Department of Education & Training
Early Childhood & School Education Group

2 Treasury Place
East Melbourne, Victoria 3002
Telephone: +61 3 9637 2000
DX 210083
GPO Box 4367
Melbourne, Victoria 3001

24 March 2015

Our Ref: COR006876

Your Ref: COR 2011 001993

Ms Emma Lindsay
Registrar
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC. 3001

By email : cpuresponses@coronerscourt.vic.gov.au

Dear Ms Lindsey,

Investigation into the death of Hailey Holmes

The Department of Education and Training **(Department)** acknowledges receipt of the findings without an inquest made on 19 December 2014 by the Coroners Court of Victoria in relation to the death of Hailey Holmes. The Department acknowledges that this finding includes recommendations made by the Coroner pursuant to section 72(2) of the *Coroners' Court Act 2008* (Vic).

Pursuant to section 72(3) of the Act, the Department provides the following response.

Relevant Background

Legislative context

The *Child Wellbeing and Safety Act 2005* sets out requirements regarding birth notification in Victoria. The Act stipulates that the birth notification is to be forwarded by maternity services to the chief executive officer of the local government area where the mother resides, within 48 hours of the child being born. It is then the responsibility of the executive officer to forward the birth notice to the relevant Maternal and Child Health (MCH) nurse, who contacts the mother and invites her to access the MCH Service.

Victoria's Maternal and Child Health (MCH) Services

Victorian MCH Services are jointly provided through a formal partnership between the Department and the Municipal Association of Victoria (MAV). The Department is responsible for the state-wide policy and program development. Municipal Councils are responsible for providing MCH Services which comply with policy and program guidelines.

Victorian MCH Services provide a schedule of contacts and activities for all families with children, with an emphasis on prevention, health promotion, early detection, and intervention where necessary. There are three components of the Victorian MCH Service including: Universal MCH Service; Enhanced MCH Service; and the MCH Line.

Universal MCH Service

The Universal MCH service is available to families with children from birth to school age. This service includes a schedule of consultations at Key Ages and Stages (KAS) as well as other activities such as the following:

- Fostering social networks via first time parent groups and playgroups
- Immunization programs
- Identification of children and families who require further assessment, intervention, referral and/or support.

Enhanced MCH Service

The Enhanced MCH Service provides additional support to disadvantaged children and their families who are at risk for one or more of the following reasons: drug and alcohol issues; mental health issues; family violence issues; families known to Department of Health and Human Services (Child Protection); homelessness; unsupported parent(s) under 24 years of age; low-income, socially isolated, single-parent families; significant parent–baby bonding and attachment issues; parent with an intellectual disability; children with a physical or intellectual disability ; infants at increased medical risk due to prematurity, low birth weight, drug dependency; and failure to thrive.

The Enhanced MCH Services provides a more intensive level of support, including short-term case management in some circumstances. Support may be provided in a variety of settings, such as the family's home, the MCH centre or another location within the community.

24 Hour MCH Line

Both the Universal MCH Service and the Enhanced MCH Service are supported by the 24-hour MCH Line. This service provides telephone advice, support, counselling and referral to families with children from birth to school age. The service is instrumental in linking families to the Universal MCH Service and to other community, health and support services.

Further information on these services is outlined in the *Maternal and Child Health Service Guidelines, 2011* which can be found at the following link:

http://www.education.vic.gov.au/Documents/childhood/professionals/health/mchsguidelines.pdf

Current MCH Practice

The current MCH services in Victoria are governed by the following practice and guidelines:

MCH Practice Guidelines

The MCH Practice Guidelines were developed in 2009. The Guidelines outline service delivery and monitoring requirements in accordance with the policy directions. These can be found on the Department's website at the following link:

http://www.education.vic.gov.au/Documents/childhood/professionals/health/mchpracticeguidelines.pdf

MCH Key Ages and Stages (KAS) Framework

The MCH KAS Framework introduced a new approach to the ten KAS visits provided to families with young children by the Universal MCH Service. The Framework sets out evidence-based activities for each of the ten KAS consultations with additional emphasis on health prevention and promotion across a range of domains, including an assessment and sighting of the child's sleeping arrangements.

The Framework also outlines practice interventions that include a Sudden Infant Death Syndrome (SIDS) risk assessment and the use of the MCH Safe Infant Sleeping Checklist.

The MCH KAS Framework can be found at the following link:

http://www.education.vic.gov.au/Documents/childhood/professionals/health/mchkasframework.pdf

In this context, we now wish to take this opportunity to provide you with a written response to each of the Coroner's recommendations:

Recommendation 1

That the maternal and child care nurses address the issue of safe sleeping, including the transition to different sleeping environments, at every 'Key Ages and Stages' appointment with infant's caregiver.

In response to this Recommendation, the Department advises that it ***supports this recommendation*** and is in the process of implementing it.

Current Practice

The current MCH Practice Guidelines outline that the MCH nurse should discuss Sudden Unexplained Death or Injury (SUDI) at the first home visit, and the next six KAS consultations (Home Visit; 2 week; 4 week; 8 week; 4 month; 8 month; and 12 months).

The key messages during these consultations consist of the following:

(i) Put baby on its back to sleep, from birth, never on its tummy or side.

(ii) Be careful that baby's head and face stay uncovered during sleep.

(iii) Keep baby smoke-free, before and after birth.

(iv) Provide a safe cot, safe mattress, safe bedding and safe sleeping place.

In addition, at the first KAS consultation in the family home, the MCH nurse is required to complete the MCH Safe Infant Sleeping Checklist. This checklist was developed with SIDS and Kids and can be found on Department's website at the following link:

http://www.education.vic.gov.au/Documents/childhood/professionals/health/Safe%20Sleeping%20Checklist%20SIDS%20and%20Kids%20Victoria.pdf

This checklist requires MCH nurses to check and assess the child's sleep environment with the parent or guardian. MCH nurses are required to tick boxes where there is a close match between the child's sleeping environment and the

corresponding statement. The MCH nurses are required to cross boxes to indicate the observed environment does not match the corresponding statement.

Where the observed or reported environment does not match the corresponding statement (i.e. a cross has been placed in one or more boxes) the MCH nurse is required to discuss this with the family and encourage changes to the child's sleeping environment. The MCH nurse then documents the discussion in the space provided on the checklist. The MCH nurse is then required to provide the Safe Sleeping Checklist to the parent/guardian and advise them to keep it with their Child Health Record. The MCH Nurse also leaves a copy of the *SIDS and Kids Safe Sleeping* brochure with the parent / guardian. This brochure can be found at the following link:

http://www.sidsandkids.org/wp-content/uploads/SIDS042-J-SafeSleeping-EasyRead-8pp-DL-Rollfold-Single-Pages-LR5.pdf

Review of Current Practice

Development of Victorian Safe Infant Sleeping Guidelines

The Department recognizes that there is currently conflicting evidence about the safety and use of portacots for infants and young children.

In 2014, the Department and the Department of Health and Human Services commissioned LaTrobe University to develop new Victorian Safe Infant Sleeping Guidelines including the consideration of evidence on the issue of the use of portacots.

The aim of the new Victorian Safe Infant Sleeping Guidelines is to provide health and community services with:

- Evidence-based key recommendations on safe infant sleeping practices for children less than one year of age
- An evidence-based guideline to support them to provide consistent and realistic safe infant sleeping information to parents, allowing for the challenges that meeting best practice can pose.

In developing the new guidelines, the Department will consult with key academics and stakeholders including:

- Kids and SIDS
- Health and community organisations
- MCH health nurses

Following the development of the guidelines a communication strategy will be implemented including training across Victoria for MCH nurses. This will include education and advice provided at the state-wide MCH conferences held twice a year and attended by more than 1000 nursed across Victoria.

It is anticipated that the Victorian Safe Infant Sleeping Guidelines will be published by July 2015.

Review of MCH Practice Guidelines

Prior to receiving the Coroners' Court findings and recommendations, the Department had also commenced a review of the current MCH Practice Guidelines.

This review will now also include implementation of this Coroner recommendation, and ensure that there are practice prompts regarding safe infant sleeping at all of the 10 KAS consultations.

In revising and updating the MCH Practice Guidelines, the Department will consult with the following stakeholders:

- MAV
- Victorian Municipal Councils
- Department of Health and Human Services and
- Academic and practice experts in the field of Safe Infant Sleeping.

Once the MCH Practice Guidelines have been revised, the Department will develop and implement a statewide communication strategy to ensure that all Victorian maternal child and health nurses are aware of the revised Guidelines and are implementing the new guidance in practice.

It is anticipated that the new MCH Practice Guidelines will be revised, published and implemented by 2016.

The Department undertakes to provide the Coroners' Court of Victoria with a copy of the Victorian Safe Infant Sleeping Guidelines and the revised MCH Practice Guidelines as soon as they have been finalised.

Recommendation 2:

That maternal and child care nurses continue to educate caregivers about the suffocation dangers of using extra mattresses or padding in potable cots.

In response to this Recommendation, the Department advises that it ***supports this recommendation*** and is already implementing it.

The MCH Practice Guidelines include the MCH Safe Infant Sleeping Checklist as discussed above. One of the key messages that is discussed with parents is that no loose bedding, quilts, doonas, pillows, cot bumpers, sheepskins or soft toys should be in any cot.

If there are any questions, please contact Pip Lyons on 9651 3477 or via email on lyons.pip.p@edumail.vic.gov.au.

Yours sincerely

Dr Stacey Gabriel

Acting Director, Prevention and Health Promotion Branch

Wellbeing, Health and Engagement Division

Department of Education and Training

Attachments

1. Victorian Maternal and Child Health Service Guidelines, 2011
2. Victorian Maternal and Child Health Practice Guidelines, 2009
3. Victorian Maternal and Child Health Key Ages and Stages Framework, 2009
4. Victorian Maternal and Child Health Safe Sleeping Checklist

State Government Victoria

Department of Education and Early Childhood Development

Maternal and Child Health Service Guidelines

Published by Maternal and Child Health,
Office for Children and Portfolio Coordination,
Department of Education and Early Childhood
Development

Melbourne
February 2011

Authorised by the Department of Education
and Early Childhood Development,
2 Treasury Place, East Melbourne, Victoria, 3002.

This document is also available on the internet at
http://www.education.vic.gov.au/mchservice

Contents

Contents

1. Quick upfront information

This publication is available as a booklet and a PDF file on the website **www.education.vic.gov.au/mchservice.** It provides new Maternal and Child Health Service guidelines and replaces the *Maternal and Child Health Resource Guide September 2006.* Please discard or archive your previous resource guide and replace it with these guidelines.

1.1 Updated information

Information on the following topics has been included or updated to reflect program changes:

- Section 5: MCH Service – page 14
- Key Ages and Stages Activity Framework – page 16
- Healthy Kids Check Initiative – page 26
- Continuity of Care communication protocol – page 27
- Section 9: Performance measures and targets – 29
- Section 11: Additional resources – page 37
- Appendix 1: Responding to concerns about children or young people – page 38
- Appendix 2: Child abuse and neglect – page 40
- Appendix 7: Using the Child Health Record for children in out-of-home care – page 60

1.2 Contacting Department of Education and Early Childhood Development

The Department of Education and Early Childhood Development (DEECD or 'the Department') has a central office in Melbourne. There are nine DEECD regions throughout the state, four metropolitan and five regional. Each region has at least one departmental office; some have more than one office, depending on the size of the region.

Each regional office has a Program and Service Adviser (PASA) who is appointed to support funded organisations and programs, including the Maternal and Child Health Service (MCH). Part of the PASAs role is to actively assist with the implementation of the Key Ages and Stages Activity (KAS) Framework (discussed in Section 5).

MCH Coordinators are encouraged to maintain regular contact with their regional PASA. All enquiries should be directed to the regional office applicable to the location of the MCH Service. Contact phone numbers for regional DEECD offices are listed below, and further details are available on the website **http://www.education.vic.gov.au/about/structure/regions**

Table 1.1: DEECD regional office addresses and phone numbers

DEECD Regional Office	Address	Phone number
Eastern Metropolitan Region	Level 3, 295 Springvale Road, Glen Waverley 3150	9265 2400
Northern Metropolitan Region	145 Smith Street, Fitzroy 3065	9412 5333
Western Metropolitan Region	PO Box 224, Footscray 3011	9275 7000
Southern Metropolitan Region	33 Princes Highway, Dandenong 3175	9213 2111
Barwon South West Region	PO Box 2086, Geelong 3220	5225 1000
Gippsland Region	PO Box 381, Moe 3825	5127 0400
Grampians Region	109 Armstrong Street North, Ballarat 3350	5337 8444
Hume Region	PO Box 403, Benalla 3672	5761 2100
Loddon Mallee Region	PO Box 442, Bendigo 3552	5440 3111

If your regional PASA is unavailable, please contact the MCH Team in the Office for Children and Portfolio Coordination, DEECD on 1300 791 423 or via email at mch@edumail.vic.gov.au.

1.3 Maternal and Child Health program changes

The central office of the Department is responsible for driving improvements in the MCH Service in partnership with the Municipal Association of Victoria (MAV) and local government.

Recent changes to the MCH Service include:

- implementation of the revised KAS Activity Framework, including the training of the MCH workforce in the new components of the Framework and development of *MCH Service Practice Guidelines 2009*
- review of the *MCH Service Program Standards*

1.4 Key dates

Important dates are:

- MCH Nurses Conference – biannually in February and October
- MCH Leaders Workshop – annually in March
- MCH Enhanced Workshop – annually in July.

2. Introduction

These guidelines have been developed to inform MCH service providers of the policies, procedures, funding criteria and data collection requirements for the MCH Service. They also provide information and resources to support the delivery of the MCH Service.

This edition of the *Maternal and Child Health Service Guidelines* applies from February 2011 to February 2013 and updates the *MCH Program Resource Guide September 2006*.

3. Policy context

3.1 Providing a universal service and reducing disadvantage

The Victorian Government has a strong policy agenda that commits to investing in the early years and reducing the effects of disadvantage on childhood development. These policy directions recognise that quality early childhood experiences, the home environment, access to health services and participation in learning and care programs such as the MCH program all directly influence a child's health and development.

Research shows that quality early childhood programs can improve a child's emotional wellbeing, their future performance at school and their life experience. This is particularly true for children experiencing disadvantage. Active participation in early childhood programs such as maternal and child health services can foster positive learning and development and lessen or eliminate the effects of disadvantage before they become entrenched.

The Victorian MCH Service is a universal service available for all families with children from birth to school age through a schedule of consultations at key ages and stages, and other activities including parent groups. Additional support is also available through the Enhanced MCH Service, which responds to disadvantaged children and families. Both the Universal MCH Service and the Enhanced MCH Service are supported by the 24-hour MCH Line.

The MCH Service provides a schedule of contacts and activities for all families, with an emphasis on prevention, health promotion, early detection, and intervention where necessary. In addition, the MCH Service provides a universal platform that can:

- help to identify children and families who require further assessment, intervention, referral and/or support
- bring families together, foster social networks, support playgroups and strengthen local community connections
- deliver other services and supports, such as family support services and immunisation programs.

3.2 Providing a comprehensive, coordinated family-centred service system

An integrated system of early childhood services capable of responding to the emerging and changing needs of children and their families in a local community setting is imperative to achieving better outcomes for children. Such a system will engender communities that are more child and family friendly while providing comprehensive and outcomes for children.

The MCH Service is part of the broader service system that builds on the identification of individual, family and community needs at a local level. MCH Services may be part of a local service network that includes general practitioners, kindergarten and child care services, Indigenous organisations, early childhood intervention services, parenting and family services, school nursing services, child protection services, and specialist services such as those addressing disability, drug and alcohol abuse, mental illness and family violence issues. Linkages with other initiatives and networks, including Best Start, Family Support Innovation Projects, Neighbourhood Renewal and Primary Care Partnerships may further enhance the capacity of services to support families.

MCH service providers have the flexibility to design innovative service models that support service integration and collaboration while maintaining the universal nature of the service. Strategies that promote service integration include co-locating services, establishing interdisciplinary teams, sharing protocols and using common assessment frameworks and referral tools, as well as joint service delivery.

3.3 National frameworks

In 2007 the Commonwealth Government set out a comprehensive plan to make the early years a national priority. This plan involves reforms to early childhood education and care, and a greater focus on early childhood development. Two major initiatives have been agreed to:

- *The National Early Childhood Development Strategy – Investing in the Early Years*
- *National Partnership Agreement of Indigenous Early Childhood Development.*

The National Early Childhood Development Strategy – Investing in the Early Years

The Council of Australian Governments (COAG) has developed *The National Early Childhood Development Strategy – Investing in the Early Years.* The strategy's vision is that 'by 2020 all children have the best start in life to create a better future for themselves and for the nation'.

The strategy contains an outcomes framework and outlines characteristics of effective early childhood services. It identifies a number of specific reform priorities:

- Strengthen universal maternal, child and family health services.
- Support vulnerable children.
- Improve early childhood infrastructure.
- Build parent and community understanding of the importance of early childhood development.
- Strengthen the workforce across early childhood development and family support services.
- Build better information and a solid evidence base.

National Partnership Agreement of Indigenous Early Childhood Development

The *National Partnership Agreement of Indigenous Early Childhood Development* brings together three key strategies to improve services and outcomes for Indigenous children and their families:

- integration of early childhood services through the development of children and family centres
- increased access to antenatal care, pre-pregnancy and teenage sexual and reproductive health
- increased access to and use of MCH services by Indigenous families.

3.4 Dardee Boorai: the Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People

Dardee Boorai: the Victorian Charter of Safety and Wellbeing for Aboriginal Children and Young People (Dardee Boorai) is an Aboriginal community and Victorian government commitment to give Aboriginal children and young people every opportunity to thrive and achieve their full potential in life.

Dardee Boorai affirms the strength and resilience of Victoria's Aboriginal culture, communities and families. A central commitment is the provision of an equitable, culturally competent service system that welcomes and supports children and young people and their families.

Further information about Dardee Boorai is available at **www.eduweb.vic.gov.au/edulibrary/public/govrel/Policy/thecharter/DardeeBooraicharter.pdf**

3.5 Legislative frameworks

The Child Wellbeing and Safety Act 2005

The *Child Wellbeing and Safety Act 2005* guides the operation of the Child Safety Commissioner, the Victorian Children's Council and the Children's Services Coordination Board. This Act sets out principles that should be used for guidance in the development and provision of government, government-funded and community services for children and their families.

The Act also sets out requirements regarding the birth notification. The Act stipulates that the birth notification is to be forwarded by maternity services to the chief executive officer of the local government area where the mother resides, within 48 hours of the child being born. It is then the responsibility of the executive officer to forward the birth notice to the relevant MCH nurse, who contacts the mother and invites her to access the MCH Service.

The Children, Youth and Families Act 2005

The core of the *Children, Youth and Families Act 2005* places children's best interests at the heart of all decision-making and service delivery relating to vulnerable children, young people and their families. While the Act is targeted at family support, child protection and out-of-home care services, these principles have resonance for the broader health and community services infrastructure, including MCH Services, early childhood services, schools and health services.

These Acts enable two possible responses with regard to ensuring the wellbeing of children:

- an early intervention response – Child FIRST teams
- a child protection response.

For important information regarding referral and/or reporting of a child or unborn child that may be at risk of harm, refer to Appendix 1: Responding to concerns about children or young people, and Appendix 2: Child abuse and neglect.

Charter of Human Rights

The *Victorian Charter of Human Rights and Responsibilities Act 2006* (the Charter) articulates the human freedoms, rights and responsibilities that are now enshrined in Victorian law. The Charter contains 20 rights that reflect four basic principles: Freedom, Respect, Equality and Dignity.

Since 1 January 2008, all Victorian government departments and public authorities have been required to act compatibly with the Charter and take human rights into account when making decisions, providing advice or services, or taking action in their day-to-day work. The Charter has an important role in protecting and promoting human rights and helping to create a fairer society that reduces disadvantage and respects diversity.

Organisations are expected to develop policies and programs that are consistent with the Charter's principles.

Further information about the Charter can be found at **www.justice.vic.gov.au/humanrights/**

4. Local government partnership

4.1 Department of Education and Early Childhood Development and local government agreements

Maternal and Child Health services are provided through a partnership between DEECD and local government.

In May 2008 the Victorian State–Local Government Agreement (VSLGA) was signed by the Victorian Government and the Municipal Association of Victoria (MAV), the legislated peak body for local government in Victoria. The VSLGA sets out agreed principles to guide relations between state and local government, and acknowledges the key role of local government in improving coordination and strategic planning of government services at the local level.

The key areas of agreement relate to:

- governance
- provision of services
- principles of agreement
- funding
- projects
- communication strategy
- mechanisms for review.

In August 2009 the MAV and the Department signed a Memorandum of Understanding (MOU), a formal partnership agreement that articulates the commitment of each to a collaborative and cooperative approach to the planning and delivery of early childhood services. The MOU agreed to principles to guide the partnership between state and local government for the planning, funding and provision of the MCH Service. The MOU is intended to supplement the VSLGA and builds on the previous MOU. The current agreement concludes in June 2012.

The Municipal Association of Victoria and Office for Children and Portfolio Coordination Partnership Working Group was established to support state and local government planning and service delivery in early childhood services, including an annual Early Years Forum. The Working Group collaborates on a number of joint projects concerning the early years, including:

- the MCH Service KAS Framework
- kindergarten participation and access, including the Council of Australian Governments' commitment to increase the minimum number of kindergarten hours to 15 hours per week
- the Council of Australian Governments' commitment to new early learning and care centres

- the rollout of the state's Children's Capital Funding Program
- the National Quality Framework for Early Childhood Education and Care, including the National Early Years Learning Framework
- workforce planning and development.

4.2 Municipal Early Years Plans

Municipal Early Years Plans are local area plans designed to provide a strategic direction for the development and coordination of education, care and health programs, activities and other local developments that impact on children 0–6 years and their families. All councils have undertaken this early years planning process, which considers the specific needs of the municipality. In most cases MEYPs include, but are not limited to, services that are funded and/or delivered by councils, and might include information regarding MCH services in the council area.

For more information on Municipal Early Years Plans, go to **www.mav.asn.au/hs/familychildren/meyp**, contact your local council or visit your local council's website.

5. The Maternal and Child Health Service

The Maternal and Child Health Service is a free, universal primary health service for all Victorian families with children from birth to school age. The service is provided in partnership with the MAV, local government and DEECD, and aims to promote healthy outcomes for children and their families.

The service provides a comprehensive and focused approach for the promotion, prevention and early detection of the physical, emotional or social factors affecting young children and their families, and intervention where appropriate.

5.1 Quality, access and inclusiveness

A vision, mission, goal, principles and program standards guide MCH Service provision to ensure that the service provides a high standard of care to Victorian families.

Vision

All Victorian children and their families will have the opportunity to optimise their health, development and wellbeing during the period of a child's life from birth to school age.

Mission

To engage with all families in Victoria with children from birth to school age, to take into account their strengths and vulnerabilities, and to provide timely contact and ongoing primary health care in order to improve their health, development and wellbeing.

Goal

To promote healthy outcomes for children and their families, providing a comprehensive and focused approach to managing the physical, emotional and social factors affecting families in contemporary communities.

Principles

Consultation and participation
Consultation with, and participation of families is integral to the service. Services will be informed by, and seek to meet, the needs of young children and their families.

Access and availability
All families with young children should be able to readily access information, services and resources that are appropriate for and useful to them.

Primacy of prevention
Preventing harm or damage is preferable to repairing it later. Early detection of risk factors is required, as well as intervention where appropriate.

Capacity building
Promotion of resilience and capacity is preferable to allowing problems to undermine health or autonomy.

Equity
All children should be able to grow up actively learning, healthy, sociable and safe, irrespective of their family circumstances and background.

Family-centred
The identification and management of child and family needs requires a family-centred approach that focuses on strengths.

Diversity
The diversity of Victorian families should be recognised and valued.

Inclusion
Inclusive practices are essential for all children to get the best start, irrespective of their family circumstances, differing abilities and background.

Partnership
Quality services are achieved through integrated service delivery and partnerships with families and early childhood and specialist services.

Quality
All families with young children must be confident of the quality of information, services and resources provided to them.

Evidence and knowledge
Policies, programs and practice are based on the best evidence and knowledge available.

Evolution of services
Programs and services will continue to evolve to meet needs in a changing environment.

Continuously improving and adding value to services
Sustained and improved services for families and children promote better outcomes for children and their families.

Program standards

1. The Maternal and Child Health Service provides universal access to its services for Victorian children from birth to school age and their families.

2. The Maternal and Child Health Service promotes optimal health and development outcomes for children from birth to school age through a focus on the child, mother and family.

3. The Maternal and Child Health Service builds partnerships with families and communities, and collaborates and integrates with other services and organisations.

4. The Maternal and Child Health Service is delivered by a competent and professional workforce.

5. The Maternal and Child Health Service, supported by local government or the governing authority, provides a responsive and accountable service for the child, mother and family through effective governance and management.

6. The Maternal and Child Health Service delivers a quality and safe service.

5.2 Components of the Maternal and Child Health Service

There are three components of the MCH Service:

- the Universal MCH Service
- the Enhanced MCH Service
- the MCH Line.

5.2.1 Universal Maternal and Child Health Service

The Universal MCH Service delivers a free, universally accessible statewide service for all families with children aged from birth to school age. The Service supports families and their children with an emphasis on parenting, prevention and health promotion, developmental assessment, early detection and referral and social support. In addition, the MCH Service provides a universal platform that can:

- help to identify children and families who require further assessment, intervention, referral and/or support
- bring families together, foster social networks, support playgroups and strengthen local community connections
- deliver other services and supports, such as family support services and immunisation.

Key Ages and Stages Activity Framework

The Universal MCH Services undertake ten KAS consultations. The KAS consultations are a schedule of contacts for all children and their families from birth to school entry. They include an initial home visit, and consultations at 2, 4 and 8 weeks; 4, 8, 12 and 18 months; and 2 and 3.5 years of age.

In 2007–08 the Office for Children within DEECD piloted and evaluated a new KAS Activity Framework with four local government authorities. The revised framework has now been implemented statewide. It introduces a new approach to the 10 consultations provided to parents and children by the Universal MCH Service. The framework:

- comprises three key components: monitoring; promotion of health and development; and intervention
- identifies the core activities for the 10 universal consultations that the MCH Service should offer to all Victorian children and their families
- is intended to be complemented by opportunistic activity by MCH nurses, on the basis of their clinical judgment and in response to parental concerns
- provides evidence-based written health information consistent with the health promotion activities listed in the Framework at each Key Age and Stage consultation.

Appendixes 3 and 4 contain the KAS Activity Framework and health promotion activities for each key age and stage.

Additional consultations and a range of other activities are available via a flexible funding model for those families who require further support. Additional consultations can include telephone consultations, group sessions and a range of other activities.

Flexible service capacity

Models that promote ease of access for families to the MCH Service may be required to engage families who underutilise the service. Additional consultations and a range of other activities are available for these families via a flexible funding model. There are a number of categories of flexible service capacity activities.

Additional consultations

Each KAS consultation is only recorded once, at the completion of the assessment. If the assessment takes two consultations, the first consultation is recorded as an additional consultation and the second consultation is recorded as the KAS consultation.

If a child is brought back to undertake a Brigance screen after the KAS consultation is completed, this consultation is recorded as an additional consultation.

Consultations in addition to the 10 KAS consultations are recorded as part of the flexible component.

Telephone consultations

The provision of advice and support to families over the telephone regarding the health and wellbeing of the child or family are also considered an aspect of flexible funding. This does not include administrative phone calls such as appointments and general enquiries. The Universal MCH Service funding includes an administrative component that incorporates phone enquiries and appointments associated with the 10 KAS consultations.

Group sessions

Group sessions include parent groups inclusive of, but not limited to, first-time parents. First-Time Parent Group sessions are a required activity within this component. Other group sessions may be tailored for teenage parents, particular cultural communities, working parents or fathers, as appropriate. Parent groups should provide health education, build parenting capacity, offer parenting support and foster community connections.

Community strengthening activities

Engaging and building community capacity may include organising volunteer programs to support socially isolated parents, contributing to parenting programs conducted by neighbourhood houses or community health services, or arranging for groups of parents such as those from a particular cultural group to meet independently from the MCH Service.

MCH Practice Guidelines

Guidelines were written and distributed in 2009 to support the implementation of the revised KAS Framework. These are provided at KAS training and are available at **www.education.vic.gov.au/mchservice**

Child Health Record

The Child Health Record is a record given to parents of all newborn babies at their place of birth. It is a communication package providing parents and professionals, including the MCH nurse, with child health information, a record of a child's health data and surveillance activities including immunisation, significant illnesses through life, and charts for mapping growth. Carbonised sheets for duplicate and triplicate copies are included in the record in order that child health professionals have access to a copy of the recorded information.

The Child Health Record is currently being revised.

For information governing the handing and disposal of the centre-based child health record, refer to Appendix 5: *Information Privacy Act 2000* and *Health Records Act 2001,* and Appendix 6: Disposal of Maternal and Child Health records.

For information regarding the use of the record for children in out-of-home care, refer to Appendix 7.

5.2.2 Enhanced MCH Service

The Enhanced MCH Service responds assertively to the needs of children and families at risk of poor outcomes, in particular where there are multiple risk factors. This service is provided in addition to the suite of services offered through the Universal MCH Service. It provides a more intensive level of support, including short-term case management in some circumstances. Support may be provided in a variety of settings, such as the family's home, the MCH centre or another location within the community.

The primary focus of the Enhanced MCH Service is families with one or more of the following risk factors:

- drug and alcohol issues
- mental health issues
- family violence issues
- families known to Child Protection
- homelessness
- unsupported parent(s) under 24 years of age
- low-income, socially isolated, single-parent families
- significant parent–baby bonding and attachment issues
- parent with an intellectual disability
- children with a physical or intellectual disability
- infants at increased medical risk due to prematurity, low birth weight, drug dependency and failure to thrive.

Indigenous families who are not linked into, or who require additional support to access, the Universal MCH Service are included in the target group. MCH Services will be encouraged to develop specific action plans to demonstrate strategies to increase the participation of Aboriginal families in both the Universal and Enhanced MCH Services.

Families receiving the Enhanced MCH Service are eligible for an average of 15 hours of service per family in metropolitan regions and an average of 17 hours in rural regions.

5.2.3 Maternal and Child Health Line

The MCH Line provides 24-hour telephone advice, support, counselling and referral to families with children from birth to school age. The service is instrumental in linking families to the Universal MCH Service and to other community, health and support services.

While the MCH Line offers support and advice to parents, it is **not** an emergency service.

5.3 Referrals from the MCH Line to the Universal MCH Service

When families experiencing particular difficulties contact the MCH Line, they will be offered a referral to the Universal MCH Service. Referrals occur with the caller's consent.

Referrals will be passed onto the MCH Service as soon as possible during business hours. If the MCH centre is not open or the nurse is unable to be contacted and an immediate referral is required, the MCH Coordinator will be contacted.

Referral details will only be discussed directly with an MCH nurse. When a nurse is not available, a telephone message will be left for the nurse to return the call and collect the caller's details.

Following a referral, there is an expectation that the family will be contacted by the Universal MCH Service. Referrals will remain open until contact with the MCH Service has been made.

The MCH Line welcomes feedback from the MCH Service regarding the outcomes of a referral. Contact can be made during business hours on (03) 9843 5448.

5.4 Language services

DEECD allocates funding for interpreters for departmental programs and funded organisations. 'All Graduates' provides interpreter services for the Department's Early Childhood Development Group.

'All Graduates' provides two types of services to funded organisations:

- on-site interpreting (both spoken and sign languages)
- telephone interpreting.

Interpreting services do not include translation of written materials, management meetings, staff meetings or social meetings.

'All Graduates' operating hours are:

Monday to Friday 8.00 a.m. to 9.00 p.m.

Saturday 9.00 a.m. to 1.00 p.m.

Bookings can be taken up to 30 days in advance by calling All Graduates on (03) 9605 3000. Please allow 5 working days notice for an on-site interpreter and 10 days for an Auslan interpreter.

To book an interpreter:

- Call All Graduates on (03) 9605 3000 or log onto **www.allgraduates.com.au**
- Quote your agency's username and password. (Your Regional Program and Service Adviser can provide you with these details.)
- Provide information about the service required – language/dialects needed, address, starting and finishing times, the name of the practitioner who will be using the service and other specific information (e.g. if a gender-specific interpreter is required).

5.5 Staffing of Maternal and Child Health Service

The Universal MCH Service is staffed by MCH nurses who meet the qualifications listed below.

The Enhanced MCH Service is provided predominantly by MCH nurses. However, services may also benefit from employing professionals from other backgrounds. These may include Aboriginal health workers, early childhood workers, family support workers, alcohol and drugs workers, social workers and psychologists. A multidisciplinary approach is encouraged within the Enhanced MCH Service.

Qualifications

To practise in Victoria, Maternal and Child Health nurses must have the following qualifications:

- Division 1 Registered Nurse
- registered Midwife
- additional qualifications in Maternal and Child Health.

These requirements are unaffected by the change to national registration.

National registration

A new national registration and accreditation scheme for nurses and midwives began on 1 July 2010, and a new national law (the *Health Practitioner Regulation National Law Act 2009*) came into effect to regulate the profession.

The Nursing and Midwifery Board of Australia (NMBA) is now responsible for setting standards and policies for the regulation of all nurses and midwives registered in Australia. It will be supported in this task by the Australian Health Practitioner Regulation Agency (AHPRA).

For more information about the way the national registration scheme operates, go to the AHPRA website **www.ahpra.gov.au** or the NMBA website **www.nursingmidwiferyboard.gov.au**

Clinical supervision

Regular clinical supervision and critical incident debriefing is a key aspect of the MCH Service to support staff delivering this service. Refer to the MCH Program Standards for more information.

5.6 Research involving MCH clients

Prior to allowing an external researcher access to MCH Service staff, parents, children or information regarding children and parents, MCH nurses should ensure that approval for the research has been obtained through the Early Childhood Research Committee at DEECD. All research requests should be referred to the Research Committee at **early.childhood.research@edumail.vic.gov.au**

6. Funding

6.1 Universal Maternal and Child Health Service

Funding for the Universal MCH Service is based on the total number of children aged 0–6 years enrolled (both active and non-active). These data are collected by service providers on 31 March each year. Data for 0–1 years are proportionally increased to give a projected full-year figure. Funding for the Universal Service is jointly provided by the DEECD and local government.

For information regarding the DEECD MCH funding formula, refer to the MCH Funding Fact Sheet at **www.education.vic.gov.au/mchservice**

Funding for KAS consultations

Funding for KAS consultations is based on the total number of children eligible to receive services at the specified KAS consultations.

Funding for flexible service capacity

Funding for flexible service capacity is based on three hours of service for 40 per cent of children 0–1 year of age and three hours of service for 40 per cent of the average number of children of each age in the 0–6 year age-group. This component of the Universal MCH Service funding can be used to provide any of the following flexible service capacity activities:

- additional consultations
- telephone consultations
- group work, typically two hours a session over six to eight weeks
- community strengthening activities that don't involve clients.

Additional weightings formula

DEECD applies an additional weightings formula to the Universal MCH Service funding using the Accessibility/Remoteness Index of Australia (ARIA) and the number of maximum Family Tax Benefit (FTB) recipients with a child aged 0–6 years. This addition of the weightings reflects the increased cost of service delivery in rural settings and the additional resources required in areas of socioeconomic disadvantage and high need.

Table 6.1 Key Ages and Stages time allocation

KAS consultation	Time allocation	KAS consultation	Time allocation
Home visit	1 hour	8 months	45 mins
2 weeks	30 mins	12 months	30 mins
4 weeks	1 hour	18 months	45 mins
8 weeks	30 mins	2 years	30 mins
4 months	30 mins	3.5 years	45 mins

6.2 Enhanced Maternal and Child Health Service funding

The Enhanced MCH Service is fully funded by the Department. Funding is allocated according to socioeconomic disadvantage, calculated on the number of Family Tax Benefit recipients in a local government area and rurality using the Remoteness Index of Australia. Metropolitan regions are funded for 15 hours of direct or indirect service delivery per family and rural regions are funded for 17 hours per family in recognition that delivery of services in rural areas takes longer.

6.3 Maternal and Child Health Line funding

The MCH Line is fully funded by DEECD to provide 24-hour telephone advice and support to families with young children.

7. New initiatives in Maternal and Child Health

7.1 Key Ages and Stages training

The statewide rollout of the revised MCH KAS Framework was completed in 2009. This involved all MCH nurses and MCH students completing the seven training components required to implement the revised KAS Framework.

Table 7.1: Training requirements for the statewide rollout of the revised MCH KAS Framework

Training component	Training time
Framework Context, guidelines, resources, data, documentation, maternal health and wellbeing, hips	2 hours
Developmental screening PEDS and Brigance	5 hours
Family violence	3 hours
Quit	3 hours
SUDI (Sudden Unexpected Death in Infancy)	3 hours
Sleep Specific interventions for 8-month infant	4 hours

Ongoing Key Ages and Stages training

Training will continue in all seven training components for all MCH nurses returning to practice.

MCH students will receive the following training components in the university curriculum:

- the Framework
- Parent Evaluation of Developmental Status (PEDS)
- Brigance.

They will need to complete the following training components through DEECD:

- Family violence – screening and response
- SIDS/SUDI (sudden unexpected death in infancy) risk assessment
- Infant sleep – intervention at an 8-month consultation if required
- Quit smoking intervention.

Registering for Key Ages and Stages training

All registrations are to be completed online. Please refer to the following website: http://www.education.vic.gov.au/ecsmanagement/mch/proflearn.htm

7.2 Key Ages and Stages Activity Framework evaluation

The Centre for Community Child Health (CCCH) is currently undertaking a three-year evaluation of the implementation of the revised MCH KAS Framework on behalf of DEECD.

The evaluation will focus on:

- consistency in the delivery of the MCH Service across the state, including an analysis of the degree to which the revised MCH KAS Framework has been implemented
- an understanding of the impact the MCH KAS Activity Framework has had on the outcomes for families and children from birth to school age
- the impact on the MCH workforce.

The evaluation commenced in February 2010 and is scheduled for completion in November 2012.

7.3 Maternal and Child Health Program Standards

The revised MCH Program Standards were released in 2009. They provide an evidence-based framework for the consistent, safe and quality delivery of the MCH Service. The Program Standards support the provision of clinical and corporate governance of the MCH Service, and provide a systematic approach to improving service provision, care and safety.

Maternal and Child Health Services are encouraged to use the Program Standards to self-assess in order to improve service quality, and to use the Program Standards as part of routine service review.

A copy of the Program Standards including a rationale for each standard, performance criteria outlining how the MCH Service demonstrates compliance with and performance relevant to each standard, and examples of evidence of how the criteria can be met, can be found at **http://www.education.vic.gov.au/mchservice**

7.4 Safe Nursery Equipment Program

A brokerage program is currently being developed for families who are enrolled with the EMCH Service. This will provide items such as cots for families facing financial hardship. MCH Coordinators will be advised once the program is operating.

7.5 Healthy Kids Check Initiative

The Healthy Kids Check Initiative is a Commonwealth Government initiative that provides 4-year-old children with a basic check to see if they are healthy, fit and ready to learn when they start school. The check is now available from general practitioners or practice nurses through the Medicare Benefit Schedule in conjunction with the 4-year-old immunisation.

The MCH consultation at 3.5 years is considered to be consistent with the Healthy Kids Check and parents are able to access either prior to their child commencing school.

Additional information regarding the Healthy Kids Check can be found through the Department of Health and Ageing website at **http://www.health.gov.au/internet/main/publishing.nsf/content/Healthy_Kids_Check**

7.6 National Perinatal Depression Initiative

The National Perinatal Depression Initiative aims to improve early detection of depression in pregnancy and after a birth. The initiative aims to provide better support and treatment for expectant and new mothers experiencing depression. Funding has been provided by Commonwealth and state governments. The main elements of the initiative are routine screening of pregnant women and new mothers for risk of depression, workforce training and treatment provision.

8. Ongoing initiatives

8.1 Continuity of Care – A communication protocol for Victorian public Maternity Services and the MCH Service

Continuity of Care is a communications protocol between Victorian Maternity Services and MCH Services. The overarching aim of the protocol is to promote seamless service provision to women and their babies during the transition from hospital to home.

The protocol recognises that quality of care and the health and wellbeing of families and communities is strongly linked to the collaboration and partnership between service sectors, and that Maternity Services and MCH Services are part of a continuum providing antenatal, intrapartum and postnatal care for women and babies.

The protocol is set out in stages and details communication requirements for all mothers and babies and for vulnerable families at the following points:

- antenatal
- postnatal
- neonatal/special care unit
- domiciliary
- discharge from Maternity Services.

The protocol is used widely and extensively by MCH and public hospital staff. Some of the larger private hospitals are also showing interest in this protocol. Its revision and updating is a high priority for Maternity Services, Koori Maternity Services and MCH nurses alike.

Since the protocol was developed there have been changes to the *Health Act 1958* and subsequent changes to birth notification, changes to the *Children, Youth and Families Act 2005* and the introduction of Child FIRST. Consequently, the protocol has become out of date. A revised protocol is required to provide an adequate framework for the care of vulnerable families, including those from CALD or Indigenous backgrounds and young single mothers. This protocol will also reflect the role of Koori Maternity Services, and will provide an opportunity for private maternity services to be included.

The Continuity of Care Protocol will be revised in 2010-2011.

8.2 Growing Communities, Thriving Children

The Growing Communities, Thriving Children initiative provides funding for children's initiatives in nine councils at the rural–metropolitan interface that have unique challenges with often rapidly growing populations and/or a mix of urban and rural communities.

The initiative is specifically aimed at expanding the Enhanced MCH Service to assist in addressing postnatal depression.

8.3 Young Readers Program

The Young Readers Program provides children's books and reading support materials to promote early childhood literacy. The program has been developed as a partnership between DEECD, the State Library of Victoria and local government. The program now provides:

- professional development to early childhood professionals, librarians and MCH nurses to promote literacy
- a free *Rhyme Time* booklet and DVD, book bags and information on local libraries for families at the 4-month MCH visit
- a free picture book for all Victorian children at their 2-year-old MCH visit.

For further information on the Young Readers Program contact Christine Andell at the State Library of Victoria on **CAndell@slv.vic.gov.au** or phone **(03) 8664 7058.**

8.4 Workforce Initiatives Project

The Workforce Initiatives Project commenced in 2004 in response to a predicted shortage of MCH nurses. This project includes funding a position within MAV to assist with developing strategies to address recruitment and retention of MCH nurses. It has to date provided annual scholarships for nurses to undertake MCH nursing qualifications, organised career expos at RMIT and La Trobe universities, promoted the re-entry course for MCH, and undertaken a survey to determine the factors affecting the conversion rate of MCH postgraduates into employment. The Workforce Initiatives Project continues to raise the profile of MCH nursing as a career and is currently funded until 2011.

MCH Nursing Postgraduate Research Scholarships

The MCH Nursing Postgraduate Research Scholarship program further supports the work of the Early Childhood Workforce Strategy and builds on the MCH Service Workforce Project.

The MCH Nursing Postgraduate Research Scholarships:

- provide support for MCH nurses currently working within an MCH Service to undertake postgraduate research in the field of MCH
- add to the body of knowledge regarding best practice in the field of MCH
- support current government policy in the field of MCH
- increase the skills base of the MCH Service.

MCH Postgraduate Nursing Scholarships

Maternal and Child Health Postgraduate Nursing Scholarships are offered annually and provide support to general nurses with midwifery qualifications to assist them to complete qualifications in Maternal and Child Health. For further information see **www.education.vic.gov.au/careers/earlychildhood/**

9. Performance measures and targets

The Maternal and Child Health Service Guidelines are an adjunct to the DEECD *Service Agreement Creation and Review Procedures*, and complement service agreements between the Department and local government in the delivery of the MCH Service.

Municipal participation rates for the Universal MCH Service are negotiated between DEECD regional staff and individual local governments. These targets are articulated in funding and service agreements. Targets are expected to focus on increasing KAS participation rates from the 8-month to the 3.5-year consultations for the whole population and reducing the gap between Aboriginal and non-Aboriginal participation rates. Individual municipal targets for the Enhanced MCH Service are aligned with the service's equity funding formula.

Refer to Appendix 8: Calculating participation rates in the Maternal and Child Health Service.

9.1 Increasing participation in the Universal Maternal and Child Health Service

Current performance data show that across Victoria participation in MCH Services at the home visit and in the early months is high but starts to decline after the 4-month visit. In recognition of the value to parents and their children of participation in the MCH Service, the goal is to lift participation rates in the later key ages and stages consultations by 5 per cent.

Participation of Indigenous families in MCH Services is lower than that of non Indigenous families for all KAS visits. In response, DEECD has set itself the goal of halving the gap between Indigenous and non-Indigenous children in participation in KAS visits in the next four years.

Measuring progress

Understanding how well MCH Services are tracking against agreed targets is important. Against the two goals above, progress will be measured by monitoring:

- participation rates for each of the KAS visits, in particular those visits following the 4-month visit
- participation rates of Indigenous and non-Indigenous children in the KAS visits.

9.2 Meeting Enhanced MCH targets

Individual municipal targets for the Enhanced MCH Service are aligned with the Enhanced MCH Service's funding formula. Each council is informed of the amount of funding and service targets in the Annual Funding and Service Agreement.

Refer to Appendix 9: Enhanced Maternal and Child Health Service counting rules.

9.3 Service Improvement Plans

To inform regional and statewide service improvement activity, MCH service providers are required by DEECD to submit an annual Service Improvement Plan (SIP). The MCH SIP tool is sent to local government by the Department each year with guidelines for development and submission.

Some of the action areas for improvement as outlined in the SIP include measures to increase participation in the Universal MCH Service, plans to improve identification and engagement of vulnerable children, and plans for increasing participation by Indigenous children.

Information regarding SIPs is available at **www.education.vic.gov.au/mchservice**

An example of the 2010–11 SIP can be found at Appendix 10.

10. Data

10.1 Data collection

Data collection is an integral part of the MCH Service and should be consistent across the state. Accurate data provides:

- a measure of performance that reflects the role of the Universal MCH Service
- a basis for calculating state government funding for the MCH service
- service information relating to the Enhanced MCH service
- an important source of information to a wide range of stakeholders
- data for comparative studies with other program areas to inform future development and planning of services, and cross-program linkages.

MCH Services are responsible for the provision to DEECD of the following data:

- the Annual Report
- Key Ages and Stages data
- workforce data
- Neighbourhood Renewal data
- March data
- Enhanced MCH Service data.

The Annual Report

The Annual Report is required by DEECD annually (from 1 July to 30 June) from each local government area. The report is sent to the Department via the regional PASAs. The Annual Report provides valuable information such as birth notification rates; enrolment and non-enrolment; participation rates in the KAS consultations; Aboriginal participation; counselling and referral activities; and breastfeeding rates.

This data is utilised by DEECD and many other organisations including the Department of Health, Ministerial Offices and researchers, to plan and implement programs, determine funding, and as indicators of health and wellbeing.

The MCH Annual Reporting Form and data definitions can be found at **www.education.vic.gov.au/mchservice**

Key Ages and Stages data

Revised KAS data collection commenced in 2009 following the completion of statewide training for all MCH nurses. KAS data is defined and explained in the document *KAS Data Dictionary,* which can be found at **www.education.vic.gov.au/mchservice**

Workforce data

MCH workforce data is collected annually by MCH Services and used to assist with identifying councils where there is a shortage of MCH nurses, and to help with forward planning.

Neighbourhood Renewal data

Neighbourhood Renewal targets the most disadvantaged communities by bringing together residents, government, business, service providers and the local community in the development and implementation of a community action plan. Neighbourhood Renewal data is collected annually from targeted sites.

For further information go to **www.neighbourhoodrenewal.vic.gov.au**

March data

This data is collected in March. Data on the number of enrolments in the current and previous years including active and non-active children for ages 0–6 is requested. This data is used by DEECD to determine annual funding allocations for each municipality.

Weighting for MCH funding is also calculated on the number of families who are receiving the maximum Family Tax Benefit, and rurality in each local government area.

Enhanced MCH Service data

The Enhanced MCH Service data are collected and collated separately to the Universal MCH Service data.

Enhanced MCH Service data provides DEECD with information including client demographic data, issues that the nurse and family have identified for inclusion in the service plan, whether a family has completed their service plan, and hours of service.

Enhanced MCH Service data should be forwarded electronically to the Department of Human Services at **iris.data@dhs.vic.gov.au** quarterly by 15 October, 15 January, 15 April and 15 July. The Department of Human Services makes available free of charge for all municipalities across Victoria the Integrated Reports and Information System (IRIS), including training and automatic upgrading of software.

Please contact the **IRIS help desk on (03) 9616 6919** to organise training and installation of the software if required.

10.2 Data input and definitions

Birth notification

The birth notification alerts the MCH Service that a birth has occurred.

When a baby is born the birth notification is forwarded by Maternity Services to the chief executive officer of the local government area where the mother resides. The executive officer then forwards the birth notice to the relevant MCH nurse, who contacts the mother and invites her to access the MCH Service.

For further information refer to Appendix 11: Birth notification from the *Child, Wellbeing and Safety Act 2005*.

Enrolment

A new baby is considered as enrolled in the MCH Service once the MCH nurse has made contact with the family or in the case of older children once the family has attended the MCH centre.

First-time mothers

A first-time mother is one who has a live baby for the first time. In the case of multiple births, a mother is only counted as a first-time mother once, not, for example, twice for twins.

Active/non-active children

A child is considered to be active on the centre held record if he or she attends a MCH centre at least once in a current financial year. A non-active child is one who has not seen their local nurse at least once in a financial year.

Children who have died or moved interstate or overseas should be made non-active on the centre-held record. Children who have died or moved interstate or overseas **are not** counted in either the March or June data reports.

If a child returns to Victoria from interstate or overseas to the MCH centre they previously attended, they will need to be made active again. If the child returns from overseas and attends a different MCH centre, the centre-held history is transferred to the new centre following parental consent for transfer of records.

Transfers in and out

Children may be transferred in and out of an MCH centre when a family moves or in rare cases when a mother wishes to see a different MCH nurse. It is important that when a transfer request is made, a response is carried out by the relevant nurse within 10 working days.

The following process should be taken when transferring a client:

- A parent or guardian visits a new MCH centre and authorises the transfer of their child's, or children's history from their previous centre.
- With parental permission the MCH nurse then requests the transfer of the centre-held child health record to the new centre, using the address in the MCH Centre Directory. The transfer request should include the type of computer system used by the council requesting the transfer as this will determine what format the history will be transferred in. It should also include the postal address of the council, not the MCH centre address.
- The previous centre needs to transfer the child's record in a form that is acceptable to the receiving council.
  All transfers of histories are to be posted to the council address, not the MCH centre, as not all centres have mail boxes or operate every day.

Aboriginal and Torres Strait Islander status

All governments throughout Australia have agreed to cooperate in sharing information that will improve the health of Aboriginal and Torres Strait Islander people. The Department requires MCH nurses to provide information on the Indigenous status of every child attending the MCH Service.

This information is used to:

- identify the main health problems for Victorian Aboriginal and Torres Strait Islander children and their families
- provide appropriate intervention to improve the health, development and wellbeing of Aboriginal and Torres Strait Islander children and their families
- record the total number of identified Aboriginal and Torres Strait Islander children aged 0–6 years
- record the number of Aboriginal and Torres Strait Islander children who have attended each of the 10 KAS consultations
- record the number of Aboriginal and Torres Strait Islander children aged 0–6 years who have attended the service at least once during the current financial year.

The official definition of an Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as being Aboriginal or Torres Strait Islander and who is accepted as such by the community with which the person associates.

In using this definition, it is important to remember that determining Aboriginality will depend upon the parent or guardian identifying their child as an Aboriginal or Torres Strait Islander.

MCH nurses cannot be certain whether any child is Aboriginal or Torres Strait Islander without asking the parent or guardian of every child born in Australia. The standard question for Indigenous Status is as follows:

Is your child of Aboriginal or Torres Strait Islander origin?

☐ No

☐ Yes, Aboriginal

☐ Yes, Torres Strait Islander

(For children of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.)

MCH nurses need to record Aboriginal status and Torres Strait Islander status separately. The answers to the question 'Is your child of Aboriginal or Torres Strait Islander origin?' should be clearly recorded on the centre-held history 'Yes' or 'No'.

When a parent is not present, the person answering for them should be in a position to do so, i.e., this person must know well the child about whom the question is being asked and feel confident to provide accurate information about them. This question must always be asked regardless of an MCH nurse's perceptions based on appearance or other factors.

Note: The information above has been sourced from the National Community Services Data Dictionary (AIHW).

The child's Aboriginal or Torres Strait Islander status is asked and recorded once. This record can then be referred to for future data collection at each KAS visit.

The KAS consultations data collection will record one entry in either the 'Key ages and stages consultations – non Aboriginal and Torres Strait Islander' column or the 'Key ages and stages consultations – Aboriginal and Torres Strait Islander' column.

Breastfeeding status

Breastfeeding status is recorded on discharge and at 2 weeks, 3 months, 4 months, 6 months and 8 months. It is recorded using the World Health Organization (WHO) definitions:

- Exclusively breastfeeding – requires that the infant receive breast milk, including milk expressed or from a wet nurse. It allows the infant to receive drops or syrups (vitamins, minerals, medicines). It does not allow the infant to receive anything else.
- Predominately breastfeeding – requires that the infant receive breast milk (including milk expressed or from a wet nurse) as the predominant source of nourishment. It allows the infant to receive liquids (water, water-based drinks, fruit juice, and oral rehydration solution), ritual fluids and drops or syrups (vitamins, minerals, medicines). It does not allow the infant to receive anything else, particularly non-human milk or food-based fluids.
- Partially breastfeeding – requires that the infant receive breast milk and solid or semi-solid foods. It allows for the infant to receive any food or liquid including non-human milk.

For the purpose of the Annual Report only two categories are reported: 'fully' and 'partially' breastfeeding. The WHO 'exclusive' and 'predominant' categories are combined to constitute 'fully' breastfeeding.

Key Ages and Stages consultations

The following dot points provide instruction regarding data input for KAS consultations:

- Consultations are recorded in the child's centre-held record and on the child health record. Key Ages and Stages consultations must be recorded as either 'Aboriginal and/or Torres Strait Islander' or 'non-Aboriginal or Torres Strait Islander'.
- Where an MCH nurse carries out a KAS consultation on a child in the Enhanced MCH Service, this consultation must be recorded in the Universal MCH data collection system – MaCHS, Xpedite, Daily Activity Sheet etc. – not in IRIS.
- The first home visit to the family following the birth of the child is the only home consultation recorded as a KAS 'home consultation'.
- Each KAS consultation is only recorded once, at the completion of the assessment. If the assessment takes two consultations, the first consultation is recorded as an additional consultation.
- If a child is brought back to undertake a Brigance screen after the KAS consultation is completed, this consultation is recorded as an additional consultation.

- The 2-year consultation must be carried out between the ages of 2 years and 2 years and 3 months. If the consultation is undertaken after the child turns 2 years and 3 months, it is to be recorded as an additional consultation.
- The 3.5-year consultation should be carried out on children aged 3 years and 6 months. After the child turns 3 years, 11 months and 14 days, the consultation cannot be recorded as a 3.5-year consultation. This consultation should be recorded as an additional consultation.

Flexible service capacity

Flexible service capacity relates to all activities undertaken by the Universal MCH Service that are not identified as KAS consultations. The type of consultation is recorded as one of the following activities:

- additional consultations
- telephone consultations
- group work, typically two hours a session over six to eight weeks
- community strengthening activities that do not involve clients.

Counselling

A counselling session is recorded when additional guidance is provided specific to an identified health concern. This should not to be confused with the range of information expected to be provided as part of the MCH schedule of activities at the KAS consultation. Therefore, not all consultations by the MCH nurse are counted as counselling.

Referral

A referral is only recorded when communication is made to the referral agency with the consent of the parent. This may take the form of a written letter, a phone call to the referral agency or a recording made in the parent-held Child Health Record by the MCH nurse.

A referral implies that counselling and referral occurs during a consultation. It is possible to provide counselling and referral at a consultation for more than one identified child, maternal or family health issue.

Opportunistic immunisations

Opportunistic immunisations are recorded for every immunisation a nurse provides.

MIST

The MIST vision screen is undertaken on all children at the 3.5-year consultation, unless they are under the ongoing care of an ophthalmologist.

11. Additional resources

11.1 Website

www.education.vic.gov.au/mchservice

The Department of Education and Early Childhood Development website provides a range of resources to support MCH practice. The site is divided into six sections:

- Universal Service – resources for parents and nurses, and clinical updates
- Enhanced Service – service overview and brokerage program
- Policy and Reports – policies, protocols, guidelines, reports, strategies and research
- Annual Report and Data Collection – data collections forms and historical annual reports
- Professional Learning and Development – training, conferences, learning tools, scholarships and research
- MCH Line – information for professionals about this service for families.

11.2 Parental Involvement in Monitoring and Assessing Young Children

The active involvement of parents as partners with health professionals in the developmental surveillance and assessment of their children is now recommended by all key authorities (e.g., American Academy of Pediatrics 2003; Green & Palfrey 2002; Oberklaid et al. 2002). For instance, in the assessment approach recommended by Greenspan et al. (1996), assessment is seen as a collaborative process involving ongoing collaboration between clinicians and parents in understanding the child and family. Greenspan et al. also recommend that young children should never be separated during the assessment from their parents or caregivers.

For further information regarding parent involvement and the above references refer to the *Best Practice Guidelines for Parental Involvement in Monitoring and Assessing Young Children,* which is located on the DEECD's website at **www.education.vic.gov.au/ecsmanagement/matchildhealth/policyreports/default.htm**

11.3 Maternal and Child Health Achievements Information Sheet

This document provides a snapshot of the development and achievements of the MCH Service since 2000, which consolidate it as a key universal service platform for Victorian families with children from birth to school age. This document can be found at **www.education.vic.gov.au/mchservice**

Appendix 1: Responding to concerns about children or young people

Children Youth and Families Act 2005

The *Children Youth and Families Act 2005* introduced a range of new reporting and referral arrangements, including the establishment of Child FIRST (Child and Family Information, Referral and Support Teams) to develop better pathways to earlier intervention services and more flexible responses to promote a child's safety, stability and development.

Maternal and Child Health Services, in working with vulnerable infants and children, their parents and families, including families with an unborn child, may from time to time consider they should report or refer a concern to either Child Protection or Child FIRST.

This section describes when a referral should be made to Child FIRST. It is important to note that MCH nurses are required by law to make a report to Child Protection whenever they form the belief on reasonable grounds that a child is in need of protection due to harm from physical or sexual abuse (see below).

Child FIRST

Child FIRST sites have been established in 24 sub-regional catchments across the state as part of sections 31 and 32 of the *Children Youth and Families Act 2005*. Child FIRST provides a community-based referral point into Family Services. Child FIRST is staffed by Family Services practitioners with experience in assessing the needs of vulnerable children, young people and families.

The legislation allows for a person who has significant concerns for the wellbeing of a child (defined as unborn children of pregnant mothers through to young people aged up to 17 years) to refer the matter to Child FIRST. This includes making a referral about concerns before the birth of a child.

In addition, the legislation outlines in section 38 that Child FIRST can consult with community-based Child Protection staff. This consultation facilitates referrals from Child Protection to Child FIRST; the provision of consultation and advice on specific cases in Child FIRST and Family Services; the provision of advice to Child FIRST and Family Services about the engagement of families with complex needs and the identification of significant risk factors to ensure timely Child Protection involvement if a child is at risk of significant harm; and participation in local professional and community education initiatives.

When to make a referral to Child FIRST

A referral to Child FIRST may be the best way of connecting children, young people and their families to the services they need where families exhibit any of the following factors that may affect a child's safety, stability or development:

- significant parenting problems that may be affecting the child's development
- family conflict, including family breakdown
- families under pressure due to a family member's physical or mental illness, substance abuse, disability or bereavement
- young, isolated and/or unsupported families
- significant social or economic disadvantage that may adversely impact on a child's care or development.

Each Child FIRST has its own phone number to call to make a referral into the catchment. An MCH nurse will need to identify their local Child FIRST catchment before making a referral.

Refer to the Children, Youth and Families website for contact in your area: **www.cyf.vic.gov.au/quick-help/first-child-and-family-information-referral-and-support-teams**

Refer to the Children, Youth and Families website for further information: **www.cyf.vic.gov.au/every-child-every-chance/how-to-make-a-referral-to-child-first**

Appendix 2: Child abuse and neglect

Child abuse and neglect is any act, or failure to act, by a parent that endangers a child's physical or emotional health or development. It may be a single incident, or pattern of parenting, which, over time, accumulates to cause harm to a child's development or wellbeing. Child abuse is classified into four categories:

1. Physical abuse
2. Emotional abuse
3. Sexual abuse
4. Neglect.

The incidence of parental drug and alcohol use, psychiatric illness and family violence is high among substantiated cases of child abuse. In situations such as these, harm can occur as a consequence of parents failing to adequately care for and protect their children as much as from direct and intentional abuse. It is the significance of the harm for the child, which results from parental actions or inaction, which should be the focus for health and welfare professionals.

The immediate and long-term effects of abuse and neglect can be disastrous for the individual child, their family and the community. Early intervention can have a dramatic effect on lessening the harm and promoting recovery of the child and the family.

MCH nurses need to be able to recognise when children may have been harmed or are at risk of harm. Physical and behavioural indicators of each abuse type are listed at the end of this document. Use of the indicators assists professionals who work with children to identify potential areas of concern. Indicators are starting points only and further consultation with supervisors and colleagues can assist in clarifying the extent of the concerns and the most appropriate action.

The legal context of abuse and harm

The law regarding children in need of protection in Victoria is contained in the *Children, Youth and Families Act 2005*. This legislation enables professionals and others in the community to notify Child Protection if they believe children are in need of protection. Its features include common principles to guide practice, better pathways to early intervention services, more flexible responses and a focus on cumulative harm.

The legislation enables two possible responses:

1. An early intervention or protective response
2. A child protection response.

1. Early intervention response – significant concerns for a child's wellbeing

Child FIRST teams

Under the *Children, Youth and Families Act 2005* a key strategy to promote children's best interests is the creation of pathways to ensure that prevention and early intervention services are provided to vulnerable children and families.

Where a person has a significant concern for the wellbeing of a child (where there is concern for a child's wellbeing or welfare, but the child is not considered to be in need of protection) they will be able to make a referral to Child FIRST (**Child** and **F**amily **I**nformation, **R**eferral and **S**upport **T**eams), which is conducted by a community-based child and family service. Child FIRST teams will operate in sub-regional areas and their contact numbers will be publicised and well known in the community.

Registered community-based child and family services can consult with a specific range of services and professionals about assessment and outreach to the child and family. This provides a strengthened prevention and early intervention capacity within the system to connect vulnerable children and families to the services that they may need. See Appendix 5 for information about responsibilities when collecting and disclosing information *(Information Privacy Act 2000 and Health Records Act 2001)*.

When a person has a significant concern for the wellbeing of a child before his or her birth (an unborn child) a referral can be made to Child FIRST or Child Protection which will enable the provision of assistance to the unborn child's mother.

Strong collaborative relationships and processes will be developed to enable Child FIRST teams and Child Protection intake workers to work with community agencies and professionals to ensure better responses to children and families to achieve better outcomes.

It is important that an MCH nurse takes action whenever she or he has concerns regarding the welfare of a child. It is important to document the observations and actions on the child's record. Action can include a number of options, depending upon the nature of the concerns.

MCH nurses often have the opportunity to counsel parents regarding issues that affect the welfare of their child, and to refer to support services, such as Child FIRST teams, family support, family violence, drug and alcohol, mental health, problem gambling or income support services.

2. Child Protection response – children in need of protection

Where a person believes on reasonable grounds that a child is in need of protection, a report may be made to Child Protection.

The *Children Youth and Families Act 2005*, section 162, defines a child in need of protection as follows:

1) For the purpose of this Act, a child is in need of protection if any of the following grounds exist—
   a) the child has been abandoned by his or her parents and after reasonable inquiries:
      i) the parents cannot be found; and
      ii) no other suitable person can be found who is willing and able to care for the child;
   b) the child's parents are dead or incapacitated and there is no other suitable person willing or able to care for the child;
   c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
   d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
   e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional and intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type;
   f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.
2) For the purposes of subsections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances.

Note that in Victoria, a child may be defined differently according to context. Section 3 of the *Children, Youth and Families Act 2005* defines a child as follows:

child means—

Section 3:

   a) in the case of a person who is alleged to have committed an offence, a person who at the time of the alleged commission of the offence was under the age of 18 years but of or above the age of 10 years but does not include any person who is of or above the age of 19 years when a proceeding for the offence is commenced in the Court; and

aa) in the case of a proceeding under the ***Family Violence Protection Act 2008,*** a person who is under the age of 18 years when an application is made under that Act; and

ab) in the case of a proceeding under the ***Stalking Intervention Orders Act 2008,*** a person who is under the age of 18 years when an application is made under that Act; and

b) in any other case, a person who is under the age of 17 years or, if a protection order, a child protection order within the meaning of Schedule 1 or an interim order within the meaning of that Schedule continues in force in respect of him or her, a person who is under the age of 18 years;

'Young person' is not separately defined.

It is the dual focus on harm to the child, and the inability or unwillingness of the parent to protect, which legally defines a child who is in need of protection. Reporters only need to form a reasonable belief a child is in need of protection. It is the responsibility of Child Protection to assess the significance of the harm and the parent's capacity and willingness to protect their child.

Reporting children at significant risk of harm to Child Protection

Any person may make a report to Child Protection if they believe on reasonable grounds that a child is in need of protection.

Some professional groups that work frequently with children are required by law to notify Child Protection whenever they form the belief on reasonable grounds that a child is in need of protection due to harm from physical or sexual abuse. This requirement is known as 'mandatory reporting'.

The following groups are mandated reporters under section 182(1)(a)–(e) of the *Children, Youth and Families Act 2005:*

- doctors (including psychiatrists)
- nurses (including MCH nurses)
- primary and secondary school teachers
- school principals
- police officers.

In addition, under section (f), 'the proprietor of, or a person with a post-secondary qualification in the care, education or minding of children who is employed by, a children's service to which the *Children's Services Act 1996* applies or a person nominated under section 16(2)(b)(iii) of that Act', is also a mandated reporter.

'Reasonable grounds' for forming the belief that a child is in need of protection may exist where, for example:

- a disclosure is made to the professional by the child that she or he has been physically or sexually abused

- someone else, such as a relative, friend or acquaintance of the child, tells the professional that the child has been abused
- the professional's observations of the child's behaviour or knowledge of children generally leads him or her to believe that the child has been abused
- the professional observes signs or indicators of abuse.

The decision to report a child in need of protection to Child Protection can be difficult. MCH nurses may fear they have insufficient grounds for their concerns or that parents may be angry or discontinue their contact with the centre.

These are legitimate concerns; however, it is important to work from the principle that children, particularly infants, are highly vulnerable and unable to protect themselves. Abuse and neglect of infants has the potential for life threatening injury, and serious impairment of brain development, attachment and the development of trust and healthy relationships in later life.

Where their parents are unable or unwilling to do so, a responsible adult must ensure that steps are taken which will ensure a child's safety and development are protected.

It is important not to assume that another person has made a notification where more than one person is aware of the cause for concern. Even where you are aware that a notification (report) has been made to Child Protection before, it is important you notify on each occasion you become aware of any further grounds to believe a child is in need of protection.

A useful guide for making the decision about whether to report to Child Protection is outlined below.

Table A2.1: Steps to deciding when to notify (report to) Child Protection

Step	Description	Action
Step 1 Concern	You are concerned about a child because you have: • received a disclosure from a child • observed warning signs (refer to **Indicators of possible child abuse and neglect)** • been made aware of a child who is as yet unborn about which you have concerns	Make sure you record your observations
	The concerns are of serious physical injury or sexual abuse	Go to Step 5
	Otherwise	Go to Step 2
Step 2 Gathering information		Consider doing the following: • Record your observations • Consult notes or records at the centre • Speak with the child if appropriate • Speak with the parents if appropriate • Follow local protocols regarding support referral and reporting of child abuse • Consult with colleagues, supervisor or centre coordinator • where established: consult with Child FIRST teams regarding possible options for assistance and support.
	Are you wondering if your concerns need to be reported to Child Protection?	
	No	Continue to monitor and support child
	Yes	Go to Step 3
Step 3 Forming a belief	Ask yourself: 'Am I **more likely** to believe that the child is in need of protection ('at risk of significant harm') or less likely to believe that the child is in need of protection?'	
	If you are **more likely** to believe there is a need for protection	Go to Step 4
	If you are **less likely** to believe there is a need for protection	Continue to monitor and support child as in Step 2

Step	Description	Action
Step 4 Referring to other services	Ask yourself: 'Would a specific service or professional assist the parents with care of this child?'	
	Yes	Discuss with the child's parents and assist with a referral to a service if they are agreeable Continue to monitor and support the child as in Step 2
	No, or can't find out	Go to Step 5
	You are in doubt about the child's safety and the parent's willingness or ability to protect the child	Go to Step 5
Step 5 Notifying Child Protection		Contact your local regional Child Protection Intake Unit. Department of Human Services. If your call is after hours, phone: 13 12 78 • Allow a minimum of 30 minutes to discuss your concern. • Have your notes at hand with your observations and child and family details. • Consider the level of immediate risks to the child.

Protection for referrers of cases to Child FIRST teams

Section 40 of the *Children, Youth and Families Act 2005* provides the following protection for reporters and referrers to Child First acting in good faith:

- a report or referral does not constitute unprofessional conduct or a breach of professional ethics on the part of the person who made it
- a report or referral does not make the person by whom it is made subject to any liability in respect of it
- does not contravene section 141 of the *Health Services Act 1988* or section 120A of the *Mental Health Act 1986*.

Section 41 requires that the name of the person who made the report, or any information likely to lead to the identification of the referrer, remain confidential. Section 37 provides similar protections for a person who provides information in confidence to a Child First Team.

Possible indicators of abuse and neglect

Physical abuse

Physical abuse refers to a situation in which a child suffers or is likely to suffer significant harm from an injury inflicted by a child's parent or caregiver. The injury may be inflicted intentionally or may be the inadvertent consequence of physical punishment or physically aggressive treatment of the child.

Physical injury and significant harm to a child may also result from neglect by a parent or caregiver. The failure of a parent or caregiver to adequately ensure the safety of a child may expose the child to extremely dangerous or life threatening situations that result in physical injury and significant harm to the child.

Physical indicators

Physical injuries include bruising, welts, burns, cuts, fractures, suffocation, poisoning, internal injuries and assault with weapons. Actions by a parent or caregiver which may result in physical injury or harm include hitting, biting, shaking, punching, burning, twisting of limbs, administration of poisonous substances and drowning.

A child may be in need of protection where the type or extent of harm is undefined, but total circumstances lead to this belief. For instance:

- threats of violence directed toward the child
- the child being left unsupervised, either at home, on the street or in a car
- the child being left with older children or persons who could not reasonably be expected to provide adequate care and protection
- inadequate attention to the safety of the home, such as children being left in rooms containing an unguarded fire, or dangerous medicines left where children may have access to them.

The nature of the abuse and the significance of the harm from physical abuse are determined by a protective assessment, which will often include a medical examination.

Behavioural indicators

- wearing inappropriate clothing in an attempt to cover injuries
- apprehension when other children cry or shout
- behavioural extremes, for example, aggression or withdrawal
- fear of adults
- afraid to go home or to school
- reports injury by parent or gives inappropriate explanation of injury
- excessive compliance
- extreme wariness
- attaching too readily to strangers.

Sexual abuse

Sexual abuse occurs when an adult or older child uses their power or authority over the child or takes advantage of the child's trust, respect or compliance to involve the child in sexual activity, and the child's parent or caregiver has not protected the child. Physical force is sometimes involved. Child sexual abuse does not only refer to sexual intercourse. Child sexual abuse involves a wide range of sexual activity. It includes fondling of the child's genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or other object, or exposure of the child to pornography.

Physical indicators

Sexual abuse is not usually identified through physical indicators, although the presence of sexually transmitted diseases, vaginal or anal bleeding or discharge may be detected during medical examination and can indicate sexual abuse.

Behavioural indicators

A child may disclose sexual abuse to a trusted person. Such disclosures should always be taken seriously. Other behavioural indicators include:

- sexual knowledge and behaviour beyond what is expected for their age
- developmentally unusual level of interest in own or other's genitals, taking into consideration their age and circumstances
- constant complaints of headaches and/or abdominal pains without organic cause
- sudden change in behaviour or temperament
- regression in toilet training, for example, soiling, wetting
- refusal to go home
- frequent or prolonged unexplained or inadequately explained absence from school
- inability to sit comfortably
- self-harming behaviour, such as cutting, scratching with implements, burning.

Emotional abuse

Emotional abuse is persistent behaviour by a parent or caregiver that impairs the emotional development of the child. This may involve threats or rejection, such as repeated humiliation, name calling, demeaning the child's achievements, coldness or open hostility. It may also involve extremely inconsistent responses to the child's developmentally appropriate behaviour, such as alternating between hostility and affection; or alternately punishing and praising the same behaviour.

Emotional abuse is most prevalent as a corollary of other forms of abuse or neglect. There are few physical indicators of such abuse.

Behavioural indicators

- behavioural extremes that cannot be explained by other circumstances
- extremely low self-esteem
- compliance, passivity, withdrawal, tearfulness
- aggressive or demanding behaviour
- depression
- persistent high anxiety
- poor social and interpersonal skills
- very delayed development, for example speech
- persistent habit disorder, for example, sucking, biting, rocking
- self-harming behaviour
- unexplained change of performance at school.

Neglect

Neglect refers to a situation in which a child's parent or caregiver fails to provide the child with the basic necessities of life, such as food, clothing, shelter, medical attention or supervision, to the extent that the child's health and development is, or is likely to be, significantly harmed. An abandoned child is also a neglected child.

Physical indicators

- constant hunger
- non-organic failure to thrive
- malnutrition
- inappropriate dress for the weather conditions
- unattended physical problems or medical needs
- health or dietary practice that endangers health or development, for example fad diets.

Behavioural signs

- stealing food
- frequent fatigue, listlessness or falling asleep during sessions
- aggressive or inappropriate behaviour.

Specific indicators of concern for infants

Infants are highly vulnerable and cannot protect themselves. Their rapid body growth and brain development in the first two years makes them extremely susceptible to the effects of neglect and malnutrition. Their soft skull, lack of muscle development and unprotected body make them extremely vulnerable to head and other serious injuries from shaking or direct blows to the body.

Where professionals who work with infants and young children identify the following indicators (particularly where several indicators are present), consultation with supervisors/colleagues should occur. Consideration should be given to a notification to Child Protection if there is a reasonable belief that the child is in need of protection.

Note: From early 2007, consultation should be sought with the local Child FIRST team where the observed indicators suggest concern for the child's development and wellbeing. Where the indicators suggest the child may be at significant risk of harm and in need of protection, a report should be made to Child Protection.

Indicators include:

- evidence of physical injury inconsistent with the child's age and stage of development
- child is listless and immobile
- child is emaciated and pale
- child is below expected birth weight
- child displays inconsistent weight gain
- child is born drug dependent
- child may sleep for longer periods than would normally be expected
- child appears depressed and unresponsive to social involvement
- child cries excessively or not at all
- child displays self-stimulatory behaviours, for example, rocking, head banging
- child does not seek comfort from the parent
- child has poor muscle tone and motor control
- child exhibits significant delays in gross and fine motor development and coordination
- parent is consistently impatient or unresponsive to infant cues
- parent does not respond to assistance from the MCH nurse
- parent misunderstands or fails to respond to the child's cues
- parent has past or current substance abuse issues
- parent had poor antenatal care
- parent was aged under 20 at birth of child
- parent is highly transient or homeless
- parent is engaged in a violent relationship
- parent has a mental illness.

Appendix 3: Maternal and Child Health Service — Key ages and Stages Framework

KAS visit	Health & Development Monitoring	Intervention*	Promotion of Health & Development
Home visit	Family Health & Wellbeing Pregnancy, birth, family history Smoking	QUIT intervention & referral Respond to assessments	Breastfeeding Immunisation SIDS: view infant sleep arrangements Safe Sleeping Checklist
2 weeks	Family Health & Wellbeing Full physical assessment - includes Developmental Review Hearing risk factors	Respond to assessments	Car restraints Communication, language and play Injury prevention - Kidsafe
4 weeks	Family Health & Wellbeing Maternal Health & Wellbeing check Hips Weight, length, head circumference	Family Violence- safety plan Respond to assessments Post Natal Depression	Breastfeeding Immunisation Women's Health
8 weeks	Family Health & Wellbeing Full physical assessment - includes Developmental Review	Respond to assessments	Immunisation SIDS risk factors
4 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight	Respond to assessments	Communication, language and play Food in first year of life Playgroup Young Readers
8 months	Family Health & Wellbeing Full physical assessment Oral health Developmental Assessment (PEDS/Brigance) Hearing risk factors Infant sleeping	Sleep Intervention Respond to assessments	Communication, language and play Injury prevention - Kidsafe Poison information Sunsmart Tooth Tips
12 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight & length	Respond to assessments	Communication, language and play Healthy eating for young toddlers Immunisation
18 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Oral health Weight, height, gait	Teeth cleaning Respond to assessments	Communication, language and play Injury prevention - Kidsafe Tooth tips
2 years	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Weight & height, gait	Promote a Healthy Weight Respond to assessments	Communication, language and play Kindergarten enrolment Young Readers
3.5 years	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Vision (MIST) Oral health Weight & height, gait	Promote a Healthy BMI Respond to assessments	Communication, language and play Healthy eating and play for kindergarten Immunisation Injury prevention - Kidsafe

* At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement *(including notifications under the Child, Youth and Families Act 2005)*

Child Outcomes

The Office for Children and Early Childhood Development has reviewed the evidence about the factors that make a real difference to children and young people and has identified 35 aspects of child health and wellbeing, learning and development and safety that are essential to our children's future. These aspects are known as the Outcomes for Children[1]. The following table identifies the outcomes, and the measurable indicators associated with each of the topics covered by the revised Maternal and Child Health Key Ages and Stages activity framework. It is important to note that the Maternal and Child Health service may play a key role, or a supportive role, in improving the identified outcomes for children and their families

Topic	Outcome	Indicator
SIDS	Optimal antenatal and infant development	Sudden Infant Death Syndrome (SIDS) rate for infants
Safe sleeping	Parent promotion of child health and development	Proportion of infants put on their back to sleep from birth
Smoking	Optimal antenatal and infant development	Proportion of children exposed to tobacco while in utero
		Proportion of women who used illicit drugs during pregnancy
	Healthy adult lifestyle	Proportion of children and young people exposed to tobacco smoke in the home
Immunisation	Free from preventable disease	Proportion of children who are fully vaccinated
Breastfeeding/Solids	Adequate nutrition	Proportion of infants breastfed
		Proportion of children and young people who eat the minimum recommended serves of fruit and vegetable every day
Post Natal Depression/ Sleep Intervention	Good parental mental health	Proportion of mothers with post-natal depression
		The proportion of children and young people who have parents with mental health difficulties
Injury prevention	Safe from injury and harm	Age specific death rates from injuries and poisoning
		Age specific hospitalisation rates from injuries and poisoning
Family violence	Free from child exposure to conflict or family violence	Proportion of mothers exposed to partner violence
		Proportion of family violence incidents witnessed by children and young people
Growth	Healthy weight	Proportion of children and young people who are overweight and obese
Oral Health	Healthy teeth and gums	Proportion of children and young people who brush their teeth twice a day
Literacy	Parent promotion of child health and development	Proportion of children who are read to by a family member every day
Vision	Early identification of and attention to child health needs	Proportion of parents concerned about their child's vision
Physical Assessment	Early identification of and attention to child health needs	Proportion of infants receiving a Maternal and Child Health Services home consultation
		Proportion of infants aged 0-1 month enrolled at Maternal and Child Health Services from birth notifications
		Hospital admissions for gastroenteritis in children under one year of age

March 2009

[1] Department of Human Services, The State of Victoria's Children Report 2006 (October 2006)

Appendix 4: Maternal and Child Health Service — Promotion of Health and Development

Evidence based written health information, listed in the following table, will be distributed at each key age and stage consultation. This information is designed to support a facilitated discussion with parents about key health promotion messages. It will also ensure that consistent quality written information is provided to parents across the state.

Key Ages & Stages Visit	Health Promotion	Pamphlets
Home visit	SIDS safe sleeping: view infant sleep arrangements, checklist	Sids and kids safe sleeping
		Safe Sleeping Checklist
	Safety	Its not OK to shake babies
	Learning	Making the most of childhood: the importance of the early years
		Kids talk 75 ways to talk to children
	Breastfeeding	Go for your life: Successfully starting and maintaining breastfeeding
2 weeks	Communication, language and play	Communication, language and play bookmark
	Road safety	Choosing and using restraints. A guide for parents with children from birth to 16 years
	Injury prevention	Safe kids now - Babies from birth to crawling. Birth – 9months
4 weeks	Education for parents	Raising Children Network the Australian Parenting Website
	Women's Health	One in three women who ever had a baby wet themselves
	Post Natal Depression	Emotional health during pregnancy and early parenthood
8 weeks	Immunisation SIDS risk factors	No pamphlets for this visit
4 months	Food in first year of life	Food in the first year of life
		Why no sweet drinks for children
	Communication, language and play	Communication, language & play bookmark and information sheet
		Young Readers - Rhyme time: book & DVD
	Playgroup	Baby Play and Baby Playgroups
8 months	Poison information	Is your home poison proof?
	Communication, language and play	Communication, language and play bookmark and information sheet
	Sunsmart	Sunsmart The outside 5
	Tooth Tips	Tooth tips 0 – 12months
	Injury prevention	Safe kids now - Toddlers on the move 9 – 18 months
12 months	Healthy eating for young toddlers	Healthy eating and play for toddlers (1 - 2 years)
	Communication, language and play	Communication, language and play bookmark and information sheet
	Dental	Tooth tips thumb and finger sucking 1 - 2 years
18 months	Communication, language and play	Communication, language and play bookmark and information sheet
	Injury prevention	Safe kids now - Inquisitive and invincible 1.5 - 3.5 years
	Dental	Tooth tips dental visits 18 months - 6 years
	Playgroup	You can start a playgroup!
2 years	Kindergarten enrolment	Why should my child go to a kindergarten program?
		Enrol in a kindergarten program.
	Communication, language and play	Communication, language and play bookmark and information sheet
		Young Readers - book
3.5 years	Healthy eating and play for kindergarten	Healthy eating and play for kindergarten children (3 - 5 years)
	Injury prevention	Try it - you'll like it, vegetable and fruit for children
		Safe kids now - Pre-schoolers: independent adventures 3.5 - 5 years
	Starting kindergarten	Is your child 3 - 4 years?
	Communication, language and play	Communication, language and play bookmark and information sheet
	Immunisation	Starting primary school - your child must have a school entry immunisation

March 2009

Pamphlet	Health information: source
It's not OK to shake babies	NAPCAN
SIDS and kids safe sleeping Safe sleeping checklist	SIDS and Kids
Making the most of childhood: the importance of the early years	Department of Education and Early Childhood Development
Is your home poison proof?	Victorian Government
National Immunisation Program Schedule Starting primary school - Your child must have a school entry immunisation certificate	Australian Government Department of Health and Ageing Department of Human Services
Kids talk 75 ways to encourage children Growth chart	Parent Kit from Department of Education and Early Childhood Development
Communication, language and play bookmarks and information sheets	Department of Education and Early Childhood Development
Choosing and using restraints: A guide for parents with children from birth to 16 years	Vic Roads
Safe kids now - From birth to crawling: Birth – 9 months Safe kids now - Toddlers on the Move 9 - 18 months Safe kids now - Inquisitive and Invincible 1.5 - 3.5 years Safe kids now - Preschoolers: Independent adventures 3.5 to 5 years	Kidsafe
Raising Children Network the Australian Parenting Website	Smart Population Foundation, Centre for Community Child Health and the Victorian Parenting Centre
One in three women who ever had a baby wet themselves	Victorian Continence Resource Centre
Emotional health during pregnancy and early parenthood	Beyond Blue
Successfully starting and maintaining breastfeeding Food in the first year of life Why no sweet drinks for children Healthy eating and play for toddlers 1 - 2 years Healthy eating and play for kindergarten children 3 - 5 years Try it - you'll like it, vegetables and fruit for children	Go for your life
Baby Play and Baby Playgroups Discover playgroup	Victorian Playgrouping Association
Sunsmart The Outside Five	Cancer Council Victoria
Tooth tips 0-12 months Tooth tips dental visits 18 months to 6 years Tooth tips thumb and finger sucking 1 - 2 years	Dental Health Services Victoria
Starting Kindergarten - Why should my child go to a kindergarten program? Enrol in a kindergarten program	Department of Education and Early Childhood Development
Is your child 3 - 4 years?	Department of Education and Early Childhood Development





Appendix 5: *Information Privacy Act 2000* and *Health Records Act 2001*

Information Privacy Act 2000

The Information Privacy Act regulates the collection and handling of personal information in Victoria. The Act applies to all Victorian public sector agencies including local government.

The purposes of the Information Privacy Act are:

- to establish a regime for the responsible handling of personal information;
- to provide individuals with rights of access to information about them held by organisations;
- to provide individuals with the right to require an organisation to correct information about them held by contracted service providers;
- to provide remedies for interferences with the information privacy of an individual;
- to provide for the appointment of a Privacy Commissioner.

'Personal information' means:

> Information or an opinion ... that is recorded in any form and whether true or not, about an individual whose identity is apparent, or can reasonably be ascertained, from the information or opinion, but does not include information of a kind to which the *Health Records Act 2001* applies.

This information might concern not only clients and their families but others related to their care. It must be kept accurate, complete and up to date, and protected from unauthorised access, modification or disclosure.

Additional safeguards apply to 'sensitive information'. This information concerns matters including an individual's ethnic or racial origin, sexual preferences or religious beliefs or affiliations. Information of this kind may only be collected in certain circumstances, such as when the individual has consented or, where the collection is necessary to prevent or lessen a serious and imminent threat to the life or health of any individual, that individual is incapable of giving consent.

Information Privacy Principles (IPPs) are set out in Schedule 1 of the Information Privacy Act. Key IPPs to note are:

- Principle 1—Collection
- Principle 2—Use and disclosure
- Principle 3—Data quality
- Principle 4—Data security
- Principle 6—Access and correction
- Principle 10—Sensitive information

When personal information is no longer needed for any purpose, disposal of records should be considered: see Appendix 6.

If personal information has been held by an organisation whose acts or practices interfere with the individual's privacy, he or she may complain to the Privacy Commissioner. For more information about the *Information Privacy Act 2000*, the 10 IPPs and the Commissioner's role go to **www.privacy.vic.gov.au**

Health Records Act 2001

The *Health Records Act 2001* regulates the collection and handling of health information in Victoria. Health information is:

Section 3:

a) information or an opinion about—

i) the physical, mental or psychological health (at any time) of an individual; or

ii) a disability (at any time) of an individual; or

iii) an individual's expressed wishes about the future provision of health services to him or her; or

iv) a health service provided, or to be provided, to an individual—

that is also personal information; or

b) other personal information collected to provide, or in providing, a health service; or

c) other personal information about an individual collected in connection with the donation, or intended donation, by the individual of his or her body parts, organs or body substances; or

d) other personal information that is genetic information about an individual in a form which is or could be predictive of the health (at any time) of the individual or of any of his or her descendants—

but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of this Act generally or for the purposes of specified provisions of this Act;

The Act's purpose is to promote fair and responsible handling of health information by:

- protecting the privacy of a person's health information that is held in the public and private sectors; and
- providing individuals with a right of access to their health information; and
- providing an accessible framework for the resolution of complaints regarding the handling of information.

Any organisation that holds health information, including kindergartens and child care centres, and MCH Service centres, is subject to the Health Records Act.

The Health Records Act contains its own Health Privacy Principles (HPPs) set out in Schedule 1. While in many respects these are similar to the IPPs, there are some differences. Note especially the provision protecting information given in confidence in HPP1.7. Special provisions also apply to the transfer and disposal of records by health service providers (see HPP 4.4 and 4.5 as well as Appendix 6 to this guide).

An individual may complain to the Health Services Commissioner about an act or practice that may be an interference with the individual's privacy. Further information about the *Health Records Act 2001* and the 11 Health Privacy Principles can be found at **www.health.vic.gov.au/doh/** and **www.health.vic.gov.au/hsc/**

It is the responsibility of each individual organisation and agency to have clearly expressed policies in line with the Information Privacy Act and the Health Records Act. An MCH nurse who has to resolve an information privacy problem should do so with the assistance of their line manager(s) and in accordance with their organisation's information privacy policy.

Neither the Information Privacy Act nor the Health Records Act prevent mandated professionals from reporting child abuse to the Department of Human Services Child FIRST.

Freedom of Information Act 1982 (Vic.)

The major premises of the *Freedom of Information Act 1982* (Vic.) are that individuals have a right to know what information is contained in government about themselves as well as information about the operation of agencies.

This Act promotes the prompt and low-cost disclosure of this information subject to exemptions. Exempt documents include those affecting others' personal privacy (section 33) and those containing material obtained in confidence (section 35). 'Document' is widely defined and includes electronically stored information and photographs.

Section 16 of the *Health Records Act 2001* establishes that provision of certain information about and access and correction rights by agencies and departments in respect of health information is only available in accordance with the *Freedom of Information Act 1982*.

The Commonwealth *Freedom of Information Act 1982* promotes similar access to information in the possession of federal government agencies.

Public Records Act 1973

The document management requirements of the *Public Records Act 1973* do not prevent a person from giving access to records where it is proper and lawful to do so (section 10A).

However, if a requirement of the *Public Records Act 1973* is inconsistent with a provision made by or under any other Act, including the Information *Privacy Act 2000* and the *Health Records Act 2001*, the Public Records Act provision prevails to the extent of the inconsistency (section 7(1) of the Health Records Act and section 6(1) of the Information Privacy Act).

Appendix 6: Disposal of Maternal and Child Health records

PROS 09/05, 'Retention and Disposal Authority (RDA) for Records of Local Government Functions' has replaced PROS 98/01 'General Retention and Disposal Authority for Records of Local Government'. PROS 09/05 was issued on 21 August 2009 and expires on 21 August 2019.

Certain general considerations apply to the disposal records. In particular it should be noted that it is an offence under the *Crimes (Document Destruction) Act 2006* for individuals or organisations to destroy documents they know are reasonably likely to be required in a future legal proceeding if the intention is to prevent them from being used in evidence.

Together with the associated *Evidence (Document Unavailability) Act 2006*, the creation of this offence also serves to assist the preservation of public records that may provide evidence or 'reasonable grounds' for disclosure of improper conduct by a public officer or public body (see the *Whistleblowers Protection Act 2001,* section 5). Documents subject to a request under the *Freedom of Information Act 1982* should also be retained.

The schedule does not refer specifically to all the documents currently used by the MCH Service. Specific document classes pertaining to the MCH Service are included below.

Table A6.1: Public Records Office Victoria: PROS 09/05 'Retention and Disposal Authority for Records of Local Government Functions' and Records General Records Authority, version 2002 incorporating variations 1 and 2, Part four, General records authority

	Function description	Disposal action	Examples of records The following is a list of common examples. It is not an exhaustive list.
12.5.0	Immunisation		
12.5.2	The process of administering an immunisation program	Destroy one year after administrative use is concluded	Campaign diaries Vaccine order and inventory book Parent consent records
4.5.0	MCH Service provision		
4.5.1	Client case management	Destroy 26 years after initial contact with client	Infant record cards Caller cards Expectant mother cards Analysis of daily activities sheets
4.5.2	Provision of group information and education sessions	Destroy 2 years after delivery of program	
4.5.3	Birth notification	Destroy when administrative use concludes	Birth notification forms Birth notification and enrolment sheets

Other RDAs may also be relevant to particular classes of documents used by MCH service providers. For advice regarding use of other RDAs and for further information contact the Public Records Office of Victoria at:

- telephone (03) 9348 5600 or 1800 657 452
- email ask.prov@prov.vic.gov.au
- www.prov.vic.gov.au/records/
- http://www.prov.vic.gov.au/records/pdf/PROS%202009-05%20Records%20of%20Local%20Gov%20Functions.pdf

The local government records departments in each municipality can also offer information.

Appendix 7: Using the Child Health Record for children in out-of-home care

When a child comes into out-of-home care, it is important for the Child Health Record to be given to the carer. This will help ensure that there are no gaps in health care for the child and that the care is right for the child.

The Child Health Record has background health and development information that is important in order to meet the child's health and developmental needs and in assessing the child on entry into care.

If the record is not available, then a new Child Health Record can be issued by the Maternal and Child Health nurse. If a child's health record is lost, it can be replaced by the Maternal and Child Health nurse. The new Child Health Record may be filled in by the nurse so that it contains as much of the information as possible that was in the previous Record.

If a child moves then his or her parent or carer can take him or her to attend the centre that was previously attended, or alternatively they can attend a centre close to the new home. Centre-held Maternal and Child Health records, with the consent of parents or carers, can be transferred to the new centre.

More details about the Child Health Record are available on the Victorian Government Health Information website at: **www.health.vic.gov.au/childhealthrecord/index.htm**

Appendix 8: Calculating participation rates in the Maternal and Child Health Service

Table A8.1: Participation of clients from birth notifications

For birth notifications received in a financial year: (Figures taken from the MCH birth notification and enrolment record columns for data collection)	Column 7.1 – number enrolled from birth notifications, plus column 9.1 – number enrolled in other centres within municipality; plus column 9.2 – number enrolled in other centres outside municipality, as a percentage of column 4 – total number of birth notifications received. Minus column 9.4 – total number of stillbirths; minus column 9.3 – total number of deaths within one month; minus column 9.5 – total number of other.

Table A8.2: Percentage of clients attending

For each year of the child's age:	Active record cards (those children who attend a centre at least once in a financial year) as a percentage of total record cards (all registered clients whether currently attending or not)

Table A8.3: Participation rates – Key Ages and Stages

A – Home visit	Number of home visits as a percentage of total infant record cards of children aged 0–1 year old
B – 2 weeks	Number of 2-week visits as a percentage of total infant record cards of children aged 0–1 year old
C – 4 weeks	Number of 4-week visits as a percentage of total infant record cards of children aged 0–1 year old
D – 8 weeks	Number of 8-week visits as a percentage of total infant record cards of children aged 0–1 year old
E – 4 months	Number of 4-month visits as a percentage of total infant record cards of children aged 0–1 year old
F – 8 months	Number of 8-month visits as a percentage of total infant record cards of children aged 0–1 year plus 1–2 years divided by 2
G – 12 months	Number of 12-month visits as a percentage of total infant record cards of children aged 0–1 year plus 1–2 years divided by 2
H – 18 months	Number of 18-month visits as a percentage of total infant record cards of children aged 1–2 years plus 2–3 years divided by 2
1 – 2 years	Number of 2-year visits as a percentage of total infant record cards of children aged 2–3 years
J – $3^1/_2$ years	Number of $3^1/_2$-year visits as a percentage of total infant record cards of children aged 3–4 years plus 4–5 years divided by 2

Table A8.4: Child health referral rate

For all of the referral categories:	Total referrals for a referral type as a percentage of total active record clients (clients who have attended at least once in the operating year).

Table A8.5: Breastfeeding rate (add together the fully and partially breastfeeding figures)

A – On discharge	Number of mothers breastfeeding at discharge as a percentage of total registered clients aged 1–2 years
B – At 2 weeks	Number of mothers breastfeeding at 2 weeks as a percentage of total registered clients aged 1–2 years
C – At 3 months	Number of mothers breastfeeding at 3 months as a percentage of total registered clients aged 1–2 years
D – At 6 months	Number of mothers breastfeeding at 6 months as a percentage of total registered client aged 1–2 years

Table A8.6: Immunisation rates

This information is obtained from the Australian Childhood Immunisation Register and will not be collected as part of the *MCH Annual Data Report*.

Appendix 9: Enhanced Maternal and Child Health Service counting rules

The counting rules are:

1. Count in the first quarter of the financial year:

- ongoing cases at the beginning of the quarter, and
- new cases opened during the quarter.

2. Count for the remaining three-quarters of the financial year:

- new cases opened during the quarter.

The number of case closures will no longer be recorded.

Example:

Ongoing cases at the beginning of the financial year = 5

New cases opened during the first quarter = 1

New cases opened during the second quarter = 2

New cases opened during the third quarter = 0

New cases opened during the fourth quarter = 1

Number of clients receiving a service (5 + 1 + 2 + 0 + 1) = 9

Cases should not be closed for data collection purposes; rather, they should be closed when the client is discharged from the Enhanced Service. The length and intensity of contact by the Enhanced MCH Service with a family is a matter for professional judgment based on the complexity of family needs and efficient and effective service provision for families.

Note: Funding arrangements require that KAS consultations delivered by the Enhanced MCH Service are reported in the Universal MCH data collection system – MaCHS, Xpedite, Daily Activity Sheet, etc.

Appendix 10: Service Improvement Plan template

Universal Key Age and Stage Consultations

The MCH Service is a statewide primary care service for Victorian families with children from birth to school age. The service is provided in partnership with the Municipal Association of Victoria, local government and the Department of Education and Early Childhood Development.

The Universal MCH service includes 10 Key Ages and Stages consultations from birth to 3.5 years for all children and their families. Current performance data show that across Victoria participation in MCH Services remains high, but starts to decline after the 4-month visit. The Department has a goal of lifting participation in the later Key Ages and Stages, i.e., following the 4-month visit. Progress against such a goal would be demonstrated by participation rates lifting by 5 per cent for each of the later Key Ages and Stages visits within the next four years.

While participation is generally high for the overall population, participation by Aboriginal and Torres Strait Islanders (ATSI) is lower for all Key Ages and Stages visits. This is an issue considering the particular needs of ATSI young children. In response, the Department has a goal that the gap in participation in the Key Age and Stage visits between ATSI and non-ATSI children should be at least halved within the next four years.

1. Increase the participation rate in the Universal service from the 4 month visit onwards.
2. Outline 1 priority area that your service will focus on to improve identification and engagement of ATSI, CALD and vulnerable families in your municipality?
3. Identify 1 strategy that you will put in place in 2010–11 to continue to implement the Key Ages and Stages project.
4. Identify 1 strategy that demonstrates how your municipality has implemented at least one of the MCH Program Standards.

	Strategies	Measure (target/outcome)	Performance
	List one strategy/priority area that you are planning for the current financial year	Identify how you will measure the success of this strategy	At the end of the current year, document your performance against your measures
Increase participation in the Universal MCH Service from the 4-month consultation onwards			
Improve identification and engagement of ATSI, CALD and vulnerable children and families in your municipality			
Continue the implementation of the KAS project			
Implement at least one of the MCH Program Standards			

Prepared by: Regional Endorsement

Title: _____

Address: _____

Phone: _____

Name: _____

Endorsed by: _____

Signature: _____ Date: _____

Plans to be endorsed by authorised signatory on DEECD Funding and Service Agreement.

Appendix 11: Birth notification from the *Child Wellbeing and Safety Act 2005*

Part 7 Birth Notification

42. Application of Part

1. This part applies in the case of every birth in Victoria, whether the child is born alive or dead, except for the delivery of a non-viable foetus.
2. This part applies in addition to the requirements of the *Births, Deaths and Marriages Registration Act 1966*.

43. Early Notification of births

1. If a child is born in Victoria, notice of the birth of the child (**'the birth notice'**) must be given by the responsible person to—
   a) the Chief Executive Officer of the council of the municipal district in which the mother of the child usually resides; or
   b) if the municipal district is not known to the person giving notice, the Chief Executive Officer of the council of the municipal district in which the birth occurs; or
   c) if the mother of the child usually resides outside Victoria, the Secretary.
2. The notice must be in the prescribed form.
3. In this section **'responsible person'** has the same meaning as it has in section 12 of the *Births, Deaths and Marriages Registration Act 1996*.

44. How must the birth notice be given?

1. The birth notice must be given
   a) personally; or
   b) by post; or
   c) by facsimile transmission; or
   d) by electronic communication.
2. The birth notice must be given within—
   a) 48 hours after the birth to which the notice relates; or
   b) if a longer period is prescribed in respect of a particular municipal district, that longer period.

45. What must be done once notice is received?

On receipt of the birth notice the Chief Executive Officer of a council must, as soon as practicable, send a copy of the notice—

a) if in the municipal district of the council there is a Maternal Child Health Centre under the control of and subsidised by the council, to the nurse whose duty it is to visit or communicate with the house to which the notice relates ;or
b) in any case, to the Secretary.

46. Offence to fail to give notice

1. Any person who fails to give notice of a birth in accordance with this Part is guilty of an offence and is liable to a penalty of not more than 1 penalty unit.
2. It is a defence to a prosecution for an offence under subsection (1) if the person—
   a) satisfies the court that he or she had reasonable grounds to believe that notice had been duly given by another person; or
   b) had other reasonable grounds for not giving the notice.

Definitions

'Maternal Child Health Centre' means a centre where health advice is given to the parents and other caregivers of children under 6 years of age.

'Responsible person' is defined in section 12(6) of the *Births, Deaths and Marriages Registration Act 1996* as follows:

(6) In this section—

responsible person means—

a) in the case of a child born in a hospital or brought to a hospital within 24 hours after birth, the chief executive officer of the hospital; or

b) in any other case—

i) the doctor or midwife responsible for the professional care of the mother at the birth or a doctor who examined the body of the still-born child after the birth; or

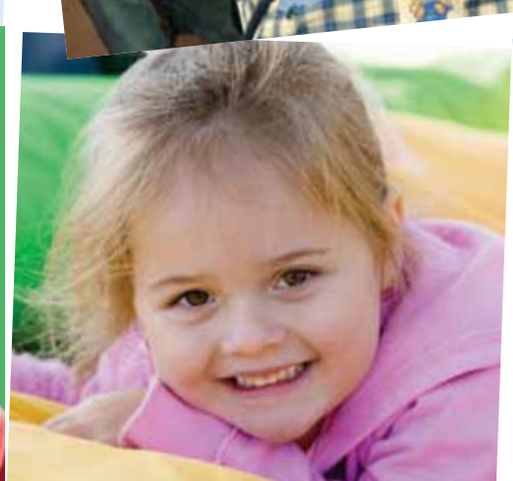
ii) if no doctor or midwife was in attendance at the birth, any other person in attendance at the birth.

State Government Victoria

Department of Education and Early Childhood Development

Maternal and Child Health Service: Practice Guidelines 2009

Every child, every opportunity



Maternal and Child Health Service

In 2007/08 the Office for Children within the Department of Education and Early Childhood Development piloted a new Key Ages and Stages (KAS) framework with four local government authorities with a view for a later statewide roll out.

The revised KAS framework introduces a new approach to the ten KAS visits provided to parents and children by the universal Maternal and Child Health Service. The new framework set out new evidence based activities for each of the ten age and stage visits with additional emphasis on health promotion across a range of domains that address both maternal and child health and wellbeing. The framework also includes the:

- Parents' Evaluation of Developmental Status (PEDS) as a primary tool to engage parents in discussion about the development of their child
- Brigance screen as a secondary screen where concerns are identified through the PEDS
- relevant health information handouts at each key age and stage consultation
- interventions that include a SIDS risk assessment, Quit smoking intervention, and screening for maternal health and the presence of family violence.
- Anticipatory Guidance underpins this framework It is intended to be complemented by opportunistic activity by MCH nurses, on the basis of their clinical judgement, in response to other parental concerns and nurse observation.

Based on the evaluation findings Department of Education and Early Childhood Development is now rolling out the revised KAS framework across the remaining Victorian local government authorities in 2009/10.

Maternal and Child Health Service Guidelines Index

Maternal and Child Health Service
Key Ages and Stages Framework

KAS visit	Health & Development Monitoring	Intervention*	Promotion of Health & Development
Home visit	Family Health & Wellbeing Pregnancy, birth, family history Smoking	QUIT intervention & referral Respond to assessments	Breastfeeding Immunisation SIDS: view infant sleep arrangements Safe Sleeping Checklist
2 weeks	Family Health & Wellbeing Full physical assessment - includes Developmental Review Hearing risk factors	Respond to assessments	Car restraints Communication, language and play Injury prevention - Kidsafe
4 weeks	Family Health & Wellbeing Maternal Health & Wellbeing check Hips Weight, length, head circumference	Family Violence- safety plan Respond to assessments Post Natal Depression	Breastfeeding Immunisation Women's Health
8 weeks	Family Health & Wellbeing Full physical assessment - includes Developmental Review	Respond to assessments	Immunisation SIDS risk factors
4 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight	Respond to assessments	Communication, language and play Food in first year of life Playgroup Young Readers
8 months	Family Health & Wellbeing Full physical assessment Oral health Developmental Assessment (PEDS/Brigance) Hearing risk factors Infant sleeping	Sleep Intervention Respond to assessments	Communication, language and play Injury prevention - Kidsafe Poison information Sunsmart Tooth Tips
12 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight & length	Respond to assessments	Communication, language and play Healthy eating for young toddlers Immunisation
18 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Oral health Weight, height, gait	Teeth cleaning Respond to assessments	Communication, language and play Injury prevention - Kidsafe Tooth tips
2 years	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Weight & height, gait	Promote a Healthy Weight Respond to assessments	Communication, language and play Kindergarten enrolment Young Readers
3.5 years	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Vision (MIST) Oral health Weight & height, gait	Promote a Healthy BMI Respond to assessments	Communication, language and play Healthy eating and play for kindergarten Immunisation Injury prevention - Kidsafe

* At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement *(including notifications under the Child, Youth and Families Act 2005)*

Maternal and Child Health Service

Child Outcomes

The Office for Children and Early Childhood Development has reviewed the evidence about the factors that make a real difference to children and young people and has identified 35 aspects of child health and wellbeing, learning and development and safety that are essential to our children's future. These aspects are known as the Outcomes for Children[1]. The following table identifies the outcomes, and the measurable indicators associated with each of the topics covered by the revised Maternal and Child Health Key Ages and Stages activity framework. It is important to note that the Maternal and Child Health service may play a key role, or a supportive role, in improving the identified outcomes for children and their families

Topic	Outcome	Indicator
SIDS	Optimal antenatal and infant development	Sudden Infant Death Syndrome (SIDS) rate for infants
Safe sleeping	Parent promotion of child health and development	Proportion of infants put on their back to sleep from birth
Smoking	Optimal antenatal and infant development	Proportion of children exposed to tobacco while in utero
		Proportion of women who used illicit drugs during pregnancy
	Healthy adult lifestyle	Proportion of children and young people exposed to tobacco smoke in the home
Immunisation	Free from preventable disease	Proportion of children who are fully vaccinated
Breastfeeding/Solids	Adequate nutrition	Proportion of infants breastfed
		Proportion of children and young people who eat the minimum recommended serves of fruit and vegetable every day
Post Natal Depression/ Sleep Intervention	Good parental mental health	Proportion of mothers with post-natal depression
		The proportion of children and young people who have parents with mental health difficulties
Injury prevention	Safe from injury and harm	Age specific death rates from injuries and poisoning
		Age specific hospitalisation rates from injuries and poisoning
Family violence	Free from child exposure to conflict or family violence	Proportion of mothers exposed to partner violence
		Proportion of family violence incidents witnessed by children and young people
Growth	Healthy weight	Proportion of children and young people who are overweight and obese
Oral Health	Healthy teeth and gums	Proportion of children and young people who brush their teeth twice a day
Literacy	Parent promotion of child health and development	Proportion of children who are read to by a family member every day
Vision	Early identification of and attention to child health needs	Proportion of parents concerned about their child's vision
Physical Assessment	Early identification of and attention to child health needs	Proportion of infants receiving a Maternal and Child Health Services home consultation
		Proportion of infants aged 0-1 month enrolled at Maternal and Child Health Services from birth notifications
		Hospital admissions for gastroenteritis in children under one year of age

March 2009

[1] Department of Human Services, The State of Victoria's Children Report 2006 (October 2006)

Maternal and Child Health Service: Promotion of Health and Development

Evidence based written health information, listed in the following table, will be distributed at each key age and stage consultation. This information is designed to support a facilitated discussion with parents about key health promotion messages. It will also ensure that consistent quality written information is provided to parents across the state.

Key Ages & Stages Visit	Health Promotion	Pamphlets
Home visit	SIDS safe sleeping: view infant sleep arrangements, checklist	Sids and kids safe sleeping
		Safe Sleeping Checklist
	Safety	Its not OK to shake babies
	Learning	Making the most of childhood: the importance of the early years
		Kids talk 75 ways to talk to children
	Breastfeeding	Go for your life: Successfully starting and maintaining breastfeeding
2 weeks	Communication, language and play	Communication, language and play bookmark
	Road safety	Choosing and using restraints. A guide for parents with children from birth to 16 years
	Injury prevention	Safe kids now - Babies from birth to crawling. Birth – 9months
4 weeks	Education for parents	Raising Children Network the Australian Parenting Website
	Women's Health	One in three women who ever had a baby wet themselves
	Post Natal Depression	Emotional health during pregnancy and early parenthood
8 weeks	Immunisation SIDS risk factors	No pamphlets for this visit
4 months	Food in first year of life	Food in the first year of life
		Why no sweet drinks for children
	Communication, language and play	Communication, language & play bookmark and information sheet
		Young Readers - Rhyme time: book & DVD
	Playgroup	Baby Play and Baby Playgroups
8 months	Poison information	Is your home poison proof?
	Communication, language and play	Communication, language and play bookmark and information sheet
	Sunsmart	Sunsmart The outside 5
	Tooth Tips	Tooth tips 0 – 12months
	Injury prevention	Safe kids now - Toddlers on the move 9 – 18 months
12 months	Healthy eating for young toddlers	Healthy eating and play for toddlers (1 - 2 years)
	Communication, language and play	Communication, language and play bookmark and information sheet
	Dental	Tooth tips thumb and finger sucking 1 - 2 years
18 months	Communication, language and play	Communication, language and play bookmark and information sheet
	Injury prevention	Safe kids now - Inquisitive and invincible 1.5 - 3.5 years
	Dental	Tooth tips dental visits 18 months - 6 years
	Playgroup	You can start a playgroup!
2 years	Kindergarten enrolment	Why should my child go to a kindergarten program?
		Enrol in a kindergarten program.
	Communication, language and play	Communication, language and play bookmark and information sheet
		Young Readers - book
3.5 years	Healthy eating and play for kindergarten	Healthy eating and play for kindergarten children (3 - 5 years)
	Injury prevention	Try it - you'll like it, vegetable and fruit for children
		Safe kids now - Pre-schoolers: independent adventures 3.5 - 5 years
	Starting kindergarten	Is your child 3 - 4 years?
	Communication, language and play	Communication, language and play bookmark and information sheet
	Immunisation	Starting primary school - your child must have a school entry

March 2009

Maternal and Child Health Service: Promotion of Health and Development

Pamphlet	Health information: source
It's not OK to shake babies	NAPCAN
SIDS and kids safe sleeping Safe sleeping checklist	SIDS and Kids
Making the most of childhood: the importance of the early years	Department of Education and Early Childhood Development
Is your home poison proof?	Victorian Government
National Immunisation Program Schedule Starting primary school - Your child must have a school entry immunisation certificate	Australian Government Department of Health and Ageing Department of Human Services
Kids talk 75 ways to encourage children Growth chart	Parent Kit from Department of Education and Early Childhood Development
Communication, language and play bookmarks and information sheets	Department of Education and Early Childhood Development
Choosing and using restraints: A guide for parents with children from birth to 16 years	Vic Roads
Safe kids now - From birth to crawling: Birth – 9 months Safe kids now - Toddlers on the Move 9 - 18 months Safe kids now - Inquisitive and Invincible 1.5 - 3.5 years Safe kids now - Preschoolers: Independent adventures 3.5 to 5 years	Kidsafe
Raising Children Network the Australian Parenting Website	Smart Population Foundation, Centre for Community Child Health and the Victorian Parenting Centre
One in three women who ever had a baby wet themselves	Victorian Continence Resource Centre
Emotional health during pregnancy and early parenthood	Beyond Blue
Successfully starting and maintaining breastfeeding Food in the first year of life Why no sweet drinks for children Healthy eating and play for toddlers 1 - 2 years Healthy eating and play for kindergarten children 3 - 5 years Try it - you'll like it, vegetables and fruit for children	Go for your life
Baby Play and Baby Playgroups Discover playgroup	Victorian Playgrouping Association
Sunsmart The Outside Five	Cancer Council Victoria
Tooth tips 0-12 months Tooth tips dental visits 18 months to 6 years Tooth tips thumb and finger sucking 1 - 2 years	Dental Health Services Victoria
Starting Kindergarten - Why should my child go to a kindergarten program? Enrol in a kindergarten program	Department of Education and Early Childhood Development
Is your child 3 - 4 years?	Department of Education and Early Childhood

Maternal and Child Health Service
Guidelines Context

Evidence base

Assessment of the physical health of infants and toddlers is an important component of the Maternal and Child Health nurses' role. The universal Key Ages and Stages (KAS) consultations provide opportunities for assessment, reassurance to parents or early intervention if findings indicate this course. Such opportunities for sequential health monitoring and surveillance outside the Maternal and Child Health (MCH) Service have been reduced in the past decade for many families by factors such as early discharge from maternity hospitals, non-universal take-up of the medical postnatal check at six weeks, and children born overseas without access to primary care services.

Guidance for revising the timing and content of physical health assessments within the universal MCH Service's Key Ages and Stages schedule, was provided by the National Health and Medical Research Council (NHMRC) publication, *Child Health Screening and Surveillance: A Critical Review of the Evidence (2002)*. This publication presents a detailed review of the evidence relating to screening a wide range of childhood diseases or conditions including physiological, biochemical or metabolic birth anomalies to language, height and weight.

For many conditions in childhood that can benefit from early detection and intervention, the age at which they appear can vary depending on children's individual rates of maturation. Some conditions, themselves, may fluctuate according to biological or environmental factors. For this reason there is a move away from the pass/fail concept of tests at single time-points towards a more flexible, longitudinal process of periodic assessment or "surveillance". Surveillance activities are broad in scope and, besides physical examination and growth measurement, include eliciting parent concerns, informal observations and the administration of tests and procedures. The NHMRC document confirms that such periodic assessment has value in identifying not only children with a condition requiring intervention, but also children at biological or environmental risk of acquiring the condition who could benefit from secondary prevention activities.

The document cautions that surveillance activities, although more flexible and longitudinal than one-off screening tests, should be conducted within an evidence-based framework and should adhere to the evidence-based principle that each such activity should lead to more benefit than harm. Furthermore, surveillance activities must be directly appropriate for the early detection of clearly-defined and specific problems which would not be expected to be reliably detected at a single point because they may develop or fluctuate over time. (Ref. NHMRC (2002), pp 221-224).

Maternal and Child Health Service Guidelines Context

Early detection program

NHMRC recommends that tests or procedures used for early detection of specific conditions should occur in the context of an adequate program or system that includes:

- clear written examination protocols
- appropriate training of examining staff
- clear pathways and/or guidelines for referral
- standardised follow-up procedures for children with abnormal findings on clinical examination
- clear pathways for communication between health professionals
- clear documentation that examination has occurred, its findings, and course of action taken in health centre and parent-held records.

Physical Health Assessment

Physical assessment activities for specific KAS consultations are organised in this schedule by body systems. This is the approach used in the recommended standard text, Engel J (2006) Pocket Guide to Pediatric Assessment, 5th Ed. Mosby, USA.

Nurses are advised to refer to this text for additional detail, the “what to” and “how to” assess each body system according to each child’s age. The highlighted clinical alerts in the text call attention to potentially serious findings and can guide the MCH nurses’ professional decision about subsequent action/s, for example, further monitoring, secondary prevention activities, referral for further or specialist assessment and/or intervention.

Use professional judgement to decide if additional activities are warranted.

This professional judgement will guide the MCH Nurse to determine whether there is need for-

- Additional consultations
- further assessment/ activities
- more flexible approach to service delivery
- follow-up – this may be by phone or appointment,
- referral to secondary services

Maternal and Child Health Service
Guidelines Definitions

• HEALTH

(World Health Organisation (WHO))

Health is state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

• BREASTFEEDING WHO

Exclusively breastfeeding

- Requires that the infant receive breast milk (including milk expressed or from wet nurse)
- Allows the infant to receive drops, syrups (vitamins, minerals, medicines)
- Does not allow the infant to receive anything else

Predominately breastfeeding

- Requires that the infant receive breast milk (including milk expressed or from wet nurse) as the predominant source of nourishment.
- Allows the infant to receive liquids (water, and water-based drinks, fruit, juice, oral rehydration solution), ritual fluids and drops or syrups (vitamins, minerals, medicines)
- Does not allow the infant to receive anything else (in particular non-human milk, food-based fluids)

Partially breastfeeding

- Requires that the infant receive breast milk and solid or semi-solid foods
- Allows the infant to receive any food or liquid including non-human milk

Note: Exclusive and predominant breastfeeding categories together constitute "full breastfeeding."

• COUNSELLING

The act of providing advice and guidance to a patient or the patients family (Mosby's Medical, Nursing and Allied Dictionary)

• REFERRAL

A process whereby a patient or the patient's family is introduced to additional health resources in the community. This may take the form of a written letter, a phone call, a fax, an email or use of the Child Health Record.

• RECOMMENDED CONTACT

When a family is encouraged to make contact with another agency, example G.P.
Not a referral.

Maternal and Child Health Service Definitons

Parents' Evaluation of Developmental Status (PEDS)

PEDS is an evidence-based developmental screening tool, used as an initial screen to detect and address developmental and behavioural problems in children o-8years.

PEDS consists of a ten item questionnaire that acknowledges parents as experts about their own child and begins a conversation that asks elicits parents, concerns.

Brigance

Brigance Screens are a series of age appropriate screening tests which can identify language, learning or global delays and intellectual giftedness.

Brigance screens are used as a secondary screen by the Maternal and Child Health Service. Secondary screening is completed when indicated by the Parents' Evaluation of Developmental Status (PEDS).

Maternal and Child Health Service
Correcting Age for Prematurity

Within the Maternal and Child Health Service correcting age for premature infants needs to be considered in the following context:

PEDS

Adjustment for prematurity-

- if child is born <37 weeks gestation
- all assessments under 2 years of age
- Thus in relation to Keys Age and Stage Visits – the adjustment will occur at the 2 weeks, 4 weeks, 8 weeks, 4 months, 8 months, 12 months, and 18 months.

Referring to the PEDS Score form, in the 18-23 months category 'social emotional' ceases to be a predictive (shaded) concern, while 'receptive language' becomes a predictive concern. Until that age group, the pattern of shaded (predictive) and unshaded (non-predictive) concerns remains the same (ie from birth to 17months) - so it's only at the cross-over from the 15-17 months into the 18 - 23 month categories that adjustment for prematurity makes a difference to the scoring and interpretation and PEDS pathway.

(Reference- Dr. Estelle Irving, Centre for Community Child Health)

BRIGANCE

Adjustment for prematurity-

- If the child is born at 36 weeks gestation or less
- When using the Infant and Toddler Screen only (birth-23months)
- Therefore all assessments under 2 years of age.

(Reference- Technical Report for the Brigance Screens, republished in Australia by Hawker Brownlow, 2007)

HIPS

There is no age correction for prematurity when assessing hips at each Key Age and Stage consultation.

(Reference- Department of Orthopaedics and Physiotherapy, The Royal Children's Hospital, DDH Education module DVD.)

GROWTH

It is recommended to correct age for prematurity for children born before 37 weeks and until the age of 2 years.

In practice, clinicians usually stop correcting for prematurity at 2 years of age. However, in research studies, this correction is often continued long term.

The Victorian Infant Collaborative Study explains the rational for ongoing correction:

Rickards AL, Kitchen WH, Doyle LW, Kelly EA. Correction of developmental and intelligence test scores for premature birth. Aust Paediatr J. 1989;25(3):127-129.

When reviewing growth or development, the trajectory is more important than a one off measurement. Very premature Victorian babies have significant catch-up growth between 0 and 2 but their weight measurements do not reach the 'normal' range until 8.

*Kan E, **Roberts G**, Anderson P J, Doyle L W and the Victorian Infant Collaborative Study Group. The association of growth impairment with neurodevelopmental outcome at eight years of age in very preterm children. Early Human Development. June 2008, Vol. 84, Issue 6, p 409-16*

So, to summarise, for most preterm children seen for clinical follow-up, correction can stopped by 2 years of age. For severely growth restricted kids, it may be advisable to continue until school age or until they make it into the normal range

Key Ages and Stages Consultation: HOME VISIT

FAMILY HEALTH & WELLBEING	**HISTORY** Note - Pregnancy and birth history - Family history (genetic disorders including metabolic disorders) **CHECK** - Newborn Screening Test (NBST) done - Child Health Record (CHR) hospital discharge summary for Vitamin K, HepB status and all components of neonatal physical examination completed - Family have received Raising Children Network DVD **OBSERVE** - Home environment for hygiene factors and safety, including infant sleep position and environment.
SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI) **SIDS**	The causes of SUDI can include- • Sudden Infant Death Syndrome • Other sudden death cause unknown (autopsy performed) • Other ill defined and unspecified casues of mortality (no autopsy performed) • Suffociation whilst sleeping (including asphyxiation by bedclothes and overlaying) • Explained: Child abuse/homicide, infection, metabolic disorders, genetic disorder, etc)
SAFE SLEEPING CHECKLIST	The requirement for Maternal & Child Health (MCH) nurses to sight the infant sleeping arrangements during their home visit to families was recommended by the Child Safety Commissioner in the *Tackling SIDS – a community responsibility* report released in November 2005 and endorsed by the Department of Education and Early Childhood Development. For the majority of families this will mean one check at the initial home visit. For families that are seen at home for additional consultations the infant sleeping arrangements need to be sighted and another checklist completed for each of these visits, until the baby reaches one year of age. Babies and young children spend a lot of their time sleeping. Some sleeping arrangements are not safe. They can increase the risk of SIDS or cause serious sleeping accidents. At all home visits, educate families about the key messages to help any baby sleep safely during their first year to reduce the risk of Sudden Infant Death Syndrome (SIDS). These key messages are- 1. Put baby on its back to sleep, from birth, never on its tummy or side. 2. Be careful that baby's head and face stay uncovered during sleep. 3. Keep baby smoke-free, before and after birth. 4. Provide a safe cot, safe mattress, safe bedding and safe sleeping place.It may also be opportunistic to include other family members or those involved in the care of the child in these discussions.

Key Ages and Stages Consultation: HOME VISIT

SAFE SLEEPING CHECKLIST (CONT)	**TASKS** **Home visit/s: Safe Sleeping checklist** MCH nurses will check the child's sleep environment with the parent or guardian using the 10 point checklist provided. Discussion with the parent without sighting the sleep environment is not sufficient. A diagram showing the features of an approved Australian Standard cot has been provided on the checklist. Tick boxes R where there is a close match between the child's sleeping environment and the corresponding statement. Cross boxes T to indicate the observed environment does not. Where the observed or reported environment does not match the corresponding statement (i.e. a cross has been placed in the box) the MCH nurse should discuss this with the family and encourage changes to the child's sleeping environment. A short note detailing the discussion should be included in the space provided on the checklist. Write N/A if not applicable, e.g. don't use or own a portacot. Return the checklist to the parent/guardian and advise them to keep it with their Child Health Record and leave a copy of the *SIDS AND KIDS SAFE SLEEPING* brochure with the parents. On the back of the checklist are a number of areas for discussion with parents. These points are also covered in the SIDS and Kids Safe Sleeping brochure. Particular focus is recommended on sleeping position, environment, cots, portacots, and co-sleeping.
FAMILY VIOLENCE	**OBSERVE** – Nurses will observe women, their children and the physical environment for signs of unsafe family life related to family violence. These signs include physical injury, emotional state, body language and developmental stages in babies. The ability of women to move freely around the home, to access all rooms and house contents will be noted. Whether mothers are free to meet with nurses on their own will be observed. **Refer to the MCH 4 week Key Age and Stage MCH consultation for specific questions to ask mother in relation to family violence.** **These four key questions can be asked at any MCH visit, if professional judgement warrants this.** Family Violence is a factor in more than half of the substantiated child protection cases and children are present at more than half of the police attendances for family violence. Family Violence is the leading contributor to preventable death, disability and illness in Victorian women aged 15 to 44. It is not uncommon for family violence to commence or intensify during pregnancy. Family violence is associated with increased rates of miscarriage, low birth rate, premature birth, foetal injury and foetal death. MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children.

Key Ages and Stages Consultation: HOME VISIT

SAFETY PLAN	To be completed if professional judgment warrants this
NUTRITION	Infant feeding: Elicit type, frequency, responses to feeding, urinary output (number of wet nappies) - Observe infant's: o appearance, colour, movements o state (deep or light sleep, drowsiness, active or quiet alertness, crying) o body tone, tissue turgor, respiratory effort. These observations do not require the infant to be woken up from sleep.
INTERVENTIONS	• Respond to concerns raised at this assessment • At all visits nurses will respond to parental concerns (e.g. Parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) **QUIT** (Refer to QUIT Training) **ASK** Have you smoked within the past 12 months? Are you currently smoking? Does your partner/another member of your household smoke? QUIT Intervention offered **OFFER** QUIT intervention Referral

Key Ages and Stages Consultation: HOME VISIT

INTERVENTIONS	**SAFE SLEEPING CHECKLIST** **When the sleep environment is not safe:** Discuss creating a safe environment with parents/guardians and the steps required. Your role is to provide support, information and advice to encourage families to adopt safe sleeping practices for their children. A consistent message from all health professionals and regular reminders of safe sleeping practices and the risks of SIDS is recommended. **When you are concerned about the safety of the child:** For some families, their difficulty in providing a safe sleeping environment for their child may result from a broader context that may place the child at risk. If you are concerned about the safety of a child, contact the local Child First, family service or Child Protection team. MCH nurses are mandated to report when they suspect the presence of physical or sexual abuse. Refer to the Maternal and Child Health Service Program Resource Guide details potential indicators of abuse and neglect. If you are unsure of which office to ring, or your call is after hours, telephone the Child Protection Crisis Line on **13 12 78**.
REFER	**Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options** SIDS and Kids Victoria employ trained counsellors if parents have particular concerns. **www.sidsandkids.org** Tel **1300 308 307** **RAISING CHILDREN NETWORK DVD** Ensure family have received this DVD If DVD not received – provide contact details for family to order this. **rcdvd@raisingchildren.net.au** or phone **02 90075848**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH framework – Promotion of Health and Development for the home visit Key Ages and Stages visit. * Note each handout provides key messages that need to be discussed

Key Ages and Stages Consultation: HOME VISIT

DATA COLLECTION		
	Family Health & Wellbeing reviewed	Yes/No
	PREGNANCY, BIRTH, FAMILY HISTORY	Yes/No
	includes AABR results	
	Child of Aboriginal or Torres Strait Islander origin	
	Not Aboriginal or Torres Strait Islander	
	Aboriginal	
	Torres Strait Islander	
	Aboriginal or Torres Strait Islander	
	MOTHER	
	Mother's date of birth	
	Mother's country of birth	
	If born elsewhere, when did you arrive in Australia?	
	Do you have a health care card?	
	FEEDING ON DISCHARGE	
	Breastfeeding Status:	
	(Exclusively breastfeeding, Predominately breastfeeding Partially breastfeeding, Artificially feeding)	
	IMMUNISATION	
	Discussed/ reviewed	Yes/No
	SIDS	
	Safe Sleeping Checklist completed	Yes/No
	QUIT	
	Have you smoked within the past 12 months?	Yes/No
	Are you currently smoking?	Yes/No
	Does your partner/another member of your household smoke?	Yes/No
	QUIT Intervention offered	Yes/No
	Referral	Yes/No
	FAMILY VIOLENCE ASSESSMENT	
	Family violence assessment completed	Yes/No
	Safety plan completed	Yes/No
	Referral	Yes/No
	RAISING CHILDREN NETWORK	
	Have parents received the DVD?	Yes/No
	Information given regarding ordering DVD	Yes/No

Key Ages and Stages Consultation: HOME VISIT

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **Recommended contact given** Yes/No When a family is encouraged to make contact with another agency (eg G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

Key Ages and Stages Consultation: 2 WEEKS

PEDS	• Question 1- complete • Note – this can be a conversation • Rephrase - "do you have any concerns about your child's learning, development and behaviour."
BRIGANCE	• Not used as secondary screen until 4 months of age
FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	Maternal and Child Health nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the 4 week MCH Key Ages and Stages consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH visit if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	• Weight, height and head circumference
NUTRITION	• Review feeding- type, frequency, responses to feedings, urine output

Key Ages and Stages Consultation: 2 WEEKS

PHYSICAL ASSESSMENT **Includes 2 week developmental assessment**	**Skin** Assess: - Odour, texture, turgor, colour, marks, rashes, lesions, pigmentation, temperature, oedema - Symmetry of creases - Nails: colour, shape, condition - Hair (head and body): distribution, colour, texture, amount, quality, tufts **Head and Neck** o Head:, swellings, hair texture, - Observe head shape, symmetry - Palpate suture lines, fontanelles - Note degree of head lag when pulled to sit, head control in ventral suspension; position of head in prone position; move head and neck through full range of motion, - Inspect neck for swelling, webbing, skin folds, vein distension **Ears** - Check momentary response or startle reflex to voice, bell - External ear: inspect structure, markings, protrusion, - External ear canal: inspect hygiene, discharge, excoriation - Pull gently on auricle for tenderness - Palpate mastoid for tenderness **Hearing** Complete "At risk" hearing screen **Eyes** Observe: - External eyes: position and placement - Eyelids: slant, placement, colour, swelling, discharge, lesions - Eyelashes: distribution, condition - Eyebrows: symmetry, pattern of hair growth - Conjunctivae and sclerae: colour, appearance - Pupils and Irises: colour, shape, inflammation, pupil size, equality, response to light - Visual behaviour: Eyes briefly fixate and follow at 20cm Eyes: clarity, brightness, membrane colour **Face, nose, mouth** Observe: - Facial features, expression around eyes and mouth, symmetry of nasolabial folds - Nose: size, shape, symmetry, - Nares: flaring, discharge, excoriation, odour - Nasal cavity: Inspect o mucosa - integrity, colour, consistency; o septum – position

Key Ages and Stages Consultation: 2 WEEKS

PHYSICAL ASSESSMENT (continued) **Includes 2 week developmental assessment**	- Mouth: Inspect o Lips: colour, symmetry, moisture, swelling, sores, fissures o Gums and palate: moisture, colour, intactness, bleeding o Tongue: movement, moisture, colour, intactness, bleeding **Thorax and Lungs** Assess: - Stridor, grunting, hoarseness, snoring, wheezing, cough Observe: - Flaring of external nares - Nail beds: colour, clubbing - Trunk: colour - Thorax: configuration, symmetry, abnormalities - Breast enlargement - Respiratory regulatory, abdominal breathing; costal retraction. **Cardiovascular System** Observe: - Body posture - Cyanosis, mottling, oedema Respiratory difficulty, nail bed anomalies, asymmetrical or abnormal chest movements **Abdomen** Inspect: - Abdomen: contour, skin colour & condition, movement, - Umbilicus: colour, discharge, odour, inflammation, herniation Palpate: - Muscle tone, turgor - For inguinal/femoral hernia Inspect: - Anal area: marks, fissures, haemorrhoids, rectal prolapse, polyps, skin tags - Buttocks and thighs: skin colour, marks, rashes, symmetry of skin folds. **Reproductive System** Inspect (female): - Labia: size, colour, skin integrity, adhesions, fusion, abnormalities - Clitoral size - Urethral and vaginal openings: oedema, redness, discharge. Inspect (male): - Penis: size, colour, integrity, urinary meatus: shape, placement - Scrotum: colour, size, symmetry, oedema. - Palpate testes

Key Ages and Stages Consultation: 2 WEEKS

PHYSICAL ASSESSMENT (continued)

Includes 2 week developmental assessment

Musculo-skeletal System

Observe:

- Head control: in ventral suspension, when pulled to sit
- (Cross reference with Head and Neck above)
- Spine: curve, mobility, dimpling, hair tufts, symmetry of shoulders and hips
- Thigh fold symmetry in prone position
- Upper extremities: mobility, shape, palmer creases
- Lower extremities: mobility, length, shape

Hips

- Assess for hip stability Ortolani/Barlow tests
- Test for asymmetry: skin creases, shortening of limb, limitation of abduction
- Perform general examination: look for packaging disorders such as plagiocephaly, torticollis and foot deformities.

Nervous System

Observe:

- Neurologic system: alertness, responsiveness
- Infant's response to mother and the examination: hyper- or hypo activity, irritability, restlessness, withdrawal

Assess motor function:

- Observe for abnormalities that may influence motor functioning, specifically, size and shape of head, inspect spine for sacs and tufts of hair.
- Muscle strength (push hands against soles of feet)
- Flaccidity or spasticity of joints when put through a range of motion.

Assess strength/weakness/presence/absence of primitive reflexes:

- Symmetrical crawling movements with arms and legs in prone position, hips high
- Placing, stepping, Babinsky's sign
- Tonic neck
- Moro/startle
- Palmer grasp
- Rooting/sucking, tongue extrusion
- Asymmetrical tonic neck
- Eyes blink, pupils react to light

Key Ages and Stages Consultation: 2 WEEKS

INTERVENTIONS	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. Parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005). • Follow up on any issues raised from the Safe Sleeping Checklist completed previously. • For families that are seen at home for additional consultations the infant sleeping arrangements need to be sighted and checklist completed for each of these visits, until the baby reaches one year of age.
SUDI & SAFE SLEEPING CHECKLIST	**When you are concerned about the safety of the child:** If you are concerned about the safety of a child, contact the local Child First, family service or Child Protection team. MCH nurses are mandated to report when they suspect the presence of physical or sexual abuse. Refer to the Maternal and Child Health Program Resource Guide for details potential indicators of abuse and neglect. If you are unsure of which office to ring, or your call is after hours, telephone the Child Protection Crisis Line on **13 12 78**. **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 2 week Key Ages and Stages consultation. * Note each handout provides key messages that need to be discussed **IMMUNISATION** • Introduce immunisation and national schedule • Refer to booklet 'Understanding Childhood immunisation' *'Australian Government Department of Health and Aging'* *Located in front of Child Health Record.*

Key Ages and Stages Consultation: 2 WEEKS

DATA COLLECTION	
	BREASTFEEDING STATUS Feeding at 2 weeks *(Exclusively breastfeeding, Predominantly breastfeeding Partially breastfeeding, Artificially feeding)*
	SUDI/ Safe Sleeping Checklist Safe Sleeping Checklist completed/followup Yes/No
	QUIT Intervention offered Yes/No Referral yes/no
	FAMILY VIOLENCE ASSESSMENT Family violence assessment completed Yes/No Safety plan completed Yes/No Referral yes/no
	FULL PHYSICAL ASSESSMENT Full physical assessment completed Yes/No (includes developmental assessment)
	HIPS *Hips assessed Yes/No* *Referral Yes/No*
	GROWTH Weight Length Head circumference
	HEARING RISK ASSESSMENT Hearing risk Assessment completed Yes/No No risk factor identified Yes/No Referral Yes/No (Refer VIHSP Hearing Loss Risk Factor Screening Assessment (2weeks) in Child Health Record book.)

Key Ages and Stages Consultation: 2 WEEKS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **Recommended contact given** Yes/No Recommended contact agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral
REFER TO	**MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

Key Ages and Stages Consultation: 4 WEEKS

PEDS	• Question 1- complete • Note – this can be a conversation • Rephrase - "do you have any concerns about your child's learning, development and behaviour."
BRIGANCE	• Not used as secondary screen until 4 months of age
FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	Recent studies of maternal morbidity have consistently found that women will give information about their health and wellbeing problems if they are asked, but they often do not voluntarily report these to relevant health professional *(Bick& MacAthur1995,Brown & Lumley 1998, Glazener et al1995, MacArthur et al 1991)* At this 4 week MCH Key Age and Stage Consultation The Maternal and Child Health nurse should ask mothers if they have experienced any of the following health problems which many women experience after childbirth

Key Ages and Stages Consultation: 4 WEEKS

MATERNAL HEALTH AND WELLBEING CHECK

Health problem	Reference/Referral
Headache	Refer
Backache	Refer
Breast/Nipple problems	Food for Health, Dietary Guidelines for Children and Adolescents in Australia, Breastfeeding in Australia(NHMRC, 2003)
Bowel problems / constipation, haemorrhoids, loss of control	One in Three brochure and refer as necessary
Urinary problems / stress incontinence, UTI, voiding problems	One in Three brochure and refer as necessary
If a urinary problem has been identified Continence Victoria recommends the following secondary screen questions are asked.	
Do you have to rush to get to the toilet?	
Do you leak before you get to the toilet?	Yes response to any of these questions- requires referral to other agencies. i.e GP, obstetrician, physiotherapist
Do you leak urine with coughing, laughing or sneezing?	
Do you pass urine more than six times per day?	
Do you get up more than once overnight to pass urine?	
Bowel accidents causing you to leak before getting to the toilet?	One in Three brochure and refer as necessary
Abnormal Bleeding	refer
Abdominal wound problems	refer
Perineal discomfort/ pain,	refer

Key Ages and Stages Consultation: 4 WEEKS

MATERNAL HEALTH AND WELLBEING CHECK (continued)

Emotional Health

MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children.

Ask all mothers if they have experienced any of the following:

Past history of depression /anxiety
Anxiety/depression
Fatigue / loss of energy
Insomnia/ hypersomnia
Significant increases or decreases in appetite

If the mother answers yes to any of the above questions discuss information in ***Emotional health during pregnancy and early parenthood,*** **Beyond Blue.**
This includes information in regard to the use of the Edinburgh Postnatal Depression Scale and support/ referral options.

FAMILY VIOLENCE

Note – although noted to be done at this 4 week consultation, these questions can be asked at any MCH consultation if professional judgement warrants.

OBSERVE

- Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence.
- These signs include physical injury, emotional state, body language and developmental stages in babies.
- The ability of the mother to move freely around the home, to access all rooms and house contents .
- Whether the mother is free to meet with nurses on their own.

Nurses will use their knowledge of family violence risk assessment framework to assess safety. This framework relies on the women's own level of fear, the evidence based risk factors and the professional judgement of nurses.

ASK

Nurses will ask in a conversational style, about family safety. Suggested questions include:

Are you in anyway worried about the safety of yourself or your children?	Yes/No
Are you afraid of someone in your family?	Yes/No
Has anyone in your household ever pushed, hit. kicked, punched or otherwise hurt you?	Yes/No
Would you like help with this now?	Yes/No

Key Ages and Stages Consultation: 4 WEEKS

GROWTH	• Weight, height and head circumference
NUTRITION	• Review feeding- type, frequency, responses to feedings, urine output
HIPS	• Assess for hip stability Ortolani/Barlow tests • Test for asymmetry: skin creases, shortening of limb • Perform general examination: look for packaging disorders such as plagiocephaly, torticollis and foot deformities
INTERVENTIONS	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. Parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) • Family Violence- Safety Plan
SUDI & SAFE SLEEPING CHECKLIST	• Follow up on any issues raised from the Safe Sleeping Checklist completed previously. • For families that are seen at home for additional consultations the infant sleeping arrangements need to be sighted and checklist completed for each of these visits, until the baby reaches one year of age. **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 4 week Key Ages and Stages visit. * Note each handout provides key messages that need to be discussed **IMMUNISATION** • Introduce immunisation and national schedule • Discuss 2 month immunisations. • Refer to booklet 'Understanding Childhood immunisation' *'Australian Government Department of Health and Aging'* *Located in front of Child Health Record.* • Refer to local agencies that provide immunisations

Key Ages and Stages Consultation: 4 WEEKS

DATA COLLECTION	**Family Health & Wellbeing** reviewed	Yes/No
	BREASTFEEDING STATUS	
	Feeding at 4 weeks *(Exclusively breastfeeding, Predominantly breastfeeding Partially breastfeeding, Artificially feeding)*	
	MATERNAL HEALTH & WELLBEING ASSESSMENT	
	Completed	Yes/No
	referral	Yes/No
	Edinburgh Postnatal Depression Scale completed	Yes/No
	EPDS score	(Score = 0-30)
	Referral	Yes/No
	IMMUNISATION	
	Discussed /reviewed	Yes/No
	SUDI/ SAFE SLEEPING CHECKLIST	
	Completed/followup	Yes/No
	QUIT	
	QUIT Intervention offered	Yes/No
	Referral	Yes/No
	FAMILY VIOLENCE ASSESSMENT	
	Family violence assessment completed	Yes/No
	Safety plan completed	Yes/No
	Referral	Yes/No
	GROWTH	
	Weight Length Head circumference	
	HIPS	
	Hips assessed	Yes/No
	Referral	Yes/No

Key Ages and Stages Consultation: 4 WEEKS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **Recommended contact given** Yes/No Recommended contact agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral
REFER TO	**MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

Key Ages and Stages Consultation: 8 WEEKS

PEDS	**Question 1-** Please list any concerns about your child's learning, development and behaviour. Note this can be re-phrased to "do you have any concern about your child's learning, development and behaviour."
BRIGANCE	• Not used as secondary screen until 4 months of age
FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	Maternal and Child Health nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH 4 week Key Ages and Stages consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	Weight, height and head circumference
NUTRITION	Feeding: Elicit type, frequency, responses to feeding, output

Key Ages and Stages Consultation: 8 WEEKS

PHYSICAL ASSESSMENT **INCLUDES DEVELOPMENTAL ASSESSMENT**	**Skin** Assess: - Odour, texture, turgor, colour, marks, rashes, lesions, pigmentation, temperature, oedema - Symmetry of creases - Nails: colour, shape, condition - Hair (head and body): distribution, colour, texture, amount, quality, tufts **Head and Neck** - Observe head shape, symmetry - Palpate suture lines, fontanelles - Note degree of head lag when pulled to sit, head control in ventral suspension; position of head in prone position; move head and neck through full range of motion, - Inspect neck for swelling, webbing, skin folds, vein distension **Ears** - Hearing: check vocalisations, response to rattle, mother's voice - External ear: inspect structure, markings, protrusion, - External ear canal: inspect hygiene, discharge, excoriation - Pull gently on auricle for tenderness - Palpate mastoid for tenderness **Eyes** Observe: - Eyes: clarity, brightness, membrane colour - External eyes: position and placement - Eyelids: slant, placement, colour, swelling, discharge, lesions - Eyelashes: distribution, condition - Eyebrows: symmetry, pattern of hair growth - Conjunctivae and sclera: colour, appearance - Pupils and Irises: colour, shape, inflammation, pupil size, equality, response to light Visual behaviour: Observe eyes follow mother's face, may follow object from side to side, may turn to light **Face, nose, mouth** Observe: - Facial features, expression around eyes and mouth, symmetry of nasolabial folds - Nose: size, shape, symmetry, - Nares: flaring, discharge, excoriation, odour - Nasal cavity: Inspect o mucosa - integrity, colour, consistency; o septum – position

Key Ages and Stages Consultation: 8 WEEKS

PHYSICAL ASSESSMENT (continued)
 	
INCLUDES DEVELOPMENTAL ASSESSMENT
	- Mouth: Inspect
	  o Lips: colour, symmetry, moisture, swelling, sores, fissures
	  o Gums and palate: moisture, colour, intactness, bleeding, swellings, nodules
	  o Tongue: movement, moisture, colour, intactness, bleeding
	- Smiling
	
	Thorax and Lungs
	Assess:
	- Stridor, grunting, hoarseness, snoring, wheezing, cough
	Observe:
	- Flaring of external nares
	- Nail beds: colour, clubbing
	- Trunk: colour
	- Thorax: configuration, symmetry, abnormalities
	- Breast enlargement
	- Respiratory regulatory, abdominal breathing; costal retraction.
	
	Cardiovascular System
	Observe:
	- Body posture
	- Cyanosis, mottling, oedema
	Respiratory difficulty, nail bed anomalies, asymmetrical or abnormal chest movements
	
	Abdomen
	Inspect:
	- Abdomen: contour, skin colour & condition, movement,
	- Umbilicus: colour, discharge, odour, inflammation, herniation
	
	Palpate:
	- Muscle tone, turgor
	- For inguinal/femoral hernia
	
	Inspect:
	- Anal area: marks, fissures, haemorrhoids, rectal prolapse, polyps, skin tags
	- Buttocks and thighs: skin colour, marks, rashes, symmetry of skin folds.
	
	Reproductive System
	Inspect (female):
	- Labia: size, colour, skin integrity, adhesions, fusion, abnormalities
	- Clitoral size
	- Urethral and vaginal openings: oedema, redness, discharge.
	Inspect (male):
	- Penis: size, colour, integrity, urinary meatus: shape, placement
	- Scrotum: colour, size, symmetry, oedema.
	- Palpate testes

Key Ages and Stages Consultation: 8 WEEKS

PHYSICAL ASSESSMENT (continued) **Includes 2 week developmental assessment**	**Musculo-skeletal System** Observe: - Head control: in ventral suspension, when pulled to sit - Head control: in ventral suspension, prone position, and when pulled to sit - Supine position: head turns to side, limbs move actively and equally - Muscle strength: when hands pushed against soles of feet, - hands together at times Hips - Assess for hip stability Ortolani/Barlow tests - Test for asymmetry: skin creases, shortening of limb, limitation of abduction - Perform general examination: look for packaging disorders such as plagiocephaly, torticollis and foot deformities. **Nervous System** Observe: - Infant's response to mother and the examination: hyper- or hypo-activity, irritability, restlessness, withdrawal, smiling responsively, spontaneously Assess: - Motor function - Reflexes, Assess strength/weakness/presence/absence of: o Symmetrical crawling movements with arms and legs in prone position o Tonic neck o Moro/startle o Eyes blink (dazzle) in response to light o Rooting/sucking, tongue extrusion o Palmar grasp Placing, stepping, Babinsky's sign
	IMMUNISATION • Discuss 2 month immunisations • Refer to booklet 'Understanding Childhood immunisation' '*Australian Government Department of Health and Aging*' *Located in front of Child Health Record.* • Refer to local agencies that provide immunisations

Key Ages and Stages Consultation: 8 WEEKS

INTERVENTIONS

SUDI & SAFE SLEEPING CHECKLIST

- Respond to concerns raised at this and previous consultations
- This 8 week Key Ages and Stages consultation provides another opportunity to continue SIDS prevention education.
  Particular focus is recommended on what happens when baby starts rolling, importance of not having bumpers, toys, doonas, pillows in the cot, what to do when travelling or baby is staying elsewhere, importance of grandparents and any other carers being aware of SIDS risk factors and general safe sleeping practices. Refer to back of checklist and SIDS and Kids Safe Sleeping brochure for more information.
- If the consultation occurs in the home, then a further check of the child's sleeping arrangements should be undertaken.

When you are concerned about the safety of the child:

If you are concerned about the safety of a child, contact the local Child First, family service or Child Protection team. MCH nurses are mandated to report when they suspect the presence of physical or sexual abuse. The Maternal and Child Health Program Resource Guide details potential indicators of abuse and neglect. If you are unsure of which office to ring, or your call is after hours, telephone the Child Protection Crisis Line on **13 12 78**.

Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options

DATA COLLECTION

Family Health & Wellbeing reviewed Yes/No

IMMUNISATION

Discussed /reviewed Yes/No

SUDI/ SAFE SLEEPING CHECKLIST

Safe Sleeping checklist completed/followup Yes/No

QUIT

QUIT Intervention offered Yes/No
Referral

FAMILY VIOLENCE ASSESSMENT

Family violence assessment completed Yes/No
Safety plan completed Yes/No
Referral Yes/No

Key Ages and Stages Consultation: 8 WEEKS

DATA COLLECTION (continued)	**FULL PHYSICAL ASSESSMENT** Full physical assessment completed (Includes Developmental assessment) Yes/No **HIPS** Hips assessed Yes/No Referral Yes/No **GROWTH** Weight, Length, Head circumference
REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**Refer to MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

Key Ages and Stages Consultation: 4 MONTHS

PEDS	• Complete PEDS Response • Complete PEDS Score & Interpretation forms • Refer to MCH PEDS tip sheet for guidance • Refer to PEDS administration and scoring guides PATH A This is a referral pathway. It may be useful to do a secondary screen and use the results to support the referral. Use professional judgement to decide this. PATH B Needs secondary screen This secondary screen will sort out which children need a referral and which are developing normally. It offers parents counselling in the areas of their concern PATH C Counselling and monitor progress Counselling means talking with parent about their concerns, offering advice or strategies for addressing these concerns, Note- if the counselling is unsuccessful and concerns remain, and then the next step of the pathway is to do a secondary screen. PATH D parental difficulties communication, will require secondary screen PATH E reassurance and routine monitoring
BRIGANCE	• Used as secondary screen when indicated by PEDS • Refer to Brigance Technical Report and Screens • Refer to MCH Brigance Training Handbook

Key Ages and Stages Consultation: 4 MONTHS

FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH 4 week Key Ages and Stages consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	Weight
NUTRITION	Review feeding - type, frequency, responses to feedings
HIPS	• Assess for hip stability Ortolani/Barlow tests *Note- after 3 months of age the Ortalani and the Barlow tests may be unreliable, hence assessment at 4 months must include-* • Test for asymmetry: skin creases, shortening of limb, limitation of abduction • Perform general examination: look for packaging disorders such as plagiocephaly, torticollis and foot deformities.

Key Ages and Stages Consultation: 4 MONTHS

INTERVENTIONS **SUDI & SAFE SLEEPING CHECKLIST**	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) • Follow up on any issues raised from the Safe Sleeping Checklist completed previously. • For families that are seen at home for additional consultations the infant sleeping arrangements need to be sighted and another checklist completed for each of these visits, until the baby reaches one year of age. **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 4 month Key Ages and Stages consultation. * Note each handout provides key messages that need to be discussed **YOUNG READERS** • Young Readers Program- Rhyme Time booklet and DVD **IMMUNISATIONS** • Discuss progress of immunisations. • Refer to booklet 'Understanding Childhood immunisation' *'Australian Government Department of Health and Aging'* *Located in the front of Child Health Record* • Refer to local agencies that provide immunisations if needed.

Key Ages and Stages Consultation: 4 MONTHS

DATA COLLECTION	**Family Health & Wellbeing** reviewed	Yes/No
	FEEDING	
	Feeding at 3months	
	Feeding at 4 months	
	(Exclusively breastfeeding, Predominantly breastfeeding, Partially breastfeeding Artificially feeding)	
	QUIT	
	QUIT Intervention offered	Yes/No
	Referral	
	FAMILY VIOLENCE ASSESSMENT	
	Family violence assessment completed	Yes/No
	Safety plan completed	Yes/No
	Referral	Yes/No
	DEVELOPMENTAL ASSESSMENT	
	PEDS	
	PEDS assessment completed	Yes/No
	Path:	A B C D E
	Please indicate any concerns identified	
	(Global/Cognitive, Expressive Language and Articulation, Receptive Language, Fine Motor, Gross Motor, Behaviour, Social-emotional, Self-help, School, Other)	
	BRIGANCE	
	Brigance assessment completed	Yes/No
	Referral	Yes/No
	GROWTH	
	Weight	
	HIPS	
	assessed	Yes/No
	Referral	Yes/No
	YOUNG READERS PROGRAM	
	Gift voucher or book bag given	Yes/No

Key Ages and Stages Consultation: 4 MONTHS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**Refer to MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

MCH PEDS TIPSHEET:
Key Ages and Stages 4 MONTHS

	KEY AGE & STAGE 4 MONTHS
QUESTION 1 **Please list any concerns about your child's learning, development and behaviour.** • Opens discussion in all areas	**QUESTION 6** **Do you have any concerns about how your child behaves?** • follows adults movement with visual field • following and converging defensive blink
QUESTION 2 **Do you have any concerns about how your child talks and makes speech sounds?** • responds to sounds • turns eyes and head toward sound • eye contact turn talking with carer • vocalises using single vowel sounds two or more different sounds	**QUESTION 7** **Do you have any concerns about how your child gets along with others?** • Reacts to familiar situations – coos, smiles, excited movements
QUESTION 3 **Do you have any concerns about how your child understands what you say?** • Reacts to familiar situations, voices	**QUESTION 8** **Do you have any concerns about how your child is learning to do things for himself/herself?** • Pulled to sit, no head lag • Head held erect and steady for a few seconds • Lifting head and chest well up
QUESTION 4 **Do you have any concerns about how your child uses his or her hands and fingers to do things?** • holds a rattle for a few moments with meaningful grasp • watches own hand movements in midline • hands open loosely	**QUESTION 9** **Do you have any concerns about how your child is learning preschool or school skills?** • opportunity to discuss- reading, talking, interacting and play
QUESTION 5 **Do you have any concerns about how your child uses his or her arms and legs?** • waves arms and legs symmetrically • holds head midline	**QUESTION 10** **Please list any other concerns**

THIS TIPSHEET- has been compiled to offer the MCH nurse some prompts, if necessary,for further discussion with parents, when completing the PEDS screen.
This has been written in context to the developmental age on the tip sheet, and is
To be used as a guide only, not exclusive.

Pocket Guide to Pediatric Assessment, 5th Ed. Engel J (2006) Mosby, USA.
Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education.
Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress

Key Ages and Stages Consultation: 8 MONTHS

PEDS	• Complete PEDS Response • Complete PEDS Score & Interpretation forms • Refer to MCH PEDS tip sheet for guidance • Refer to PEDS administration and scoring guides PATH A This is a referral pathway. It may be useful to do a secondary screen and use the results to support the referral. Use professional judgement to decide this. PATH B Needs secondary screen This secondary screen will sort out which children need a referral and which are developing normally. It offers parents counselling in the areas of their concern PATH C Counselling and monitor progress Counselling means talking with parent about their concerns, offering advice or strategies for addressing these concerns, Note- if the counselling is unsuccessful and concerns remain, and then the next step of the pathway is to do a secondary screen. PATH D parental difficulties communication, will require secondary screen PATH E reassurance and routine monitoring
BRIGANCE	• Used as secondary screen when indicated by PEDS • Refer to Brigance Technical Report and Screens • Refer to MCH Brigance Training Handbook

Key Ages and Stages Consultation: 8 MONTHS

FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH 4 week Key Ages and Stages consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	• Weight, length & head circumference
NUTRITION	• Feeding: Elicit type, frequency • Solids introduction- progress

Key Ages and Stages Consultation: 8 MONTHS

PHYSICAL ASSESSMENT	**Skin** Assess: - Odour, texture, turgor, colour, marks, rashes, lesions, pigmentation, temperature, oedema - Symmetry of creases - Nails: colour, shape, condition - Hair (head and body): distribution, colour, texture, amount, quality, tufts **Head and Neck** - Observe head shape, symmetry - Palpate suture lines, fontanelles - Note degree of head lag when pulled to sit, head control in ventral suspension; position of head in prone position; move head and neck through full range of motion, - Inspect neck for swelling, webbing, skin folds, vein distension **Ears** Examine: - External ear canal: presence/absence of wax, discharge, excoriation - Pull gently on auricle for tenderness - Palpate mastoid for tenderness Complete: - Hearing Loss Risk Factor Screen **(hearing risk factors)** **Eyes** Observe: - clarity, brightness, membrane colour - Eyelids: colour, swelling, discharge, lesions - Eyelashes: distribution, condition - Eyebrows: symmetry, pattern of hair growth - Conjunctivae: colour, appearance - Pupils and Irises: colour, shape, inflammation, pupil size, equality, response to light Visual behaviour: fixation, following, nystagmus **Face, nose, mouth** Observe: - Facial features, expression around eyes and mouth, symmetry of nasolabial folds - Nose: size, shape, symmetry, - Nares: flaring, discharge, excoriation, odour o Nasal cavity: Inspect mucosa - integrity, colour, consistency; o septum – position

Key Ages and Stages Consultation: 8 MONTHS

PHYSICAL ASSESSMENT (continued)	**Mouth** – Inspect o Lips: colour, symmetry, moisture, swelling, sores, fissures o Gums and palate: moisture, colour, intactness, bleeding, swellings, nodules o Tongue: movement, moisture, colour, intactness, bleeding **Thorax and Lungs** Assess: - Stridor, grunting, hoarseness, snoring, wheezing, cough Observe: - Flaring of external nares - Nail beds: colour, clubbing - Trunk: colour - Thorax: configuration, symmetry, abnormalities - Breast enlargement - Respiratory regulatory, abdominal breathing; costal retraction. **Cardiovascular System** Observe: - Body posture - Cyanosis, mottling, oedema - Respiratory difficulty, nail bed anomalies, asymmetrical or abnormal chest movements **Abdomen** Inspect: - Abdomen: contour, skin colour & condition, movement, - Umbilicus: colour, discharge, odour, inflammation, herniation Palpate: - Muscle tone, turgor - For inguinal/femoral hernia Inspect: - Anal area: marks, fissures, haemorrhoids, rectal prolapse, polyps, skin tags - Buttocks and thighs: skin colour, marks, rashes, symmetry of skin folds. **Reproductive System** Inspect (female): - Labia: size, colour, skin integrity, adhesions, fusion, abnormalities - Clitoral size - Urethral and vaginal openings: oedema, redness, discharge. Inspect (male): - Penis: size, colour, integrity, urinary meatus: shape, placement - Scrotum: colour, size, symmetry, oedema. - Palpate testes

Key Ages and Stages Consultation: 8 MONTHS

PHYSICAL ASSESSMENT (continued)	**Musculo-skeletal System** Observe: - Head control - Symmetry and movement of limbs when in prone, supine and sitting. - Muscle strength: degree of push-away pressure against surface when held to stand, hand grasp when holding objects or hands **Hips** - Test for asymmetry- Asymmetry of skin creases Galeazzi test Limitation of abduction of the hip - General examination **Nervous System** Observe: • Infant's response to mother and the examination: hyper- or hypo-activity, irritability, restlessness, withdrawal, smiling/vocalising responsively, spontaneously Assess: • Motor function, flaccidity, spasticity • Residual reflexes: • Eye blink (dazzle) in response to light • Babinsky's sign
ORAL HEALTH	• Dentition: presence/absence, colour, shape, marks if present • Check- Lift the lip, Look, Locate • Refer to DHSV handout Tooth Tips 0-12months
INTERVENTIONS	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. Parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) **SUDI & SAFE SLEEPING CHECKLIST** • Follow up on any concerns raised from the Safe Sleeping Checklist completed previously. • For families that are seen at home for additional consultations the infant sleeping arrangements need to be sighted and checklist completed for each of these visits, until the baby reaches one year of age. • Dentition: presence/absence, colour, shape, marks if present • Check- Lift the lip, Look, Locate • Refer to DHSV handout Tooth Tips 0-12months **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**

Key Ages and Stages Consultation: 8 MONTHS

SLEEP INTERVENTION	
	Obtain a detailed history Ask a range of open-ended questions to elicit further detail. Questions could include, but are not limited to: How often does your child wake? How well does your child sleep? What is the child's bedtime routine? Number and duration of daytime naps? Sleeping arrangements? What do you/others do when your child wakes? Which strategies have you tried? How long did you try these strategies? How do family members feel about the waking/settling (include extended family). Any recent changes to routine? Sibling waking/settling? What other advice have you been given and/or tried? **Determine parent goals for the waking/settling difficulty** **Provide information/handouts on the following:** • normal sleep cycles • habits that reinforce waking/settling • need for a regular daytime nap • good bedtime routine • put the child to bed awake. **Discuss the range of evidence based sleep interventions** Behavioural interventions are clearly the most effective evidence based strategies to reduce sleep difficulties. Moreover, there is no evidence to suggest that behavioural interventions cause psychological or physical harm to the child. Behavioural interventions include: • Positive bedtime routine • Controlled comforting (or controlled crying) • Systematic ignoring • Scheduled waking • Camping out Further information **www.rch.org.au/ccch** search 'publications/ practice resources/ Settling & Sleep problems In these instances, MCH nurses should encourage the parent to explore alternative strategies, provide reassurance and respect for the strategy decided upon. **Follow up appointment or telephone call** This should be arranged to provide support and evaluate the effectiveness of the planned intervention

Key Ages and Stages Consultation: 8 MONTHS

HEALTH PROMOTION	• Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 8 month Key Ages and Stages consultation. * Note each handout provides key messages that need to be discussed **SUNSMART** • "Sunsmart. The outside 5" brochure includes information about: • Using the SunSmart UV Alert to determine when sun protection is needed • Using a combination of sun protection measures to achieve best possible sun protection • The special sun protection needs of infants • Achieving a healthy balance of UV exposure for vitamin D **IMMUNISATIONS** • Discuss 12 month immunisations. • Refer to booklet 'Understanding Childhood immunisation' *'Australian Government Department of Health and Aging'* *Located in front of Child Health Record.* • Refer to local agencies that provide immunisations
DATA COLLECTION	**Family Health & Wellbeing** discussed Yes/No **BREASTFEEDING FEEDING STATUS** **Feeding at 6 months** **Feeding at 8 months** *(Exclusively breastfeeding, Predominantly breastfeeding, Partially breastfeeding Artificially feeding)* **QUIT** Intervention offered Yes/No Referral Yes/No **FAMILY VIOLENCE** Family violence assessment completed Yes/No Safety plan completed Yes/No **CHILD PHYSICAL ASSESSMENT** Completed Yes/No

Key Ages and Stages Consultation: 8 MONTHS

DATA COLLECTION (continued)

GROWTH

weight
Height
Head circumference

ORAL HEALTH

Assessment completed Yes/No

DEVELOPMENTAL ASSESSMENT

PEDS

PEDS assessment completed Yes/No
Path: A B C D E

Please indicate any concerns identified
(Global/Cognitive, Expressive Language and Articulation, Receptive Language, Fine Motor,Gross Motor, Behaviour, Social-emotional, Self-help, School, Other)

BRIGANCE

Brigance assessment completed Yes/No

Hearing risk Assessment completed Yes/No
No risk factor identified Yes/No
Referral Yes/No
(refer VIHSP Hearing Loss Risk Factor Screening Assessment (8 months) in Child Health Record book.)

INFANT SLEEP

Is your baby's sleeping a concern for the parent? Yes/No

If yes, does the parent want help? Yes/No
Intervention offered
(BOX= controlled comforting, camping out, other)
Referral Yes/No
Referral agency
(BOX= day stay program, residential program, GP, psychologist, paediatrician, other)

Key Ages and Stages Consultation: 8 MONTHS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

MCH PEDS TIPSHEET:
Key Ages and Stages 8 MONTHS

QUESTION 1 **Please list any concerns about your child's learning, development and behaviour.** Opens a discussion in all areas	**QUESTION 6** **Do you have any concerns about how your child gets along with others?** • Increased stranger awareness and fear of separation
QUESTION 2 **Do you have any concerns about how your child talks and makes speech sounds?** • Turns head to sound above ear in midline • Expectation in response to repetition of stimulus • Responds to name • Single syllables e.g. ba, da,ra • Four or more different sounds	**QUESTION 7** **Do you have any concerns about how your child behaves?** • Enjoys cuddles • Eye contact with parent • Plays peek-a-boo • Keeps lips closed when offered food which is not wanted • Increased stranger awareness and fear of separation
QUESTION 3 **Do you have any concerns about how your child understands what you say?** • Responds to name	**QUESTION 8** **Do you have any concerns about how your child is learning to do things for himself/herself?** • Attempts to self feed • Retains one block when second offered • Attempts to chew lumpy food
QUESTION 4 **Do you have any concerns about how your child uses his or her hands and fingers to do things?** • Transfers object from one hand to another • Attempts to self feed • Bangs object on table • Cast object, does not release	**QUESTION 9** **Do you have any concerns about how your child is learning preschool or school skills?** • opportunity to discuss- reading, talking, interacting and play
QUESTION 5 **Do you have any concerns about how your child uses his or her arms and legs?** • Held standing, bounces with pleasure • Sitting without support • May commando crawl	**QUESTION 10** **Please list any other concerns** • Possible categories of concern- global, behavioural and language

THIS TIPSHEET- has been compiled to offer the MCH nurse some prompts, if necessary, for further discussion with parents, when completing the PEDS screen.
This has been written in context to the developmental age on the tip sheet, and is
To be used as a guide only, not exclusive.

Pocket Guide to Pediatric Assessment, *5th Ed. Engel J (2006) Mosby, USA.*
Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education.
Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress

Key Ages and Stages Consultation: 12 MONTHS

PEDS	• Complete PEDS Response • Complete PEDS Score & Interpretation forms • Refer to MCH PEDS tip sheet for guidance • Refer to PEDS administration and scoring guides PATH A This is a referral pathway. It may be useful to do a secondary screen and use the results to support the referral. Use professional judgement to decide this. PATH B Needs secondary screen This secondary screen will sort out which children need a referral and which are developing normally. It offers parents counselling in the areas of their concern PATH C Counselling and monitor progress Counselling means talking with parent about their concerns, offering advice or strategies for addressing these concerns, Note- if the counselling is unsuccessful and concerns remain, and then the next step of the pathway is to do a secondary screen. PATH D parental difficulties communication, will require secondary screen PATH E reassurance and routine monitoring
BRIGANCE	• Used as secondary screen when indicated by PEDS • Refer to Brigance Technical Report and Screens • Refer to MCH Brigance Training Handbook

Key Ages and Stages Consultation: 12 MONTHS

FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH 4 week Key Ages and Stages consultations for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	• Weight and length
NUTRITION	• Breastfeeding , bottle to cup • Solids – progress to family foods
HIPS	• Asymmetry • Galeazzi test • Limitation of abduction of the hip • General examination

Key Ages and Stages Consultation: 12 MONTHS

INTERVENTIONS	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005)
REFER	**SUDI & SAFE SLEEPING CHECKLIST** • Follow up on any issues raised from the Safe Sleeping Checklist completed previously. • For families that are seen at home for additional consultations the infant sleeping arrangements need to be sighted and checklist completed for each of these visits, until the baby reaches one year of age. **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 12 month Key Ages and Stages consultations. * Note each handout provides key messages that need to be discussed **YOUNG READERS** • Young Readers Program- Rhyme Time booklet and DVD **IMMUNISATIONS** • Discuss 12 & 18 month immunisations. • Refer to booklet 'Understanding Childhood immunisation' *'Australian Government Department of Health and Aging'* *Located in the front of Child Health Record* • Refer to local agencies that provide immunisations.

Key Ages and Stages Consultation: 12 MONTHS

DATA COLLECTION	**Family Health & Wellbeing** reviewed Yes/No **FEEDING** Feeding at 12 months *(Exclusively breastfeeding, Partially breastfeeding, artificially feeding)* **IMMUNISATION** Discussed /reviewed Yes/No **QUIT** Intervention offered Yes/No Referral **FAMILY VIOLENCE ASSESSMENT** Family violence assessment completed Yes/No Safety plan completed Yes/No Referral Yes/No **DEVELOPMENTAL ASSESSMENT** **PEDS** **PEDS assessment completed** Yes/No Path: *A B C D E* **Please indicate any concerns identified** (Global/Cognitive, Expressive Language and Articulation, Receptive Language, Fine Motor, Gross Motor, Behaviour, Social-emotional, Self-help, School, Other) **BRIGANCE** Brigance assessment completed Yes/No Referral Yes/No **HIPS** assessed Yes/No Referral Yes/No **GROWTH** weight height **INFANT SLEEPING** Assessment/review Yes/No Referral Yes/No

Key Ages and Stages Consultation: 12 MONTHS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**Refer to MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

MCH PEDS TIPSHEET:
Key Ages and Stages 12 MONTHS

QUESTION 1 **Please list any concerns about your child's learning, development and behaviour.** • Opens a discussion in all areas	**QUESTION 6** **Do you have any concerns about how your child behaves?** • Sensitive to approval/ disapproval • Reacts to music and moves
QUESTION 2 **Do you have any concerns about how your child talks and makes speech sounds?** • May say 1-3 clear words • Multiple syllables and word babble e.g. dada, mimi	**QUESTION 7** **Do you have any concerns about how your child gets along with others?** • enjoys cuddle • eye contact with carer • sensitive to approval or disapproval
QUESTION 3 **Do you have any concerns about how your child understands what you say?** • Understands simple instructions i.e 'give me' • Sensitive to approval or disapproval • Knows and turns to own name	**QUESTION 8** **Do you have any concerns about how your child is learning to do things for himself/herself?** • helps with dressing- holds foot or arm out • holding spoon, but cannot use it yet
QUESTION 4 **Do you have any concerns about how your child uses his or her hands and fingers to do things?** • Bangs blocks together • Precise finger grasp- small objects- pincer • Points purposely with index finger • Uses both hands freely	**QUESTION 9** **Do you have any concerns about how your child is learning preschool or school skills?** • opportunity to discuss- reading, talking, interacting and play
QUESTION 5 **Do you have any concerns about how your child uses his or her arms and legs?** • Crawls • May stand alone • May walk alone • Can rise to sitting from lying down • Pulls to stand holding furniture	**QUESTION 10** **Please list any other concerns** • Possible categories of concern- global, behavioural and language

THIS TIPSHEET- has been compiled to offer the MCH nurse some prompts, if necessary, for further discussion with parents, when completing the PEDS screen.
This has been written in context to the developmental age on the tip sheet, and is
To be used as a guide only, not exclusive.

Pocket Guide to Pediatric Assessment, 5th Ed. Engel J (2006) Mosby, USA.
Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education.
Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress

Key Ages and Stages Consultation: 18 MONTHS

PEDS	• Complete PEDS Response • Complete PEDS Score & Interpretation forms • Refer to MCH PEDS tip sheet for guidance • Refer to PEDS administration and scoring guides PATH A This is a referral pathway. It may be useful to do a secondary screen and use the results to support the referral. Use professional judgement to decide this. PATH B Needs secondary screen This secondary screen will sort out which children need a referral and which are developing normally. It offers parents counselling in the areas of their concern PATH C Counselling and monitor progress Counselling means talking with parent about their concerns, offering advice or strategies for addressing these concerns, Note- if the counselling is unsuccessful and concerns remain, and then the next step of the pathway is to do a secondary screen. PATH D parental difficulties communication, will require secondary screen PATH E reassurance and routine monitoring
BRIGANCE	• Used as secondary screen when indicated by PEDS • PEDS Pathways B & D and possibly A • Refer to Brigance Technical Report and Screens • Refer to MCH Brigance Training Handbook

Key Ages and Stages Consultation: 18 MONTHS

FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children. • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH 4 week Key Ages and Stages consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	• Weight and length
NUTRITION	• Discuss – child and family • Refer to- Go for Your Life handout- 'Healthy eating and play for toddlers
HIPS/GAIT	Observe • Gait: symmetry,(Trendelenberg Gait)

Key Ages and Stages Consultation: 18 MONTHS

ORAL HEALTH	**Lift the lip, Look and Locate** Discuss and Inspect: • Gums: moisture, colour • Tongue: movement, moisture, colour • Teeth: number, type, marks, oral hygiene **Teeth Cleaning demonstration** Reference: Teeth: Oral Health Information for MCH Nurses, July 2004, DHSV • How to perform an oral health check, refer to pages 23-28 • How to demonstrate teeth cleaning, refer to pages 29 –31
INTERVENTIONS	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	• Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 18 month Key Ages and Stages consultation. • Note each handout provides key messages that need to be discussed **IMMUNISATIONS** • Discuss 18 month immunisations. • Refer to booklet 'Understanding Childhood immunisation' *'Australian Government Department of Health and Aging'* *Located in the front of Child Health Record* • Refer to local agencies that provide immunisations.

Key Ages and Stages Consultation: 18 MONTHS

DATA COLLECTION	**Family Health & Wellbeing** reviewed Yes/No **QUIT** Intervention offered Yes/No Referral **FAMILY VIOLENCE ASSESSMENT** Family violence assessment completed Yes/No Safety plan completed Yes/No Referral yes/no **DEVELOPMENTAL ASSESSMENT** **PEDS** PEDS assessment completed Yes/No Path: *A B C D E* **Please indicate any concerns identified** (Global/Cognitive, Expressive Language and Articulation, Receptive Language, Fine Motor, Gross Motor, Behaviour, Social-emotional, Self-help, School, Other) **BRIGANCE** Brigance assessment completed Yes/No Referral yes/no **GROWTH** weight height **GAIT/HIPS** assessed Yes/No Referral yes/no **ORAL HEALTH** Assessment/review Yes/No Referral yes/no

Key Ages and Stages Consultation: 18 MONTHS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

MCH PEDS TIPSHEET:
Key Ages and Stages 18 MONTHS

QUESTION 1 **Please list any concerns about your child's learning, development and behaviour.** Opens a discussion in all areas	**QUESTION 6** **Do you have any concerns about how your child gets along with others?** • Points to indicate interest • Early pretend play • Explores the environment
QUESTION 2 **Do you have any concerns about how your child talks and makes speech sounds?** • Uses 5-10 words • Understands many more words • jabbers	**QUESTION 7** **Do you have any concerns about how your child behaves?** • enjoys cuddles • gives eye contact with parent
QUESTION 3 **Do you have any concerns about how your child understands what you say?** • Understands many words • Points to eyes, nose and mouth • Obey simple instructions • Waves bye	**QUESTION 8** **Do you have any concerns about how your child is learning to do things for himself/herself?** • uses spoon and cup • takes off shoes and socks
QUESTION 4 **Do you have any concerns about how your child uses his or her hands and fingers to do things?** • Builds a tower of 3-4 blocks • Scribbles with palmer grasp • Fine pincer grasp • Turns pages • Points to objects • Points to eyes, nose and mouth • Points to indicate interest	**QUESTION 9** **Do you have any concerns about how your child is learning preschool or school skills?** • opportunity to discuss- reading, talking, interacting and play
QUESTION 5 **Do you have any concerns about how your child uses his or her arms and legs?** • Walks well • Climbs onto a chair • Walks upstairs with help • Run stiffly watching the ground • Carries toy while walking • Gestures • Waves bye	**QUESTION 10** **Please list any other concerns** • Possible categories of concern- global, behavioural and language

THIS TIPSHEET- has been compiled to offer the MCH nurse some prompts, if necessary, for further discussion with parents, when completing the PEDS screen.
This has been written in context to the developmental age on the tip sheet, and is
To be used as a guide only, not exclusive.

Pocket Guide to Pediatric Assessment, *5th Ed. Engel J (2006) Mosby, USA.*
Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education.
Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress

Key Ages and Stages Consultation: 2 YEARS

PEDS	• Complete PEDS Response • Complete PEDS Score & Interpretation forms • Refer to MCH PEDS tip sheet for guidance • Refer to PEDS administration and scoring guides PATH A This is a referral pathway. It may be useful to do a secondary screen and use the results to support the referral. Use professional judgement to decide this. PATH B Needs secondary screen This secondary screen will sort out which children need a referral and which are developing normally. It offers parents counselling in the areas of their concern PATH C Counselling and monitor progress Counselling means talking with parent about their concerns, offering advice or strategies for addressing these concerns, Note- if the counselling is unsuccessful and concerns remain, and then the next step of the pathway is to do a secondary screen. PATH D parental difficulties communication, will require secondary screen PATH E reassurance and routine monitoring
BRIGANCE	• Used as secondary screen when indicated by PEDS • PEDS Pathways B & D and possibly A • Refer to Brigance Technical Report and Screens • Refer to MCH Brigance Training Handbook

Key Ages and Stages Consultation: 2 YEARS

FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH4 week Key Ages and Stages consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	• Weight, height
NUTRITION	• Discuss child and family nutrition
ORAL HYGIENE	• Inspect and discuss • Gums: moisture, colour • Tongue: movement, moisture, colour • Teeth: number, type, marks, oral hygiene
HIPS/GAIT	• Observe • Gait: symmetry,(Trendelenberg Gait)

Key Ages and Stages Consultation: 2 YEARS

INTERVENTIONS	• Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) **KINDERGARTEN** • Discuss and provide information regarding kindergarten enrolment **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH framework – Promotion of Health and Development for the 2 year Key Ages and Stages visit. • Note each handout provides key messages that need to be discussed **YOUNG READERS** • Young Readers Program - book **IMMUNISATIONS** • Discuss progress of immunisations. • Refer to booklet 'Understanding Childhood immunisation' '*Australian Government Department of Health and Aging*' • Refer to local agencies that provide immunisations if needed.

Key Ages and Stages Consultation: 2 YEARS

DATA COLLECTION	**Family Health & Wellbeing** reviewed Yes/No **QUIT** Intervention offered Yes/No Referral Yes/No **FAMILY VIOLENCE ASSESSMENT** Family violence assessment completed Yes/No Safety plan completed Yes/No Referral Yes/No **DEVELOPMENTAL ASSESSMENT** **PEDS** PEDS assessment completed Yes/No Path: *A B C D E* **Please indicate any concerns identified** (Global/Cognitive, Expressive Language and Articulation, Receptive Language, Fine Motor, Gross Motor, Behaviour, Social-emotional, Self-help, School, Other) **BRIGANCE** Brigance assessment completed Yes/No Referral Yes/No **GROWTH** weight height **HIPS/GAIT** assessed Yes/No Referral Yes/No **BMI** BMI assessment completed Yes/No BMI Referral Yes/No **YOUNG READERS** Young Readers book given Yes/No **KINDERGARTEN** Enrolment discussed Yes/No

Key Ages and Stages Consultation: 2 YEARS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

MCH PEDS TIPSHEET:
Key Ages and Stages 2 YEARS

QUESTION 1 **Please list any concerns about your child's learning, development and behaviour.** • Opens a discussion in all areas	**QUESTION 6** **Do you have any concerns about how your child behaves?** • Follows simple commands • Imitates adults in domestic activities • Pretend play • Parallel play • No concept of sharing • Tantrums when frustrated • Recognises fine detail in pictures
QUESTION 2 **Do you have any concerns about how your child talks and makes speech sounds?** • Understands many words • Uses at least 20 (usually 50+) words • Some 2 words utterances • Uses many gestures e.g. pointing, rocking 'baby'	**QUESTION 7** **Do you have any concerns about how your child gets along with others?** • No concept of sharing • Comes to parent for affection/comfort • Parallel play • Tantrums when frustrated
QUESTION 3 **Do you have any concerns about how your child understands what you say?** • Understands many words • Follows simple instructions	**QUESTION 8** **Do you have any concerns about how your child is learning to do things for himself/herself?** • Spoon feeds well • May verbalise toilet needs • Recognises fine detail in pictures
QUESTION 4 **Do you have any concerns about how your child uses his or her hands and fingers to do things?** • Build tower of 4-6 blocks • Able to pick up '100' & '1000's • Spontaneous circular scribble • May imitate vertical lines • Turns pages singly	**QUESTION 9** **Do you have any concerns about how your child is learning preschool or school skills?** • opportunity to discuss - reading, talking, interacting and play
QUESTION 5 **Do you have any concerns about how your child uses his or her arms and legs?** • Runs well- around obstacles • Upstairs 2 feet at a time • Climbs well • Stoops at play- good balance • Kicks ball • Throws small ball	**QUESTION 10** **Please list any other concerns** • Possible categories of concern- global, behavioural and language

THIS TIPSHEET- has been compiled to offer the MCH nurse some prompts, if necessary, for further discussion with parents, when completing the PEDS screen.
This has been written in context to the developmental age on the tip sheet, and is
To be used as a guide only, not exclusive.

Pocket Guide to Pediatric Assessment, 5th Ed. Engel J (2006) Mosby, USA.
Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education.
Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress T**o be used as a guide only**

Key Ages and Stages Consultation: 3.5 YEARS

PEDS	• Complete PEDS Response • Complete PEDS Score & Interpretation forms • Refer to MCH PEDS tip sheet for guidance • Refer to PEDS administration and scoring guides PATH A This is a referral pathway. It may be useful to do a secondary screen and use the results to support the referral. Use professional judgement to decide this. PATH B Needs secondary screen This secondary screen will sort out which children need a referral and which are developing normally. It offers parents counselling in the areas of their concern PATH C Counselling and monitor progress Counselling means talking with parent about their concerns, offering advice or strategies for addressing these concerns, Note- if the counselling is unsuccessful and concerns remain, and then the next step of the pathway is to do a secondary screen. PATH D parental difficulties communication, will require secondary screen PATH E reassurance and routine monitoring
BRIGANCE	• Used as secondary screen when indicated by PEDS • PEDS Pathways B & D and possibly A • Refer to Brigance Technical Report and Screens • Refer to MCH Brigance Training Handbook

Key Ages and Stages Consultation: 3.5 YEARS

FAMILY HEALTH & WELLBEING	Family Health and Wellbeing can be reviewed under the following - • Physical Health • Emotional Health • Social Wellbeing
FAMILY VIOLENCE	MCH nurses can play an important role in identifying family violence and providing information and support to mothers and their children. **OBSERVE** • Women, their children, their interaction and the physical environment for signs of unsafe family life related to family violence. • These signs include physical injury, emotional state, body language and developmental stages in babies. • The ability of the mother to move freely around the home, to access all rooms and house contents. • Whether the mother is free to meet with nurses on their own. **Refer to the MCH 4 week Key Ages and Stages MCH consultation for specific questions to ask the mother in relation to family violence.** **These four key questions can be asked at any MCH consultation if professional judgement warrants this.**
SAFETY PLAN	To be completed if professional judgement warrants this.
GROWTH	• Weight, height • Promote a healthy BMI
NUTRITION	• Discuss child and family nutrition
EYES	• Visual acuity: MIST screen
HIPS/GAIT	• Observe • Gait: symmetry,(Trendelenberg Gait)

Key Ages and Stages Consultation: 3.5 YEARS

ORAL HEALTH	**Lift the lip, Look and Locate** • Inspect and discuss: • Gums: moisture, colour • Tongue: movement, moisture, colour • Teeth: number, type, marks, oral hygiene Reference: Teeth: Oral Health Information for MCH Nurses, July 2004, DHSV How to perform an oral health check, refer to pages 23-28 How to demonstrate teeth cleaning, refer to pages 29-31
INTERVENTIONS	Respond to concerns raised at this and previous assessments • At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement (including notifications under the Children, Youth and Families Act 2005) **KINDERGARTEN** • Discuss and provide information regarding kindergarten enrolment **Refer to MCH GUIDELINES – References, Resources & Referral options for details of all regional Child Protection Services and other referral/contact options**
HEALTH PROMOTION	**HANDOUTS** • Provide and discuss each handout listed on the MCH service framework – Promotion of Health and Development for the 3.5 year Key Ages and Stages consultation. • Note each handout provides key messages that need to be discussed
	IMMUNISATIONS • Discuss 4 year immunisations. • Refer to booklet 'Understanding Childhood immunisation' '*Australian Government Department of Health and Aging*' • Refer to local agencies that provide immunisations

Key Ages and Stages Consultation: 3.5 YEARS

DATA COLLECTION	**Family Health & Wellbeing** reviewed	Yes/No
	IMMUNISATION	
	Discussed and reviewed	Yes/No
	QUIT	
	Intervention offered	Yes/No
	Referral	
	FAMILY VIOLENCE ASSESSMENT	
	Family violence assessment completed	Yes/No
	Safety plan completed	Yes/No
	Referral	yes/no
	ORAL HEALTH	
	Assessment completed	Yes/No
	Referral	yes/no
	MIST VISION SCREENING	
	MIST completed	Yes/No
	Referral	Yes/No
	Referral agency	
	(BOX= optometrist, ophthalmologist, GP)	
	DEVELOPMENTAL ASSESSMENT	
	PEDS	
	PEDS assessment completed	Yes/No
	Path:	*A B C D E*
	Please indicate any concerns identified	
	(Global/Cognitive, Expressive Language and Articulation, Receptive Language, Fine Motor, Gross Motor, Behaviour, Social-emotional, Self-help, School, Other)	
	BRIGANCE	
	Brigance assessment completed	Yes/No
	Referral	yes/no
	GROWTH	
	weight	
	height	
	HIPS/GAIT	
	assessed	Yes/No
	Referral	yes/no
	BODY MASS INDEX	
	BMI assessment completed	Yes/No
	BMI Referral	Yes/No

Key Ages and Stages Consultation: 3.5 YEARS

REFERRALS, COUNSELLING, & RECOMMENDED CONTACTS	**COUNSELLING, REFERRAL & RECOMMENDED CONTACT DETAILS FOR ALL ACTIVITES** **COUNSELLING- Mother or Family** Yes/No Counselling reason **COUNSELLING- Child Health & Wellbeing** counselling reason **REFERRAL- Mother or Family** Yes/No Referral reason Referral agency **REFERRAL- Child Health & Wellbeing** Yes/No Referral reason Referral agency **RECOMMENDED CONTACT-** When a family is encouraged o make contact with another agency. (eg. G.P.) Not a referral **Recommended contact given** Yes/No Recommended contact agency
REFER TO	**Refer to MCH GUIDELINES-** **References, Resources & Referral options**

Use professional judgement to decide if additional activities are warranted

MCH PEDS TIPSHEET:
Key Ages and Stages 3.5 YEARS

QUESTION 1 **Please list any concerns about your child's learning, development and behaviour.** • Opens a discussion in all areas	**QUESTION 6** **Do you have any concerns about how your child behaves?** • Loves stories and demands favourites • Likes to help adults • Imaginative play • Loves stories & demands favourites
QUESTION 2 **Do you have any concerns about how your child talks and makes speech sounds?** • Large vocabulary • 3-4 word sentences • Speech generally understandable • Asks many questions- what, where, who • Uses many verbs • Uses tense • Uses personal pronouns	**QUESTION 7** **Do you have any concerns about how your child gets along with others?** • Beginning to share • Likes to help adults • Joins in play with other children
QUESTION 3 **Do you have any concerns about how your child understands what you say?** • copies a circle • matches 2 or more primary colours • counts to ten by rote	**QUESTION 8** **Do you have any concerns about how your child is learning to do things for himself/herself?** • Can feed without spilling • Washes hands, needs help with drying • Daytime toilet training often attained • Can dress but needs help with buttons
QUESTION 4 **Do you have any concerns about how your child uses his or her hands and fingers to do things?** • Build tower of 9 blocks • Builds a bridge of 3 from model • Copies a circle • Cuts with scissors • Can paint with a brush	**QUESTION 9** **Do you have any concerns about how your child is learning preschool or school skills?** • Opportunity to discuss- reading, talking, interacting and play, pencil grasp, toilet training and preschool enrolment procedures
QUESTION 5 **Do you have any concerns about how your child uses his or her arms and legs?** • Walks upstairs 1 foot per step • Comes downstairs, 2 feet per step • Can walk on tiptoe • Competent at running • Turns tricycle pedals	**QUESTION 10** **Please list any other concerns** • Possible categories of concern- global, behavioural and language

THIS TIPSHEET- has been compiled to offer the MCH nurse some prompts, if necessary, for further discussion with parents, when completing the PEDS screen.
This has been written in context to the developmental age on the tip sheet, and is
To be used as a guide only, not exclusive.

Pocket Guide to Pediatric Assessment, 5th Ed. Engel J (2006) Mosby, USA.
Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education.
Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress

Guidelines for Recording Referrals

REFERRALS

A referral is only recorded when communication is made to the referral agency with the consent of the parent. This may take the form of a written letter, a phone call to the referral agency or a recording made in the parent-held *Child health* record by the maternal and child health nurse. The exception is in the case of mandatory reporting when parental consent is not required (Program Resource Guide)

A referral implies that counselling has also occurred at the time of consultation- thus document as referral and counselling.

RECOMMENDED CONTACTS

It is important not to confuse this with linkage to a community agency where a person may be given the option of contacting the agency, but the formal referral procedure is not used; for example, it may be suggested that a breastfeeding mother contacts the Australian Breastfeeding Association for extra support or information for a breastfeeding issue.

In acknowledging the importance however of this process the MCH Practice Guidelines have added the option to record such activity. This is referred to as 'Recommended Contacts'.

Note when recording Recommended Contacts- also record counselling

REASON FOR REFERRAL

Referrals fall under the following criteria for data collection. These are the only criteria noted by DEECD and use of others will alter data analysis.

CHILD HEALTH & WELLBEING

Visual
Auditory
Communication
DDH
Congenital anomaly
Growth
Development
Potentially disabling condition
Accident
Illness
Nutrition
Dental and oral conditions
Protective Notification

MOTHER OR FAMILY

Domestic violence
Emotional
Family planning
Physical
Social interaction impaired

Guidelines for Recording Referrals

REFERRAL OPTIONS- FOR DATA COLLECTION

Aboriginal Services
Audiology
Child Care
Child Protection
Community Health Centre
Counselling services
Dental Services
Dietician
Domestic Violence services
Drug and alcohol services
Early Parenting Centres
ECIS Early Childhood Intervention Services
Emergency housing
Enhanced MCH Service
Family planning
Family Support Services
Financial assistance
GP
Hospital
Immunisation services
Kindergarten
Lactation services
Legal Services
Mental Health Services
Mother Baby Unit
Obstetrician
Occupational Therapist
Other
Paediatrician
Physiotherapist
Playgroup
Police
QUIT
Self Help group
SIDS
Speech therapist
Specialist Childrens Services
Supported groups ie., CALD, father, PND, young parents
Telephone services
Websites

Developing Referral lists

- Using local resources and knowledge, develop a list of local relevant services
- Confirm opening hours
- Find out intake procedures
- Develop relationships with other professionals for feedback
- Research has shown that using a combination of verbal and written information is very powerful. This method also caters for the needs of different parents

References, Resources & Referral Options

BIRTH DEFECTS REGISTER	The Victorian Birth Defects Register (VBDR) collects information on all birth defects for live births, stillbirths and terminations of pregnancy. A birth defect is an abnormality in body structure or chemistry which was present at birth, although it may not have been noticed at birth. Birth defects may be first recognised long after birth. Maternal and child health nurses and health care clinics are regularly sent booklets containing Birth Defects Notification Form MCH Nurses are to complete these forms for all children identified with a congenital anomaly Completed forms are to be forwarded to The Victorian Births Defects Register Perinatal Data Collection Unit GPO Box 4003 Melbourne 3001 **Enquiries** **Telephone:** National (03) 9096 2695 or 1300 858 505 International (61 3) 9096 2695 On line registration The VBDR now has an on-line mechanism for notification of birth defects to the Register, along with maintaining our notification booklets for those who prefer to use hardcopy. To access this electronic form, go to the Perinatal Home Page **www.health.vic.gov.au/perinatal** and follow these steps: 1. Go to the box on the left-hand side titled“Perinatal Home”. 2. Select “Forms”. 3. Select “Complete VBDR notification on-line”. 4. Complete the form. 5. Print off the form if you want to keep a copy. 6. Send. The information will be encrypted and sent directly to a server at the Department of Human Services. Access to the data is restricted to only authorised staff at the Victorian Perinatal Data Collection Unit.

References, Resources & Referral Options

BODY MASS INDEX (BMI)	**Introducing- Body Mass Index (BMI) in children** Education CD ROM for the Maternal and Child Health Nurse Developed by Centre for Community Child Health, Murdoch Childrens Research Institute and Royal Children's Hospital **Pocket Guide to Paediatric Assessment**, 5th Ed. Engel J (2006) Mosby, USA. In 2003, the Australian National Health and Medical Research Council released guidelines on children's BMI. These make it possible to classify healthy weight and overweight in children from the age of 2 upwards.
BREASTFEEDING	**Australian Breastfeeding Association** 03 9885 0855 **www.breastfeeding.asn.au** **Raising Children Network** **www.raisingchildren.net.au** **NHMRC** Food for health Dietary guidelines for Children and Adolescents in Australia A guide to healthy eating NHMRC (2003) Dietary Guidelines for Children and Adolescents in Australia ** Chapter 3 Enjoy a Wide Variety of Nutritious Foods-* Dietary Guidelines for Children and Adolescents in Australia - Infant Feeding Guidelines for Health workers **Go for your life** ***www.goforyourlife.vic.gov.au***
CHILD MENTAL HEALTH	RCH infant sleep clinic (03) 9345 5466 Infant Mental Health RCH (03) 9345 5511 Alfred Camhs Infant Program, Moorabbin (03) 8552 0515

References, Resources & Referral Options

CHILD PROTECTION SERVICES	**Potential indicators- abuse and neglect** Appendix 5 of the 2006 Maternal and Child Health Program Resource Guide details potential indicators of abuse and neglect. If you are unsure of which office to ring, or your call is after hours, telephone the **Child Protection Crisis line** - Toll free for all Victoria (24 hrs, 7 days a week) - **13 1278** An outreach service is available to provide a crisis response. **Metropolitan Regions** **Eastern** 1300 360 391 **Southern** 1300 655 795 **Northern & Western** 1300 369 536 **Rural Regions** **Gippsland** 1800 020 202 **Grampians** 1800 000 551 **Hume** 1800 650 227 **Loddon Mallee** 1800 675 598 **Barwon South Western** 1800 075 599
DEVELOPMENT (PEDS & BRIGANCE)	Maternal and Child Health Program Resource Guide, September 2006, Department of Human Services Glascoe F.P Collaborating with Parents – Using Parents Evaluations of Developmental Status to Detect and Address Developmental and Behavioural Problems. Glascoe F.P (2005) Technical Report for the Brigance Screens Hawker Brownlow Education. Mary D. Sheridan. From Birth to Five Years, Children's Developmental Progress **http://www.pedstest.com/content.php?content=faq.html** **www.hbe.com.au** **www.rch.org.au/ccch/peds**
EARLY PARENTING CENTRES	O'Connell Family Centre (03) 8416 7600 Queen Elizabeth Centre (03) 9549 2777 Tweddle Child and Family Service (03) 9689 1577

References, Resources & Referral Options

FAMILY HEALTH & WELLBEING	The Maternal and Child Health Service provides a comprehensive and focused approach to managing the physical, emotional and social factors affecting families in contemporary communities. Children are vulnerable to poor developmental outcomes when there is a discrepancy between the parenting they need and the parenting they receive. This discrepancy can arise from factors that can impair a parent's ability to adapt to their children's needs. These include-Personal factors (e.g. Stress, ill health, drug abuse, mental health problems) and Social factors (e.g. social isolation, poverty, poor housing) ***(Reference: Government Department of Family and Community Services, Parenting Information Project Volume I: Main Report March 2007)*** **Raising Children – DVD** **A guide to parenting from birth to 5** **www.raisingchildren.net.au** **Live in Victoria- website with links to all services- GP, hospitals, nurse on call, specialists, mother and baby services, childrens services, and dental.** **www.liveinvictoria.vic.gov.au** **MCH Line** **132229** **Parentline** **132289** **Lifeline** **131114** **Mensline** **1300 789 978** **Suicide Help line** **1300 651 251**
PHYSICAL	**One in Three Women Who have ever had a Baby Wet Themselves;** Continence Australia (booklet) **National Continence Health Line** **www.continence.org.au** 1800 33 00 66 **Australian Physiotherapy Association** (03) 9429 1799 **http://physiotherapy.asn.au** Bick,D., MacArthur,C., Winter,H.,(200) **Postnatal Care Evidence and Guidelines for Management** Churchill Livingstone. UK.
EMOTIONAL HEALTH	**PANDA** 1300 726 306 **www.panda.org.au** **Beyond Blue** 1300 224 636 **www.beyondblue.org.au/postnataldepression** • Emotional health during pregnancy and early parenthood booklet- pink card at back- is different for each state and future reprints will have date added. Updated regularly. • Additional resources available for MCH to order directly from Beyond Blue as needed. • Orders via phone or email • Recommended - posters and Fact Sheet 22 • Fact Sheet 22 - contains information about PND, treatment and referral options. Also contains the EPDS- with explanation. • All orders are free

References, Resources & Referral Options

FAMILY VIOLENCE	**Statewide service** Police for urgent attendance ring 000 For non urgent police contact your Community Policing Squad. **Women's Domestic Violence Crisis Service.** State-wide 24 hour crisis support and safe accommodation (refuges for women and their children. (03) 9373 0123 or 1800-015 –188 **Immigrant Women's Domestic Violence Service** Support to immigrant women in their primary language. (03) 8413 6800. **www.iwdvs.org.au** **Domestic Violence Resource Centre Victoria (previously DVIRC)** DVRCV (formerly DVIRC) is a statewide service in Victoria, Australia. DVRCV aims to reduce and prevent family violence by providing education to improve service and policy responses, and by assisting people who have experienced abuse. DVRCV provides information and referral to specialist support services; helpful pamphlets and websites; professional training courses; a comprehensive library; a quarterly newsletter; Discussion papers, books and other publications; and commentary on policy initiatives and law reform. **www.dvrcv.org.au** (03) 9486-9866, TTY :(03) 9417 1255 **Women's Information & Referral Exchange** 1300 134 130
GROWTH	National Health and Medical Research Council (NHMRC) publication, *Child Health Screening and Surveillance*: ***A Critical Review of the Evidence (2002).*** ***Pocket Guide to Pediatric Assessment***, 5th Ed. Engel J (2006) Mosby, USA.
HEARING	Victorian Infant Hearing Screening Program vih**sp@rch.org.au** 9345 5932
HIPS/GAIT	DDH- Department of Orthopaedics and Physiotherapy, The Royal Children's Hospital, DDH Education module DVD. Pediatric Assessment (2006) fifth Edition Engel .J. Mosby Elsevier

References, Resources & Referral Options

IMMUNISATION	**Immunisation Programme** ***www.health.vic.gov.au/immunisation*** *1300 882 008*
MCH SERVICES	MCH websites: **www.education.vic.gov.au\Parents** **www.eduweb.vic.gov** MCH telephone service **13 2229** MCH program resource guide
MOTHER BABY UNITS	Austin Hospital - Banksia House: **www.austin.org.au** search - Banksia House **(03) 9496 5108** Monash Medical Centre: **www.southernhealth.org.au/motherbabyunit** **(03) 9594 1414** Werribee Mercy Hospital – Mother Baby Unit: **www.mercy.com.au/htmlso02article/articleview.asp?id=560&nav cat id=257&nav top id=84** **(03) 9216 8465**
NUTRITION	**Australian Breastfeeding Association** 03 9885 0855 **www.breastfeeding.asn.au** **Raising Children Network** **www.raisingchildren.net.au** **NHMRC** Food for health Dietary guidelines for Children and Adolescents in Australia A guide to healthy eating NHMRC (2003) Dietary Guidelines for Children and Adolescents in Australia ** Chapter 3 Enjoy a Wide Variety of Nutritious Foods-* Dietary Guidelines for Children and Adolescents in Australia - Infant Feeding Guidelines for Health workers **Go for your life** ***www.goforyourlife.vic.gov.au*** **Go for Your Life tip sheets** • Successfully starting and maintaining breastfeeding • Food in the first year of life • Why no sweet drinks for children • Healthy eating and play for toddlers 1-2years • Healthy eating and play for kindergarten children 3-5years • Try it- you'll like it, vegetables and fruit for children For further

References, Resources & Referral Options

ORAL HEALTH	detail: • How to perform an oral health check, refer to pages 23-28 • How to demonstrate teeth cleaning, refer to pages 29 –31 Reference: Teeth: Oral Health Information for MCH Nurses, July 2004, DHSV MCH nurses should refer an infant or child showing with any signs of early childhood caries. Signs and symptoms refer to pages 45-54 Teeth: Oral Health Information for MCH Nurses. Dental Health Services Victoria **www.dhsv.org.au** Oral Health Information for Maternal & Child Health Nurses Refer to DHSV handout Tooth Tips 18months- 6years Public Health Division, DHS Oral health promotion & publications **www.dhs.vic.gov.au/phd/oral/index.htm** • Early Childhood Oral Health Program 1300 360 054 • Community Dental program (03) 9341 1200 • Private Dental Service Yellow pages 'Dentists' • Royal Dental Hospital of Melbourne emergency care for urgent or serious dental problems including management of accidents, swelling, bleeding and pain. (03) 9341 1000 • The Australian Dental Association (Vic Branch) (03) 9826 8318 • DHSV **www.dhsv.org.au** provides a listing of local dental services (03) 9341 1005 • School Dental Service 1300 360 954 **www.raisingchildren.net.au**
PHYSICAL ASSESSMENT	Pediatric Assessment (2006) fifth Edition Engel .J. Mosby Elsevier Wong's Nursing Care of Infants and Children 7th Edition Authors Hockenberry, Wilson, Winkelstein, Kline Mosby Publisher, St Louis Missouri 2003 Paediatric Handbook 7th edition Royal Children's Hospital, Melbourne Australia *Refer to Physical Assessment preamble in these MCH guidelines*
QUIT	**www.quit.org.au** Quit line, Ph 13 18 48

References, Resources & Referral Options

PROGRAM RESOURCE GUIDE	Office for Children (2006) Maternal and Child Health Program Resource Guide. Melbourne, Victoria: Office for Children, Victorian Government Department of Human Services **www.education.vic.gov.au/earlychildhood/mch**
RAISING CHILDREN	From 5 November 2007, the Australian Government is giving the Raising Children DVD to new parents when they leave the hospital, free of charge, as part of the new Parent Pack (which also contains the Baby Bonus Application form). If you did not get your free copy, please contact us with the following information and we will send you one. *The date of your child's birth* *The name of the hospital or birthing centre where he/she was born* *Your postal address (for delivery of the DVD)* **Email: rcdvd@raisingchildren.net.au or** **Phone: 02 9007 5848**
ROAD SAFETY	**www.vicroads.vic.gov.au** **www.raisingchildren.net.au**
SAFE SLEEPING	SUDI- definition The Consultative Council on obstetric and Paediatric mortality and morbidity incorporating the 44th Survey of Perinatal Deaths in Victoria, Annual Report for the year 2005 **www.sidsandkids.org** Tel 1300 308 307
SAFETY	**www.standards.com.au** Australian Standards for cots (AS 2172) Australian Standards for portacots – voluntary (AS 2195) **www.consumer.gov.au** A full guide to safe nursery furniture, and the publication, "Keeping Baby Safe-a guide to Nursery Furniture", Australian Competition and Consumer Commission. Toy & Nursery Safety Line 1300 364 894 **www.inpaa.asn.au**/ iNPAA "Product safety" link ACCC Australian Competition & Consumer Commission **www.accc.gov.au** Kidsafe Victorian branch- 9251 7725 **www.kidsafe.com.au**

References, Resources & Referral Options

SAFETY	The Safety Centre (Royal Children's hospital) **www.rch.org.au/safetycentre** 9345 5085 **www.rch.org**.au/poisons **www.kidsafe.com.au** **Consumer Affairs Victoria** Booklet – Safe products for your baby **www.consumer.vic.gov.au** Consumer & Tenancy Helpline 1300 55 81 81 Toy & Nursery Safety Line 1300 36 48 94 **ACCC** **www.accc.gov.au** **National Association for Prevention of Child Abuse and Neglect** Napcan - **www.napcan.org.au**
SLEEP	Bayer et al J, Hiscock H, Hampton A, Wake, M. Sleep problems in young infants and maternal mental and physical health, *Paediatrics & Child Health* 43, 2007 p66-73 Raising children network **www.raisingchildren.net.au** Child youth health **www.cyh.com** BBC Parenting Sleep **www.bbc.uk/parenting/yourkids/toddlerssleeping** Sleeping like a baby: Avi Sadeh **www.tau.ac.il/sadeh/infant/aboutsleep** Centre for Community Child Health **www.rch.org/ccch**
SUNSMART	• Sun protection for babies and toddlers (information sheet) • SunSmart UV Alert – your daily guide to sun protection (brochure) • How much sun is enough? Getting the right balance: vitamin D and sun protection (brochure) • UV radiation and vitamin D: A special note for people with very dark skin (information sheet) – also available in Amharic, Arabic, Dinka, Nuer, Somali, and Tigrigna • Shade (information sheet) • Sun protective clothing (information sheet) • Sun protective hats (information sheet) • Sunglasses (information sheet) • Sunscreen (information sheet) • Ultraviolet radiation (information sheet) Visit **www.sunsmart.com.au/resources.asp** for a list of resources and further information or call 13 11 20. **Cancer Council of Victoria** **www.sunsmart.com.au** 9635 5000

State Government Victoria
Department of Education and Early Childhood Development

MAV
MUNICIPAL ASSOCIATION OF VICTORIA

Maternal and Child Health Service: Key Ages and Stages Framework

KAS visit	Health & Development Monitoring	Intervention*	Promotion of Health & Development
Home visit	Family Health & Wellbeing Pregnancy, birth, family history Smoking	QUIT intervention & referral Respond to assessments	Breastfeeding Immunisation SIDS: view infant sleep arrangements Safe Sleeping Checklist
2 weeks	Family Health & Wellbeing Full physical assessment - includes Developmental Review Hearing risk factors	Respond to assessments	Car restraints Communication, language and play Injury prevention - Kidsafe
4 weeks	Family Health & Wellbeing Maternal Health & Wellbeing check Hips Weight, length, head circumference	Family Violence- safety plan Respond to assessments Post Natal Depression	Breastfeeding Immunisation Women's Health
8 weeks	Family Health & Wellbeing Full physical assessment - includes Developmental Review	Respond to assessments	Immunisation SIDS risk factors
4 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight	Respond to assessments	Communication, language and play Food in first year of life Playgroup Young Readers
8 months	Family Health & Wellbeing Full physical assessment Oral health Developmental Assessment (PEDS/Brigance) Hearing risk factors Infant sleeping	Sleep Intervention Respond to assessments	Communication, language and play Injury prevention - Kidsafe Poison information Sunsmart Tooth Tips
12 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Hips Weight & length	Respond to assessments	Communication, language and play Healthy eating for young toddlers Immunisation
18 months	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Oral health Weight, height, gait	Teeth cleaning Respond to assessments	Communication, language and play Injury prevention - Kidsafe Tooth tips
2 years	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Weight & height, gait	Promote a Healthy Weight Respond to assessments	Communication, language and play Kindergarten enrolment Young Readers
3.5 years	Family Health & Wellbeing Developmental Assessment (PEDS/Brigance) Vision (MIST) Oral health Weight & height, gait	Promote a Healthy BMI Respond to assessments	Communication, language and play Healthy eating and play for kindergarten Immunisation Injury prevention - Kidsafe

* At all visits nurses will respond to parental concerns (e.g. parenting, safety or health issues) and act on professional observation and judgement *(including notifications under the Child, Youth and Families Act 2005)*




Every child, every opportunity

State Government Victoria

Department of Education and Early Childhood Development

MAV
MUNICIPAL ASSOCIATION OF VICTORIA

Maternal and Child Health Service

Child Outcomes

The Office for Children and Early Childhood Development has reviewed the evidence about the factors that make a real difference to children and young people and has identified 35 aspects of child health and wellbeing, learning and development and safety that are essential to our children's future. These aspects are known as the Outcomes for Children[1]. The following table identifies the outcomes, and the measurable indicators associated with each of the topics covered by the revised Maternal and Child Health Key Ages and Stages activity framework. It is important to note that the Maternal and Child Health service may play a key role, or a supportive role, in improving the identified outcomes for children and their families

Topic	Outcome	Indicator
SIDS	Optimal antenatal and infant development	Sudden Infant Death Syndrome (SIDS) rate for infants
Safe sleeping	Parent promotion of child health and development	Proportion of infants put on their back to sleep from birth
Smoking	Optimal antenatal and infant development	Proportion of children exposed to tobacco while in utero
		Proportion of women who used illicit drugs during pregnancy
	Healthy adult lifestyle	Proportion of children and young people exposed to tobacco smoke in the home
Immunisation	Free from preventable disease	Proportion of children who are fully vaccinated
Breastfeeding/Solids	Adequate nutrition	Proportion of infants breastfed
		Proportion of children and young people who eat the minimum recommended serves of fruit and vegetable every day
Post Natal Depression/ Sleep Intervention	Good parental mental health	Proportion of mothers with post-natal depression
		The proportion of children and young people who have parents with mental health difficulties
Injury prevention	Safe from injury and harm	Age specific death rates from injuries and poisoning
		Age specific hospitalisation rates from injuries and poisoning
Family violence	Free from child exposure to conflict or family violence	Proportion of mothers exposed to partner violence
		Proportion of family violence incidents witnessed by children and young people
Growth	Healthy weight	Proportion of children and young people who are overweight and obese
Oral Health	Healthy teeth and gums	Proportion of children and young people who brush their teeth twice a day
Literacy	Parent promotion of child health and development	Proportion of children who are read to by a family member every day
Vision	Early identification of and attention to child health needs	Proportion of parents concerned about their child's vision
Physical Assessment	Early identification of and attention to child health needs	Proportion of infants receiving a Maternal and Child Health Services home consultation
		Proportion of infants aged 0-1 month enrolled at Maternal and Child Health Services from birth notifications
		Hospital admissions for gastroenteritis in children under one year of age

March 2009

[1] Department of Human Services, The State of Victoria's Children Report 2006 (October 2006)



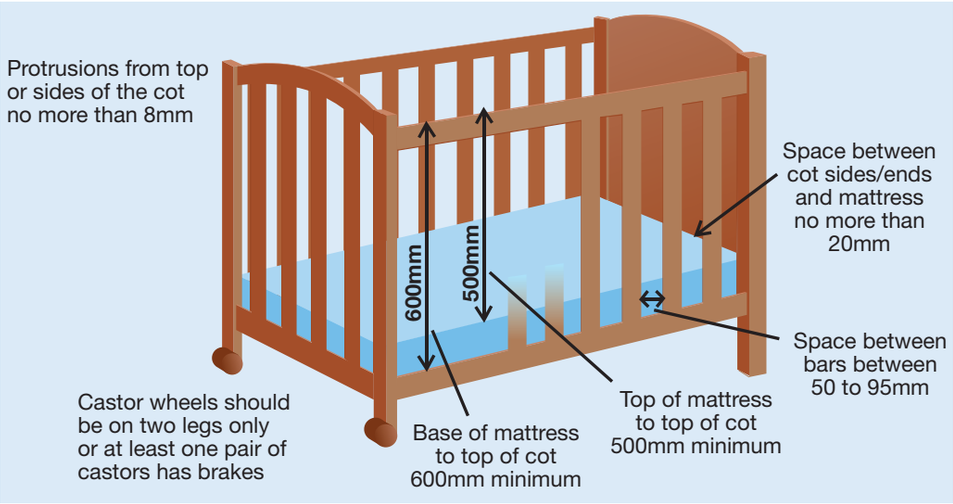

Every child, every opportunity

Department of Education and Early Childhood Development

MUNICIPAL ASSOCIATION OF VICTORIA

Maternal and Child Health Service:
Safe Sleeping Checklist

CHILD'S NAME: ..... DATE: .....



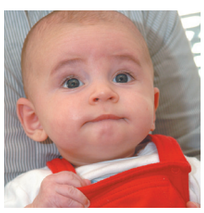
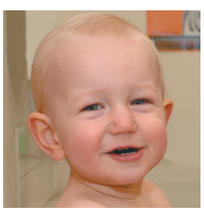
For further information about cots and safe nursery products: www.productsafety.gov.au

Source: *Keeping baby safe*. Australian Competition and Consumer Commission, Dickson ACT, 2006

PLEASE CHECK: ✓ close match to statement ✗ does not match N/A not applicable

- ☐ Baby is placed on his/her back to sleep with head and face uncovered (no bonnet, no hood, hooded clothing).
- ☐ Cords hanging from blinds, curtains, electrical appliances and mobiles are out of reach of a child inside the cot.
- ☐ Heaters or electrical appliances are well away from the cot to avoid the risk of overheating. No electric blankets.
- ☐ Cot (new or second hand) meets the mandatory Australian Safety Standards (AS 2172) above.
- ☐ Portable cot complies with the mandatory Australian Safety Standard (AS 2195).
- ☐ Locking pin is firmly in place in bassinets/cots that rock whenever baby is unsupervised.
- ☐ Mattress is firm, clean, well fitted and flat, with less than 20mm gap between mattress and cot.
- ☐ Plastic packaging is removed from the mattress before use.
- ☐ Cot is made up with baby's feet positioned at the bottom of the cot.
- ☐ No loose bedding, quilts, doonas, pillows, cot bumpers, sheepskins or soft toys in the cot.




Topics for discussion with parents

Sleep baby on the back from birth, not on the tummy or side.

- [ ] Healthy babies placed on the back to sleep are less likely to choke on vomit than tummy sleeping infants.
- [ ] The chance of babies dying suddenly and unexpectantly is greater if they sleep on their tummies or side.
- [ ] Tummy play is safe and good for babies when they are awake and an adult is present.
- [ ] Older babies can turn over and move around the cot. Put them on their back but let them find their own sleeping position and make sure that the sleeping environment is safe for baby for when they can roll on their tummy. The risk of SIDS in babies over six months is extremely low.

Sleep baby with head and face uncovered

- [ ] All head coverings including hats, bonnets, hooded clothing, are all removed before baby is placed for sleep.
- [ ] Baby's feet are positioned at the bottom of the cot
- [ ] Bedclothes are tucked in securely so bedding is not loose, or place baby in a safe sleeping bag.
- [ ] Hammocks can be dangerous for young babies if they are unsupervised and not positioned on their backs.

Keep baby smoke free before birth and after

- [ ] The risk of SIDS is increased if parents are smokers, both during the pregnancy and after the baby is born
- [ ] If the mother smokes the risk of SIDS doubles and if the father smokes too the risk doubles again.

Provide a Safe Sleeping Environment night and day. Adding to the key messages on the front of this Safe Sleeping Checklist

- [ ] Soft bedding, such as soft mattresses, or folded doonas, pillows and cushions and sheepskins should not be used as substitutes for mattresses.
- [ ] Do not sleep baby or sleep with baby on a sofa or couch.
- [ ] There is a very high risk of a sleeping accident occurring.
- [ ] Portacots: Use the mattress that is supplied with the cot **(AS2195)**
- [ ] Never add a second mattress or additional padding under or over the mattress supplied with the portacot.
- [ ] Portable cots are only intended for temporary use and convenience when travelling and should not be used on a long-term or permanent basis.

sids and kids® VICTORIA

- [ ] Bouncinettes, rockers and prams should not be used as a sleeping environment unsupervised and restraints should be done up properl when in use.
- [ ] Do not sleep baby or sleep with baby in a water bed can be dangerous and are not considered a safe sleeping environment for infants.
- [ ] The risk of an accident is increased if baby or toddler is left unsupervised and alone on an adult bed or a bunk bed

Sleep baby in their own Safe Sleeping place in the same room as an adult caregiver for the first 6 six to twelve months.

- [ ] Sharing a sleep surface with a baby increases the risk of Sudden Infant Death Syndrome (SIDS) and fatal sleep accidents in some circumstances.
- [ ] Sleeping a baby in a cot next to the parent's bed for the first six to twelve months of life has been shown to lower the risk of SIDS.
- [ ] There appears to be no increased risk of SIDS whilst sharing a sleep surface with a baby during feeding, cuddling and playing providing that the baby is returned to a cot or a safe sleeping surface before the parent goes to sleep.
- [ ] Babies who are most at risk of SIDS or sleeping accidents whilst sharing a sleep surface, are babies who are less than four months of age, and babies who are born premature or small for gestational age.

Breastfeed baby if you can

- [ ] There is strong evidence that breastfeeding baby reduces the risk SIDS

Carers and Baby sitters

- [ ] Carers and baby sitters need to know the recommendations to reduce the risk of SIDS and how to create a safe sleeping environment for babies and infants. This includes baby sitters, grandparents, day care, child care centres and the homes of family and friends.

Authorised by:
Department of Education and Early Childhood Development

Revised August 2012

Useful Contacts

Toy & Nursery Safety Line 1300 364 894
www.consumer.vic.gov.au

Maternal and Child Health Line 132229
www.education.vic.gov.au/earlychildhood/mch/

http://sidsandkidswa.org/assets/info-statements/room_sharing.pdf