Youth health clinical audit protocol

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Abbreviations

ABCD	Audit and Best Practice for Chronic Disease
ACR	Albumin creatinine ratio
AIHW	Australian Institute of Health and Welfare
AUDIT C	Alcohol Use Disorders Identification Test Consumption
BBV	Blood borne virus
BMI	Body mass index
CRAFFT	Car, Relax, Alone, Forget, Family/friends, Trouble
DoHA	Department of Health and Ageing
ENT	Ear, nose and throat services
EPDS	Edinburgh Postnatal Depression Scale
EWB	Emotional Well Being
HEEADSS	Home, Education/employment, Exercise/eating, Activities and peer relationships, (Gambling), Drugs, alcohol and tobacco use, Sexual risk behaviours, Suicide/self-harm/mood and depression
IRIS	Indigenous Risk Impact Screen
K5	Kessler 5
K6	Kessler 6
K10	Kessler 10
MBS	Medicare Benefits Scheme
N/A	Not applicable
NACCHO	National Aboriginal Community Controlled Health Organisation
NHMRC	National Health and Medical Research Council
PHQ2+	Patient Health Questionnaire 2
PHQ9	Patient Health Questionnaire 9
RACGP	Royal Australian College of General Practitioners
SACS	Substances and Choices Scale
SAT	Systems Assessment Tool
SNAPE	Smoking, Nutrition, Alcohol, Physical, Emotional
STI	Sexually transmitted infection
WHO	World Health Organisation

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Version control

Version	Release date	Description
1.0	2013	Tool development
1.0	2014	Tool release

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.

Introduction

This protocol should be used in conjunction with *Improving the quality of primary healthcare: A training manual for the One21seventy CQI cycle* (Version 2.0).

When to do a Youth Health Audit

The youth health audit is designed to audit key indicators of care for young people, with a specific focus on social and emotional wellbeing issues. Your health service may decide to do a youth health audit to provide data to inform priority areas and improvements in the quality of care for young people.

As the tool covers the 12 – 24 year age group, it overlaps with the adult preventive health audit (15 – 54 years) and the child health audit (3 months – 14 years). The youth health audit tool has a different focus to these tools and is designed to supplement, rather than replace them. It is acceptable for a client record to be included in the youth health audit sample as well as other audit samples.

Eligibility of clients

To be eligible for inclusion in the youth health audit, a client must:

- Be aged 12 – 24 years
- Have been a resident in the community for 6 months or more of the last twelve months.

Note: Young people attending boarding schools may not fulfil the criteria. Clients who have a long term health condition, chronic illness, or are pregnant, and fulfil the above criteria remain eligible for inclusion.

Sample Size and Confidence Interval

Refer to *Improving the quality of primary health care: a training manual for the One21seventy cycle*, version 2, Section 5, for more information on determining the sample size with regard to the population size for this audit and the confidence interval required for the reported indicators. The 'eligible population' referred to in this protocol is the number of clients who are deemed eligible against the criteria described above.

Recommendations for sample size

- For services with up to 100 clients in the eligible population, we recommend a sample size of *at least 30 client records* per audit. If possible, audit records should be divided evenly between male and female. This sample will provide an adequate estimate (for quality improvement purposes) of the proportion of clients receiving specific services.
- Health services with large eligible populations may wish to increase the sample size to reduce the confidence intervals around the sample estimates. Health services with smaller eligible populations (30 or fewer) should audit all client records and be cautious when using and comparing reported data.
- Be aware of the confidence interval for your results — this is important when interpreting the data in your reports.

Using the youth 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 is 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 Auditor

Record the name (initial and surname) of the person doing the audit (e.g. J Smith). You may want to make a stamp if you are a regular auditor.

1.2 Audit date

You may wish to use a date stamp. Record as **dd/mm/yyyy**.

Note that the audit date will be the same for all medical records being audited for youth health services in this cycle. Even if the auditing cannot be completed in a single day, continue to use the same audit date for all client records and audit the records retrospectively from this date.

1.3 Client ID

For each participating health service, the auditor will prepare a master list of participants that contains the participant name, date of birth, and participant number (client ID). This list will be marked 'confidential' and stored securely to prevent inappropriate identification of client records.

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

1.4 Medicare number

Much of the funding for community controlled health services is via Medicare (general practitioners or allied health). If the Medicare number is not on file or has expired then the claim for the service may be rejected. It is important to have up to date Medicare numbers on file to ensure claims are processed quickly.

Indicate if there is a **current** Medicare number documented in the client's medical record.

1.5 Date of birth

The auditor will need to know the client's age at date of audit, as many questions are age related.

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

1.6 Gender

Record the gender of the client. Indicate

1-Male or **2-Female**

1.7 Indigenous status

Record the client's Indigenous status as stated in their health record. Indicate

1- Aboriginal

2-Torres Strait Islander

3-Both Aboriginal and Torres Strait Islander

4-Neither Aboriginal nor Torres Strait Islander or

5-No record there is no clear documentation of the client's Indigenous status.

1.8 Mature minor assessment

A mature minor assessment is made by a GP and is based on a young person's ability to understand health information and make informed decisions in relation to a specific treatment or procedure. GPs who are unsure about a young person's competency should seek peer review (consensus of two GPs is also a legal requirement in SA – see Appendix 1). Auditors should search the progress notes for this information. In some instances, people under the age of 18 years, (and assessed as mature minors) may be able to attend health services on their own and provide consent to screening, assessment and treatment (see Appendix 1). Is there documentation of mature minor assessment? Indicate:

1-Yes if there is documentation that a client has been assessed as a mature minor for a health check by two GPs in SA; or by one GP in other jurisdictions.

0-No if the client attended the health centre without a parent/guardian for a health check; is aged 14-15 in NSW; aged under 16 in SA; aged under 18 in other jurisdictions; and there is no documentation of a mature minor assessment.

9-N/A if there is no evidence that the client attended the health centre without a parent/guardian for a health check; or the client is aged under 14 in NSW; or aged 16 and over in NSW or SA; or aged 18 and over in other jurisdictions.

Section 2 Attendance at health service

Attendance

Indigenous young people under-utilise health services and engage with services at later stages of illness and for shorter periods in comparison to non-Indigenous youth (Westerman 2010). Time since last attendance is a useful measure of the level of client engagement with the health centre. Which staff member was the first point of contact for the client and involvement of an Aboriginal and/or Torres Strait Islander Health Practitioner at their last attendance is a measure of clinic processes and cultural safety. The reason for last attendance can shed light on client engagement in the ongoing management of their healthcare.

2.1 Date of last attendance

A record of attendance includes documentation that the client was seen by a health professional (refer to question 2.5 for types of health professional). If the client made a visit to the health centre but left without an assessment by a health professional, this should *not* be recorded as having attended the health centre.

If a regular service is being provided (e.g. school screening), this can be included as attendance.

It is acknowledged that some clients who receive care never visit the health service itself.

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

2.2 Follow-up attempt

All clients who have a health check should be followed up and provided with feedback (QH, 2010). Health centres 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 has been notified of an appointment but has not presented to the health centre, this is classified as an unsuccessful follow up attempt.

If the client has **not** attended the health service in the last 24 months, is there a record of an unsuccessful follow up attempt by health service staff since last attendance? Indicate

1-Yes, **0-No** or

9-N/A if the client has attended in the last 24 months

2.3 Reason for last attendance

The reason for last attendance can provide information on the client's level of engagement in the ongoing management of their condition, as well as identify opportunities for routine checks and tests that may arise in other visits to the health centre. Indicate the primary reason for last attendance.

Table 2.1 Examples of reasons why clients may attend the health service

Reason	Examples
1-Well person's check	Child/Adult/Youth health check
2-Acute care	Infections, trauma
3-Mental illness	Follow-up or acute episode
4-Immunisation	The client presented for immunisation
5-Antenatal	Pregnancy check-up
6-Sexual health	STI screening or follow-up, contraception
7-No record	Reason for attendance not recorded
8-Long term health condition	Ongoing management of a long term health condition or chronic disease that the client has had for 6 months or more, or any condition that can reasonably be expected to last for at least 6 months
9-N/A	Not applicable if client has not attended the health service in the last 24 months
10-Other	Social issues, domestic violence – please record on audit

2.4 Other reason

If reason for last attendance is 'Other' please provide description.

2.5 Seen by at last attendance

Identifying which health professional was the first point of contact for the client at their most recent attendance is a measure of clinic processes and culturally competent care. It is acknowledged that sometimes a health professional will meet more than one criterion, eg an Aboriginal nurse.

If the client is Aboriginal and/or Torres Strait Islander, when the client last attended the health service, did the client see an Aboriginal and/or Torres Strait Islander health worker/health professional first? Indicate

1-Yes or **0-No**

7- No record

9- N/A if the client is not Aboriginal and/or Torres Strait Islander or has not attended the health centre within the last 24 months.

2.6 Other regular primary health care services

Identifying other health centres that the client regularly attends may help to improve care coordination, particularly in urban and regional settings where multiple providers exist, and in remote settings where clients regularly visit other communities. Identifying other services accessed by clients in health records is recommended in the Interpretive Guide of the RACGP Standards for General Practice for Aboriginal and Torres Strait Islander Health Services (RACGP 2010).

Is there documentation that the client regularly attends other primary health care services? Indicate

1-Yes or 0-No

2.7 Name of other primary health care services

If Yes, **record the name/s of the other primary health care service/s**.

If date of last attendance is more than 24 months before the audit date:

- audit ceases here, only complete section 1 and 2.

When entering answers into the website

- N/A will be preselected for the remaining questions
- complete sections 1 and 2, then go to the end of section 6 and select 'save record' to save the audit

Section 3 Key Information in client record summaries

Health Summary

A health summary may also be called a medical summary or problem list. RACGP (2010) suggest that health summaries are useful to quickly access important client information. An up to date health summary would contain valid information at the date of last attendance, and may have been updated since the client last attended.

For the purpose of this audit, the terms chronic condition/s and long term conditions are used interchangeably.

3.1 Chronic conditions on health summary

Diagnosis of all long-term health conditions should be recorded in the client's medical summary to identify comorbidities. A long-term health condition is any condition the client has had for 6 months or more, or any condition that can reasonably be expected to last for at least 6 months. Examples of long-term health conditions include, but not limited to: congenital abnormalities, ARF/RHD, Foetal Alcohol Spectrum Disorders, diabetes type 1 and 2, mental illness and hypertension. Clients with long-term health conditions and/or chronic illness may receive care not usually required by other clients.

Is there any record in the client's health summary that indicates they have any chronic or long term health condition(s) for which they attend the health service regularly? Indicate

1-Yes or **0-No**

3.2 What is/are the condition/s?

Data on local prevalence rates of long-term health conditions can assist in regional planning.

If long-term health condition/s was/were recorded in question 3.1, record the condition/s.

3.3 Management plan

For the purpose of this question, a current management plan refers to MBS item 721, GP management plan, or a local alternative, which may be a template based on the 721, but not signed off by a GP. It is current if it was initiated or has been updated in the last 12 months.

If a long-term or chronic health condition was recorded in 3.1, is there a documented current management plan? Indicate

1-MBS 721 GP Management Plan

2-Alternative chronic disease care plan

0-No if no documented management plan

9-N/A if there is no long-term health condition recorded in 3.1

3.4 Health check

The federal government funds this health assessment as an annual service. The minimum time allowed between services is 9 months. This allows flexibility for very remote communities, where medical practitioner visits may be less frequent and may make it more difficult to follow a consistent schedule of health assessments (DoHA, 2010). It is suggested that the components of the adult health check (MBS item 715), are completed annually (NACCHO/RACGP 2012), however for the purposes of this audit, record whether a health check has been completed in the last 24 months. By knowing the percentage of the eligible population who have had a MBS or alternative health check completed in the last 24 months, a comprehensive population health approach by health care providers will be enabled.

If the client is Aboriginal and/or Torres Strait Islander, without a chronic disease management plan (in question 3.3), is there a Child or Adult Health Check MBS item 715 in the client's health record that has been completed within the last 2 years? Indicate:

1-Yes or 0-No

9-N/A if the client is not Aboriginal and/or Torres Strait Islander or if a chronic condition care plan was identified in 3.3

3.5 Alternative child or adult health check

An alternative child or adult health check may be a locally produced template that mimics the MBS 715. It may or may not be age specific. If the client is Aboriginal or Torres Strait Islander, without a chronic disease management plan (in question 3.3), is there an alternative Child or Adult Health Check similar to MBS item 715 appropriate to client age in the last 24 months? Indicate

1-Yes or 0-No

9-N/A if the client is not Aboriginal and/or Torres Strait Islander; if a chronic condition care plan was identified in 3.3; or if a MBS item 715 Child or Adult Check was present in 3.4.

3.6 Youth health check

A youth health check may be a locally produced template that is used specifically for youth, it should be recognised and named as a youth health check.

If the client is Aboriginal or Torres Strait Islander, without a chronic disease management plan (in question 3.3), is there a complete youth health check in the client's health record that has been completed within the last 2 years? Indicate

1-Yes or 0-No

9-N/A if the client is not Aboriginal and/or Torres Strait Islander; if a chronic condition care plan was identified in question 3.3; or if a MBS item 715 Child or Adult Check was present in question 3.4.

3.7 Consent

Ideally, if a client is a mature minor, client consent should be obtained the first time the client visits the health centre without a parent or guardian. If the client is not an adult and is not assessed as a mature minor, a parent or guardian must provide consent to screening, assessment and treatment on their behalf (see Appendix 1). Some electronic patient record systems have a field to indicate a completed consent process. If not present or not filled out, auditors should also search health check forms and progress notes for this information.

If there is any documented health check in the last 24 months, and the client is documented as a mature minor in question 1.8, is an adult, or a minor, has a valid consent from the client or a parent/guardian as appropriate been obtained for a health check? Indicate:

1-Yes or **0-No**

9-N/A if the client has not received a health check in the last 24 months

Section 4 Scheduled Immunisations

Table 4.1: Currently Scheduled Immunisations for Youth by State/Territory

State/Territory	Link
National	http://www.health.gov.au/internet/immunise/publishing.nsf/content/nips2
NSW	http://www.health.nsw.gov.au/pubs/2007/pdf/progschedule.pdf
VIC	http://www.health.vic.gov.au/immunisation/factsheets/schedule-victoria.htm
SA	http://www.health.sa.gov.au/immunisationcalculator/SAJul2013.pdf
QLD	http://www.health.qld.gov.au/immunisation/health_professionals/qhip.asp
WA	http://www.public.health.wa.gov.au/1/51/2/immunisation.pm
TAS	http://www.dhhs.tas.gov.au/peh/immunisation/school_based_immunisation_program/school_based_immunisation_schedule
NT	http://www.health.nt.gov.au/Centre_for_Disease_Control/Immunisation/index.aspx

See Appendix 2 for further information about common vaccines for youth, brand names and diseases/infections/organisms.

Eligibility for immunisations may depend on client age, school year, level of risk, indigenous status and scheduled immunisations for the jurisdiction.

4.1 Immunisation record

This is a standard chart or record that documents the delivery of immunisations against the standard schedule for the jurisdiction. A complete immunisation chart/record is one that shows signs of being updated each time a client has an immunisation, either at this facility or another. Is there an up-to-date immunisation record present in the client's record? Indicate:
1-Yes or 0-No

4.2 Hep B

Is there a record that the client has received all scheduled Hep B immunisations, based on their age or school level, according to the local schedule? Indicate:

1-Yes or 0-No

8-Decl if there is documentation that the client was offered a Hep B immunisation but declined

9- N/A if client is not eligible for Hep B immunisation or date of last attendance is more than 2 years before audit date

4.3 HPV

Is there a record that the client has received all scheduled HPV immunisations, based on their age or school level, according to the local schedule? Indicate:

1-Yes or 0-No

8-Decl if there is documentation that the client was offered a HPV immunisation but declined

9- N/A if client is not eligible for HPV immunisation or date of last attendance is more than 2 years before audit date

4.4 VZV

Is there a record that the client has received all scheduled VZV immunisations, based on their age or school level, according to the local schedule? Indicate:

1-Yes or 0-No

8-Decl if there is documentation that the client was offered a VZV immunisation but declined

9- N/A if client is not eligible for VZV immunisation or date of last attendance is more than 2 years before audit date

4.5 DTPa

Is there a record that the client has received all scheduled DTPa immunisations, based on their age or school level, according to the local schedule? Indicate:

1-Yes or 0-No

8-Decl if there is documentation that the client was offered a DTPa immunisation but declined

9- N/A if client is not eligible for DTPa immunisation or date of last attendance is more than 2 years before audit date

4.6 Fluvax

Is there a record that the client has received all scheduled fluvax immunisations, based on their age or school level, according to the local schedule? Indicate:

1-Yes or 0-No

8-Decl if there is documentation that the client was offered a fluvax immunisation but declined

9- N/A if client is not eligible for fluvax immunisation or date of last attendance is more than 2 years before audit date

4.7 Pneumococcal

Is there a record that the client has received all scheduled pneumococcal immunisations, based on their age or school level, according to the local schedule? Indicate:

1-Yes or 0-No

8-Decl if there is documentation that the client was offered a pneumococcal immunisation but declined

9- N/A if client is not eligible for pneumococcal immunisation or date of last attendance is more than 2 years before audit date

Section 5 Protective Factors, Risk Factors, Brief Interventions and Referral

HEEADSS tool

Mental health, sexual health and alcohol and other drug problems are the leading health concerns for Indigenous young people (AIHW 2011). This section is based on the areas addressed by the HEEADSS tool (Home, Education/employment, Exercise and eating, Activities and peer relationships, Drugs, alcohol and tobacco use, Sexual risk behaviours, Suicide/self-harm/mood and depression), with the addition of gambling. The HEEADSS tool is a widely recognised assessment tool for conducting a comprehensive social and emotional wellbeing assessment of young people (WHO 2007; Chown et al 2008). It facilitates systematic gathering of information about young peoples' lives, performing risk assessments and screening and identifying areas for intervention. Additionally, discussing activities, hobbies, interests and peer relationships with a young person can help to build rapport and may provide information on potential protective factors to allow staff to discuss things that are going well for a young person, as well as risk factors. The HEEADSS tool and assessment of gambling problems is endorsed by NACCHO/RACGP (2012).

5.1 Tobacco use

Assessment of an Indigenous young person's other drug and substance use is endorsed by NACCHO/RACGP (2012).

What is the documented **tobacco use** status (in the last 24 months)? Indicate

1-Tobacco user

2-Non-tobacco user

3-No record

9- N/A if date of last attendance was more than 2 years before audit date.

5.2 Tobacco: actions taken

Documentation of client referral and follow-up appointments in client records are an important feature of high quality primary healthcare systems according to the Interpretive Guide to the RACGP Standards for General Practice for Aboriginal and Torres Strait Islander Health Services (2010).

If there is documented tobacco use, indicate the actions taken within one month of the recorded tobacco use status (you may indicate more than one).

Brief intervention

A brief intervention is a discussion about health-related issues or healthy lifestyle that takes very little time. It includes information sharing and problem solving or goal setting. Such an opportunity can be taken by anyone in the health team as part of day-to-day work, whenever there is interaction with a client. Brief interventions may be delivered in a variety of ways depending on the clinician's approach and the client's circumstances. Approaches to recording brief interventions will also vary. For the purpose of the audit, the record of a brief intervention should at least indicate either that a brief intervention has been delivered; or that the client has been asked about the issue and their intentions or interest in changing their behaviour.

Referral to an appropriate service

Examples of referral services may include Quitline, Aboriginal and Torres Strait Islander tobacco action/control workers, tobacco, alcohol and other drug services, local support groups.

Social/cultural treatment

Social/cultural treatments occur in the community setting. They may include, but are not limited to, visiting a traditional healer, returning to country, engagement in sporting activities, involvement in a strong women's group or 'men's shed'.

Medication prescribed

See Appendix 4 for further information on medications commonly prescribed for tobacco withdrawal.

Other action Record the action

No record of any action

Declined if the client was recorded as a tobacco user in previous question and there is documentation that any action was offered but declined by the client

OR

N/A if the client was not recorded as a tobacco user in previous question or if a concern was documented less than one month prior to the audit date and no action was documented

5.3 Tobacco: action/s reviewed

Evidence of review may include evidence that the action was discussed with the client again in a separate consultation. If there is documentation of actions in previous question, is there documentation of those actions being reviewed within 3 months?

1-Yes or 0-No

9-N/A if no action/s were documented in previous question, or if actions were documented less than three months prior to the audit date and no review was documented.

5.4 Tobacco: referral report

Documentation may include documented feedback, any information provided about client progression or a report in the client record. If referral was documented, is there documentation that a report or communication was received from the referral service within 6 months of referral? Indicate:

1-Yes or **0-No**

9-N/A if no referral was recorded in previous question; or if the referral was less than 6 months prior to the audit date and there is no documentation of a report received from the referral service; or if there is evidence that the client did not attend the referral service.

Screening tools

The Interpretive Guide of the RACGP Standards for General Practice for Aboriginal and Torres Strait Islander Health Services (2010) recommends recording discussions with clients about prevention. This may be facilitated through the use of standard resources and screening tools. Screening tools may be used to help screen and assess social and emotional wellbeing issues, however some clinicians may prefer to conduct assessments through discussion with clients. For further information about common screening tools see Appendix 3.

Table 5.1: Australian Alcohol Use Guidelines

Category	Recommended Alcohol Use
Healthy adults	Drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol related disease or injury Drinking no more than four standard drinks on a single occasion reduces the risk of alcohol related injury arising from that occasion
Children and young people under 18	Not drinking alcohol is the safest option. Parents and carers should be advised that children under 15 years of age are at the greatest risk of harm from drinking and that for this age group, not drinking alcohol is especially important For young people aged 15−17 years, the safest option is to delay the initiation of drinking for as long as possible
Pregnant women, women planning a pregnancy, breastfeeding women	Not drinking is the safest option

Source: NACCHO 2012

5.5 Alcohol use

Assessment of an Indigenous young person's alcohol use is endorsed by NACCHO/RACGP (2012) (see Table 3 below). Concerns about alcohol consumption may include, but are not limited to, binge drinking and alcohol dependency. What is the client's current recorded use of alcohol, as documented in the last 24 months?

0-No documented concerns/ screened not at risk

1-Documented concerns/screened at risk

2-No record of discussion

5.6 Alcohol use: AUDIT C

The AUDIT C tool is recommended for use in the general population and has been adapted to the Indigenous context but not validated. It has been validated for use with younger populations (13 years and above). In men, a score of ≥ 4, and in women a score of ≥3 is considered positive, optimal for identifying hazardous drinking, or active alcohol disorders.

If there is documentation of alcohol use discussion, was the client's alcohol use assessed using the AUDIT C tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for alcohol use in previous question

5.7 Alcohol use: IRIS

The IRIS tool has been validated with Indigenous populations and is recommended for clients aged 18 and above and endorsed by NACCHO/RACGP (2012).

Is there documentation of alcohol use discussion was the client's alcohol use assessed using the IRIS tool? Indicate

1-Yes or **0-No**

9-N/A if the client was not assessed for alcohol use in previous question

5.8 Alcohol use: CRAFFT

The CRAFFT tool is recommended for clients aged 21 and below and endorsed by NACCHO/RACGP (2012).

If there is documentation of alcohol use discussion was the client's alcohol use assessed using the CRAFFT tool? Indicate

1-Yes or **0-No**

9-N/A if the client was not assessed for alcohol use in previous question

5.9 Alcohol use: SACS

The SACS tool is recommended for clients aged 13 – 18 and is endorsed by NACCHO/RACGP (2012). If there is documentation of alcohol use discussion was the client's alcohol use assessed using the SACS tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for alcohol use in question 5.5

5.10 Alcohol use: Other tools

The SNAP/SNAPE is considered a clinician prompt tool but not a screening tool.

If there is documentation of alcohol use discussion record whether a tool other than the recommended screening tools was used by **specifying the name of the tool**.

5.11 Alcohol: Action/s taken

Documentation of client referral and follow-up appointments in client records are an important feature of high quality primary healthcare systems according to the Interpretive Guide to the RACGP Standards for General Practice for Aboriginal and Torres Strait Islander Health Services (2010).

If the client was documented as at risk alcohol user in previous question, indicate if there is documentation of the following actions within one month of the recorded alcohol use status (you may indicate more than one):

Brief intervention

A brief intervention is a discussion about health-related issues or healthy lifestyle that takes very little time. It includes information sharing and problem solving or goal setting. Such an opportunity can be taken by anyone in the health team as part of day-to-day work, whenever there is interaction with a client. Brief interventions may be delivered in a variety of ways depending on the clinician's approach and the client's circumstances. Approaches to recording brief interventions will also vary. For the purpose of the audit, the record of a brief intervention should at least indicate either that a brief intervention has been delivered; or that the client has been asked about the issue and their intentions or interest in changing their behaviour.

Referral to an appropriate service

Examples of referral services may include drug and alcohol services, local alcohol support groups, Alcoholics Anonymous, counselling services, detoxification services.

Social/cultural treatment

Social/cultural treatments occur in the community setting. They may include, but are not limited to, visiting a traditional healer, returning to country, engagement in sporting activities, involvement in a strong women's group or 'men's shed'.

Medication prescribed

See Appendix 4 for further information on medications commonly prescribed for alcohol abuse.

Other action

Record other action.

No record of any action

Declined if there is documentation that any action was offered but declined by the client

OR

N/A if there is no record of alcohol use discussion in previous question, or if a concern was documented less than one month prior to the audit date and no action was documented

5.12 Alcohol: action/s reviewed

Evidence of review may include evidence that the action was discussed with the client again in a separate consultation.

If actions were documented in question 5.11, is there documentation that any or all of the actions were reviewed within 3 months? Indicate

1-Yes or **0-No**

9-N/A if no actions were documented in question 5.11, or if actions were documented less than three months prior to the audit date and no review was documented.

5.13 Alcohol: referral report

If referral was documented, record whether a report was received from the referral service or there is documentation of communication with the service within 6 months of referral. Documentation may include documented feedback, any information provided about client progression or a report in the client record.

If a referral was documented in question 5.11, is there documentation of a report from the referral service within 6 months of referral? Indicate

1-Yes or **0-No**

9-N/A if no referral was recorded in 5.11; or if the referral was less than 6 months prior to the audit date and there is no documentation of a report received from the referral service; or if there is evidence that the client did not attend the referral service.

5.14 Other drug and substances use

For the purposes of this audit, 'other drug' refers to any legal, illegal, prescription or non -prescription drug other than alcohol and tobacco which is used inappropriately. It may include one or more of the following: pharmaceutical drugs such as pain killers, analgesics, tranquilisers or sleeping pills; steroids; barbiturates; amphetamines or methamphetamines (speed); heroin; methadone; other opiates (opioids); cocaine; LSD or other synthetic hallucinogens; natural hallucinogens; ecstasy; ketamine; GHB; kava. 'Substance' refers to any substance used inappropriately, and may include petrol, glue, paint, methylated spirits. Assessment of an Indigenous young person's other drug and substance use is endorsed by NACCHO/RACGP (2012).

What is the client's current recorded use of drugs or substances, as documented in the last 24 months?

1-Documented concerns/screened at risk

0-No documented concerns/ screened not at risk

2-No record of discussion

5.15 Other drug and substances use: IRIS

The IRIS tool has been validated with Indigenous populations and is recommended for clients aged 18 and above and endorsed by NACCHO/RACGP (2012).

If there is documentation of drug and substance use discussion, was the client's other drug and substance use assessed using the IRIS tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for drug and substances use in question 5.14

5.16 Other drug and substances use: CRAFFT

The CRAFFT tool is recommended for clients aged 21 and below and endorsed by NACCHO/RACGP (2012).

If there is documentation of drug and substance use discussion, was the client's other drug and substance use assessed using the CRAFFT tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for drug and substances use in question 5.14

5.17 Other drug and substances use: SACS

The SACS tool is recommended for clients aged 13 – 18 and is endorsed by NACCHO/RACGP (2012).

If there is documentation of drug and substance use discussion, was the client's other drug and substance use assessed using the SACS tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for drug and substances use in question 5.14

5.18 Other drug and substances use: other tools

The Severity of Dependence Scale is an example of another tool which may be used. The SNAP/SNAPE is considered a clinician prompt tool but not a screening tool.

If there is documentation of other drug and substance use discussion, record whether a tool other than the recommended screening tools was used by **specifying the name of the tool**.

5.19 Other drug and substances: drug/s and/or substance/s used

If any drug or substance use is documented, specify the drug/s and/or substance/s.

5.20 Other drug and substances use: actions taken

Documentation of client referral and follow-up appointments in client records are an important feature of high quality primary healthcare systems according to the Interpretive Guide to the RACGP Standards for General Practice for Aboriginal and Torres Strait Islander Health Services (2010).

If the client was documented as an 'at risk' other drug and/or substance user in question 5.14, indicate if there is documentation of the following actions within one month of the recorded other drug and/or substance use status:

Brief intervention

A brief intervention is a discussion about health-related issues or healthy lifestyle that takes very little time. It includes information sharing and problem solving or goal setting. Such an opportunity can be taken by anyone in the health team as part of day-to-day work, whenever there is interaction with a client. Brief interventions may be delivered in a variety of ways depending on the clinician's approach and the client's circumstances. Approaches to recording brief interventions will also vary. For the purpose of the audit, the record of a brief intervention should at least indicate either that a brief intervention has been delivered; or that the client has been asked about the issue and their intentions or interest in changing their behaviour.

Referral to an appropriate service

Examples of referral services may include drug services, local support groups, volatile substance abuse services and programs, counselling services, detoxification services.

Social/cultural treatment

Social/cultural treatments occur in the community setting. They may include, but are not limited to, visiting a traditional healer, returning to country, engagement in sporting activities, involvement in a strong women's group or 'men's shed'.

Medication

See Appendix 4 for further information on medications commonly prescribed for other drug and substance abuse.

Other action

Record the action.

No record of action

Declined if there is documentation that any action was offered but declined by the client

OR

9-N/A if there is no record of discussion or N/A were recorded in question 5.14, or if a concern was documented less than one month prior to the audit date and no action was documented

5.21 Other drug and substances use: action/s reviewed

Evidence of review may include evidence that the action was discussed with the client again in a separate consultation.

If actions were documented in question 5.19, is there documentation that any or all of the actions were reviewed within 3 months? Indicate

1-Yes or 0-No

9-N/A if no actions were documented in question 5.19, or if actions were documented less than three months prior to the audit date and no review was documented.

5.22 Other drug and substances use: referral report

If referral was documented, record whether a report was received from the referral service or there is documentation of communication with the service within 6 months of referral. Documentation may include documented feedback, any information provided about client progression or a report in the client record.

If a referral was documented in question 5.19, is there documentation of a report from the referral service within 6 months of referral? Indicate

1-Yes or **0-No**

9-N/A if no referral was recorded in 5.19; or if the referral was less than 6 months prior to the audit date and there is no documentation of a report received from the referral service; or if there is evidence that the client did not attend the referral service.

Table 5.2: Australian Age of Consent for Sexual Activity Legislation

State/Territory	Age of Consent Legislation
ACT	The age of consent for sexual interactions is 16 years.
NSW	The age of consent for sexual interactions is 16 years. There is no legal defence in legislation when charges are made to a person charged with engaging in sexual activities with a person under the legal age.
NT	The age of consent for sexual interactions is 16 years. There is a legal defence if the child was of or above the age of 14 years.
QLD	The age of consent for anal sex (referred to as sodomy in legislation) is 18 years, and for all other sexual acts (referred to as carnal knowledge in legislation) is 16 years.
SA	The age of consent for sexual interactions is 17 years. There is a legal defence if the child was 16 and the accused was under 17.
TAS	The age of consent for sexual interactions is 17 years. There is a legal defence if consent was provided and the child was aged 15 or over and the accused was not more than 5 years older than the child; or that the child was aged 12 or over and the accused was not more than 3 years older.
VIC	The age of consent for sexual interactions is 16 years. There is a legal defence if the accused was not more than 2 years older than the child.
WA	The age of consent for sexual interactions is 16 years. There is a legal defence if the accused was not more than 3 years older than the child.

Sources: Australian Institute of Family Studies (2010), The Medical Insurance Group (2011), NT Department of Health (2012), WA Department of Health (2012), ACT Department of Health and Community Services (2011), Tasmanian Department of Health and Human Services (2012), Victorian Department of Human Services (2011), SA Department of Communities and Social Inclusion (2009), Queensland Department of Communities, Child Safety and Disability Services (2012).

5.23 Sexual behaviour risks

Assessment of an Indigenous young person's sexual behaviour risks for clients aged 12-24 years is endorsed by NACCHO/RACGP (2012). Even if the client is not sexually active, national guidelines recommend providing anticipatory guidance on sexual health and blood borne viruses and contraception, tailoring the information to whether a person is sexually active or not. Concerns about sexual behaviour risks may include, but are not limited to, underage sex (according to local laws – see Table 5.2), non-consensual sex, sex in exchange for money/alcohol/drugs/food, unprotected sex. Recommended forms of contraception may include, but are not limited to, condoms, the oral contraceptive pill, implanon/depo provera and intrauterine devices.

What is the client's current recorded sexual behaviour risk, as documented in the last 24 months?

0-No concerns/ screened not at risk

1-Documented concerns/screened at risk

2-No record of discussion/not screened

5.24 Sexual behaviour risks: action/s taken

If there is a documented concern about sexual behaviour in question 5.22, indicate if there is documentation of the following actions within one month of the recorded concerns about sexual behaviour (you may indicate more than one).

Brief intervention

A brief intervention is a discussion about health-related issues or healthy lifestyle that takes very little time. It includes information sharing and problem solving or goal setting. Such an opportunity can be taken by anyone in the health team as part of day-to-day work, whenever there is interaction with a client. Brief interventions may be delivered in a variety of ways depending on the clinician's approach and the client's circumstances. Approaches to recording brief interventions will also vary. For the purpose of the audit, the record of a brief intervention should at least indicate either that a brief intervention has been delivered; or that the client has been asked about the issue and their intentions or interest in changing their behaviour.

Referral

Examples of referral services may include sexual health services, family planning services, family wellbeing services, child protection services, paediatric services.

Social/cultural treatment

Social/cultural treatments occur in the community setting. They may include, but are not limited to, visiting a traditional healer, returning to country, engagement in sporting activities, involvement in a strong women's group or 'men's shed'.

Contraception prescribed/recommended

Other action

Record the action.

No record of action

Declined if there is documentation that any action was offered but declined by the client

OR

N/A if no record of discussion, or N/A was recorded in question 5.22, or if a concern was documented less than one month prior to the audit date and no action was documented

5.25 Sexual behaviour risks: action/s reviewed

Evidence of review may include evidence that the action was discussed with the client again in a separate consultation. If actions were documented in question 5.23, is there documentation that any or all of the actions were reviewed within 3 months? Indicate

1-Yes or 0-No

9-N/A if no actions were documented in 5.23 or if actions were documented less than three months prior to the audit date and no review was documented.

5.26 Sexual behaviour risks: referral report

If referral was documented, record whether a report was received from the referral service or there is documentation of communication with the service within 6 months of referral. Documentation may include documented feedback, any information provided about client progression or a report in the client record.

If a referral was documented in question 5.23, is there documentation of a report from the referral service within 6 months of referral? Indicate

1-Yes or **0-No**

9-N/A if no referral was recorded in 5.23, or if the referral was less than 6 months prior to the audit date and there is no documentation of a report received from the referral service; or if there is evidence that the client did not attend the referral service.

5.27 Emotional wellbeing

Assessment of an Indigenous young person's emotional wellbeing is endorsed by NACCHO/RACGP (2012).

What is the client's current recorded emotional wellbeing status, as documented in the last 24 months?

1-Documented concerns/screened at risk

0-No concerns/not screened at risk

2-No record of discussion

5.28 Emotional wellbeing: K5

The K5 tool has been validated with the Indigenous population.

If there is documentation of emotional wellbeing discussion, was the client's emotional wellbeing assessed using the K5 tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for emotional wellbeing in question 5.26

5.29 Emotional wellbeing: K6

The K6 tool has been validated with the Indigenous population.

If there is documentation of emotional wellbeing discussion, was the client's emotional wellbeing assessed using the K5 tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for emotional wellbeing in question 5.26

5.30 Emotional wellbeing: K10

The K10 tool has been validated with the Indigenous population.

If there is documentation of emotional wellbeing discussion, was the client's emotional wellbeing assessed using the K10 tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for emotional wellbeing in question 5.26

5.31 Emotional wellbeing: IRIS

The IRIS tool has been validated with Indigenous populations and is recommended for clients aged 18 and above. It incorporates the K6 tool.

If there is documentation of emotional wellbeing discussion, was the client's emotional wellbeing assessed using the IRIS tool? Indicate

1-Yes or **0- No**

9-N/A if the client was not assessed for emotional wellbeing in question 5.26

5.32 Emotional wellbeing: Other tools

The PHQ2+, PHQ9, HoNOSCA and EPDS are examples of other tools which may be used. The SNAP/SNAPE is considered a clinician prompt tool but not a screening tool.

If there is documentation of emotional wellbeing discussion, record whether a tool other than the recommended screening tools was used by **specifying the name of the tool**

5.33 Suicidal ideation and self harm behaviour

Guidelines recommend screening for suicidal ideation in the presence of the following risk factors:

- Past history of intentional self harm
- History of mood disorders
- Hazardous alcohol consumption or use of other recreational drugs (NACCHO/RACGP 2012).

What is the client's current recorded risk status for suicide and self harm, as documented in the last 24 months? Indicate

1-Documented concerns/screened at risk

0-No concerns/not screened at risk

2-No record of discussion

9-N/A if no risk factors are documented

5.34 Emotional wellbeing: action/s taken

Documentation of client referral and follow-up appointments in client records are an important feature of high quality primary healthcare systems according to the Interpretive Guide to the RACGP Standards for General Practice for Aboriginal and Torres Strait Islander Health Services (2010). If the client was documented as being at risk for emotional wellbeing in question 5.27, and/or at risk of suicide or self harm in question 5.33, indicate if there is a record of the following actions within one month of the documented concern (you may indicate more than one).

Brief intervention

A brief intervention is a discussion about health-related issues or healthy lifestyle that takes very little time. It includes information sharing and problem solving or goal setting. Such an opportunity can be taken by anyone in the health team as part of day-to-day work, whenever there is interaction with a client. Brief interventions may be delivered in a variety of ways depending on the clinician's approach and the client's circumstances. Approaches to recording brief interventions will also vary. For the purpose of the audit, the record of a brief intervention should at least indicate either that a brief intervention has been delivered; or that the client has been asked about the issue and their intentions or interest in changing their behaviour.

Referral

Examples of referral services may include referral to specialist mental health services, psychology services, Aboriginal or Torres Strait Islander mental health worker, counsellor, local support group or telephone counselling.

Social/cultural treatment

Social/cultural treatments occur in the community setting. They may include, but are not limited to, visiting a traditional healer, returning to country, engagement in sporting activities, involvement in a strong women's group or 'men's shed'.

Medication

See Appendix 4 for further information on medications commonly prescribed for emotional wellbeing issues.

Other

Record the other action.

No record of action if concerns were recorded in 5.27 or 5.33 and no action was documented, or was documented more than 1 month after the recorded concern

Declined if concerns were recorded in 5.27 or 5.33 and there is documentation that any action was offered but declined by the client

OR
9-N/A if no record of discussion or N/A were recorded in 5.27 or 5.33 or if a concern was documented less than one month prior to the audit date and no action was documented

5.35 Emotional wellbeing: action/s reviewed

Evidence of review may include evidence that the action was discussed with the client again in a separate consultation.

If actions were documented in question 5.34, is there documentation that any or all of the actions were reviewed within 3 months? Indicate

1-Yes or 0-No

9-N/A if no actions were documented in question 5.34, or if actions were documented less than three months prior to the audit date and no review was documented.

5.36 Emotional wellbeing: referral report

If referral was documented, record whether a report was received from the referral service or there is documentation of communication with the service within 6 months of referral. Documentation may include documented feedback, any information provided about client progression or a report in the client record.

If a referral was documented in question 5.33, is there documentation of a report from the referral service within 6 months of referral? Indicate

1-Yes or **0-No**

9-N/A if no referral was recorded in 5.33; or if the referral was less than 6 months prior to the audit date and there is no documentation of a report received from the referral service; or if there is evidence that the client did not attend the referral service.

5.37 Lifestyle

Indicate if there is documentation of the following discussions in the client record.

Home environment

Assessment of an Indigenous young person's home environment is endorsed by NACCHO/RACGP (2012). Concerns relating to the home environment may include poor family relationships, overcrowding, lack of access to permanent accommodation/homelessness, domestic and family violence and abuse.

Education/employment

Assessment of an Indigenous young person's education and/or employment situation is endorsed by NACCHO/RACGP (2012). Concerns about education and/or employment may include disengagement with schooling, poor educational outcomes, unemployment, and/or difficulty with concentration.

Activities/peer relationships

Assessment of an Indigenous young person's activities and peer relationships is endorsed by NACCHO/RACGP (2012). Discussion of activities may include exploring the young person's interests, hobbies, favourite school subjects, what they do in their spare time, etc. This may provide information about risk and protective factors impacting on a young person's physical health and social and emotional wellbeing. Concerns relating to activities and peer relationships can include difficulties forming friendships, bullying, a lack of interests or hobbies, boredom or high risk behaviour.

Diet and eating

NHMRC (2012) recommend that people eat a variety of foods in the five food groups and avoid foods containing too much added fat, salt and sugar. These healthy eating habits can reduce the risk of chronic diseases later in life (see Table 5 below). Assessment of an Indigenous young person's diet and eating habits is endorsed by NACCHO/RACGP (2012).

Physical activity

Assessment of an Indigenous young person's levels of physical activity is endorsed by NACCHO/RACGP (2012) (see Table 6 below). Recommended levels of physical activity may vary for clients with certain chronic conditions

Table 5.3: Australian Dietary Guidelines

Age group	Recommended Daily Dietary Intake
12–18 years	5-11 serves cereals 4 serves vegetables, legumes 3 serves fruit 3 serves milk, yoghurt, cheese 1 serve lean meat, fish, poultry, nuts, legumes 1-3 serves extra foods (cakes, pies, soft drinks, lollies)
Women 19-60 years	4-9 serves cereals 5 serves vegetables, legumes 2 serves fruit 2 serves milk, yoghurt, cheese 1 serve lean meat, fish, poultry, nuts, legumes 0-2.5 serves extra foods (cakes, pies, soft drinks, lollies)
Men 19-60 years	6-12 serves cereals 5 serves vegetables, legumes 2 serves fruit 2 serves milk, yoghurt, cheese 1 serve lean meat, fish, poultry, nuts, legumes 0-3 serves extra foods (cakes, pies, soft drinks, lollies)

Source: NHMRC (2012)

Table 5.4: Australian Physical Activity Guidelines for Youth and Adults

Age group	Recommended Daily Physical Activity
12–18 years	At least 60 minutes of moderate to vigorous physical activity every day No more than 2 hours per day using electronic media for entertainment (eg. computer games, TV, internet)
18–54 years	The following 4 steps are recommended: • Think of movement as an opportunity, not an inconvenience • Be active every day in as many ways as you can • Put together at least 30 minutes of moderate physical activity on most, preferably all days. 30 minutes can be accumulated throughout the day in 10–15 minute sessions or done in one session • If you can, also enjoy some regular vigorous activity for extra health and fitness

Source: DoHA (2010)

Gambling

Assessment of an Indigenous young person's gambling behaviour is endorsed by NACCHO/RACGP (2012).

Cultural engagement

Discussion about cultural engagement may include exploring a young person's cultural identity, involvement in cultural activities, connectedness to a clan, tribe or extended family group. (Applicable only if the client is Aboriginal and/or Torres Strait Islander)

OR

7-No record

There is no record of any discussions about lifestyle factors described above.

Section 6 Scheduled services

6.1 BMI

A BMI is based on a person's weight and height, and is calculated to determine whether a person is in a healthy weight range for their age (see Tables 7 and 8 below). BMI is calculated by *weight (kgs) / height (m2)*. Note that a BMI doesn't distinguish between fat and muscle, so there can be some exceptions to this guideline. Some people may have a normal BMI but larger-than-normal waist circumference. As described further below; these people are at risk and should be advised to lose weight and increase physical activity.

Table 6.1: BMI Cut Off Points for Adolescents

Age	Underweight	Normal	Overweight	Obese
Boys				
12	<15.35	15.35-21.21	21.22-26.01	≥26.02
12.5	<15.58	15.58-21.55	21.56-26.42	≥26.43
13	<15.84	15.84-21.90	21.91-26.83	≥26.84
13.5	<16.12	16.12-22.26	22.27-27.24	≥27.25
14	<16.41	16.41-22.61	22.62-27.62	≥27.63
14.5	<16.69	16.69-22.95	22.96-27.97	≥27.98
15	<16.98	16.98-23.28	23.29-28.29	≥28.30
15.5	<17.26	17.26-23.59	23.60-28.59	≥28.60
16	<17.54	17.54-23.89	23.90-28.87	≥28.88
16.5	<17.80	17.80-24.18	24.19-29.13	≥29.14
17	<18.05	18.05-24.45	24.46-29.40	≥29.41
17.5	<18.28	18.28-24.72	24.73-29.69	≥29.70
18	<18.50	18.50-24.59	25.00-29.99	≥30.00
Girls				
12	<15.62	15.62-21.67	21.68-26.66	≥26.67
12.5	<15.93	15.93-22.13	22.14-27.73	≥27.74
13	<16.26	16.26-22.57	22.58-27.75	≥27.76
13.5	<16.57	16.57-22.97	22.98-28.19	≥28.20
14	<16.88	16.88-23.33	23.34-28.56	≥28.57
14.5	<17.18	17.18-23.65	23.66-28.86	≥28.87
15	<17.45	17.45-23.93	23.94-29.10	≥29.11
15.5	<17.69	17.69-24.16	24.17-29.28	≥29.29
16	<17.91	17.91-24.36	24.37-29.42	≥29.43
16.5	<18.09	18.09-24.53	24.54-29.55	≥29.56
17	<18.25	18.25-24.69	24.70-29.68	≥29.69
17.5	<18.38	18.38-24.84	24.85-29.83	≥29.84
18	<18.50	18.50-24.99	25.00-29.99	≥30.00

Source: DoHA (2009)

Table 6.2: BMI for Age for Adults and Children

Category	Adults 18+	Children 2 - 18
Underweight	BMI <18.5	BMI-for-age < 5th percentile
Normal weight	18.5 - 24.9	BMI-for-age between 5th and 85th percentile
Overweight	25 - 29.9	BMI-for-age between 85th and 95th percentile
Obesity	BMI of 30 or greater	BMI-for-age >95th percentile

Sources: NACCHO (2012), US Centre for Disease Control (2009)

Recording a BMI is required as part of an annual Aboriginal and Torres Strait Islander Child or Adult Health Check. National guidelines also recommend measuring BMI annually.

Record the most recent BMI result, documented in the last 24 months.

or

0-No record

8-Decl if there is documentation that a BMI measurement was offered but declined by the client in the last 24 months

6.2 Waist circumference

Measuring waist circumference is a simple way to check the amount of body fat a person has. Waist measurement guidelines are used to increase clients' understanding of their likelihood of developing lifestyle-related chronic diseases, including cardiovascular disease, stroke, type 2 diabetes and some cancers. An 'at-risk' waist circumference for an adult male is more than 94 centimetres. An 'at-risk' waist circumference for an adult female is more than 80 centimetres (see Table 9 below). Waist circumference measurement is required as part of an annual Aboriginal and Torres Strait Islander Adult Health Check. An annual waist measurement is also recommended by national guidelines for people aged 18 and over.

Table 6.3: Waist Circumference and Chronic Disease Risk for Clients Aged 15+

Waist circumference (15+)	Result	Action
Male <94 cm Female <80 cm	Normal	Advise to maintain healthy weight
Male 94–102 cm Female 80–88 cm	Increased risk of chronic disease	Advise to keep active Advise not to gain more weight
Male >102 cm Female >88 cm	Greatly increased risk of chronic disease	Advise to lose weight

Source: CARPA 2009

Record the most recent waist circumference measurement, documented in the last 24 months (in cm)

or

0-No record

8-Decl if there is documentation that a waist measurement was offered but declined by the client in the last 24 months

6.3 Weight and waist: abnormal

Abnormal ranges are described in the tables above.

Using the tables 6.1, 6.2 and 6.3, indicate if the client fits into any abnormal range.

1-Yes or 0-No

9-N/A if there was no record of waist measurement or BMI in questions 6.1 or 6.2.

6.4 Weight and waist: action/s taken

If the client is documented as underweight, overweight or obese in question 6.1 and/or increased risk or greatly increased risk of chronic disease in question 6.2, indicate if there is documentation of the following actions within one month of the recorded BMI or waist circumference (you may indicate more than one)

Weight management plan

A weight management plan must include targeted information as per the Australian dietary guidelines, goal setting and at least one follow up consultation.

Blood lipids measurement

7-No record of action

8-Declined if there is evidence that a weight management plan or blood lipid measurement was offered but declined by the client

OR

9-N/A if there was no evidence of underweight, overweight or obesity or increased risk or greatly increased risk of chronic disease recorded in question 6.3

6.5 Oral health check

An oral health check is required as part of an annual Aboriginal and Torres Strait Islander Child or Adult Health Check. National guidelines also recommend an annual oral health check for clients under 18 years, every two years for clients aged 18 and over; and annually for those with risk factors or diabetes. An oral health check includes assessment of gums, teeth and dental hygiene by any health professional.

If the client has had an oral health check the last 24 months indicate one of the following:

1-No concerns if there was no documented concern about gums, teeth or dental hygiene

2-Poor oral health if there is documented concern about gums, teeth or dental hygiene

0-No record if there is no evidence that an oral health check was performed in the last 24 months

8-Decl if there is evidence that an oral health check was offered but declined by the client in the last 24 months

6.6 Oral health: action taken

If poor oral health was indicated in question 6.5, is there a record of referral to a dentist within one month of oral check? Indicate:

1-Yes or 0-No

8-Decl if there is evidence that a referral to a dentist was offered but declined by the client in the last 24 months

9-N/A if there was no record of poor oral health recorded in 6.5; or if poor oral health was documented less than one month prior to the audit date and no referral to a dentist was recorded.

6.7 Ears and hearing

Ear and hearing checks are required as part of an annual Aboriginal and Torres Strait Islander Child or Adult Health Check and by national guidelines. This should include hearing screening, otoscopic examination and 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.

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

Indicate the results of the most recent ear and hearing check in the last 24 months:
1-No concerns if there is documentation that ear and hearing checks were performed, and there was no documented recurrent or chronic ear infections or possible hearing loss

2-Recurrent or chronic ear infections or possible hearing loss if there is documentation that ear and hearing checks were performed, and recurrent or chronic ear infections or possible hearing loss were documented

8-Declined if there is evidence that ear and hearing checks were offered but declined by the client
7-No record if there is no evidence that ear and hearing checks were performed

6.8 Ear and hearing: action/s taken

If recurrent or chronic ear infections were documented in question 6.7, record the documented actions taken within one month of assessment.

Treatment

Treatment may include prescription of antibiotics, advice on ear care and/or an action plan

Referral to audiology
Referral to ENT specialist
Follow-up examination *within 3 months*
7-No record of action

8-Declined

9-N/A if no if recurrent or chronic ear infections or possible hearing loss were documented in 6.7; or if recurrent or chronic ear infections or possible hearing loss were documented less than one month prior to the audit date and no action was recorded.

6.9 Cardiac auscultation (heart check)

This should be a clinical examination by a qualified health worker in line with the health centre policy on roles within the health team. A GP is required to listen to the child's heart at any presentation and will check for unusual sounds or murmurs during the examination. A health worker or nurse is not expected to distinguish heart sounds unless they have been appropriately trained.

A cardiac auscultation is recommended for all age groups by national guidelines and part of an annual Aboriginal and Torres Strait Islander Health Check. If the client is Aboriginal and/or Torres Strait Islander, record the results of the most recent cardiac auscultation in the last 24 months. Indicate:

1-No concerns no evidence of murmur suggesting possible valve disease or past rheumatic fever
2-Evidence of heart murmur evidence of a murmur suggesting possible valve disease or past rheumatic fever
7-No record no evidence that a cardiac auscultation was performed
8-Declined if there is evidence that a cardiac auscultation was offered but declined by the client
9-N/A if the client is not Aboriginal and/or Torres Strait Islander, or cardiac auscultation is not scheduled in your jurisdiction.

6.10 Cardiac auscultation: action/s taken

If there is a record of heart murmur suggesting possible valve disease or past rheumatic fever in question 6.8, is there a record of the following actions within one month of diagnosis? Indicate

Echocardiogram
Referral to GP or specialist
No record
Declined

N/A if no murmur suggesting possible valve disease or past rheumatic fever was documented in 6.9; or if a murmur suggesting possible valve disease or past rheumatic fever was documented in 6.9 less than one month prior to the audit date and there was no evidence of an echocardiogram or referral to a GP or specialist.

6.11 Skin examination

A skin exam is required for clients aged less than 15 as part of an annual Aboriginal and Torres Strait Islander Child Health Check. Local guidelines and protocols also recommend a routine skin exam for children in areas with a high prevalence of skin infections. This includes assessment of the overall skin and /or enquiry about skin problems. If the client is <15 years, indicate the results of the most recent skin exam documented in the last 24 months.

1-No concerns
2-Evidence of skin sores/infection
7-No record
8-Declined
9-N/A if the client was aged ≥15

6.12 Skin examination: action/s taken

If there is evidence of skin sores/infection in question 6.11, indicate the action/s documented.

Cleaning and treatment
if there is evidence that cleaning by either the child's care givers or the health service **and** intramuscular or oral antibiotic treatment was commenced
Follow-up check *within 3 months*
7-No record of any action/s
9-N/A if no skin sores or infections were recorded in 6.11

6.13 Blood pressure

Blood pressure measurement is recommended by national guidelines for clients aged 18 years and over and required as part of an annual Aboriginal and Torres Strait Islander Adult Health Check. For a healthy adult, blood pressure is abnormal if the systolic pressure is greater than or equal to 140 mmHg and/or the diastolic pressure is greater than or equal to 90 mmHg (≥140/90). Abnormal blood pressure for a client with a chronic disease (except chronic kidney disease) is 130/80 or higher (CARPA 2009, Queensland Health 2010). For chronic kidney disease, a BP greater than 125/75 is considered abnormal.

If the client age is ≥ 18 years, record the most recent documented BP in the last 24 months (systolic/diastolic)
or
7-No record
8-Declined
9-N/A if the client was aged <18

Table 6.4: Diabetes Risk Factors

Risk Factors
People living in regions with a high prevalence of diabetes (≥5%)
Previous impaired glucose tolerance and/or impaired fasting glucose
History of gestational diabetes mellitus
History of polycystic ovary syndrome
History of cardiovascular disease
Current antipsychotic medication use

Source: NACCHO 2012

6.14 Blood glucose test

If the client is aboriginal and/or Torres Strait Islander and aged 15 and over or non-Indigenous with risk factors and aged 18 and over record the most recent BGL value, within the last 24 months. (mmol/L, to one decimal place) or

7-No record

8-Declined if there is documentation that a blood glucose test was offered but declined by the client in the last 24 months

9-N/A if the client was Indigenous and aged <15; or non-Indigenous, aged <18 and had no diabetes risk factors documented

6.15 Blood glucose: action taken

If a blood glucose level of ≥5.5 mmol was recorded in 6.14, is there documentation of a management plan including repeat blood glucose testing? Indicate

1-Yes or **0-No**

8-Decl if there is evidence that a management plan was offered but declined by the client

9-NA if a glucose level ≥5.5 mmol was not recorded in 6.14

6.16 Pap smear

A pap smear is required for all women every two years commencing from age 18 years or two years after first sexual intercourse (whichever is later and regardless of whether HPV vaccination has been received) by national guidelines. A pap smear is also required within an Aboriginal and Torres Strait Islander Adult Health Check following the same eligibility criteria. If the client is female and ≥ 20 years, record the result of the most recent pap smear in the last 24 months

1-Normal test result

2- Abnormal test result

7-No record

8-Decl if there is evidence that a pap smear was offered but declined by the client in the last 24 months

9-N/A if the client was male, female aged under 20; or female aged ≥20 and there is documentation that the client is not sexually active.

6.17 Pap smear: action taken

Actions recommended for the follow up of abnormal pap smears vary according to the result and age of the woman. Women with any low grade abnormalities should have another pap smear in 12 months. Women with any high grade abnormalities should have a colposcopic evaluation by a gynaecologist within 2 weeks of the abnormal result (DoH, 2010).

For the purpose of this audit, appropriate follow up for an abnormal pap smear result may include: repeat pap smear within 12 months or referral for colposcopic assessment. This may include referral to a gynaecologist.
If there is a record of an abnormal pap smear test in question 6.16, is there documentation of the appropriate follow up within 12 months of abnormal result?
1-Yes or 0-No
8-Decl if there is evidence that a repeat pap smear or referral was offered but declined by the client
9-N/A if an abnormal test result was not recorded in 6.15

Table 6.5: STI Risk Factors

Risk Factors
Age <30 years
Age <35 years and sexual network relates to a remote community
Multiple current partners
Engaging in group sex
New partner
Using condoms inconsistently
Living in an area with a high incidence of STIs
Having sex while under the influence of drugs or alcohol
Having sex in exchange for money or drugs
Prison incarceration
Victim of sexual assault
Men who have sex with men

Source: NACCHO (2012)

Individual State and Territory sexual health guidelines vary (see Table 12 below) but national guidelines generally recommend:

- Screening for chlamydia annually for all sexually active clients aged 15-29 years, all pregnant women and all men who have sex with other men.
- Screening for gonorrhoea annually for all sexually active people aged 15–39 years and pregnant women where local prevalence rates are high and all men who have sex with men.
- Screening for syphilis annually for all men who have sex with men, others at high risk of contracting an STI and all pregnant women.
- Screening for trichomoniasis opportunistically for all sexually active people aged <35 years where local prevalence rates are high.
- Screening for other STIs as determined by local guidelines and prevalence rates.

Jurisdiction	Sexual Health Guidelines
National	NACCHO (2012) National Guide to a Preventive Health Assessment in Aboriginal and Torres Strait Islander Peoples, 2nd ed, Royal Australian College of General Practitioners, Melbourne http://www.naccho.org.au/
NT	CARPA Standard Treatment Manual (2009) 5th edition, Central Australian Rural Practitioners Association, Alice Springs.
QLD	Queensland Government (2010) Queensland Sexual Health Clinical Management Guidelines, Queensland Government Queensland Health and the Royal Flying Doctor Service Queensland Section (2011) Primary Clinical Care Manual, 7th edition, Queensland Health Queensland Health, (2013) Aboriginal and Torres Strait Islander adolescent sexual health guideline
WA	WA Department of Health (2011) Guidelines for Managing Sexually Transmitted Infections, WA Department of Health http://silverbook.health.wa.gov.au/
VIC	Sexual Health Society of Victoria (2008) National Management Guidelines for Sexually Transmissible Infections, Sexual Health Society of Victoria

6.18 Sexual health check

Young people are considered a high risk group for contracting STIs (see Table 11). A sexual health check is required for clients aged 15 and over as part of an annual Aboriginal and Torres Strait Islander Adult Health Check. See Appendix 5 for a list of common STIs

If sexual activity is not specifically identified, prescription of contraception may be used as an indication that a client is sexually active for the purpose of this audit.

If the client is aged ≥15, or any sexual activity is documented and a sexual health check was performed according to local guidelines in the previous 24 months, were any of the results positive? Indicate:

1- Yes or **0-No**
7-No record (no record that any sexual health tests were ordered, or no record of results)
8-Decl if there is evidence that a sexual health check was offered but declined by the client
9-N/A if the client is aged <15; or ≥15 and there is documentation that the client is sexually inactive

6.19 Sexual health: action/s taken

See Appendix 5 for common medications used to treat STIs.
If any positive STI test result was recorded in question 6.18 is there documentation of the following?

Appropriate treatment (according to local guidelines)
Retest within 3 months
Contact tracing (attempted, in progress or completed)
Auditors should search for contact tracing information in the progress notes or the STI management template if it is installed in the health centre's client record system.
7-No record
8-Declined treatment, follow-up or contact tracing were offered but declined by the client
9-N/A if a positive STI test result was not recorded in question 6.18

Appendix 1 Assessment of Mature Minors

Table A1: Assessment of Mature Minors in Australia

National
The common law applies in Australian jurisdictions that have not specifically legislated in relation to the issue of minors' consent to medical treatment. The English House of Lords decision in Gillick v West Norfolk and Wisbech Area Health Authority [1986] determined that minors may authorise medical treatment when they are old enough and mature enough to decide for themselves, provided they are capable of understanding what is proposed and of expressing their own wishes. Assessing capacity is a matter for professional judgment. Judgment about a minor's competence involves consideration of: • Their ability to understand the issues and circumstances • Their maturity and degree of autonomy • The type and sensitivity of the information to be disclosed • The age of the minor, and • The complexity and nature of the treatment (e.g. elective, therapeutic or emergency).
ACT
The Age of Majority Act 1974 requires a parent or legal guardian to consent to medical procedures for persons under the age of 18 years. However, if the practitioner assesses the child to have sufficient maturity to give consent and finds that the child adequately understands the nature and consequences of the treatment, that child is able to give their own consent.
NSW
According to the Minors (Property and Contracts) Act 1970, • A child aged 14 years or over may consent to his or her medical treatment, and the consent of the child will be effective in terms of defending an action for assault or battery relating to the treatment • Parents of children under the age of 16 can validly consent to their child's medical treatment.
NT
No state-based legislation – see national legislation above
QLD
No state-based legislation– see national legislation above
SA
The Consent to Medical Treatment and Palliative Care Act 1995 prescribes that • An individual of 16 years of age or over can consent to medical treatment 'as validly and effectively as an adult'; • When two medical practitioners believe and state in writing that certain treatment is in the best interests of the child and the child is 'capable of understanding the nature, consequences and risks' involved, that child can validly consent to their own treatment. This is so even when the child has not attained 16 years of age.
TAS
No state-based legislation – see national legislation above
VIC
No state-based legislation – see national legislation above
WA
No state-based legislation – see national legislation above

Sources: Australian Institute of Family Studies (2010), The Medical Insurance Group (2011), NT Department of Health (2012), WA Department of Health (2012), ACT Department of Health and Community Services (2011), Tasmanian Department of Health and Human Services (2012), Victorian Department of Human Services (2011), SA Department of Communities and Social Inclusion (2009), Queensland Department of Communities, Child Safety and Disability Services (2012).

Appendix 2 Common Vaccines for Youth

Table A2: Common Vaccines for Youth

Vaccine	Vaccine Brand Names (example only – refer to state-based protocols)	Disease/infection/organism
HPV	Gardasil	Human papillomavirus
VZV	Varilrix Varivax	Varicella zoster virus (chickenpox)
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 B	H-B-VaxII Energix-B Hexa B Comvax (HepB and Hib)	Hepatitis B
DPTa	Boostrix	Diphtheria, tetanus, acellular pertussis (whooping cough)
DPTa IPV	Infanrix Quadracel	Diphtheria, tetanus and acellular pertussis Poliomyelitis
7vPCV	Prevenar	Pneumococcal disease
10vPCV	Synflorix	Pneumococcal disease
23vPPV	Prevenar Pneumovax	Pneumococcal disease
Influenza	Fluvax Vaxigrip Fluarix	Influenza

Appendix 3 Common Screening Tools for Youth

Table A3: Applicability of screening tools to social and emotional wellbeing issues

	Alcohol	Other drugs/ substances	Tobacco	EWB	Age Applicable	At Risk Score
AUDIT C					13+	At risk ≥ 3 Women At risk ≥ 4 Men
IRIS					18+	At risk > 9
CRAFFT					≤21	Probability of abuse /dependence over 50%: 2+
SACS					13-18	Problems of clinical severity: 4+
K5						At risk >12
K6						At risk=12-24
K10						At risk >22

Legend

Applicable to risk

Appendix 4 Common Medications for Alcohol, Other Drugs and Substances; Tobacco; and Mental Health Issues

Table A4: Medications Used for Alcohol Withdrawal

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Naltrexone	Revia	Opioid antagonist that reduces cravings	nausea, headache, dizziness, fatigue, nervousness, insomnia, vomiting, anxiety	25-50
Acamprosate	Campral	Works via glutamate pathways to reduce alcohol cravings	gastrointestinal adverse effects	666

Source: DoHA 2012; 2009

Table A4a: Medications Used for Opioid Withdrawal

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Buprenorphine	Subutex	A strong opioid analgesic with both partial agonist and partial antagonist properties	Constipation, disturbed sleep, drowsiness, sweating, headaches, nausea, reduced libido	4-16
Methadone	Methadone	long-acting synthetic opioid which can be used for both withdrawal and maintenance treatment	Sleep disturbances, nausea and vomiting, constipation, dry mouth, sweating, vasodilation and itching, menstrual irregularities in women, gynaecomastia in men, sexual dysfunction in men, fluid retention and weight gain	20-100

Source: DoHA 2006, 2003; NCETA Consortium 2004

Table A4b: Medications Used in Tobacco Withdrawal

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Nicotine replacement therapy	Nicabate	Nicotine replacement	skin erythema, skin irritation, sleep disturbance, dyspepsia, nausea, mouth and throat irritation	Various
Varenicline	Champix	nicotine partial agonist	Nausea, abnormal dreams	0.5-2
Bupropion	Buproprion-RL	adjunctive therapy for nicotine dependence	Seizures, insomnia, headache, dry mouth, nausea, dizziness, anxiety	150-300

Source: RACGP 2011

Table A4c: Medications Used in Mental Health — Antidepressants

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Sertraline	Zoloft	Depression/ anxiety	Gastrointestinal, insomnia, sexual, agitation	50–200
Fluoxetine	Prozac	Depression/ anxiety	Agitation, headache, withdrawal, weight loss	20–80
Mirtazepine	Avanza	Depression/ anxiety	Weight gain, sedation, dreams, dizziness	15–60
Escitalopram	Lexapro	Depression/ anxiety	Insomnia, sedation, gastrointestinal, dizziness	10–20
Nefazodone	Serzone	Depression/ anxiety	Gastrointestinal, hypotension, sedation, dizziness	200–600
Paroxetine	Aropax	Depression/ anxiety	Withdrawal, sedation, sexual	20–60
Fluvoxamine	Luvox	Depression/ anxiety	CNS, cardiac, gastrointestinal, sweating, headache	100 –300
Amitryptaline	Tryptanol	Depression/ anxiety	Anticholinergic, sedation	75–150
Tranylcyproamine	Parnate	Depression/ anxiety	Hypertensive crisis, insomnia, headache, palpitations, dizziness	10–30
Venlafaxine	Effexor	Depression/ anxiety	Withdrawal effects, sexual, gastrointestinal, hypertension, insomnia	75–375 Effexor XR 150–225
Mianserin	Tolvon	Depression/ anxiety	Sedation, hypomania, anticholinergic	30–120
Moclobemide	Aurorix	Depression/ anxiety	Insomnia, dizziness, nausea, headache	300–600
Phenelzine sulfate	Nardil	Depression/ anxiety	Hypotension, hypomania, agitation	15–60
Reboxetine	Edronax	Depression/ anxiety	Headache, insomnia, tachycardia, nausea, sedation, weight gain	4–10

*Lower doses in physically unwell and at commencement

Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Table A4d: Medications Used in Mental Health — Antipsychotics

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Aripiprazole	Abilify	Psychosis	Tardive dyskinesia, neuroleptic malignant syndrome, headache, hypotension, gastrointestinal, hyperglycaemia	15–30
Chlorpromazine	Largactil	Psychosis	Sedation, tardive dyskinesia, hypotension, photosensitivity	25–300
Clozapine	Clopine	Psychosis	Sedation, weight gain, constipation, agranulocytosis	200–900
Droperidol	Droleptan	Psychosis	Hypotension, sedation, extrapyramidal symptoms, arrhythmias	5–25 IMI
Flupenthixol	Fluanxol depot	Psychosis	Extrapyramidal symptoms, tardive dyskinesia, anticholinergic	20 2–4 wkly
Haloperidol	Serenace	Psychosis	Extrapyramidal symptoms, neuroleptic malignant syndrome, endocrine, QT prolongation	1–15
Olanzapine/ wafers	Zyprexa/ Wafers	Psychosis/ mood stabiliser	Weight gain, sedation, hypotension	5 - 20
Paliperidone	Invega	Psychosis	Headache, akathisia, extrapyramidal symptoms, nausea, tachycardia, extrapyramidal symptoms, weight gain, hyperprolactinaemia, orthostatic hypotension, hyperglycaemia	IM 4 wkly
Quetiapine	Seroquel	Psychosis	Hypotension, sedation, hyperglycaemia, neuroleptic malignant syndrome, tardive dyskinesia, weight gain	200–400
Risperidone (depot)	Risperdal Consta	Psychosis	Tardive dyskinesia, neuroleptic malignant syndrome, hypotension, agitation, weight gain, increased prolactin, hyperglycaemia	25–50 IM 2 wkly
Risperidone (oral)	Risperdal	Psychosis	(As above;.Drug is also available as disintegrating tabs)	2–6
Trifluoperazine	Stelazine	Psychosis	Sedation, extrapyramidal symptoms, tardive dyskinesia, neuroleptic malignant syndrome, hypotension, anticholinergic effects	1–6
Zuclopenthixol	Clopixol	Psychosis	Sedation, extrapyramidal symptoms, anticholinergic, neuroleptic malignant syndrome	10–50
Zuclopenthixol	Clopixol acuphase	Psychosis	Sedation, extrapyramidal symptoms, anticholinergic, neuroleptic malignant syndrome	50–150 IMI
Zuclopenthixol	Clopixol depot	Psychosis	Sedation, extrapyramidal symptoms, anticholinergic, neuroleptic malignant syndrome	200–400 IMI 2–4 wkly

*Lower doses in elderly, physically unwell and at commencement
(depot) — many depot preparations are also available as oral preparations
Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Table A4e: Medications Used in Mental Health — Mood Stabilisers (Oral)

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Lithium carbonate	Lithicarb	Mood stabiliser	Renal effects, polyuria, goitre, thirst, weight gain	500 –1000
Sodium valproate	Valpro	Mood stabiliser	Haematological, neurological, hepatic dysfunction, gi, hair loss, weight gain	600–2000
Carbamazepine	Tegretol	Mood stabiliser	Sedation, gi, hepatic, endocrine, haematological	600–1000
Lamotrigine	Seaze	Mood stabiliser	Rash, central nervous system disturbance, arthralgia	50–400

*Lower doses in physically unwell and at commencement

Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Table A4f: Medications Used in Mental Health — Anti-Anxiety/Other

Medication	Trade name	Used for	Common side effects	Usual dosage mg/day *
Benztropine	Cogentin	Parkinsonism	Anticholinergic, tachycardia, confusion	2–6
Zolpidem	Stilnox	Insomnia	Tolerance, dependence, withdrawal	5–10
Clonazepam	Rivotril	Anxiety, agitation, mania	Dependence, sedation	1–8
Diazepam	Valium	Anxiety agitation	Tolerance, dependence, sedation	5–60
Oxazepam	Serepax	Anxiety agitation	Tolerance, dependence, sedation	15–45

*Lower doses in physically unwell and at commencement

Note: Only common side effects recorded above, check dosage regime before prescribing. Only one trade name is included for each medication

Appendix 5: Common Medications for the Treatment of STIs

Table A5: Common STI medications and dosages

Medication	Route	Infection	Usual dosage day *	Number of days
ZAP pack	oral	Chlamydia and gonorrhoea	(contains Amoxicillin 3 grams Probenecid 1 gram, and Azithromycin 1 gram)	Single dose
Amoxicillin	oral	Uncomplicated gonorrhoea in Kimberley, Pilbara and Goldfields where penicillin resistance is less common	3 grams	single dose
Probenecid	oral	For NT clients if gonorrhoea is acquired from a partner outside of the Top End or Central Australia or contact of known penicillin resistant gonorrhoea	1 gram	single dose
Azithromycin	oral	Chlamydia	1 gram	single dose
		Donovanosis	1 gram	Per week for four weeks or until lesion is healed
Ceftriaxone	IM	Gonorrhoea (oral or anal)	500 mg (mixed with 2 ml lignocaine 1%)	single dose
Metronidazole	oral	Trichomoniasis	2 gram	single dose
Tinidazole	oral	Trichomoniasis	2 grams	single dose
Benzathine penicillin	IM	Donovanosis	1.8 gram (2.4 million units)	single dose
Benzathine penicillin		Syphilis	1.8 gram (2.4 million units)	Single dose if primary or secondary and weekly for 3 weeks if late latent or for > 2 years
Valaciclovir	oral	Herpes (first episode)	500 mg b.d.	5-10 days
Valaciclovir.	oral	Herpes (recurrent episode)	500 mg b.d.....	3 days

Source: CARPA 2009; WA Department of Health 2011

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