PROCEDURE	
Children in Care – conducting an assessment	
Scope (Staff):	Community health staff
Scope (Area):	CAHS-CH, WACHS

This document should be read in conjunction with this DISCLAIMER

Aim

To enable community health staff to meet legislative and departmental requirements for referral management within the health care planning pathway for children in care (CIC).

Risk

Failure to follow this guideline may result in a:

- child's health / developmental needs not identified or addressed in a timely manner
- failure to meet performance indicators.

Background

Children who come into care are traumatised and vulnerable. Children are entering care at a younger age and staying in care for longer[1]. Aboriginal* children are over-represented, currently constituting 55% of children in care in WA[2]. Most commonly, children enter care as a result of emotional abuse or neglect[1]. Family and domestic violence, mental health issues and drug and alcohol misuse are significant contributing factors, as are intergenerational trauma and social disadvantage[3, 4]. The impact of these factors can persist resulting in children having complex health needs and being at high risk of poor physical, developmental and psychosocial health outcomes[5, 6]. Opportunistic health care is an inadequate long term solution to meeting the chronic and complex health needs of these children.

The National Clinical Assessment Framework for Children and Young People in Out-of-Home Care 2011[7] (children in out-of-home care are known as "children in care" in WA) is aligned under the National Framework for Protecting Australia's Children 2009-2020[8]. The former Framework describes the scope and focus of health assessments for children in care according to specified age groups.

The *Children and Community Services Act* 2004[9] ("the Act") is the legal framework guiding the protection and care of children in WA. The Department of Communities Child Protection and Family Support (CPFS) administers the Act and is the key government organisation providing child safety and family support services. The Act requires children in care to have a care plan which identifies their needs while they are in care, and outlines measures to address those needs.

* Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

The healthcare planning pathway for children in care is informed by *Guidelines for Protecting Children* 2020[4], *Bilateral Schedule between the Department for Child Protection and Family Support and WA Health for collaborative responses to: child abuse and neglect identified by WA health; and children in care*[10], the *Level 1 Strategic Bilateral MOU between WA Health and Department for Child Protection 2011-2015*[11], *Schedule Between the Department for Child Protection and Family Support and WA Health Care Planning for Children in Care (January 2015)*[12] and *Joint guidelines on information sharing between WA Health and CPFS*[13].

CPFS and WA Health are signatories to the Cabinet endorsed Rapid Response framework[14], which prioritises access to services for a child in the CEO's care. The Schedule[12] states that all health service providers should prioritise services on the basis of clinical need and acknowledges children in care have high needs.

Role of Department of Communities Child Protection and Family Support

CPFS is responsible for the wellbeing of children in care in WA[3]. The Chief Executive Officer (CEO) assumes parental responsibility for most children in care as described in the Act. In practice for those children, the CEO delegate's authority to give consent, and develop and implement a child's care plan, to a case manager, in lieu of a parent.

In most cases consent for the provision of health services must be obtained from CPFS before the service is provided. Where the CEO does not have responsibility for a child under the Act, or an agreement under a negotiated placement agreement to provide consent on behalf of a child who is not a mature minor, consent from the person with parental responsibility for that child needs to be sought by the case manager (see Information Sharing, Communication and Consent).

CPFS must ensure each child in care has a care plan which identifies their needs across nine areas of care planning, including health needs, and outline measures to address those needs. The CPFS case manager is responsible for developing and implementing a child's care plan. This includes responsibility for making decisions regarding any medical or dental examination, treatment or procedure on behalf of the child (The Act; S29(2) and 29(3A))[9]. A child's appointed carer is responsible for their day to day physical and emotional care; including universal child health schedule contacts (see CAHS *Consent for Services* operational policy).

Role of Community Health Staff

Children in care will have been exposed to a range of adverse experiences[1, 15], and are at high risk of health and developmental vulnerability[5, 6]. For this reason, Health Service Providers should prioritise undertaking comprehensive health assessments and health care planning to identify and address any health and development concerns.

For a child new to the CEO's care, the health assessment will be undertaken **within 30 business days** (6 weeks) of either Child and Adolescent Health Service - Community Health (CAHS-CH) or WA Country Health Service (WACHS) receiving a completed referral from CPFS[12]. For all other children in the care of CPFS, the timeframe to undertake the assessment will be based on clinical need, acknowledging that children in care have high needs[12], and availability of resources. CAHS-CH staff will aim to complete annual assessments **within 30 business days** (6 weeks) and WACHS staff will aim to complete annual assessments within **60 business days** (12 weeks) of receiving a completed referral.

Community health staff must send a report on the assessment outcomes **within five business days** (1 week) of the assessment. This report must be **written in a way that may be understood by a lay person** with a focus on a child's health needs, priorities and actions required to inform the development of a 12 month health care plan. The report must also identify the consequences for the child if the recommendations are not followed.

Community health staff must liaise with relevant parties and implement strategies which will produce the best outcome for the child. This may include **liaising with the child, the child's case manager, carer, other health service providers, teacher, student service team and others** who may have information about the child's physical, developmental and or psychosocial wellbeing. Obtaining information from multiple sources is important to corroborate information or identify inconsistencies which may highlight areas of concern.

The development of the health plan is intended to be a collaborative process between a child's case manager and those health professionals informing the plan. Community health staff may be consulted to support this process, as CPFS staff may not have a health background and their knowledge of the health system may be limited.

Community health staff may also be asked to support CPFS case managers in identifying an appropriate health service provider for a child, particularly where they assess the child's health needs would be better managed by an alternative provider.

The Healthcare Planning Pathway

The Schedule[12] to the Strategic Bilateral Memorandum of Understanding between CPFS and WA Health[11] (referred to as "the Schedule") outlines the joint processes and procedures between CPFS and providers of community health services to support provision of health assessments and health care planning for a child in the CEO's care, where entities and contractors of the WA Health system are the service providers.

The Health Care Planning Pathway describes a multi-agency model for the management of the health needs of children in care through coordinated, regular health assessments which inform and review a child's health care plan. In order that a child's current and emerging health needs are identified the health assessment must be holistic; addressing the physical, developmental and mental health domains. CPFS is responsible for identifying when a child in care requires a health assessment through their case review cycle.

The pathway comprises three phases:

- **Initial Medical Assessment:** a General Practitioner (GP) or Paediatrician provides screening and preliminary assessment of the child's health and wellbeing to identify and treat any immediate health concerns. In the case of a newborn, a recent paediatric review such as at hospital discharge may be substituted for an Initial Medical Assessment.
- **Comprehensive Health Assessment:** a health care provider, most commonly community health nurses or a GP, provides a more in depth assessment across each health domain.
- **Annual Review:** a health care provider, most commonly a nurse or GP, provides ongoing monitoring of a child's health needs to ensure current and emerging health issues and required actions are identified. Each child's health care plan should be reviewed annually by a health care provider, using a comprehensive health assessment form as a guide. However, the frequency of monitoring different components of the assessment should be a clinical decision for each individual and

have both case-dependent and age-dependent considerations. The depth of the assessment should be appropriate for the age, risk factors, clinical needs and any major changes in circumstances of the child at the time of assessment.

All processes in the health care planning pathway must focus on the best interests of a child in care and include:

- A child centred, age appropriate and culturally respectful assessment process.
- Effective information sharing and collaboration between community health staff and CPFS.
- Engagement of children in the assessment process. Wherever possible, their views on their own health and wellbeing is invited and taken into account. Children are kept informed of matters that affect them, according to their age and capacity to understand and consent to a service. Their rights to confidential health care and issues of consent must be acknowledged, discussed (including the limits of confidentiality) and respected.
- Engagement of carers, considering their views and, where appropriate, sharing information with them. Carers can be invited to support a child by attending assessment appointments (where age appropriate), provide information to help identify areas of concern for a child and be made aware of any health issues and requirements.
- Acknowledgement of issues of trauma and associated effects on physical health, development, social and emotional wellbeing, and educational outcomes. These are considered holistically rather than in isolation.
- Continuity of health care providers to allow relationships to develop. Maintenance of this relationship supports the ongoing health needs of a child. If a child already has a relationship with a particular primary care provider, then that relationship is utilised in health care planning assessments wherever possible. A carer's preference for a particular health care provider is also considered.
- Utilisation of standardised, evidence-based screening and assessment tools wherever appropriate/practicable in assessments.

Groups of children in care with special considerations for their health care pathway

1. **Children from a culturally and linguistically diverse background (CaLD)**: There are a number of considerations needed in meeting the health needs of these children, such as whether an interpreter service is required, gender of the health assessment provider, use of culturally appropriate screening tools and assessments, an understanding of trauma experienced prior to (such as war) or since moving to Australia (e.g. social isolation), and specific physical health considerations such as potential exposure to communicable diseases.
2. **Aboriginal children**: More than 55 per cent of children in care in Western Australia are Aboriginal[2]. It is important to determine whether the child/carer would prefer for the health care planning health assessments be completed by an Aboriginal service provider.
3. **Children with a disability**: Children in care with a diagnosed disability may be engaged with disability-specific services. Although a child may already be under the care of a health team, the case manager should discuss health care planning

assessments with current health providers to ensure all aspects of the child's health care are being addressed, such as immunisation or oral health care. The process of assessment through this pathway may lead to some children becoming eligible for disability services.

4. **Newborns**: Where a child is taken into provisional protection and care at birth their immediate health needs will have been addressed in discharge planning processes as outlined in the *Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as At Risk of Abuse and/or Neglect* (OD 0518/14). Health care planning assessments therefore need to align with these arrangements, and involve those professionals already engaged in the care of the newborn. A recent paediatric review may be accepted for new to care referrals in lieu of an Initial Medical Assessment.

Information Sharing, Communication and Consent

The information sharing protocols that support the Schedule[12] and this procedure are outlined in the *Joint guidelines on the mutual exchange of relevant information between WA Health and the CPFS*[13] for the purpose of promoting the wellbeing of children.

The method for sharing information between community health staff and CPFS staff is bound by organisational policies[11]. In health care planning:

- CPFS policy is to email all referrals and supplementary information.
- Community health staff must communicate all confidential information, including health assessment information, to CPFS in accordance with the Department of Health (DoH) *Information Security Policy* (MP 0067/17). My File Transfer / My File eXchange (MyFT/MyFX) allows for encrypted electronic transfer of confidential information. Confidential information should not be sent via unencrypted email.
- DoH *Guidelines for the Transmission of Personal Health Information by Facsimile Machine* (IC0179/14) requires nurses to notify the case manager or CPFS District Office if the report is being sent by fax, or follow up to ensure the report has been received.
- In the first instance, communications should be with the CPFS case manager. The CPFS team leader should be contacted when a case manager is not contactable. Contact details are provided on the CPFS Form 510.

Consent for health assessments is given by the person who has parental responsibility for decisions made on behalf of the child. Where CPFS does not have parental responsibility to provide consent, the case manager will obtain consent from a person who has parental responsibility. In the case of a child assessed as a mature minor, he or she can provide consent on their own behalf to assessment, treatment and release of confidential information[4]. See CAHS-CH *Consent for services* policy.

Key Points

- Children in care are a group at high risk of poor physical, developmental and psychosocial health outcomes.
- Department of Communities Child Protection and Family Services (CPFS) case managers are delegated the responsibility of developing and implementing care plans for each child in the care of the CEO. Health assessments inform the health component

of the child's care plan, comprise the physical, developmental and psychosocial domains of health and wellbeing and are reviewed annually.

- Community health staff will support the CPFS case managers and carers to be responsive to, and plan for, the health needs of children in care.
- The best interests of the child are the paramount consideration. Healthcare planning should be a collaborative process between the child, CPFS case manager, carer (if appropriate) and most appropriate health service provider.
- The health service system in WA is complex and CPFS case managers and the child's carer need to be informed and supported to enable a child in care to access the appropriate service.
- Difficulties in communication with a CPFS case manager will be escalated to the relevant CPFS team leader as required. See *Guidelines for Protecting Children 2020*[4] for further information.
- If a nurse is aware that a child in care is due for an annual health assessment, the nurse can request a referral for a Comprehensive Assessment from CPFS.

Process

This procedure should be read in conjunction with *Children in Care – managing referrals for assessment* guideline.

Whilst assessments need to be conducted on a case by case basis, sensitive consideration and professional judgement is required to provide an assessment which covers the scope of each health domain and which may require accessing alternative sources of information on the child.

Appendix A outlines the key steps in the process for nurses managing CIC referrals.

The CIC assessments may be conducted simultaneously with scheduled age-appropriate contacts to avoid duplication of services. See Appendix B for further information.

Steps	Additional Information
Receive referral **CAHS-CH:** Referrals from a CIC Key Contact are assigned to community health nurses in the Child Development Information System (CDIS). Alert flags are generated automatically by CDIS for children in care. A notification will be sent by email once a referral has been assigned by a CIC Key Contact. **WACHS:** A CIC Key Contact will allocate CIC referrals by forwarding the referral email to a nurse. All children (0-18 years) who are in the care of CPFS require a *child at risk alert* to be entered into webPAS, which flows through to Community Health Information System (CHIS) automatically. Refer to the WACHS *WebPAS Child at Risk*	A child's CPFS case manager will make a referral for a comprehensive health assessment, either for a child new to care or as an annual review, using CPFS Form 510. This will be received by the community health Central Referral Administration and allocated to a CIC Key Contact. All referrals for a comprehensive health assessment sent directly from CPFS to nurses must be returned to CPFS with the response stating the referral must be resent to DOH.CICreferrals@health.wa.gov.au

Steps	Additional Information
Alert procedure for more information.	
Review referral Review the referral form and all attachments for: • type of referral - new to care, annual review or special request. • continuity of care – would the child benefit more from receiving an assessment from an appropriate, current service provider or community health? • information required from the CPFS case manager prior to conducting the assessment. Have they indicated on the referral form that a discussion regarding the child is advisable prior to the assessment? • Date of CPFS Annual Health Care Planning Meeting if known.	**If you are unable to contact the CPFS case manager, contact their team leader.** Acceptance of the referral is at the discretion of the Key Contact and the nurse. If there are factors indicating that the referral should not be accepted at this time, and the Key Contact and nurse agree to decline the referral, the referral must be returned to CPFS (or declined in CDIS – CAHS-CH) with the reason for decline and advice as to how to proceed. The Key Contact will advise CPFS of declined referrals. Reasons for declining a referral may include: • the child is currently undergoing assessments with other service providers • the assessment should be aligned with the due date of next health care plan so as to inform the plan • due to the child's current change in circumstances, the assessment would not yield accurate or useful information (for a 12 month health care plan) about their physical, developmental and/or psychosocial health.
Schedule an appointment Contact the carer identified on the referral form (or child if a mature minor). • A minimum of 2 attempts should be made to contact the carer and/or child within 10 working days of receiving the referral. • Determine the carer's/child's preferred service provider. • Book an appointment time (1 hour) for the assessment. • Request the carer/child bring their CPFS Child Health Passport if possible. Discuss with the carer: • any concerns for the child's wellbeing • if they would like to be present at the assessment	It is not the responsibility of community health staff to locate a child or reassign the referral using contact details which differ from the referral form. If a child or carer cannot be contacted via the details provided, the referral must be declined by the Key Contact and returned to CPFS (refer CAHS-CH and WACH processes). Special consideration of service provider may be required for some children in care, including: • children with a CaLD background • newborns and infants who are being monitored by a paediatrician • children with disabilities or complex medical issues • Aboriginal children:

Steps	Additional Information
• options for providing the assessment particularly where a group of siblings require assessment. If the carer cannot be contacted, the carer or child declines the assessment or the child does not arrive for two appointments: **CAHS-CH:** Nurse to advise the Key Contact or nurse manager. Document the reason for decline in CDIS. **WACHS:** Return the referral to the case manager directly with the reason for not conducting the requested assessment. Notify the Key Contact of the return and keep a copy of the correspondence in the client record.	○ **CAHS-CH:** if the child is under 5 years, ask whether the carer would prefer to receive an assessment from the AHT or another Aboriginal Health Service. If the AHT is nominated, advise the CIC Key Contact. If a different Aboriginal Health service is nominated, the Key Contact will return the referral directly to the CPFS case manager with name of the preferred service provider. ○ **WACHS:** the child's health assessment may be provided by WACHS Community Health Services or a partner agency, according to carer's preference, local and contractual arrangements. Involving a child's carer in the assessment process wherever possible: • provides support for the child during the assessment • allows the carer to provide supplementary information • ensures the carer receives information on all health concerns and the actions recommended. If required, liaise with the organisation/staff member in charge of room bookings at the assessment location as well as the carer to organise a room, date and time to complete an assessment. For home visits see the *Home and Community Visits* procedure for guidance Mature minors may wish to: • attend on their own or have their carer or another person present • have the assessment with a nurse or another service provider (e.g. usual GP). If a different service provider is preferred, the Key Contact will return the referral to the CPFS case manager, with recommendation to redirect the referral to this provider.
Assessment preparation • Check immunisation records where possible. • Identify if the referral is for a child new to care or annual review.	If it is identified that immunisation is required, contact the case manager to obtain consent and to discuss when the immunisations could be provided. Immunisation services: CAHS-CH / WACHS

Steps	Additional Information
○ Where a child is new to care, a full comprehensive health assessment is required. ○ Annual reviews may be customised to reflect monitoring of existing issues from previous assessments or the current CPFS health care plan together with any new concerns identified in each health domain. • Identify modification to the assessment process required when combining other assessments (see Appendix B for more information). • View the *CIC Comprehensive Health Assessment Reference Guide: 0 -18 years* for more information on specific assessment items. • Have any concerns been identified by the case manager, carer, teacher, student service team or child in the previous assessment or more recently? • Consider other sources which may assist in identifying concerns about a child such as their carer, classroom teacher, the student services team and other health care providers. • Obtaining information from multiple sources is important to corroborate information or identify inconsistencies which may highlight areas of concern. • Identify if the child is due for any scheduled age-appropriate contacts and conduct simultaneously. • Review all information available from previous contact with the child.	CPFS conducts annual psychosocial screening of children in care 4 - 18 years of age using the Strengths and Difficulties Questionnaire (SDQ), commencing when the child has been in care for six months and is settled in their placement. Any concerns or referrals arising from the SDQ are included in CPFS Referral Form 510, Section 2. For children new to care, assessment of each health domain is necessary to create a complete health picture for each child. Annual reviews focus on monitoring existing health concerns and identifying new concerns through questioning, self-report and assessment as indicated. The frequency of monitoring different components of the assessment should be a clinical decision for each individual and have both case-dependent and age-dependent considerations. The depth of the annual review assessment should be appropriate for the age, risk factors, clinical needs and any major changes in circumstances of the child at the time of assessment. Ideally, an annual review assessment should precede the date for the next case review meeting (provided in CPFS Referral Form 510, Section 2) in order to facilitate timely review of a child's health care plan. Teachers or a relevant member of the student service team may be approached with a checklist if concerns are specific to areas such as fine and gross motor skills, psychosocial and speech (see CAHS-CH resources-*Teacher Checklists*).
Conduct an assessment: general health information for all children in care assessments • Include issues identified on paediatric discharge summary (relevant to all age groups if information available). • Current medications and past medications. **Assessment tools**	**Physical**: must include the identification of any concerns regarding nutrition, growth indicators, skin integrity and hygiene, ears and hearing, eyes and vision, sleep behaviours and oral health. • **Dental Health:** Children in care are eligible for assessment and treatment of dental concerns through North Metropolitan Health Service (NMHS) Dental Health Services (DHS) which

Steps	Additional Information
• View the *CIC Comprehensive Health Assessment Reference Guide: 0 -18 years* for more information on specific assessment items. • Some tools are parent informed which can be challenging to administer and interpret in the context of this group of children, and where a child is experiencing stress and anxiety from being brought into care. • To help identify concerns for the child, alternative sources of information such as the case manager, carer, teacher, student services team or biological parent (where appropriate) may be consulted and/or directly assessed using developmental, social and emotional milestones as required. • If aspects of developmental, psychosocial and mental health can only be partially assessed, delaying the use of an assessment tool until a child is settled in their placement may be warranted. It is vital to note this on the report to CPFS, together with the recommended follow-up action. • Where it is not possible to assess an element/s of the child's health as outlined by the assessment form, ensure advice on how, when and by whom this should be assessed or referral to an appropriate health professional is completed as part of the assessment and/or report. Some children may require more than one appointment to complete a comprehensive health assessment.	coordinates this aspect of the health care planning pathway. Children in care are prioritised for assessment and treatment by DHS. The CPFS case manager, as a safety net, enrols all children in care of school age (5 years and above) in the school dental service, although most will already attend this service. Oral health remains a component of health care planning assessments as concerns may arise between school dental service appointments. Prior to school age, an oral health inspection is part of the health assessment and referral to DHS by the CPFS case manager follows if required. **Developmental** *How Children Develop* is a resource for nurses which includes developmental, social and emotional milestones and warning signs for children 0-12 years. This may be used to guide the assessment or specific concerns requiring investigation where a developmental tool is not readily available or appropriate. **Mental health screening** Due to the high proportion of children in care with complex health issues, mental health screening is very important. If SDQ results are available, liaise with CPFS case manager regarding any concerns. If an SDQ has not been conducted, follow the recommended psychosocial assessment appropriate for of the child in this guideline. For annual reviews, it is still important that either through assessment or interviewing, all domains of the assessment scope are covered to identify new concerns. For example, with vision assessment, if the child has no previous concerns identified, and no new concerns are noted on the referral, then the vision component of the assessment may be covered by asking the child or carer if they have any concerns

Steps	Additional Information
	about vision or recommendation for an optometrist assessment of the child's vision could be made for older school aged children if appropriate.
Conduct an assessment: **Child in care 0-5 years old** (Form: CHS450) Refer to: • *Practice Guide for Community Health Nurses* • *Children in Care Comprehensive Health Assessment Reference Guide: 0-18 years* • *How Children Develop* • General • Physical • Developmental • Psychosocial and Mental Health • Safety issues and carer's health promoting behaviours. While the Universal Contact Schedule/ Enhanced Child Health Schedule 0-5 years and the health care planning pathway are separate processes, it is recommended to align these assessments where possible. Where applicable, align with School Entry Health Assessment (in the Universal contact schedule 4 year guideline) processes.	Assessment must cover the following domains: **General** Past and present health concerns including current management plan, family history, immunisation, medications, allergies, nutrition and physical activity. **Physical** Growth monitoring, skin integrity and hygiene, ears and hearing, eyes and vision, sleep behaviours, breathing and oral examination (Lift the Lip). • If an oral health referral is required, advise CPFS case manager in the assessment report to contact the relevant Dental Health Service clinic to arrange an appointment. **Developmental** • Tools - Ages and Stages Questionnaire-3™ or ASQ TRAK. • SEHA • Speech, language and communication - play and pre-literacy/ literacy skills. • Gross and fine motor development • Cognition – assess problem solving skills. **Psychosocial** • Tool - Ages and Stages Questionnaire-3:SE-3™. • Mental health – indicators of trauma associated with past abuse and neglect. • Behavioural –sleep and self-regulation, self-harm, behaviour. • Emotional development – attachment disorders, relationship insecurity. • Social competence – socialisation, social skills including self-help skills, and communication. • Development of cultural and spiritual identity for Aboriginal and Torres Strait Islander children and as appropriate for

Steps	Additional Information
	other populations.
Conduct an assessment: **Child in care 6-11 years old** (Form: CHS450) Refer to: • *Children in Care Comprehensive Health Assessment Reference Guide: 0-18 years* • *How Children Develop* • General • Physical • Developmental • Psychosocial and Mental Health	Assessment must cover the following domains: **General** Past and present health including management plan, family history, immunisation, medication, allergies, nutrition and physical activity. **Physical** - Growth monitoring, skin integrity and hygiene, ears and hearing, eyes and vision, sleep behaviours, breathing and oral health examination. • Oral health should be discussed and any concerns identified. If an oral health referral is required, advise CPFS case manager in the assessment report to contact the relevant Dental Health Service clinic to arrange an appointment. **Developmental** *How Children Develop* is a resource for nurses which includes developmental, social and emotional milestones and warning signs for children 0-12 years. This may be used to guide the assessment of specific concerns requiring investigation where a developmental tool is not readily available or appropriate. • Speech, language and communication - play and literacy skills. • Gross and fine motor development. • Cognition – assess problem solving skills. **Psychosocial** • Mental health – indicators of trauma associated with past abuse and neglect, self-esteem, and enjoyment of life/depression. • Behavioural – sleep and self-regulation, self-harm, sexual behaviour, behaviour. • Emotional development – attachment disorders, relationship insecurity. • Social competence - social skills, self-help skills, awareness of basic safety issues such as road safety, talking with

Steps	Additional Information
	strangers. Gentle enquiry into the child's perception of their own safety and from whom they would seek help if they were feeling unsafe. • Health literacy on understanding of healthy lifestyle (diet, exercise, screen time and sleep), pubertal changes, and risks of substance use. • Development of cultural and spiritual identity for Aboriginal and Torres Strait Islander children and as appropriate for other populations. Consider how the carer responds/ manages these issues.
Conduct an assessment: **Child in care 12-18 years old** (Form: CHS450) Refer to: • *Children in Care Comprehensive Health Assessment Reference Guide: 0-18 years* • *How Children Develop* • General • Physical • Developmental • Psychosocial and Mental Health	Assessment must cover the following domains: **General** Past and present health including management plan, family history, immunisation, medication, allergies, nutrition and physical activity. **Physical** - Growth monitoring, skin integrity and hygiene, personal hygiene, ears and hearing, eyes and vision, sleep, breathing, and oral health examination. • Oral health should be discussed and any concerns identified. If an oral health referral is required, advise CPFS case manager in the assessment report to contact the relevant Dental Health Service clinic to arrange an appointment. **Developmental** • History of developmental issues. • Speech, language and communication - play and literacy skills. • Gross and fine motor skills • Cognition – assess problem solving skills. **Psychosocial** • Tool – HEADSS (if appropriate). • Mental health – trauma related behavioural issues, self-esteem, and enjoyment of life/depression. • Behavioural –sleep and self-regulation, self-harm, sexual behaviour problems, sexual activity and behaviour,

Steps	Additional Information
	independent living skills, partner violence, behaviour. • Emotional development – attachment disorders, relationship insecurity and sexual knowledge. • Social competence - social skills, self-help skills, awareness of safety issues. • Development of cultural and spiritual identity for Aboriginal and Torres Strait Islander children and as appropriate for other populations.
Record outcomes and develop report **CAHS-CH:** Complete the relevant CIC Comprehensive Assessment Form and CDIS CIC module. Additional clinical notes can be recorded in the health record. After providing the report to CPFS, complete a CNP for service type "CIC Report sent to DCPFS (CIC only)". **WACHS:** Complete the relevant CIC Comprehensive Assessment Form and Health Improvement Plan (attached to referral). The health improvement plan/report must directly address: • concerns or requests identified on the referral form, previous health assessment and/or health care plan. • assessment tools completed. • sources of information that have contributed to the assessment, such as the carer, teacher etc. • physical, psychosocial and developmental concerns identified in the assessment which require action in the next healthcare planning cycle (12 months). Include information about required timelines. • If all components of an assessment are not completed in one appointment, record outcomes from the initial appointment in the Child Health Information System (CHIS), noting how these will be addressed. See WACHS *CHIS Child Health Clinical Item Guide*. • Referrals enacted or required. • Timing of any Universal Contact or	• Information on assessment/s is required by a child's CPFS Case Manager to update their health care plan as part of their care plan review. • Writing style - The report must be completed using language as you would use with a parent. The information will be read, interpreted and recorded by CPFS staff who may have varying levels of health literacy. • Anticipatory guidance - Wherever possible, the report should provide anticipatory guidance on issues which affect the management of health concerns, timing of future health assessments or follow up appointments, so that services and appointments can be coordinated. • Where referrals and/or actions are suggested, the potential consequences of the child not seeing the recommended health professional should be outlined, for example a child's vision will never develop in the eye affected by amblyopia if the child is not referred to an ophthalmologist for treatment. • No concerns - Where there are no concerns, state "No concerns have been identified at this time." Consider providing an overview of what was covered in the assessment. Indicate the date of any scheduled appointments. • Complete Child's Health Passport if available. **CAHS-CH considerations** • If all components of an assessment are

Steps	Additional Information

Enhanced Child Health Schedule visits due in the next year.	not completed in one appointment, record outcomes from the initial appointment (in CDIS – CAHS-CH).
	• Determine when an additional appointment can be arranged.
	  ○ If this is arranged 1 to 2 weeks after the initial appointment, it may be treated as the same service event. Additional information is entered into CDIS and the report for CPFS finalised when the additional appointment is completed. The referral can then be closed by the CIC Key Contact.
	  ○ If the additional appointment is arranged for a later date, it should then be treated as a follow-up appointment from a process perspective. The report from the initial appointment should be generated, including information on the components not assessed and the date of the follow-up appointment and the report provided to CPFS. The referral can then be closed by the CIC Key Contact.
	• Follow up appointment for assessment – a follow up required by the CAHS-CH nurse is deemed to be a separate service event and must be recorded in CDIS as a separate service (see *CDIS tip sheet*). The original CIC referral must be closed and not left open for a follow-up appointment. A report on the follow-up appointment should be sent to the CPFS Case Manager to allow them to further update a child's health plan with additional findings, actions and recommendations.
	• Referrals - If assessment identifies an additional health service is required, this should be discussed with the CPFS case manager in person or by telephone. A decision should be reached regarding who will make the referral. Refer to the CAHS-CH *Consent for Services* policy for further information on consent requirements. It is important that the CPFS case manager is aware of the findings and

Steps	Additional Information
	any recommendations of any additional appointment / service so they can modify the child's health plan.
Send report **1. CPFS case manager** Send the report/ Health Improvement Plan to the CPFS case manager via MyFT/MyFX or fax **within five days** of completing the assessment. **2. CIC Key Contact** **CAHS-CH:** in CDIS, a Client Not Present (CNP) must be completed by the nurse for the activity of sending the report to the CPFS case manager. **WACHS:** send the following information to your CIC Key Contact according to the local communication process: • name of CHN • date assessment completed • date report forwarded to CPFS • comments or information • if no assessment, reason and date referral returned to CPFS.	The Comprehensive Assessment form should be scanned into CDIS or CHIS, and filed in the paper client health record. Scanned documents must meet the minimum requirements of the DoH *Digitisation and Disposal of Patient Records* policy (OD0583/15).

Follow-up

If the nurse requests a discussion about the assessment for the development of the child's health care plan on the report/Health Improvement Plan, the case manager should directly contact the nurse within 20 business days (4 weeks) of receiving the report. If there are concerns that require more urgent action or follow up than this timeframe allows, the nurse should contact the CPFS case manager or team leader.

Documentation

Community health staff must keep a record of the comprehensive health assessment referral form, CAHS-CH or WACHS and CPFS consent documents for individual assessments and the Health Improvement Plan/Report forwarded to CPFS. All documentation regarding children in care must be completed using minimal medical terminology and no shorthand, as the information reported will be read, interpreted and recorded elsewhere by CPFS staff who may not have a health system background or clinical training.

Monitoring

- Assessments for children new to care will be undertaken within 30 business days of receipt of a completed referral from CPFS.
- Annual reviews will be undertaken within 30 business days (CAHS-CH) or 60 business days (WACHS) of receipt of a completed referral from CPFS.

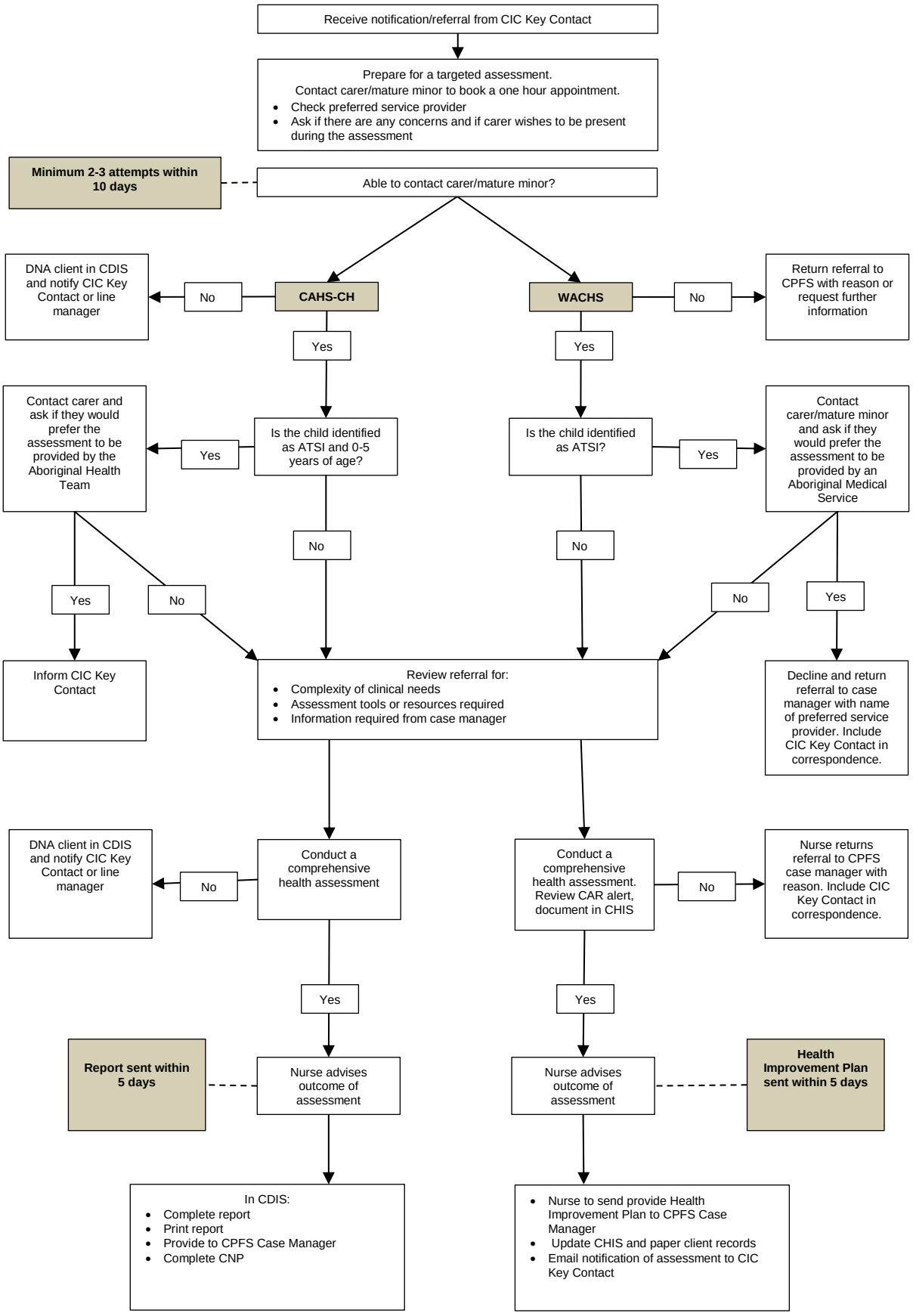
- The report will be sent to CPFS within 5 business days of completing the assessment.

Appendices

Appendix A: Community health nurse CIC health referral management process

Appendix B: Summary of Community Health Schedule for children in care

Appendix A
Community health nurse CIC health referral management process



Appendix B
Summary of Community Health Schedule for Children in Care

Age	Assessments	Comments
Birth to school entry 0-4.5 years	Where possible the CIC comprehensive health assessment should align with the Universal Child Health Contact Schedule and the Enhanced Child Health Schedule. Children in Care Comprehensive Health Assessment 0-18 years (CHS450) ***Plus*** Oral Health Inspection	Where possible provide services as per Universal services or Universal Plus services. Ensure the child health record is completed and conduct routine assessment. Additionally, perform an oral health inspection.
School Entry (Kindy or Pre-primary 4 years and older	CHS409-1 School Entry Assessment ***Plus*** Children in Care Comprehensive Health Assessment 0-18 years (CHS450) ***Plus*** If required, Oral Health Inspection.	CHNs are able to request a list of children in care from the school principal at the beginning of the school year. When scheduling an appointment for a comprehensive health assessment, as a courtesy, advise the school principal that the assessment is for a 'child in care'. Ensure CHS409-1 is completed and conduct routine School Entry Health Assessment. From the year they turn five, school-aged children will be enrolled by CPFS with the School Dental Service.
Primary School 6-11 years	Children in Care Comprehensive Health Assessment 0-18 years (CHS450)	No universal annual assessments occur within this age group.
High School 12-18 years	Children in Care Comprehensive Health Assessment 0-18 years (CHS450) If required, use HEADSS as a psychosocial and mental health assessment.	No universal annual assessments occur within this age group.

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10. Department for Child Protection and Family Support and WA Health. Bilateral Schedule between the Department for Child Protection and Family Support and WA Health for Collaborative responses to: Child Abuse and Neglect Identified by WA Health; and Children in Care. 2017.
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14. Department of Communities. Rapid Response: Prioritising services for children and young people in care. 2019.
15. Western Australian Department of Communities. Child Protection Activity Performance Report 2017-2018. Perth, Western Australia; 2018.

Related policies, procedures and guidelines
The following documents can be accessed in the **Clinical Nursing Manual** via the HealthPoint link, or the Internet link or for WACHS staff in the WACHS Policy link
Ages and Stages Questionnaires (ASQ)
Children in Care – managing referrals for assessment
HEADSS adolescent psychosocial assessment
Universal child health schedule
The following documents can be accessed in the CAHS-CH Operational Manual
Client Record Transfer
Consent for Services
The following documents can be accessed in WACHS Policy
Enhanced Child Health Schedule
WebPAS Child at Risk Alert
The following documents can be accessed in the Department of Health Policy Frameworks
Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as At Risk of Abuse and/or Neglect (OD0518/14)
Digitisation and Disposal of Patient Records (OD0583/15)
Guidelines for the Transmission of Personal Health Information by Facsimile Machine (IC0179/14)
Information Security policy (MP0067/17)

Related CAHS-CH forms
The following forms can be accessed from the CAHS-Community Health Forms page on HealthPoint
CHS409-1 SEHA Parent Questionnaire
CHS450 Children in Care Comprehensive Health Assessment 0-18 years

Related CAHS-CH resources
The following resources can be accessed from the CAHS-Community Health Resources page on HealthPoint

CDIS tip sheets (W:\CACH\Common Folders\CDIS)
Children in Care Comprehensive Health Assessment Reference Guide 0-18 years
Practice Guide for Community Health Nurses
How Children Develop
Teacher Checklists

Additional related resources
CPFS Child Health Passport
CAHS-CH Immunisation / Infection Control
My File eXchange (MyFX) User Guide
My File Transfer / My File eXchange
Training by WA Health State-wide Protection of Children Coordination (SPOCC) Unit http://ww2.health.wa.gov.au/Articles/A_E/About-child-abuse-and-neglect/Mandatory-reporting-of-child-sexual-abuse
WACHS Community Health Information System Child Health Clinical Item Guide
WACHS Immunisation

This document can be made available in alternative formats on request for a person with a disability.

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