PROCEDURE

Children in Care – conducting an assessment

Scope (Staff):	Community health
Scope (Area):	CAHS-CH, WACHS

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

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Aim

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

Risk

Failure to follow this guideline may result in a child's health and developmental needs not being identified or addressed in a timely manner and failure to meet performance indicators.

Background

The *National Clinical Assessment Framework for Children and Young People in Out-of-Home Care 2011*[1] (children in out-of-home care are known as "children in care" in WA) describes the scope and focus of health assessments for children in care. It is aligned under the *National Framework for Protecting Australia's Children*[2], which represents a level of collaboration between Australian, State and Territory governments and non-government organisations to protect children.

The *Children and Community Services Act, 2004* (the Act)[3] is the legal framework guiding the protection and care of children in WA. The Department of Communities 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.

The Healthcare Planning Pathway for children in care is informed by the *Guidelines for Protecting Children 2020* [3].

The *Children in Care – Supporting information* resource is **required pre-reading** to inform the implementation of this procedure.

Terminology

- Department of Communities - formerly known as Department of Child Protection and Family Services - referred to throughout procedure as Communities
- Department of Communities case manager - referred to throughout procedure as case manager
- Department of Communities team leader - referred to throughout procedure as team leader
- CEO - refers to the Chief Executive Officer of the Department of Communities
- Comprehensive health and development assessments are also referred to as Comprehensive Health Assessments by the Department of Communities

Key points

- The best interests of the child are paramount. Healthcare planning should be a collaborative process between the child, case manager, carer (if appropriate) and most appropriate health service provider.
- Nurses need to be sensitive and client-focused and consider trauma and its associated effects on physical health, development, social and emotional wellbeing, and educational outcomes when working with children and young people. These factors are considered holistically rather than in isolation.
- Nurses need to provide culturally safe service delivery which demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of all clients.
- Health and developmental assessments inform the health component of the child's Communities care plan. The assessments include the physical, mental, developmental and psychosocial domains of health and wellbeing.
- The health service system in WA is complex. To enable a child in care to access appropriate services, community health staff need to inform and support case managers and the child's carer to respond to, and plan for the child's health needs.
- All nurses will refer to the Nursing and Midwifery Board AHPRA Decision-making framework in relation to scope of practice and delegation of care to ensure that decision-making is consistent, safe, person-centred and evidence-based.

The Healthcare Planning Pathway

The Healthcare Planning Pathway is described in more detail in the *Children in Care – Supporting information* resource.

The pathway is comprised of three phases. These are the initial medical assessment of the child's health to identify and treat any immediate health concerns, and then a comprehensive health and development assessment and subsequent annual reviews by a community nurse or GP to identify current and emerging health issues and required actions.

All processes in the Healthcare Planning pathway must include:

- Engagement of children in the assessment process.
- Effective information sharing and collaboration between community health staff and Communities.
- Engagement of carers, consideration of their views, and sharing of information with them where appropriate. 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.
- Engagement of carers, consideration of their views, and sharing of information with them where appropriate.

- Use of standardised, evidence-based screening and assessment tools wherever appropriate/practicable in assessments.

Role of Department of Communities

Communities is responsible for the wellbeing of children in care in WA[4]. The Chief Executive Officer (CEO) assumes parental responsibility for most children in care as described in the Act. In practice, the CEO delegates authority to a case manager to give consent (including provision of a CIC health assessment) and to develop and implement a care plan for these children.

The Healthcare Planning Pathway is described in more detail in the *Children in Care – Supporting information* resource.

Role of Central Referrals Administration

The initial management of referrals from Communities for CIC Comprehensive Health Assessments is coordinated by WA Health Central Referrals Administration (CRA).

CRA receives ALL Comprehensive Health Assessment referrals from Communities case managers state-wide for WA community health services. CRA screens referrals for completeness of required information, not for clinical information. If information is incomplete, CRA returns the referral to Communities for completion. Complete referrals are allocated to CIC Key Contacts in CAHS-CH or WACHS.

The CRA manages the central email address for all CIC referrals: DOH.CICreferrals@health.wa.gov.au

Role of Community Health Staff

Community Health Clinical Nurse Managers (and some Clinical Nurses Specialists in WACHS) carries out the CIC Key Contact role. The CIC Key Contact coordinates between the CRA, nurses and case managers in the management of CIC healthcare planning pathway referrals allocated to their area. The CIC Key Contact reviews CIC referrals to their health service area and allocates them to community health nurses.

The community health nurse provides Comprehensive Health and Development Assessments and annual reviews as requested though the referral process. Health Service Providers must prioritise undertaking comprehensive CIC health assessments and health care planning. The nurse is the advocate for the child in care and must escalate any identified concerns to Communities[5].

- For a child new to the CEO's care, the initial Comprehensive Health and Development Assessment will be undertaken **within 30 business days** (6 weeks) of CRA receiving the completed referral from Communities for allocation to either CAHS-CH or WACHS[6].
- For all other children in the care of Communities, staff will complete annual assessments **within 30 business days** (6 weeks) of CRA receiving a completed referral.

- Community health staff must send the CIC Assessment report and any associated documents to Communities **within five business days** (1 week) of completing the assessment.

Refer to *Children in Care – managing referrals for assessment* guideline for further information about the role of the CIC Key Contact.

See *Children in Care – Supporting information* resource for information about groups of children in care with special considerations for their health care pathway.

Information Sharing, Communication and Consent

The method for sharing information between community health staff and Communities staff is bound by organisational policies and the *Joint Guidelines on the mutual exchange of relevant information between WA Health and Department of Child Protection for the purpose of promoting the safety and wellbeing of children*[7].

In health care planning, note that:

- Communities' policy is for their staff to email all referrals and supplementary information.
- Community health staff must communicate all confidential information, including health assessment information, via encryption.

Refer to CAHS CH *Consent for Services* and *Consent for release of client information* policies or WACHS *Consent for Sharing of Information: Child 0-17 years* procedure for further information on consent requirements.

Process for conducting a Children in Care assessment

Sensitive consideration and professional judgement are required to provide a holistic assessment which covers the scope of each domain of the comprehensive health and development assessment. This may require accessing alternative sources of information about the child. For each child the depth of the assessment of each domain will be a clinical decision, appropriate to the age, risk factors, clinical needs, and any major changes in circumstances of the child at the time of assessment.

Protective factors should be assessed as well as any risk factors and health concerns. Protective factors contribute to providing a physical and psychosocial environment that enables people to feel strong and resilient and in which a child might achieve optimal growth, development, and wellbeing.

See Appendix A CAHS-CH CIC Health assessment process and Appendix B WACHS CIC Health assessment process for an outline of the key steps.

To avoid duplication of services, the CIC assessments may be conducted simultaneously with scheduled age-appropriate contacts. See Appendix C for further information.

Process

Steps
Communication The following points apply throughout the process **Confidential information should not be sent via unencrypted email**. My File Transfer / My File eXchange (MyFT/MyFX) allows for encrypted electronic transfer of confidential information. • Department of Health *Guidelines for the Transmission of Personal Health Information by Fax Machine* (IC0179/14) requires that fax machines are **only** to be used when no other secure and sufficiently rapid transmission method is available Nurses must notify the case manager or Communities District Office if the report is being sent by fax and should follow up immediately to ensure the report has been received. • In the first instance, communications should be with the case manager, with the team leader copied into all correspondence. The contact details for case manager and team leader are provided on the Communities Form 510 - Comprehensive Health Assessment: Health Care Planning for Children in Care.
Receive referral **CAHS-CH:** • CIC Key Contact allocates CIC referral by assigning to nurse's CIC List in CDIS and sending email notification to nurse. Alert flags are generated automatically by CDIS for children in care • Children in Care should be placed on the relevant Client of Concern (COC) list if applicable. Any actions and/or referrals arising from the CIC assessment are noted on the COC list, to ensure adequate follow up. • Additional flags for developmental, social, health or client safety risks to be added by the nurse as identified. **WACHS:** • CIC Key Contact allocates CIC referrals by forwarding the referral email to a nurse. Generate or review existing *Child at Risk* (CAR) *Alert* in WebPAS as per WACHS *WebPAS Child at Risk Alert* procedure. • All Children in Care should be placed on the relevant Client of Concern (COC) register.
Review referral **Review referral form and all attachments for:** • Type of referral - new to care, annual review, or special request. • Continuity of care – would child benefit from assessment by a current service provider or by community health?   ○ If child is identified as Aboriginal, determine whether the child/carer would prefer the health care planning health assessments be completed by a team providing services to Aboriginal children and families. Consider the need to work alongside

MP 0097/18 - 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.

Steps
Aboriginal Health Workers to provide culturally acceptable care. An interpreter service may be required for children and carers who have English as a second language. o Children from a refugee or culturally and linguistically diverse (CaLD) background require consideration of their experiences prior to or since moving to Australia, including exposure to trauma, being an unaccompanied minor, displacement, and social isolation. The nurse should also consider the gender of the health assessment provider and the use of interpreter services and culturally appropriate screening tools, assessments, and referral pathways. The child's level of education, health literacy, visa status and service eligibility may affect care provision, and specific physical health issues such as potential exposure to communicable diseases also need consideration. Contact Refugee Health Team or Perth Children's Hospital Refugee Health Service to identify if the child is known/open with these services, and for advice about recent health checks, specific health queries, and CaLD health services and specialist organisations. o Children in care with a diagnosed disability may already be engaged with disability-specific services. Although a child may already be under the care of a health team, the nurse can discuss health care planning assessments with the case manager to ensure all aspects of the child's health care, such as immunisation or oral health care, are being addressed. • Information required from case manager prior to conducting the assessment. Case manager may indicate on the referral that discussion about the child is advisable prior to the assessment. • Any concerns or referrals arising from the Strengths and Difficulties Questionnaire (SDQ), as noted in Communities Referral Form 510, Section 2. **Acceptance of the referral** is at the discretion of Key Contact and nurse. If factors indicate that the referral should not be accepted at this time and Key Contact and nurse agree to **decline the referral**, the referral must be returned to Communities with the reason for declining and suggestions for further management. • Key Contact advises Communities of declined referrals. **Reasons to decline** a referral include: • the child currently undergoing assessments with other service providers • aligning the assessment with due date of child's next CIC health care plan • a temporary change in the child's current circumstances that may make the annual health assessment of physical, developmental and/or psychosocial health inaccurate • inability to engage carer or locate child. **NB. Difficulties in communication** with a case manager at any point will be escalated to the relevant team leader as required. See *Guidelines for Protecting Children 2020* for further information.

Steps

Schedule an appointment

Contact the carer identified on the referral form (or mature minor).

- A minimum of 3 attempts using a variety of contact methods should be made to contact carer and/or child, within 10 working days of receiving the referral.
- Determine the carer/mature minor's preferred service provider.
- Book a 1 hour appointment time for the assessment.
- Request the carer/child bring their Communities Child Health Passport if possible.

Discuss with the carer:

- any concerns for the child's wellbeing
- if they want to be present at the assessment
- options in location for the assessment, particularly where a group of siblings require assessment. This may be at the clinic, school, or the carer's home.

Involve the child's carer in the assessment process wherever possible to:

- provide support for the child during the assessment
- provide supplementary information
- ensure carer understands all health concerns and the recommended actions.

The nurse will **schedule the appointment** with the carer for children under school age, while school age children will usually be seen at school.

- For home visits, see the *Home and Community Visits* procedure for guidance.
- Liaise as needed with the organisation/staff member in charge of room bookings at the assessment location to organise a room for the assessment.

Mature minors may wish to:

- attend on their own or have their carer or another person present
- have the assessment with the community nurse or with another appropriate service provider such as their usual GP or an Aboriginal Medical Service (AMS).
  - If a different appropriate service provider is preferred, the Key Contact will decline the referral and notify the case manager and team leader, with recommendation to redirect the referral to this preferred provider.

A child assessed as a mature minor can provide consent on their own behalf to assessment, treatment and release of confidential information[9]. A holistic assessment of mature minor status requires consideration of the effects of trauma, protective and risk factors, and health concerns.

Every effort must be made to contact the client in order to schedule or reschedule appointments. This includes trying different methods of contact at different times of the

Steps
day and also includes contacting the case manager and team leader in order to confirm current contact details and to receive advice on how best to contact the client. **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 advises Key Contact or nurse manager, who will decline the referral and notify the case manager and team leader. The reason for declining is documented in CDIS. • **WACHS:** Nurse sends the referral to Key Contact, for return to case manager and team leader with the reason for not conducting the requested assessment. Document correspondence in the client record. **NB.** It is **not the responsibility of community health staff** to locate a child or reassign the referral if their contact details differ from the referral form. If child or carer cannot be contacted using the details provided, the referral must be declined by the Key Contact and returned to Communities (refer CAHS-CH and WACH processes).
Assessment preparation **Check immunisation records where possible.** • If immunisation is required, record this in Health Improvement Plan and contact the case manager to advise on immunisation service providers (CAHS-CH / WACHS). **Consider if the referral is for a child new to care or for an annual review.** • Where a child is new to care, a full Comprehensive Health and Development Assessment is required. • Annual reviews may be adapted to monitor issues identified in previous assessments, noted in the current Communities health care plan, or identified as new concerns while assessing each health domain. The frequency and depth of monitoring various components of the assessment require clinical judgment of the child's age, risk factors, clinical needs, and any major changes in circumstances at the time of assessment. **Review:** • All information available from previous contacts with the child • CAHS-CH alert flags or WACHS CAR Alerts, and update if required • Any concerns identified by the child themselves recently or in previous assessments • Consultation as relevant with other sources for assistance in identifying concerns about the child's physical, developmental and or psychosocial wellbeing. This may include the child, the child's case manager, the carer, classroom teacher, student services team, other health care providers or biological parent (where appropriate).

Steps

  - Teachers or a relevant member of the student service team may be contacted if concerns are specific to areas such as fine and gross motor skills, psychosocial and speech (see CAHS-CH resources-*Teacher Checklists*).
  - Obtaining information from multiple sources helps to corroborate information or identify inconsistencies and may highlight areas of concern.

Identify if child is due for a scheduled Universal contact and conduct this simultaneously.

- If combining the CIC and Universal assessments, consider additional assessments that may be required. See Appendix C for more information.
- View *CIC Comprehensive Health Assessment Reference Guide: 0 -18 years* for more information on specific assessment items.

Overview of CIC assessment[1]:

General health information reviewed

- Issues identified on paediatric discharge summary (if available).
- Current and past health history, allergies, and medications.

Assessment tools

View the *CIC Comprehensive Health Assessment Reference Guide: 0 -18 years* for more information on specific assessment items.

- Some tools are parent-informed and can be challenging to administer and interpret in the context of this group of children, especially where a child is experiencing stress and anxiety from being brought into care.
- Developmental or social/emotional assessment tools may be used as required.

Physical Health:

Assessment must include nutrition, growth indicators, skin integrity and hygiene, ears and hearing, eyes and vision, sleep behaviours, and oral health.

- All assessment domains must be addressed at each annual review to identify new concerns.
- Use clinical judgment to determine if a discussion or assessment is appropriate for each domain.

NB: A complete age-appropriate ear health and hearing assessment is required at each assessment for all Aboriginal CIC clients, and other children at risk of hearing and ear health issues (see *Hearing and Ear Health* guideline for more information).

Dental Health:

- Children in care are eligible for the statewide Dental Health Services (DHS). DHS prioritises the assessment and treatment of children in care and coordinates their dental health care planning.

Steps

- The case manager ensures that all children in care of school age (5 years and above) are enrolled in the school dental service, although most younger children already attend this service.

NB. Oral health remains an essential component of the CIC health assessment, as concerns may arise between school dental service appointments.

Development:

Use *How Children Develop 0-12 years* resource to guide assessment of developmental, cognitive, and social/emotional milestones, and to help identify specific concerns requiring investigation where a developmental tool is not readily available or appropriate.

Mental health:

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 case manager about any concerns. If an SDQ has not been conducted, follow the age-appropriate psychosocial assessment recommended below. If concerns are identified, request psychologist review.

NB. Some children may require **more than one appointment** to complete a comprehensive health assessment.

- All assessments should be completed by one clinician whenever possible.
- Sometimes an aspect of developmental, psychosocial or mental health can only be partially assessed, or the nurse may need to delay using an assessment tool until the child is settled in their placement. This must be noted on the report to Communities, together with the recommended follow-up action.
- If any element/s of the assessment cannot be completed, advise case manager/team leader. Document in report how and when this will be assessed or suggest referral to an appropriate health professional.

Conduct an assessment: Child in care 0-5 years old

Refer to: *Practice Guide for Community Health Nurses, Children in Care Comprehensive Health Assessment Reference Guide (0-18 years), How Children Develop 0-12 years*

Assessments must cover the domains of general, physical, developmental, psychosocial and mental health, and behaviour, safety issues and carer's health promoting behaviours.

NB. Although the Universal Contact Schedule/ Enhanced Child Health Schedule 0-5 years and the Healthcare Planning Pathway are separate processes, it is recommended to **align these assessments where possible and appropriate**. A Universal contact may require some assessments in addition to the CIC assessment, such as testes and hips.

- Offer FDV and EPDS screening to carers of children as for Universal contacts, and if indicators of concern are identified.
- Where possible, align CIC assessment with Universal School Entry Health Assessment.

NB: A complete age-appropriate ear health and hearing assessment is required at each assessment for all Aboriginal CIC clients, and other children at risk of hearing and ear health issues (see Hearing and Ear Health guideline for more information).

General Health

Past and present health concerns including current management plan, family history, immunisation, medications, allergies, nutrition, and physical activity.

Physical Health

Growth monitoring, skin integrity and hygiene, ears and hearing, eyes and vision, and oral health/Lift the Lip.

- **Oral health** inspection is essential. If oral health concerns are present, advise case manager in report to make referral to relevant DHS clinic.

Development

- Tool - Ages and Stages Questionnaire-3™ or ASQ TRAK™ (as appropriate). (See *ASQ™* guideline for more information)
- SEHA
- Speech, language and communication - play and pre-literacy/ literacy skills
- Gross and fine motor development
- Cognition – problem solving skills.

Behavioural, Psychosocial and Mental Health

- Tool - Ages and Stages Questionnaire-3:SE-3™.
- Mental health – observe interactions and behaviours such as eye contact and facial expression
- 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

Steps

- Development of cultural and spiritual identity for Aboriginal children and as appropriate for other populations should be addressed by case manager.
- Consider how the carer responds to child and makes them feel safe.

Document outcomes on CHS450 (paper or electronic format as relevant)

Complete the child's Health Passport if available.

Conduct an assessment: Child in care 6-11 years old

Refer to *Children in Care Comprehensive Health Assessment Reference Guide: 0-18 years, How Children Develop 0-12 years*

Assessments must cover the domains of general, physical, developmental, psychosocial and mental health, and behaviour, safety issues and carer's health promoting behaviours.

NB: Hearing and vision assessment to be performed where screening questions indicate that there are concerns.

A complete age-appropriate ear health and hearing assessment is required at each assessment for all Aboriginal CIC clients, and other children at risk of hearing and ear health issues (see *Hearing and Ear Health* guideline for more information).

General Health

Past and present health concerns including current management plan, family history, immunisation, medications, allergies, nutrition and physical activity.

Physical Health

Growth monitoring, skin integrity and hygiene ears and hearing, eyes and vision, and oral health examination.

- Oral health should be discussed, and an oral health assessment conducted if concerns are identified. If an oral health referral is required, advise case manager in assessment report to arrange an appointment with Dental Health Service clinic.

Development

- Speech, language and communication - play and literacy skills
- Gross and fine motor development
- Cognition – problem solving skills

Consider feedback from child's teacher.

Psychosocial

- Mental health – indicators of trauma associated with past abuse and neglect, self-esteem, enjoyment of life, and anxiety/depression.

Steps
• Behavioural –conduct, sleep and self-regulation, behavioural problems such as inattention and hyperactivity, self-harm, sexual behaviour problems • Emotional development – attachment disorders, relationship insecurity • Social competence - social skills, self-help skills, and awareness of basic safety issues such as road safety and talking with strangers. Child's perception of their own safety and who they would ask for help if feeling unsafe. • Health literacy - understanding of healthy lifestyle (diet, exercise, screen time and sleep), changes related to puberty, and risks of substance use. • Development of cultural and spiritual identity for Aboriginal children and as appropriate for other populations should be addressed by case manager. Consider feedback from teacher or a relevant member of the student service team. If carer is present, consider how the carer responds/ manages the issues identified. **Document** outcomes on CHS450 (paper or electronic format as relevant) **Complete** the child's Health Passport if available.
Conduct an assessment: Child in care 12-18 years old **Refer to** *Children in Care Comprehensive Health Assessment Reference Guide: 0-18 years* and *How Children Develop 0-12 years* **Assessments** must cover the domains of general, physical, developmental, psychosocial and mental health, and behaviour, safety issues and carer's health promoting behaviours. **NB.** Hearing and vision assessment to be performed where screening questions indicate that there are concerns. A complete age-appropriate ear health and hearing assessment is required at each assessment for all Aboriginal CIC clients, and other children at risk of hearing and ear health issues (see *Hearing and Ear Health* guideline for more information). **General Health** Past and present health concerns including current management plan, family history, immunisation, medications, allergies, nutrition, and physical activity. **Physical Health** Growth monitoring, skin integrity and personal hygiene, ears and hearing, eyes and vision, and oral health **NB:** Oral health should be discussed, and an oral health assessment conducted if concerns are identified. If an oral health referral is required, advise case manager via the assessment report arrange an appointment with relevant Dental Health Service clinic. **Psychosocial** • Tool – HEADSS (if appropriate)

Steps

• Mental health – indicators of trauma associated with past abuse and neglect, self-esteem, enjoyment of life, anxiety and depression.
  ○ Behavioural – conduct, sleep, self-regulation, behavioural problems such as inattention and hyperactivity, self-harm, problems with sexual behaviour, partner violence, and independent living skills.
  ○ Emotional development – attachment disorders, relationship insecurity, and sexual knowledge
  ○ Social competence – social skills, self-help skills, and awareness of basic safety issues such as road safety and talking with strangers. Child's perception of their own safety and who they would ask for help if feeling unsafe.
  ○ Health literacy – understanding of healthy lifestyle (diet, exercise, screen time and sleep), changes related to puberty and issues related to sexuality and sexual activity, contraception, STIs, and risks of substance use
  ○ Development of cultural and spiritual identity for Aboriginal children and as appropriate for other populations should be addressed by case manager.
Document outcomes on CHS450 (paper or electronic format as relevant)

Record outcomes Complete the relevant electronic Universal contact screen/clinical item if the CIC assessment was combined with a Universal contact. **CAHS-CH:** Complete the relevant CDIS CIC Assessment clinical items as per CDIS CIC Tip Sheet. • If all components of the CIC assessment are not completed in one appointment, record the outcomes from the initial appointment in CDIS. **WACHS:** • Complete the relevant CHIS CIC Comprehensive Assessment clinical items and the Health Improvement Plan letter template as per the CHIS Child/School Health Clinical User Guides. • 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*.
Develop report The Health Improvement Plan (HIP) report will inform the development by Communities of the child's 12-month Health Care Plan. • The HIP report is generated after completing the CIC Assessment screens (CDIS) and clinical items (CHIS).

Steps

• All HIP 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 by Communities staff who may have varying levels of health literacy.
• The HIP report must include the significant findings from the health assessment, any recommended referrals, and other actions the nurse suggests need to be taken and by whom.
• The Health Improvement Plan report must directly address:
  o Concerns or requests identified on the referral form, previous health assessment and/or health care plan
  o Assessment tools completed
  o Those contributing information to the assessment, such as the carer, teacher.
  o Physical, psychosocial, and developmental concerns identified which require action in the next healthcare planning cycle (12 months), with information about required timelines.
  o Referrals enacted or required.
  o The timing of any follow up appointments, and Universal or Enhanced Child Health Schedule contacts due in the next year.
• Wherever possible, the report should provide anticipatory guidance on issues which affect the management of health concerns.
• Where there are no concerns, state “No concerns have been identified at this time.” Consider also providing an overview of what was covered in the assessment.
 	
Referrals:
• If referral to an additional health service is recommended, advise the relevant case manager and team leader about any decisions and/or consent needed from Communities regarding the referrals.
• Where referrals and/or actions are suggested, **the suggested timeframe and the potential consequences for the child if these recommendations are not followed must be outlined**. For example, vision will not develop in the affected eye if the child is not referred promptly to an ophthalmologist for treatment of strabismus.
• It is important that the case manager is aware of the findings and any recommendations of any additional appointment / service so they can modify the child’s health plan.
• Discuss with the case manager in person or by telephone to reach a decision regarding who will make the referral.

Steps

- Refer to the CAHS-CH *Consent for Services* and CAHS *Consent for release of client information* policies or WACHS *Consent for Sharing of Information: Child 0-17 years* procedure for further information on consent requirements.

NB. Consent for internal and external referrals must be obtained from the case manager, but this should not delay completion and forwarding of the report.

Send report

CAHS-CH:

- Send the CIC Report - Health Improvement Plan report (Form 510), and any other associated documents to the case manager and team leader via MyFT/MyFX or fax **within five days** of completing the assessment.
- Complete a CDIS Client Not Present (CNP) – service type "CIC Report sent to DCPFS (CIC only)" for the activity of sending the report and associated documents to the Communities.
- Notify CIC Key Contact via email that the assessment is completed, Communities has been notified, and the referral is ready to be closed.

WACHS:

- Send CIC Report - Health Improvement Plan (Form 510), any associated documents, and the following information to your CIC Key Contact according to the local communication process:
  - name of CHN
  - date assessment completed
  - comments or information
  - if no assessment done, the reason and date that referral returned to Communities.
- CIC Key Contact returns CIC Report/Health Improvement Plan and associated documents via encrypted email to the requesting case manager and team leader **within five days** of the assessment being completed.

CAHS-CH and WACHS:

- The Comprehensive Health Assessment CHS450 form should be scanned into CDIS/CHIS and filed in the client's paper health record. Scanned documents must meet the minimum requirements of the DoH Digitisation and Disposal of Patient Records policy (OD0583/15).
- Any actions and/or referrals arising from the CIC assessment are noted briefly on COC list to ensure adequate follow up.

Follow-up

- The nurse may indicate on the Health Improvement Plan report if a discussion with case manager about the assessment is required to assist the development of the child's health care plan.

Steps
• If there are **concerns that require urgent action or follow up**, the nurse should contact the case manager or team leader directly. **NB.** Nurse should follow up with Communities to ensure that actions or referrals arising from the comprehensive assessment have been addressed within a reasonable timeframe that reflects the clinical urgency of the identified concern. • Nurses will follow the WA Systems Escalation Process with Department of Communities[3] and discuss concerns with line manager if there are difficulties or delays in communicating with the case manager or team leader.

Documentation

Nurses maintain accurate, comprehensive, and contemporaneous documentation of assessments, planning, decision making and evaluations according to CAHS-CH and WACHS processes.

Compliance Monitoring

Monthly reviews of the timely assessment and reporting of CIC referrals are conducted, and compliance reports are reviewed by Clinical Governance.

- Assessments for both children new to care and for annual reviews will be undertaken within 30 business days of CRA receiving a completed referral from Communities.

References

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6. Department of Communities, Department of Health. Bilateral Schedule between the Department for Child Protection and Family Support and WA Health: Health Care Planning for Children in Care. Government of Western Australia; 2015.
7. Department of Communities, Department of Health. Joint guidelines on the mutual exchange of relevant information between WA Health and Department of Child Protection for the purpose of promoting the safety and wellbeing of children (Appendix 2 of Bilateral Schedule MOU). Government of Western Australia; N/A.
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of-healing-shifting-from-trauma-informed-care-to-healing-centered-engagement-634f557ce69c#:~:text=A%20shift%20from%20trauma%20informed%20care%20to%20healing,re-centers%20culture%20as%20a%20central%20feature%20in%20well-being.
9. Child and Adolescent Health Service - Statewide Protection of Children Coordination Unit. Guidelines for protecting children 2020. 2020.

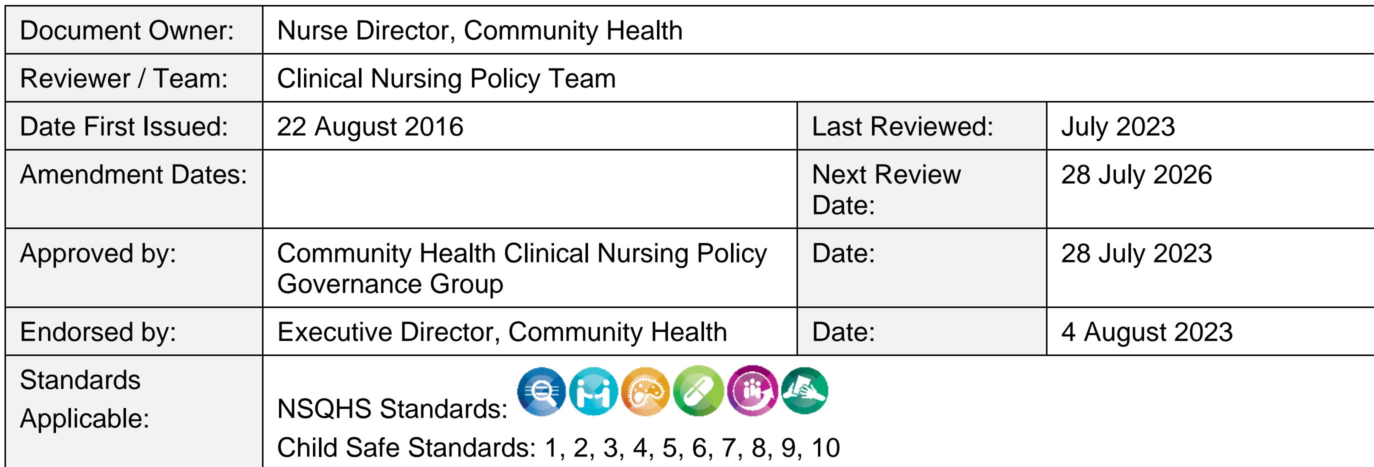
Related internal policies, procedures and guidelines
The following documents can be accessed in the Community Health Clinical Nursing Manual: HealthPoint link or Internet link or for WACHS staff in the WACHS Policy link
Aboriginal child health
Ages and Stages Questionnaires (ASQ)
Children in care - managing referrals for assessment
Factors impacting child health and development
HEADSS adolescent psychosocial assessment
Physical Assessment 0-4 years
Refugee Health Service
Universal child health schedule
The following documents can be accessed in the CAHS-CH Operational Manual
Client Record Transfer
Consent for release of client information
Consent for Services
The following documents can be accessed in WACHS Policy
Consent for Sharing of Information: Child 0-17 years
Enhanced Child Health Schedule
WebPAS Child at Risk Alert
WebPAS PMI Standards
The following documents can be accessed in the CAHS Policy Manual

Child Safety and Protection
Language Services
The following documents can be accessed in the Department of Health Policy Frameworks
Guidelines for the Transmission of Personal Health Information by Fax Machine (IC0179/14)
WA Aboriginal Health and Wellbeing Framework 2015-2030
Related internal resources and forms
The following resources can be accessed from the CAHS-Community Health Resources page on HealthPoint
CDIS tip sheets
Children in Care Comprehensive Health Assessment Reference Guide 0-18 years
CHS450 Children in Care Comprehensive Health Assessment 0-18 years
Children in Care: Process for Assessment by CHNs (Infographic)
Children in Care – Supporting information
eHFN_030 form
Factors impacting child health and development - Staff Resources
Guidelines for Protecting Children 2020
How Children Develop
Practice Guide for Community Health Nurses
Teacher Checklists

Additional related resources
Consumer Care and Cultural Learning Guidelines
CAHS-CH Immunisation
CAHS Infection Control
Child Safety Toolbox (WACHS)

Employee Assistance Program (CAHS)
Employee Assistance Program (sharepoint.com) (WACHS)
Framework for Understanding and Guiding Responses to Harmful Sexual Behaviours in Children and Young People
Mandatory Reporting of Child Sexual Abuse eLearning
My File eXchange (MyFX) User Guide
My File Transfer / My File eXchange
SPOCC Education Videos
The Impact of Trauma on the Child (WACHS-only online training)
Trauma – Understanding the Impact on Children, Adolescents and Families (CAHS-only training)
WA Child Development and Trauma Guide
WACHS Community Health Information System Child Health Clinical Item Guide
WACHS Immunisation
WA Systems Escalation Process with Department of Communities

This document can be made available in alternative formats on request.



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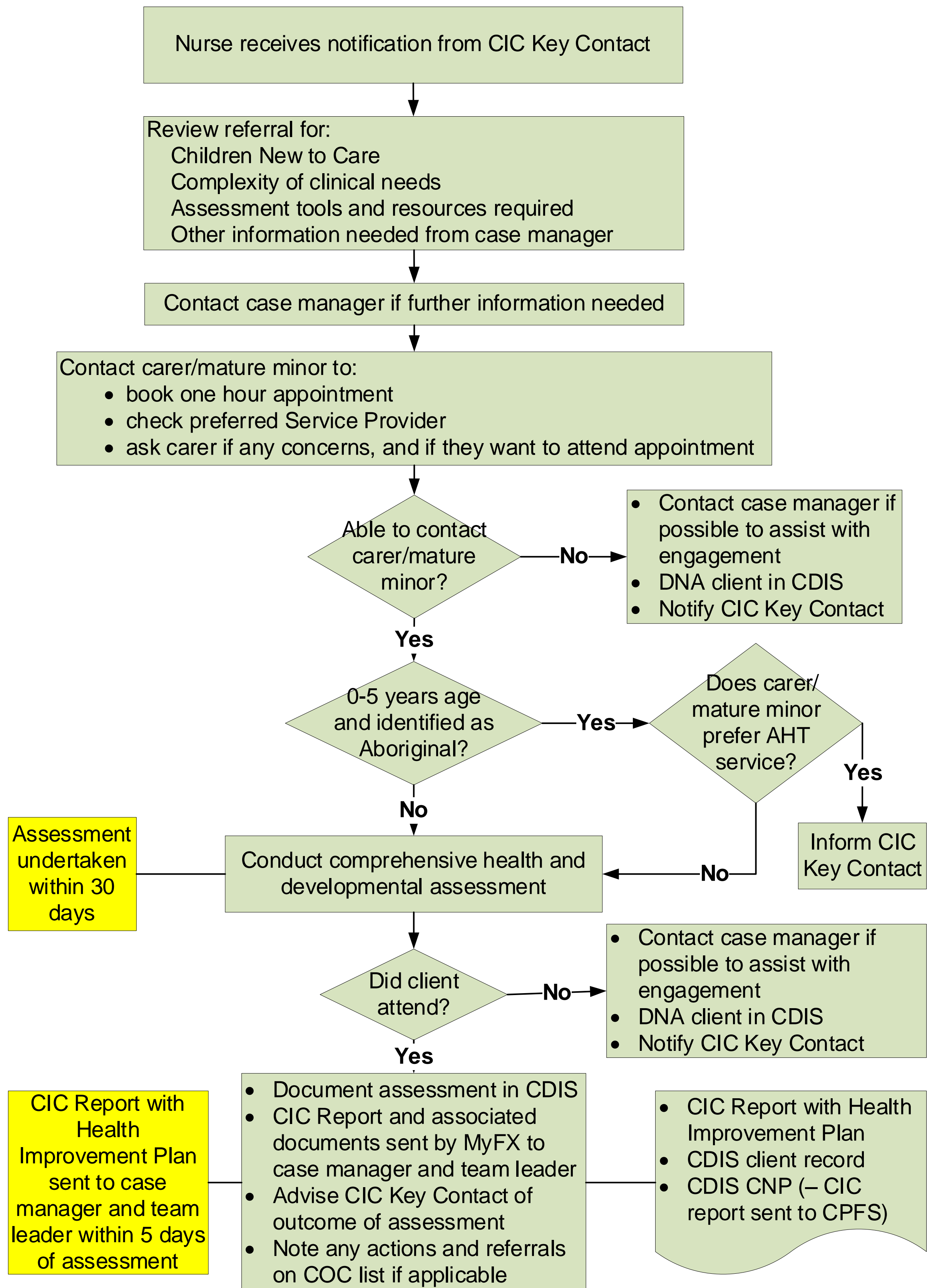
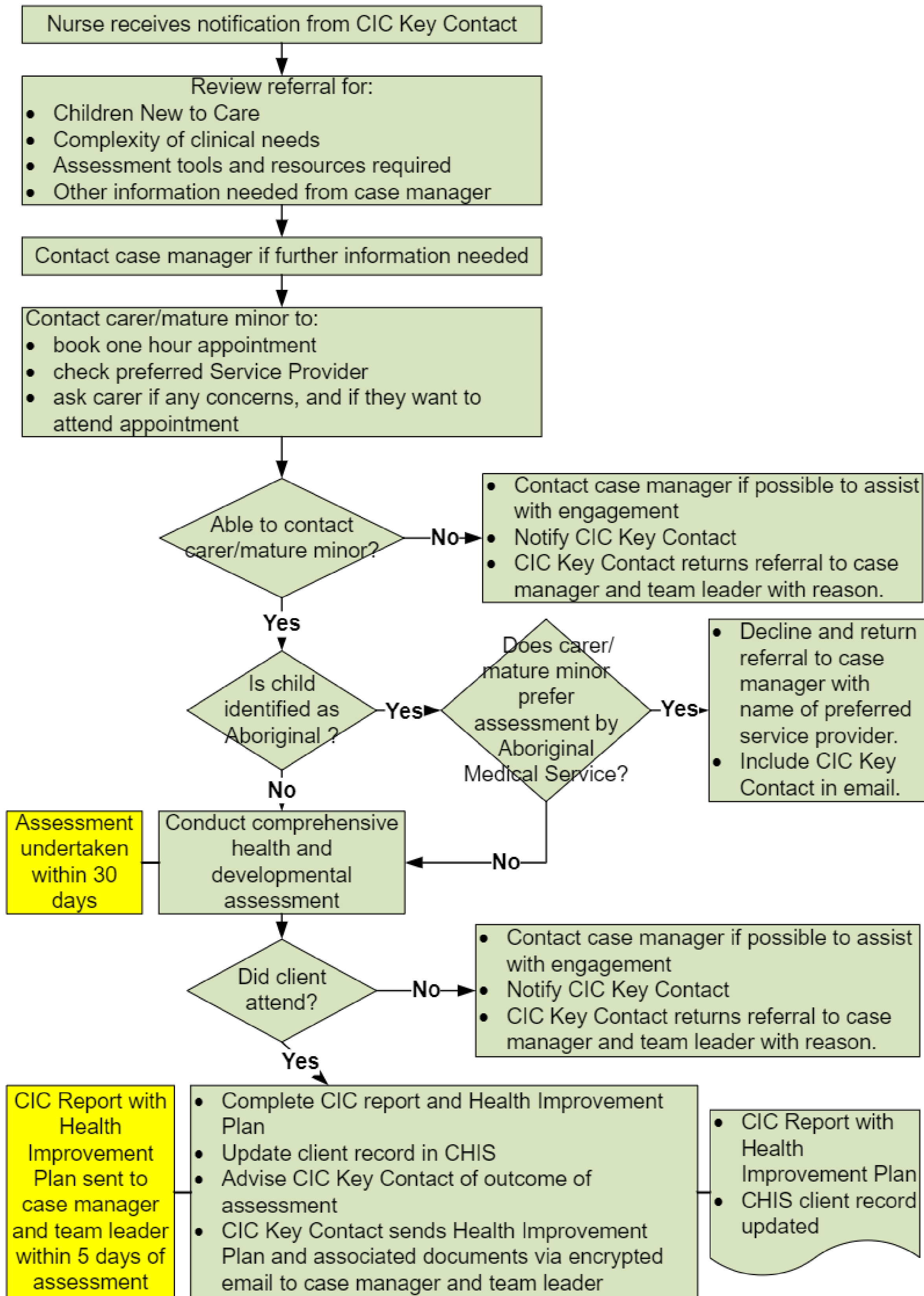
Appendix A: CAHS-CH CIC Health assessment process



Appendix B: WACHS CIC Health assessment process



Appendix C: Aligning Community Health Schedule with CIC assessments – Summary

<table>
<tr><th>Age</th><th>Assessments</th><th>Comments</th></tr>
<tr><td>Birth to School Entry

0 - 4.5 years</td><td>Universal Child Health contact schedule or Enhanced Child Health schedule
Plus
Children in Care Comprehensive Health and Development Assessment 0-18 years (CHS450)
• Oral Health inspection essential</td><td>• If possible, align CIC assessment with Universal Child Health contact schedule or Enhanced Child Health schedule.
• In addition to CIC assessment, provide any services required for Universal, Universal Plus or Enhanced Child Health Schedule contact.</td></tr>
<tr><td>School Entry (Kindy or Pre-primary)
4 - 6 years</td><td>School Entry Health Assessment
Plus
Children in Care Comprehensive Health and Development Assessment 0-18 years (CHS450)
• Oral Health inspection essential</td><td>• CHN can request a list of CIC students from principal at start of school year.
• As a courtesy, advise principal when scheduling a CIC assessment.
• Conduct routine SEHA assessments and complete CHS409-1
• Communities enrols all CIC clients with School Dental Service from the year they turn five.</td></tr>
<tr><td>Primary School

6 - 11 years</td><td>Children in Care Comprehensive Health and Development Assessment 0-18 years (CHS450)
• Enquire about Oral Health</td><td>• No Universal screening required for this age group.</td></tr>
<tr><td>Secondary School

12 - 18 years</td><td>Children in Care Comprehensive Health and Development Assessment 0-18 years (CHS450)
• Enquire about Oral Health
• If required, use HEADSS tool for mental and psychosocial health assessment.</td><td>• No Universal screening required for this age group.</td></tr>
</table>