Assessment of infant / child nutrition, growth and development, within the primary health care setting.

Statewide Child and Youth Clinical Network (SCYCN)

1. Purpose
This Guideline has been developed to promote and facilitate a standard approach for assessing nutrition, growth and development within the primary health care setting, for infants and children aged between 0-5 years. The assessment ages are in line with the child health checks in the Personal Health Record [1].

2. Scope
This Guideline has been developed for use by all Queensland Health Child Health Nurses, Registered Nurses, Midwives, Youth Health Nurses, and Aboriginal and Torres Strait Islander Health Workers, working within the Primary Health Care setting.

3. Related documents Policy and Standard/s:
4. **Assessment of infant / child nutrition, growth and development, within the primary health care setting**

4.1 **Considerations for conducting an assessment [3]**

4.1.1 Prior to assessing an infant / child’s nutrition, growth and development review all available infant / child and maternal documentation i.e. medical record, referral

4.1.2 Provide an appropriate environment and utilise a family partnership approach [4]

- Provide privacy and confidentiality
- Utilise CALD and Aboriginal & Torres Strait Islander supports e.g. Interpreter, Aboriginal & Torres Strait Islander health liaison / health worker [5]

4.1.3 Utilise principles of communication: the AIDET framework may be used as a guide [6]

- **A** - acknowledge; greet the family – make them feel welcome
- **I** - introduce yourself
- **D** - duration; estimate how long the assessment will take
- **E** - explain your role to the parent/s and or carer/s and the purpose of the assessment;
- **T** - thank the client for their time and attending the service

4.1.4 Collect and document family health information that could impact on the infant / child’s nutrition, growth and development i.e. [3]

- Antenatal history
- Birth and neonatal details
- Maternal and paternal medical history
- Maternal mental health history [7]
- Observe maternal / infant interaction, attachment [7]
- Family and psychosocial history
- Social / community supports available to the family

4.1.5 Elicit parental concerns regarding infant / child’s nutrition, growth and development, and discuss concerns identified utilising a partnership approach – the Family Partnership Model can be used to explore parental / carer challenges. Refer to reference [4] for further explanation of the Family Partnership Model.

4.2 **Nutritional Assessment**

4.2.1 Nutritional assessment requires a holistic approach including physical, social / cultural, emotional and environmental factors [3]

4.2.2 Assess nutritional intake (quality / quantity) at each child health check. Refer to appendix 1 & 2 for further nutritional assessment information and resources.
4.2.3 Assess / review the child and family’s eating practices at each health check.

4.2.4 Provide opportunistic education and health promotion regarding healthy eating practices and recommended dietary guidelines [3] at each well child health check.

4.2.5 Provide parent/s and or carer/s with evidenced-based nutritional information and resources. Refer to appendix 2 for nutritional resources.

4.3 Growth and Physical Assessment

4.3.1 Utilise a systematic, body systems approach – head to toe, front to back when performing a physical examination [8, 9]. Refer to appendix 1 & 2 – physical assessment for an overview of the head to toe physical assessment, and resources.

4.3.2 Conduct the assessment in partnership [4] with the parent/s and or carer/s – provide explanations for what you are doing and why.

4.3.3 Follow local Health Service Infection control policies and procedures and the “Australian Guidelines for Prevention and Control of Infection in Healthcare” Prevention and Infection Control Guidelines;

- “Standard and Transmission – Based Precautions” [10]

4.3.4 Perform growth measurements i.e. weight, length / height, head circumference. Refer to appendix 1 & 2 – growth.

4.3.5 During the assessment take the opportunity to provide parent/s and or carer/s with developmentally appropriate anticipatory guidance [3] i.e.

- Promote the value of parent / carer/ infant attachment and observing infant cues [7]
- Demonstrate developmentally appropriate skills e.g. tummy time
- Promote infant safety e.g. not leaving the infant unattended on the change table

4.3.6 During the assessment role model positive interaction with the infant / child and observe interaction between the parent/s and or carer/s and infant / child i.e.

- Talk to the infant / child
- Explain to the infant / child what is happening
- Observe infants / child’s responses
- Observe parental and or carer/s response to the infant / child

4.3.7 Perform additional assessment / screening as indicated for infants and children living in rural and remote Queensland populations, as per the Chronic Disease Guidelines. Refer to appendix 1 & 2 - additional information for infants and children who are living in rural and remote populations.

4.3.8 Document assessment findings in;

- Infant / child’s PHR
- Medical record
- Plot weight and height on percentile chart.
4.4 Developmental Assessment

4.4.1 Knowledge of normal infant / child development facilitates performing a developmental assessment. Appendix 1 provides a brief overview of developmental domains and milestones in line with the well child health check ages, and appendix 2 provides further developmental assessment information and resources.

4.4.2 When performing a developmental assessment utilise a holistic approach [3], which involves eliciting parental and or carer/s concerns and responding appropriately.

4.4.3 When performing a developmental assessment use the developmental assessment screening tool that is utilised in your health service, document developmental assessment findings, and follow referral and review guidelines recommended by the developmental assessment screening tool being used. Current versions of the developmental assessment tool used by the Children’s Health Service (Central) are available from http://qheps.health.qld.gov.au/rch/CCHS/cchsforms.htm

4.5 Planning

4.5.1 Work in partnership with parent/s and or carer/s when exploring parental challengers and strengths to gain a clear understanding of their situation before goal setting [4], document plan.

4.5.2 Consider appropriate CALD resources.

4.5.3 Inform parent/s and or carer/s of the recommended well child health checks – as per the infant / child’s PHR.

4.5.4 Provide parent/s and or carer/s with appropriate evidenced-based resources and inform them of Child Health and Community supports available [11] refer to appendix 2 for nutritional, growth and developmental resources.

4.6 Ending the Assessment

4.6.1 Assess at the next NHMRC targeted assessment / screening [3] unless an earlier review is indicated.

4.6.2 Discuss the follow up plan with the family

4.6.3 Thank the family for their cooperation / time [6]
### 5. Definition of Terms

Definitions of key terms are provided below.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition / Explanation / Details</th>
<th>Source</th>
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<tbody>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>CPLO</td>
<td>Child Protection Liaison Officer</td>
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<td>CDG</td>
<td>Chronic Disease Guidelines</td>
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<td>CNC</td>
<td>Clinical Nurse Consultant</td>
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<td>CLR</td>
<td>Corneal Light Reflex</td>
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<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
<td>[3]</td>
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<td>EBM</td>
<td>Expressed Breast Milk</td>
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<td>HC</td>
<td>Head Circumference</td>
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<td>LBW</td>
<td>Low Birth Weight</td>
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<td>NUM</td>
<td>Nurse Unit Manager</td>
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<tr>
<td>PHR</td>
<td>Personal Health Record</td>
<td>[3]</td>
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6. References and Suggested Reading


25. Queensland Health and the Royal Flying Doctors Service (Queesland Section) and Apunipima Cape York Health Council, *Chronic Disease Guidelines*. 2010, Queensland Health: Cairns.


33. Queensland Health and the Royal Flying Doctors Service (Queesland Section), *Primary Clinical Care Manual*. 2009, Queensland Health: Cairns.

7. **Consultation**

Refer to appendix 3 for acknowledgements
8. Guideline Revision and Approval History

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9. Level of Evidence

The Joanna Briggs Institute, our Collaborating Centres and Evidence Translation Groups currently assign a level of evidence to all conclusions drawn in JBI Systematic Reviews.

The JBI Levels of Evidence are:

<table>
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<tr>
<th>Levels of Evidence</th>
<th>Feasibility F(1-4)</th>
<th>Appropriateness A(1-4)</th>
<th>Meaningfulness M(1-4)</th>
<th>Effectiveness E(1-4)</th>
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<td>Meta-analysis (with homogeneity) of experimental studies (e.g., RCT with concealed randomisation) OR One or more large experimental studies with narrow confidence intervals</td>
<td>Meta-analysis (with homogeneity) of evaluations of important alternative interventions comparing all clinically relevant outcomes against appropriate cost measurement, and including a clinically sensible sensitivity analysis</td>
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<td>a. Metasynthesis of text/opinion with credible synthesised findings b. One or more single research studies of high quality</td>
<td>a. Metasynthesis of text/opinion with credible synthesised findings b. One or more single research studies of high quality</td>
<td>a. Cohort studies (with control group) b. Case-controlled c. Observational studies (without control group)</td>
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<td>4</td>
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10. Disclaimer

This guideline has been developed to promote and facilitate standard and consistent practice.

Clinical material offered in this guideline does not replace or remove clinical judgement or the professional duty of care necessary for each individual client.

Clinicians and health care workers must work within their individual scope of practice, adhering to legislative requirements and Code of Conduct [12].

Clinical care provided in accordance with this guideline should be provided within the context of locally available resources and expertise.
### Appendix 1

#### Assessing: nutrition, growth and development from 0-5 years of age

<table>
<thead>
<tr>
<th>Domain</th>
<th>AGE</th>
<th>0-4 weeks</th>
<th>2 months</th>
<th>4 months</th>
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<th>18 months</th>
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Queensland Health

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### Appendix 1

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**Growth**
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- **2 months**
  - weight
  - length
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- **4 months**
  - weight
  - length
  - HC
- **6 months**
  - weight
  - length
  - HC
- **12 months**
  - weight
  - length
  - HC
- **18 months**
  - weight
  - length
  - HC
- **2.5-3.5 years**
  - weight
  - length
  - BMI
- **4-5 years**
  - weight
  - height
  - BMI

**Elimination**
- **0-4 weeks**
  - number of nappies; wet / bowel motions
- **2 months**
  - number of nappies; wet / bowel motions
- **4 months**
  - number of nappies; wet / bowel motions
- **6 months**
  - number of nappies; wet / bowel motions
- **12 months**
  - number of nappies; wet / bowel motions
- **18 months**
  - number of nappies; wet / bowel motions
- **2.5-3.5 years**
  - number of nappies; wet / bowel motions
- **4-5 years**
  - number of nappies; wet / bowel motions

**Oral Health**
- **0-4 weeks**
  - Oral health [16] Elimination
- **2 months**
  - Oral health [16] Elimination
- **4 months**
  - Oral health [16] Elimination
- **6 months**
  - Oral health [16] Elimination
- **12 months**
  - Oral health [16] Elimination
- **18 months**
  - Oral health [16] Elimination
- **2.5-3.5 years**
  - Oral health [16] Elimination
- **4-5 years**
  - Oral health [16] Elimination

**Mealtime Environment**
- **0-4 weeks**
  - Mealtime environment
- **2 months**
  - Mealtime environment
- **4 months**
  - Mealtime environment
- **6 months**
  - Mealtime environment
- **12 months**
  - Mealtime environment
- **18 months**
  - Mealtime environment
- **2.5-3.5 years**
  - Mealtime environment
- **4-5 years**
  - Mealtime environment

**Self-feeding**
- **0-4 weeks**
  - Self-feeding
- **2 months**
  - Self-feeding
- **4 months**
  - Self-feeding
- **6 months**
  - Self-feeding
- **12 months**
  - Self-feeding
- **18 months**
  - Self-feeding
- **2.5-3.5 years**
  - Self-feeding
- **4-5 years**
  - Self-feeding

**Food Security**
- **0-4 weeks**
  - Food security (availability, access, preparation & storage)
- **2 months**
  - Food security (availability, access, preparation & storage)
- **4 months**
  - Food security (availability, access, preparation & storage)
- **6 months**
  - Food security (availability, access, preparation & storage)
- **12 months**
  - Food security (availability, access, preparation & storage)
- **18 months**
  - Food security (availability, access, preparation & storage)
- **2.5-3.5 years**
  - Food security (availability, access, preparation & storage)
- **4-5 years**
  - Food security (availability, access, preparation & storage)
## Appendix 1

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<th>Domain</th>
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<th>4 months</th>
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- **HC (up to 2 yrs)**
- **BMI (from 2 yrs)**
- **BMI**
## Appendix 1

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<th>Domain</th>
<th>AGE</th>
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<tr>
<td></td>
<td>0-4 weeks</td>
</tr>
<tr>
<td>Development</td>
<td>Perform age appropriate Developmental Assessment (when performing a developmental assessment, knowledge of developmental stages will facilitate assessment)</td>
</tr>
<tr>
<td>Social / Emotional</td>
<td>Infant momentarily looks at faces</td>
</tr>
<tr>
<td>Domain</td>
<td>AGE</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>0-4 weeks</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>**Communication / Language</td>
<td>[8, 24]</td>
</tr>
<tr>
<td>[8, 24]</td>
<td>• Cries to alert parent/s they require attention e.g. feeding, cuddle, nappy change etc</td>
</tr>
<tr>
<td></td>
<td>• Vocalizes coos</td>
</tr>
<tr>
<td></td>
<td>• Cries to alert parent/s they require attention e.g. feeding, cuddle, nappy change etc</td>
</tr>
<tr>
<td></td>
<td>• Looks at and plays with his/her hands</td>
</tr>
<tr>
<td></td>
<td>• Scribbles</td>
</tr>
<tr>
<td></td>
<td>• Holds crayon with fingers</td>
</tr>
<tr>
<td></td>
<td>• Uses scissors</td>
</tr>
<tr>
<td></td>
<td>• Uses a person in three parts</td>
</tr>
<tr>
<td><strong>Fine Motor</strong></td>
<td>[8, 24]</td>
</tr>
<tr>
<td>[8, 24]</td>
<td>• In the prone position Infant can turn his/her head to 45</td>
</tr>
<tr>
<td></td>
<td>• In the prone position infant can lift their head to 45</td>
</tr>
<tr>
<td></td>
<td>• In the prone position infant can lift their head to 45</td>
</tr>
<tr>
<td></td>
<td>• Infant is able to walk holding onto furniture</td>
</tr>
<tr>
<td></td>
<td>• When sitting</td>
</tr>
<tr>
<td></td>
<td>• Hops on one foot</td>
</tr>
<tr>
<td></td>
<td>• Throws and catches a ball</td>
</tr>
</tbody>
</table>

Appendix 1
## Appendix 1

### Assessing infant / child nutrition, growth and development within the primary health care setting

<table>
<thead>
<tr>
<th>Domain</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4 weeks</td>
<td>2 months</td>
</tr>
<tr>
<td>the side</td>
<td>degrees.</td>
</tr>
<tr>
<td>In the supine position moves arms &amp; legs, generally spontaneous motor activity</td>
<td>When pulled to the sitting position head follows (little or no head lag)</td>
</tr>
</tbody>
</table>

### Additional Information for rural and remote populations and Aboriginal & Torres Strait Islander Children [25] section 4

<table>
<thead>
<tr>
<th>Clinical Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing</td>
</tr>
<tr>
<td>Heart sounds</td>
</tr>
</tbody>
</table>

<table>
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<tr>
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<tbody>
<tr>
<td>Hearing</td>
</tr>
<tr>
<td>Ask hearing assessment questions</td>
</tr>
<tr>
<td>Otoscopy</td>
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</table>

| Hearing |
| Ask hearing assessment questions |
| Otoscopy |

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| Hearing |
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| Otoscopy |

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</table>

- Audiometry
### Appendix 1

#### Domain

<table>
<thead>
<tr>
<th>AGE</th>
<th>0-4 weeks</th>
<th>2 months</th>
<th>4 months</th>
<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
<th>2.5-3.5 years</th>
<th>4-5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes and vision</td>
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<td>Eyes and vision</td>
</tr>
</tbody>
</table>
  - Appearance
  - Red Eye Reflex
  - Appearance
  - Red Eye Reflex
  - Appearance
  - Red Eye Reflex
  - CLR
  - Red Eye Reflex
  - CLR
  - CLR

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**Version No.: 1.0; Effective From: 2/27/2012**

*Printed copies are uncontrolled*
## Appendix 2

<table>
<thead>
<tr>
<th>Domain</th>
<th>Assessment</th>
<th>Resources</th>
</tr>
</thead>
</table>
| Nutrition| • Breastfeeding is the normal way of providing infants and young children with the nutrition they need for healthy growth and development [13]  
• Assess infant / child’s nutritional status at each child health check [26] [13] ; ask broad open – ended questions e.g. what signs does your baby show when she/he is hungry? Ask closed ended questions if you need specific details e.g. how many wet nappies does your baby have each day? [8]  
• Provide mothers with support to manage breastfeeding challenges, when establishing and also maintaining breastfeeding [3]. Refer mothers for further breastfeeding assessment / support as required [11]  
• Assess safe use of infant formula; preparation and cleaning of infant feeding equipment, storage and transport of infant formula [15, 27]  
• Food security assessment; availability, access, preparation and storage of food e.g. if the toddler / child is hungry is there food available?  
• Provide parent/s and or carer/s with accurate evidenced-based information and resources  
• Discuss with parent/s and or carer/s developmental signs that indicate infants readiness to start solid foods, refer to section 4 [13] ‘A Healthy Start in Life  
• Breastfeeding Helpline 1800 mum 2 mum 1800 686 2 686  
• Australian Breastfeeding Association [www.breastfeeding.asn.au](http://www.breastfeeding.asn.au)  
• Lactation Consultants of Australia and New Zealand (LCANZ) [www.lcanz.org](http://www.lcanz.org)  
• 13 HEALTH 13 43 25 84 (24 hr health information phone line)  
• Child Health Information Your guide to the first 12 months [27] [http://qheps.health.qld.gov.au/cyhv/info_booklet.htm](http://qheps.health.qld.gov.au/cyhv/info_booklet.htm)  
• Fun not fuss with food |
### Appendix 2

#### Assessment Domain Resources

<table>
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</table>
| Growth   | • Normal physical growth is an important indicator of an infant / child’s overall health and nutritional status. Physical growth is best assessed by measuring weight, length/height and head circumference [28]  
• Following birth infants can lose up to 10% of their birth weight. By day 6 they should start to regain this weight and should have regained their birth weight by 2 weeks [28, 29]. There should be regular weight gain throughout the first year of life, approximately;  
  o birth to 3 months a gain of 150g – 200g per week  
  o 3 - 6 months a gain of 100g – 150g per week  
  o 6 - 12 months a gain of 70g – 90g per week [13, 28]  
  o Weight gain between 1-5 years of age approximately 2-3kg per year [8]  
• Breastfeed infants have different growth patterns compared with formula fed infants in the first 12 months therefore caution should be exercised when interpreting results for breast fed infants using Centre for Disease Control (CDC) charts. Breastfeed infants appear to grow faster than average during the first 6 months but more slowly thereafter. They also tend to be taller and thinner compared with mostly formula fed infants.  
• Refer to the Child and Youth Health Practice Manual Section 3 for the recommended procedures for measuring infants and children – weight, length / height and head circumference; link available in resource column.  
• The WHO Child Growth Standards [www.who.int/childgrowth/standards/en](http://www.who.int/childgrowth/standards/en)  
• Centres for Disease Control [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts) [30]  
• Community Child Health Service www.health.qld.gov.au/cchs  
### Appendix 2

**Growth**

- Document growth measurements in the infant/child’s medical record and PHR.
- Plot measurements on the CDC growth chart – correct age for preterm infants [3, 31]
- **Interpreting growth charts** – After measuring the child and plotting measurements on the appropriate chart for age and gender, assess the child’s growth curve against the growth percentile lines.

#### Assessment Resources

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**Growth**

![Figure 1](image1.png) ![Figure 2](image2.png) ![Figure 3](image3.png)

Figure 1 → If the child’s growth is following the growth trend percentiles, it is an indication of good growth [25]

Figure 2 & 3 → A flat line or a downwards direction can indicate growth faltering [25]

## Appendix 2

<table>
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<tr>
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</table>
| Physical Assessment  | • **General appearance** – Infant’s response to parent/s & examiner, state of alertness, activity, range of spontaneous movement, posture, muscle tone, odour, how infant is dressed i.e. clean / dressed appropriately for weather.  
  • **Skin** – integrity, turgor, colour, marks, pigmentation, rashes, lesions, sores, bites, jaundice, bruising, anomalies  
  • **Head**  
    o Shape and symmetry  
    o Fontanelle; posterior fontanelle closed by 8 weeks, anterior fontanelle closes 12-18 months.  
    o sutures  
  • **Face**  
    o Symmetry  
    o Note any unusual facial proportions e.g. small receding chin, wide or close set eyes  
    o Ears – position, structure – including patency of the external auditory meatus, startle reflex present to sudden loud noise, check that Neonatal hearing screen has been completed  
    o Eyes – pupil restricts in response to light, **No** opacities or haziness, white / clear sclera, 0-4 weeks- infants ability to look at faces and by 6 months their ability to follow moving objects.  
    o Mouth – hard and soft palates, mucosal lining of lips cheeks, tongue and frenulum  
    o Nose – patent nares  
  • **Neck**  
    o Normal range of movement – limited range of movement may indicate torticollis or wryneck  
  • **Back**  
    o Symmetry of scapulae and buttocks  
    o spine intact  
  • **Hips**  
    o Equal hip abduction  
    o Prone - thigh symmetry  
    o Supine - symmetric thigh and gluteal folds.  
  • **Nervous system**  
    o Behaviour  
    o Posture  
    o Muscle tone  
    o Movement  
    Reflexes → Moro, Suck, Rooting, Grasp, Stepping/Walking | • Wong’s Nursing Care Of Infants And Children [8]  
• Pocket Guide to Pediatric Assessment [9]  
• Paediatric Handbook [17]  
• Newborn screening laboratory **36 36 70 51**  
### Appendix 2

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Information for rural and remote</strong></td>
<td>Perform additional child health assessments / screening for rural and remote populations, as outlined in the Chronic Disease Guideline [25];&lt;br&gt;• Perform additional child health checks at 9, 15 and 21 months → The</td>
<td>• Chronic Diseases Guidelines; Section 4, Child Health Check and Attachment – Child Health Check Activity Summary&lt;br&gt;<a href="http://www.health.qld.gov.au/cdg/html/cdg_resource.asp">http://www.health.qld.gov.au/cdg/html/cdg_resource.asp</a></td>
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| populations AND Aboriginal & Torres Strait Islander Children | purpose of these additional child health checks are to ensure follow up for those children who have not met growth and nutrition targets at previous checks  
- Fontanelle → Check at each well child health check from 0-4 weeks up to and including 2 years  
- Ears and hearing (There is a high level of hearing loss in Aboriginal and Torres Strait Islander people)  
- Eyes and vision → Appearance of the eye, Red eye reflex and Corneal light reflex  
- Haemoglobin → Check haemoglobin at 6 months of age (if preterm or LBW infant check from 4 months) then 3 monthly to 2 years  
- BMI yearly from 2 years of age | - Primary Clinical Care Manual [33]  
- Growing Strong Feeding You And Your Baby Resources available for download from:  
Appendix 3

Project Officer
Tracey Button

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Marilyn Chew, Director of Nursing, Community & Extended Care Services, Sunshine Coast Health Service District

Consultative Members
Catherine Marron, CNC, Primary Care Program, Children’s Health Services
Caroline Diamond, Clinical Practice Supervisor for Early Intervention Specialists, Northern Queensland
Deanne Minniecon, Senior Project Officer, Health Promotion Unit
Gloria Ireland, Child Protection Liaison Officer, Community Health, Longreach
Gwen Kemp, Project Officer, Child Health, Community & Primary Prevention Services, Cairns and Hinterland Health Service District
Helen Luyendyk, Manager, Child Health and Safety Unit, Primary Community and Extended Care Branch
Helen Miller, Acting Nurse Unit Manager, Coorparoo Child Health, Children’s Health Services
Irene Hamner, Nurse Educator, Maternal & Child Youth Health, RBWH
Jan Pratt, Nursing Director, Primary Care Program, Children’s Health Services
Jody Antrobus, Senior Health Promotion Officer, Skin Cancer Prevention
Julie-Anne Harrison, Clinical Nurse, Coorparoo Child Health, Children’s Health Services
Karen Adcock, Nurse Unit Manager, Child & Family Health, Caboolture
Karen Berry, Nursing Director, Ellen Barron Family Centre
Assessing infant / child nutrition, growth and development within the primary health care setting

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Liz de Plater, Service Development Leader – PIMH, Queensland Centre for Perinatal and Infant Mental Health
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Neil Wigg, Director of Community Child Health, St Pauls Terrace Springhill
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Ronell Wilson, Project Officer, Community Child Health Service