food supply, and their capacity and resources to access and use that food (COAG, 2009).

Food supply is an ongoing issue with people in rural and remote areas paying at least 30% more for basic nutritious foods than people living in urban and metropolitan areas. Basic food items are less available in the more remote stores, as are fresh vegetables and fruits and better nutritional choices. The quality of dietary intake has been shown to vary in close association with the income cycle in remote Aboriginal communities (NHMRC, 2013)

Improving food security for the more than 80 000 Indigenous people living in very remote Australia would be expected to make a significant contribution to closing the gap in these locations, particularly with regard to life expectancy, infant mortality and educational attainment (COAG, 2009)

6.24 Housing condition and food security

Look for concern of crowding, if any major repairs are required to the house, and if there is access to clean running water. In addition, check the availability and accessibility of nutritious food on a regular and reliable basis.

Is there evidence of concern regarding housing condition and food security *within the past 12 months?*

Indicate **1-Yes** or **0-No**.

Indicate **9-N/A** if the child has not attended within 12 months of audit date.

6.25 Action taken: housing condition and food security

If there is evidence of concern regarding housing condition and food security, there should be a record of one or more of the following actions:

- a record of referral
- evidence of a follow-up report.

Indicate **1-Yes** or **0-No** for each action.

Indicate **9-N/A** for each action if there is no evidence of concern regarding housing condition and food security in 6.24.

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