



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Training Programme

for Public Health Nurses and Doctors

in Child Health Screening, Surveillance and Health Promotion

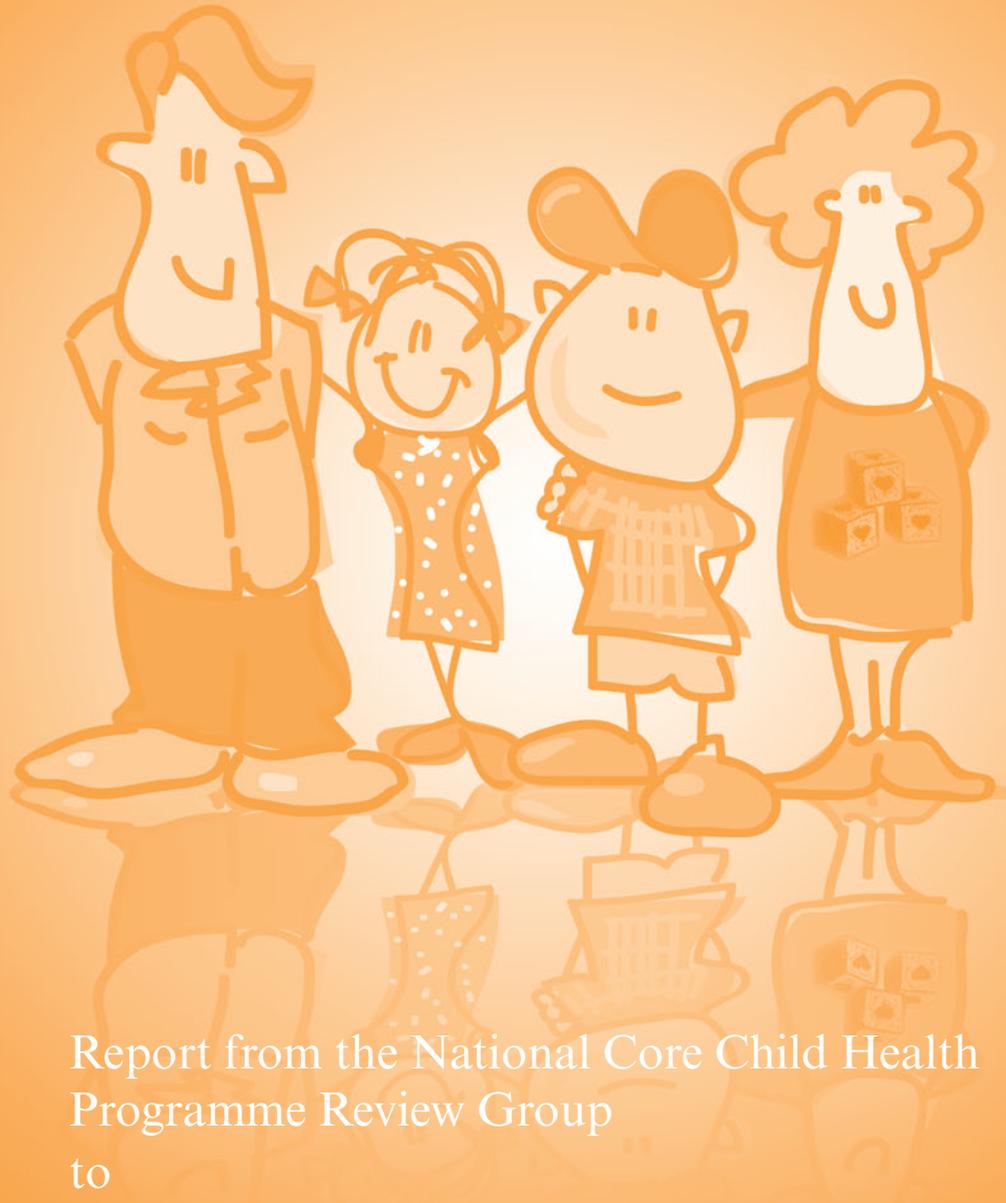
Appendix 2

Best Health for Children Revisited

October 2005



Best Health for Children Revisited



Report from the National Core Child Health
Programme Review Group
to
the Health Service Executive

October 2005



Programme of
Action for Children



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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Foreword

The national review of child health services, which resulted in the strategic report *Best Health for Children - Developing a Partnership with Families* (BHFC) was published in 1999. This included an outline of a core programme for child health surveillance.

In line with an evidence based approach, a review of these recommendations has now been carried out. This reflects the need, recognised in the original BHFC report, to adapt practice in light of emerging research findings and is extremely timely, given the development of national and regional training programmes in child health.

This report contains recommendations for a revised core programme for child health surveillance in Ireland in eight key areas, which will be incorporated into the ongoing national and regional training programmes for doctors and nurses. A summary of the research evidence underpinning the recommendations is posted and will be kept updated on the Programme of Action for Children website www.pacirl.ie.

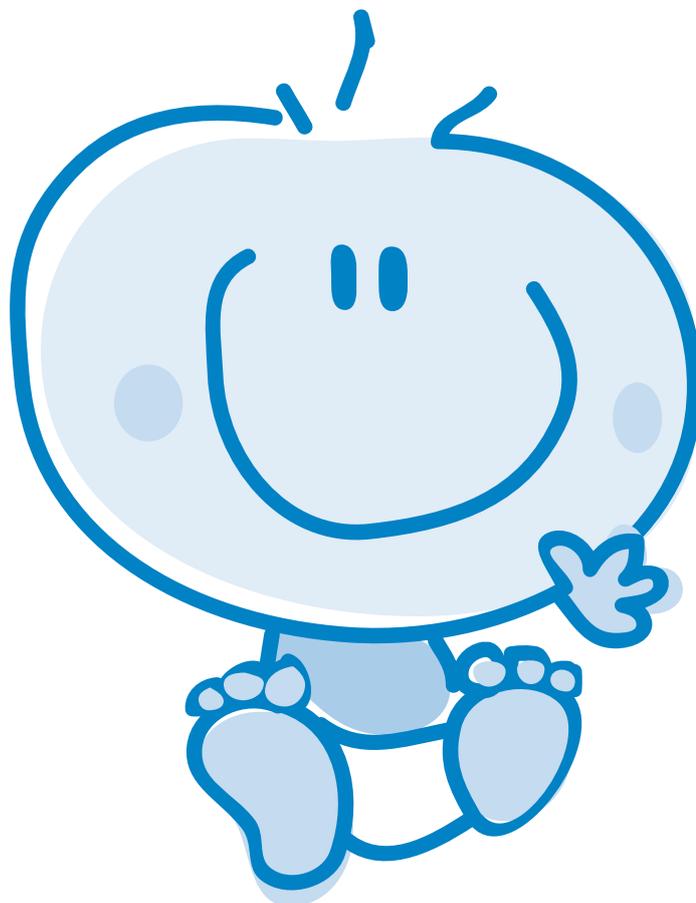
I would like to thank the members of the National Core Programme Review Group and co-opted members for completing a comprehensive review of child health surveillance standards within such a short time frame. In particular I would like to thank Dr. Christine McMaster for chairing the working group and the members of the sub-groups for their work in producing the templates for the new standards.

Dr. Sean Denyer

Director

HSE Programme of Action for Children

December 2004



Membership of National Core Programme Review Group

Dr Brenda Corcoran	Assistant Director (from June 2004)	Programme of Action for Children
Ms Carmel Cummins	Training & Development Officer	Programme of Action for Children
Dr Emma Curtis	Community Paediatrician	South Western Area Health Board
Ms Majella Doherty	Child Health Development Officer	Southern Health Board
Ms Marie Faughey	Director Public Health Nursing	South Western Area Health Board
Dr Mary Fitzgerald	Senior Area Medical Officer	Western Health Board
Dr Pat Henn	Area Medical Officer	Southern Health Board
Dr Maureen Hillery	Community Ophthalmic Physician	South Eastern Health Board
Ms Majella Loftus	Child & Adolescent Health Development Officer	Northern Area Health Board
Mr Bernard McDonald	Regional Child & Adolescent Health Development Officer	North Eastern Health Board
Dr Christine McMaster (Chairperson)	Regional Child & Adolescent Health Development Officer	North Western Health Board
Ms Lily McPeake	Public Health Nurse	East Coast Area Health Board
Dr Anne O'Connell	Consultant in Paediatric Dentistry	Dublin Dental School
Dr Theresa Pitt	Senior Audiological Scientist	South Eastern Health Board
Dr Louise Power	Area Medical Officer	Midland Health Board
Dr Edna Roche	Lecturer in Paediatrics	Trinity Centre for Health Sciences
Ms Mary Roche	Project Manager, Adolescent Health	Programme of Action for Children
Ms Breda Ryan	Regional Child & Adolescent Health Development Officer	Mid Western Health Board
Ms Jean Kilroe	Knowledge Officer (Child Health)	Programme of Action for Children

Co-opted Members

Ms Teresa Cawley	Training & Development Officer	North Western Health Board
Ms Clare Farrell	Public Health Nurse	Northern Area Health Board
Dr Hilary Greaney	Community Paediatrician	North Western Health Board
Professor Hilary Hoey	Professor of Paediatrics	Trinity College Dublin /National Children's Hospital
Ms Theresa Lynch	Training & Development Officer	Southern Health Board
Ms Eileen Maguire	Training & Development Officer	North Eastern Health Board
Ms Grace O'Neill	Training & Development Officer	South Eastern Health Board
Ms Maria Quaid	Audiological Scientist	Our Lady's Hospital for Sick Children, Crumlin

Acknowledgements

The Review Group Members wish to acknowledge the support and advice received from:

- Ms Patricia Barr, Audiological Scientist, North Western Health Board
- Dr Donal Brosnahan, Ophthalmic Surgeon, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12
- Community Ophthalmic Physicians
- Directors of Public Health Nursing
- Ms Maureen Fallon, National Breastfeeding Co-ordinator
- Dr Nader Farvardin, Principal Dental Surgeon, North Western Health Board
- Professor Ray Fitzgerald, Consultant Paediatric Surgeon, Our Lady's Hospital for Sick Children, Crumlin
- Mr Esmond Fogarty, Consultant Orthopaedic Surgeon, Our Lady's Hospital for Sick Children, Crumlin
- Ms Beatrix Haskins, Senior Orthoptist, Southern Health Board
- Health Promotion Managers Group, Health Boards
- Irish Orthoptic Association
- Dr Joanne Kearney, Community Ophthalmic Physician, North Western Health Board
- Dr. Philip Mayne, Director, National Newborn Screening Laboratory, The Children's Hospital, Temple Street, Dublin
- Members of the Regional Child Developmental Assessment Working Group, North Western Health Board
- Mr John McCance, Senior Orthoptist, North Western Health Board
- Ms Olive McGovern, Youth Health Promotion, Department of Health & Children
- Dr Saoirse NicGabhainn, Dept of Health Promotion, NUI Galway
- Ms Bidy O'Neill, Health Promotion Advisor, Department of Health & Children
- Participants at the "BHFC Revisited" Seminars, Programme of Action for Children Conference, Kilkenny, October 11th and 12th 2004
- Participants at the National Symposium on Growth Monitoring of Children in Ireland, Dublin, November 23rd 2004
- Principal Medical Officers
- Ms Deirdre Rooney, Administrative support, Programme of Action for Children
- Dr Kevin Walsh, Consultant Paediatrician, Our Lady's Hospital for Sick Children, Crumlin

Executive Summary

In 1996 a strategic report reviewing child health services was commissioned by the Chief Executive Officers of all Health Boards and *Best Health for Children- Developing a Partnership with Families (BHFC)* was published in 1999. This included an outline of a core programme for child health surveillance. In order to quality assure the delivery of this recommended programme, a national training programme framework was developed and the report *Training of Doctors and Public Health Nurses in Child Health Surveillance* was published in 2000.

Since then BHFC has become a national programme under the Health Board Executive (HeBE) and in 2003 was enlarged to integrate other services for children and young people as the Programme of Action for Children (PAC).

Funding for a national training programme was received from the Department of Health and Children (DoH&C) in 2003 and in conjunction with Trinity College Dublin (TCD) a national training programme for doctors and public health nurses working in child health surveillance began in January 2004. It was recognised that a review of the core child health programme recommendations from BHFC, 1999 in light of emerging evidence was required.

In response, a multidisciplinary National Core Programme Review Group was established by PAC in March 2004. The group met four times between March and September 2004. Eight working groups were formed to focus on the following areas: developmental assessment, hearing assessment, vision screening, medical examination, health promotion and education, newborn metabolic screening, growth monitoring and oral and dental health.

Recommendations are included in this report for child health surveillance in each of the eight working group areas. General recommendations include a reduction in the number of formal tests with a shift to observation of child behaviour and development. There is a continued emphasis on the value of parental observations and concern. The importance of determinants of child health and the need to work in partnership with parents to achieve positive health outcomes for children are recognised. Standardised tools, equipment and facilities are essential to ensure consistent and equitable delivery of a child health surveillance programme, as well as audit of the implementation of revised practice. This will be facilitated through ongoing delivery of regional training programmes, thereby ensuring translation of the revised BHFC recommendations into clinical practice. Further development of community child health services is required to ensure equitable and timely access for all children.

Chapter 1 - Introduction

1.1 Background

In 1996, the Chief Executive Officers of all Health Boards commissioned a national review of the child health services for the 0-12 year age group in Ireland. This was long overdue as similar work had not been undertaken for 30 years. The findings and recommendations resulting from this process were published in 1999 in the form of a strategic report called *Best Health for Children-Developing a Partnership with Families (BHFC)*. A national project team was established in 2000 to drive the implementation of the report's recommendations. Since then, BHFC has become a national programme under the umbrella of the Health Board Executive (HeBE) and was recently given an extended role in the development of a national service framework for integrated children's services, the *Programme for Action for Children (PAC)*.

The BHFC report, endorsed in the National Health Strategy *Quality and Fairness- A Health System for You* in 2001, is based on an assessment of existing child health service provision. Its recommendations for best practice are drawn from international research based evidence and consultation with service users and providers in Ireland. They are underpinned by the principles of quality assurance through standardisation of service provision, training of staff, information management, improved communication and accountability. In addition there is an emphasis on partnership with parents, equity and the importance of moving to a child centred model of service provision.

1.2 National BHFC Training Programme

The publication of the BHFC report recognised the importance of training for professionals. To quality assure delivery of the recommended national core child health programme, a national training programme framework was developed. The report *Training of Doctors and Public Health Nurses in Child Health Surveillance* was published in 2000 and endorsed by the Health Board CEOs within HeBE. Partial funding for a national training programme to be co-ordinated and facilitated by PAC was received from the Department of Health and Children (DoH&C) in 2003. This enabled the recruitment of a National Child Health Training and Development Officer and the development of a modular training programme in co-operation with Trinity College Dublin (TCD). This process was overseen by the National Expert Group on Training (NEG) convened towards the end of 2003. Regional Training and Development Officers for Child Health were recruited by health boards, and the National Training the Trainers Programme commenced in January 2004.

1.3 National Core Programme Review Group

In line with an evidence based approach, a review process of recommendations contained in the original BHFC report had commenced in 2003. It became apparent that completion of this process was required to allow reflection of current best practice in the national and regional training programmes. To address this need, the National Core Programme Review Group was established by PAC in March 2004.

Chapter 2 - Methodology

2.1 Terms of Reference of Core Programme Review Group

Aim

- To establish a standardised, equitable and quality assured national core child health screening, surveillance and health promotion programme

Objectives

- To review evidence and recommendations for best practice
- To develop guidelines and standards for each surveillance and screening opportunity
- To consult with professional and academic organisations and representative bodies towards building broad based national support
- To agree appropriate tools and equipment
- To identify resource constraints

Process

The review group members were nominated by PAC and additional members were co-opted. The group met four times between March and September 2004. Eight working groups were established to focus on the following areas:

- Developmental assessment
- Hearing assessment
- Vision screening
- Medical examination
- Health promotion and education
- Newborn metabolic screening
- Growth monitoring
- Oral and dental health

Draft recommendations were developed by the working groups, based on literature reviews of available national and international evidence and approved by the National Core Review Group. Members of the working groups endeavoured to consult with colleagues and relevant experts to achieve consensus prior to formal consultation with academic and professional organisations.

Chapter 3 - Recommendations

3.1 General

- There needs to be an ongoing *shift from formal testing to observation of child behaviour and development* by trained professionals in light of existing and emerging evidence.
- The importance of *parental observation and concern* needs to be further emphasised.
- There is a need to continuously strengthen the role of *health promotion and parent support* in all areas of child health, taking cognisance of the broad determinants of child health and the pivotal role of parents and other primary caregivers in influencing child health outcomes.
- The *role of individual professional groups* involved in the delivery of evidence based child health service delivery is evolving. This process requires ongoing support through the national BHFC training programme.
- *Training of professionals in child health service delivery* is needed on an ongoing basis to reflect an evidence based approach to an evolving national core child health programme and to quality assure its delivery.
- Many HSE areas are unable to meet *statutory child health service requirements*. Staffing shortages in Area Medical Officer and Public Health Nursing Services need to be addressed urgently. It is necessary to develop innovative models of service delivery to optimise the use of limited resources in response to the needs of children and their families
- There is an urgent need to adequately resource and develop *Community Child Health Services* in Ireland, as existing services are often unable to respond to identified needs of children in a timely and appropriate manner.
- *A mechanism for ongoing review of the evidence base and content of the national core programme* needs to be developed and maintained. It is proposed to establish a national core child health committee.
- *Standardised protocols, tools, equipment and facilities* are a cornerstone for quality assurance, without which a national programme in child health surveillance, screening and health promotion could do more harm than good. This has resource implications at local, regional and national level.
- *National standards for facilities* appropriate to the needs of children, their families and health service providers need to be developed as a basis for gradual improvement of the often inadequate physical surroundings in which child health services are delivered.
- The implementation of a revised national core child health programme needs to be evaluated through *audit*.

- The introduction of the *Personal Health Record (PHR)* nationally is urgently required to support the delivery of a standardised national core programme and requires national funding. This will ensure equity, allow evaluation through data collection and analysis and information sharing with parents and amongst service providers.
- The national dissemination of child health information for parents ‘Caring for your child’ developed by the *Child Health Information Service Project (CHISP)* for use in conjunction with the PHR is recommended and requires national funding
- The publication and implementation of the recommendations from the *National Report on Universal Neonatal Hearing Screening* is necessary to provide hearing screening in line with current evidence and best practice.
- Implementation of the recommendations from the *National Newborn Screening Programme for Inherited Metabolic Disorders* is required to provide screening in line with current evidence and best practice.
- Oral and Dental Health are an integral part of child health. PAC is requested to seek a mandate to develop evidence based recommendations for the national *statutory school dental health service*.
- There is a need to improve and standardise *school entry questionnaires* currently in use throughout the country to provide a valid instrument for assessment of primary school children’s health needs.
- Designated *school health nurses* are essential for the provision of a modern school screening, surveillance and health promoting service. These staff require training in line with evidence based recommendations for best practice on an ongoing basis.
- The introduction of a *school health module* that reflects the recommendations of this report as an extension to the existing PHR developed in the Mid Western Health Board (MWHB) is necessary.
- *Screening for childhood overweight and obesity* is currently not recommended, but further discussion is required on *definitions of overweight and obesity* for children in Ireland. The role of *prevention and intervention* for children at risk of or with manifest overweight and obesity needs to be strengthened.
- Models for effective *prevention and management of behavioural difficulties and mental health problems in children* need to be strengthened and incorporated into the core programme for child health screening, surveillance and health promotion.

3.2 Developmental Assessment

Working Group Membership

Dr Emma Curtis, Community Paediatrician, SWAHB

Dr Mary Fitzgerald, Senior Area Medical Officer, WHB

Dr Pat Henn (chair), Area Medical Officer, SHB

Ms Lily McPeake, Public Health Nurse, ECAHB

Rationale

- There is insufficient evidence for or against universal periodic screening for developmental delay in the form of tests.
- Parental concern needs to be taken seriously always and can be sufficient reason for referral, further assessment and investigation.
- Service providers need to possess the knowledge and skills to recognise developmental delay and disorders in children.
- Parents value early diagnosis.
- There is some evidence that early intervention improves outcome and quality of life for children and their families.

Recommendations

- Staff training in the recognition of childhood developmental delay and disorders needs to be provided to facilitate early referral and intervention.
- Instruments by whose use one can elicit parental concern in relation to any area of child development need to be evaluated in the Irish context and introduced if found valid.
- The role of specific tools to guide practitioners in the assessment of childhood development needs to be explored in the Irish context, as the use of individualised checklists is no longer in line with available evidence.

Equipment

- In light of this, developmental assessment tool kits containing items like:
 - rattle
 - crayons and paper
 - picture story book
 - doll
 - hair brush
 - spoon
 - cup
 - bricks
 - 3 to 4 piece form boardscan be used to support the assessment process, but are not employed for formal testing.

Developmental Assessment

Timing	History	Examination
Birth	Family, pregnancy and birth history Parental and professional concerns	Posture, movements, tone, reflexes
Postnatal visit	As above	Posture, movements, tone, reflexes
6 to 8 weeks	As above	Posture, movements, tone, reflexes, early eye contact and smiling
3 months	As above	Lifts head when prone, using forearms for support, little or no head lag when pulled to sit Hands loosely open, beginning to clasp and unclasp objects, engaging in finger play and watching hands Reacts to familiar situations and people by smiles, coos or excited movements, laughs and gurgles Vocalising when spoken to, quietens or smiles to familiar voice, even if speaker not visible
7 to 9 months	As above	Sits unsupported, attempts to crawl Beginning to poke at objects with index finger, reaches out for and manipulates toys with both hands Loud tuneful babble, imitates playful vocal sounds Plays peek a boo, imitates clap hands Begins to point with index finger at distant objects Eats finger foods and begins to drink from cup
18 to 24 months	As above Consider any evidence that may indicate specific disorders	Walks unaided, feeds self with spoon, drinks from cup Follows simple requests, points to named objects and pictures Develops imitative behaviour and play Uses words by 18 months and simple phrases by 24 months Enjoys messy play and noisy toys, plays contentedly near familiar adult
3.25 to 3.5 years	As above	Jumps, walks around corners and on tiptoe Holds pencil, copies circle Talks in sentences, understood by strangers Pulls up pants, dry during day Takes turns in games, separates from parents

The above represents a brief selective overview of normal developmental milestones, but does not constitute a validated instrument for assessment and should not be used as a checklist. For more comprehensive summary of developmental milestones and indicators of possible developmental problems, please also see the PHR and CHISP documents, referenced at the end of this document. Health promotion and education topics are covered in Section 3.6 of this report.

3.3 Hearing Assessment

Working Group Membership

Dr Theresa Pitt, Senior Audiological Scientist, SEHB (chair)

Ms Majella Doherty, Child Health Development Officer, SHB

Ms Clare Farrell, Public Health Nurse, NAHB

Ms Marie Quaid, Audiological Scientist, OLHSC

Rationale

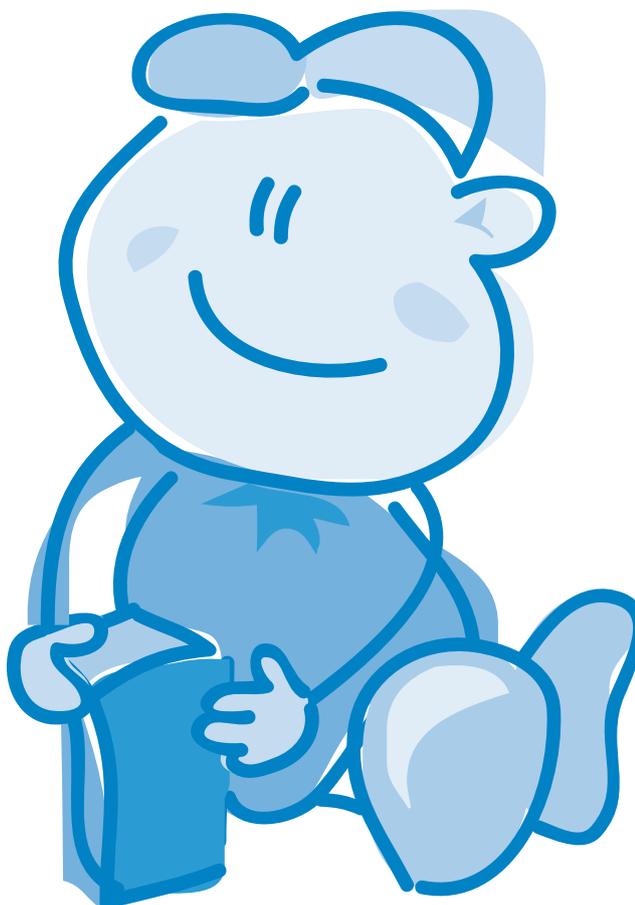
- Early intervention and habilitation of congenital hearing loss before 6 months of age is best practice

Recommendations

- Early implementation of Universal Neonatal Hearing Screening (UNHS) programmes
- Retention of and staff training in Universal Distraction Hearing Test (UDHT) and School Sweep Test as an interim measure
- Implementation of clear referral criteria as agreed by National Core Child Health Programme Review Group
- Education of parents and professionals in using 'Can Your Baby Hear You' surveillance tool

Equipment

- 'Can Your Baby Hear You?'
- Sound level meters
- Calibrated hand held warblers
- Free field audiometers
- Manchester rattle
- Distraction toys
- Low table
- Audiometer
- Oscopes



Hearing Assessment

Timing	History	Examination	Equipment	Health Promotion
Birth	Antenatal, birth and family history, risk factors for hearing loss, parental concerns	UNHS is gold standard (two-stage screen as per UNHS report recommendations) Inspection of ears, facial morphology, associated physical findings or syndromes	Otoscope	Encourage parental observation, 'Can your baby hear you?'
Postnatal visit	As above	As above		As above
6 to 8 weeks	As above	Observation of auditory behaviour	Otoscope	As above
3 months	As above	Observation of auditory behaviour		As above
7 to 9 months	As above	Distraction hearing test in the absence of UNHS	Sound treated/ quiet room (ambient noise <35dB(A), carpets, curtains & low table, toys. Calibrated warbler, trained LF/HF voice, Manchester HF rattle. Access to sound level meter	As above
18 to 24 months	As above	Observation of speech and language behaviour		Encourage parental observation
3.25 to 3.5 years	As above	Observation of speech and language behaviour		As above
School entry (Junior Infants)	As above	In the absence of UNHS - pure tone audiometry (sweep test screen, 1st and 2nd test stages)	Quiet room <40dB(A) ambient noise, bricks, tapper or hammer for child responses Small screening audiometer Sound level meter	

3.4 Vision Screening

Working Group Membership

Dr Maureen Hillery (chair), Community Ophthalmic Physician, SEHB

Ms Theresa Lynch, Training & Development Officer, SHB

Rationale

- Many abnormalities are first recognized by parents or other family members.
- There is insufficient evidence to make a recommendation for preschool visual acuity screening beyond observation of visual behaviour.
- There is evidence to support vision screening at school entry to identify and treat children with moderate and severe visual acuity loss to prevent amblyopia.
- Myopia is more appropriately detected by opportunistic visual acuity testing in schools at the request of parents and teachers rather than by universal vision screening of all children at fixed intervals.
- LogMAR crowded 3 metres test is gold standard for visual acuity testing and will be introduced gradually in cooperation with community ophthalmic departments. In the interim, illuminated Snellen Acuity test at 6 metres and Sonksen Silver Visual Acuity matching test remain tools of acceptable quality for screening.
- The evidence for stereo acuity testing as a screening tool is weak.
- There is insufficient evidence for or against colour vision screening. It should therefore continue in areas where it is in operation, but not commence in other areas.

Recommendations

Preschool Children

- Observation of visual behaviour
- Clear referral criteria
 - History of amblyopia or squint in first degree relative
AND
 - Parental concern

Primary School Children

- School entry and exit screening- omit second class screening
- Clear referral criteria
 - visual acuity of less than 6/9 in one or both eyes
OR
 - difference of more than one line between both eyes

Personnel

- Ideally, screening should be carried out by orthoptists.
- Designated school nurses are required for school vision screening.
- Children with special needs should be screened by orthoptists.

Vision Screening

Timing	History	Examination	Equipment	Health Promotion
Birth	Birth and family history Parental concern Visual behaviour	Observation: Inspection of eyes Red reflex Corneal light reflex	Ophthalmoscope Pen torch	Inform parents of normal vision development
Postnatal visit	Past, birth, family history Parental concern Visual behaviour	Observation: Inspection of eyes Corneal light reflex	Pen torch	As above
6 to 8 weeks	As above	Observation: Inspection of eyes Corneal light reflex Red reflex	Ophthalmoscope Pen torch	As above
3 months	As above	Observation: Inspection of eyes Corneal light reflex	Pen torch	As above
7 to 9 months	As above Ask about first degree relatives with: ?Squint ?Amblyopia	Observation: Inspection of eyes Corneal light reflex	Pen torch	As above
18 to 24 months	As above	As above	Pen torch	As above
3.25 to 3.5 years	As above	As above	Pen torch	As above
School entry (Junior Infants)	As above Parental/ teacher concern	Observation: Inspection of eyes Vision assessment	Illuminated Snellen chart at 6 metres (use the most difficult test the child can do- Snellen, then matching Sonksen Silver) Adhesive patch occluder Replacement panel Standard 20 ft/ 6m room (Until introduction of logMAR crowded 3 metres test as gold standard)	As above
School exit (5th or 6th class)	As above	As for school entry Evidence for or against colour vision screening equivocal	As for school entry Ishihara colour plates where colour screening in operation	Eye protection/ Eye health Career choices

N.B. Vision screening should also be offered to children wearing glasses, this is for reasons of equity and to identify children who may have been lost to follow-up. These children should be screened with their glasses on. For some children visual acuity in one or both eyes may intentionally be lower with the corrective glasses than without. This should not be highlighted to the child as any comment might be misinterpreted as a reason for the child to discontinue wearing glasses. If in doubt, refer the child for reassessment by the community ophthalmic department.

Working Group Membership

Dr Hilary Greaney, Community Paediatrician, NWHB

Dr Louise Power (chair), Area Medical Officer, MHB

Rationale

- Due to the very small number of significant findings from cardiovascular examination as part of screening programmes in children, continuation of such examinations after 8 weeks of age is not justified. It remains good clinical practice for suitably trained professionals to include cardiovascular examination in any examination of children.
- Testicular descent in boys is unlikely to occur after the 3rd month of age in term infants and after 6 months of age in preterm infants. There is evidence for irreparable histological changes to occur in testes remaining undescended beyond two years of age. Where testes are found to be impalpable bilaterally, the presence of Congenital Adrenal Hypoplasia (CAH) needs to be considered, and immediate referral is mandatory at any age to minimise the risk of life threatening complications.
- Developmental Dysplasia of Hips (DDH) is detected mainly by clinical examination. There is a need to ensure that children at particular risk of DDH have been appropriately investigated. Ongoing professional and parental observation is important to detect late presenting cases. Ortolani Barlow manoeuvre is inappropriate after the age of 8 weeks.

Recommendations

- Medical examination at birth and 6 weeks of age.
- Early referral for orchidopexy of boys with UDT to achieve surgery prior to reaching 2 years of age.
- In the absence of a record or other documentation that testicular descent has been confirmed in an individual child, clinical examination for UDT is necessary at any age.
- Detection of DDH at different ages:
 - o Ortolani Barlow manoeuvre from birth until 6 to 8 weeks of age
 - o Symmetry of skin folds and range of movement/abduction
 - o Galeazzi sign from birth to walking age
 - o Recognition of risk factors (family history, breech presentation) and appropriate referral for DDH until walking age
 - o Delayed walking beyond 2 years of age
 - o Waddling gait

Medical Examination

Timing	History	Examination	Equipment	Health Promotion
Birth	Antenatal, birth and family history Parental concerns	Heart, respiratory system, skin appearance, fontanelles, features, mouth, neck, eyes, abdomen, genitalia (exclude UDT in boys), hips (exclude DDH), spine, limbs	Ophthalmoscope Stethoscope	Managing acute illness
Postnatal visit	As above	Skin appearance, fontanelles, ears, eyes, mouth, chest inspection and respiration, abdomen and umbilicus inspection, genitalia (check for UDT in boys), upper and lower limbs, spine		As above Parental awareness of developmental nature of DDH
6 to 8 weeks	As above	Respiration, colour, skin, fontanelles, palate, hands, feet, eyes, ears, heart, femoral pulses, genitalia (check for UDT in boys), DDH (Ortolani- Barlow manoeuvre, asymmetry of appearance and range of movements/ abduction, risk factors)	Ophthalmoscope Stethoscope	As above
3 months	As above	Skin, fontanelles, genitalia (ensure UDT checked for in boys and referred as appropriate), DDH (asymmetry of appearance and range of movements/ abduction, risk factors, Galeazzi sign), signs of heart failure		As above
7 to 9 months	As above	UDT- ensure that testicular descent has either been documented or referral initiated DDH- asymmetry of appearance and range of movements/ abduction, risk factors, Galeazzi sign CVS- not supported by evidence, but remains routine medical practice		As above
18 to 24 months	As above	Observation of gait- waddling gait and difference in leg length		As above

3.6 Health Promotion

Working Group Membership

Ms Carmel Cummins (chair), Training & Development Officer, PAC

Ms Eileen Maguire, Training & Development Officer, NEHB

Mr Bernard McDonald, Regional Child & Adolescent Health Development Officer, NEHB

Ms Grace O'Neill, Training & Development Officer, SEHB

Ms Teresa Cawley, Training & Development Officer, NWHB

Ms Mary Roche, Project Manager, Adolescent Health, PAC

Rationale

- Each child has a right to realise his/her potential in terms of good health, well-being and development.
- There is a need to work in partnership with parents and other primary carers.
- There is a need to develop a holistic health service for children and their families, in which mental and social well-being are as important as physical well-being.

Recommendations

- Increased emphasis on affirming and promoting bonding, parenting skills and age appropriate play
- Early identification of families in need of additional supports
- Health promotion literature, and its use, needs to meet criteria set out in *Good Practice Guidelines for using Health Promotion Information Materials* as established by the National Health Promotion Information Project (2004).

Equipment

- Personal Health Record (PHR) developed by MWHB
- Health promotion literature e.g. Child Health Information Services Project (CHISP) materials developed by SEHB
- Child Safety Awareness Manual developed by MHB
- Mechanisms to support multidisciplinary and interagency working

Personnel

Health promotion and education is the responsibility of all child health professionals, who require knowledge of the key determinants of child health and skills in reflective and responsive practice.

Health Promotion

Timing	History	Equipment	Health Promotion
Birth	Parental concerns	Skills to work in partnership with parents on all issues related to their baby's health and well being. Mechanisms to support multidisciplinary and interagency working	Parental health and well-being Prevention of SIDS Transport in cars Feeding practice Sibling management Parent–infant interactions Child development Accident prevention Information about local support networks and contacts for additional advice and support when needed Identification of parents who may be in need of additional supports
Postnatal visit	As above	As above PHR – MWHB <i>Caring for your child</i> – Health Promotion Unit, DoHC <i>Child Safety Awareness Manual</i> - MHB <i>Caring for your baby</i> (CHISP) – SEHB <i>Breastfed is bestfed</i> – NWHB	As above
6 to 8 weeks	As above	As above	As above Family planning
3 months	As above	As above	As above Oral health promotion Age appropriate play Return to work Child care
7 to 9 months	As above	As above	As above
18 to 24 months	As above	As above Mother and toddler groups	As above Management of challenging behaviour Toilet training
3 to 4 years	As above	As above Access to information on local playschools/ pre-schools/ schools	As above
School entry (Junior infants)	Parental and teacher concerns	Skills to work in partnership with parents on all issues related to their child's health and well being Mechanisms to support multidisciplinary and interagency working	As per SPHE programme Advisory and supporting role to teacher in SPHE
School exit (5th or 6th class)	As per school entry	As per school entry	As per school entry

3.7 Neonatal Metabolic Screening

Working Group Membership

Ms Majella Loftus (chair), Regional Child & Adolescent Health Development Officer, NAHB

Ms Marie Faughey, Director of Public Health Nursing, SWAHB

Rationale

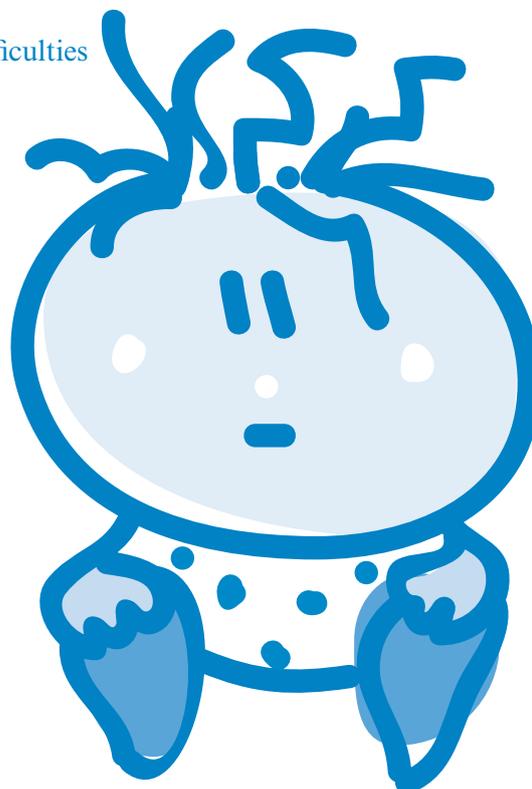
- Early detection of five inborn errors of metabolism allows dietary and medical management to prevent or ameliorate adverse effects on child intellectual and physical development.
- Requirements for quality assured national neonatal metabolic screening programme based on evidence and principles of best practice have been outlined in a recent national review report.

Recommendations

- Staff training in appropriate technique and use of equipment
- Improved communication with and information for parents
- Inclusion of visual aids to meet information needs of less literate population groups

Equipment

- Introduction of a standardised sample taking pack
- Introduction of consent form and refusal form
- Introduction of information materials for parents
- Visual aids for people with reading or language difficulties



Neonatal Metabolic Screening

Timing	History	Examination	Equipment	Health Promotion
After 72 hours and before 120 hours after birth	<p>Breast Fed Infants: sample taken towards end of the 72 to 120 hour window. If protein sample is deemed to be suboptimal, further sample taken on about day 10 after birth.</p> <p>Premature Infants: sample taken after 72 hours and before 120 hours from birth. Further samples should be collected at weekly intervals until infant established on full feeds.</p>	Newborn Screening for Inherited Metabolic and Congenital Disorders	Disposable latex free gloves Newborn screening card Sterile lancet, controlled depth of to 2.5mm Paper towel Dry sterile gauze pad Cotton wool Warm water and soap Sharps bin Drying rack Consent form and Refusal form Parent information leaflet	Visual aids incorporating the needs of non- nationals/ ethnic minorities Ante natal health promotion

High Risk Screening

Family history must be stated clearly on newborn metabolic screening card.

Siblings of known cases of Phenylketonuria (PKU): Sample should be taken between 72 and 120 hours following birth and liquid sample taken on day 3 and day 10 for plasma phenylalanine and tyrosine determination.

Siblings of known cases of Homocystinuria: Sample should be taken on day 3 and day 10 for plasma total homocysteine, methionine and cysteine determination. This may be repeated on further occasions on the advice from the national screening laboratory, depending on results.

Siblings of known cases of Maple Syrup Urine Disease: A liquid sample should be taken on day 1 and after the second feed and then daily until established on full feeds. Urine should be tested daily for ketones. A newborn metabolic screening sample card should be taken between 72 and 120 hours after birth to test for the other conditions. The national newborn screening laboratory (NNSL) must be informed prior to delivery.

Siblings of known cases of Galactosaemia and all infants of traveller parents (including settled travellers): Sample should be taken immediately after birth and sent to the NNSL for the Beutler test.

The newborn metabolic screening sample should be taken between 72 and 120 hours following birth to test for the other conditions. All these at risk infants should be fed with a lactose/galactose free feed until results of Beutler test is known. It is important to state clearly on newborn metabolic screening card the reason why the sample was taken on day 1.

3.8 Growth Monitoring

Working Group Membership

Professor Hilary Hoey, Department of Paediatrics, Trinity Centre for Health Sciences, National Children's Hospital

Dr Christine McMaster, Regional Child & Adolescent Health Development Officer, NWHB

Dr Edna Roche, Lecturer in Paediatrics, Trinity Centre for Health Sciences (chair), National Children's Hospital

Ms Breda Ryan, Regional Child & Adolescent Health Development Officer, MWHB

Rationale

- The potential benefits of growth monitoring are:
 - Health Promotion
 - Early intervention in growth disorders
 - Identification of and early intervention in chronic disorders associated with abnormal growth
 - Reassurance to parents
 - Epidemiological data collection
- There is insufficient evidence to recommend screening for overweight and obesity, but growth monitoring data can be used to establish prevalence rates.

Recommendations

- Reduced number of mandatory growth monitoring assessments (birth, 6 to 8 week check and school entry), but children should be weighed and measured at opportunistic times including birth, at immunisations and during child health surveillance checks.
- Focus on accuracy of measurement, documentation and interpretation of findings
- Development of nine centile growth charts based on Irish data

Equipment

- Electronic self zeroing scales
- Supine length measure (infantometer or babymat)
- Lasso- o- tape or other non- stretchable tape measure
- Age calculator to correct for prematurity until age 2 years
- Leicester height measure (selfcalibrating)
- Nine centile charts

Referral Criteria

- Below 0.4th centile for weight, length and height
- Seek advice if head circumference below 0.4th or above 99.6th centile
- Parental or professional concern



Growth Monitoring

Timing	History	Examination	Equipment	Health Promotion
Birth	Gestational age Low Birth Weight (LBW) Dysmorphic features Major medical problems Parental concerns Professional concerns	Weight (naked) in kg Length in cm <i>Head circumference in cm</i>	Electronic self-zeroing scales Supine length measure (infantometer or baby mat) Lasso- o or other thin non stretchable measure tape Nine centile charts Nine centile charts for children with special needs	Nutritional advice Infant care
Postnatal visit	Gestational age LBW Dysmorphic features Major medical problems Parental concerns Professional concerns	Weight (naked) in kg <i>Length in cm</i> Head circumference in cm	Electronic self-zeroing scales Supine length measure Lasso- o or other thin non stretchable measure tape Age calculator to correct for prematurity (infants born before 36 weeks gestation) Nine centile charts Nine centile charts for children with special needs	Nutritional advice Infant care
6 to 8 weeks	As for postnatal visit	Weight (naked) in kg <i>Head circumference in cm</i> <i>Length in cm</i>	As for postnatal visit	Nutritional advice Infant care
3 months	As for postnatal visit	<i>Weight (naked) in kg</i> <i>Head circumference in cm</i> <i>Length in cm</i>	As for postnatal visit	Nutritional advice Infant care Weaning
7 to 9 months	As for postnatal visit	<i>Weight (naked) in kg</i> <i>Head circumference in cm</i> <i>Length in cm</i>	As for postnatal visit	Nutritional advice Infant care Weaning
18 to 24 months	As for postnatal visit	<i>Weight (light clothing) in kg</i> <i>Height in cm</i>	Leicester Height Measure (self calibrating) Electronic self-zeroing scales Nine centile charts Nine centile charts for children with special needs	Nutritional advice Active play
3.25 to 3.5 years	Medical history Parental concern Professional concern	<i>Weight (light clothing) in kg</i> <i>Height in cm</i>	As above	As above
School entry (Junior infants)	Parental concern Professional concern Health questionnaire to elicit underlying chronic illness	Weight in kg (light clothing) Height in cm BMI for epidemiological purposes	As above	As above

Please note: *Italics* indicate items not fulfilling screening criteria, but constituting accepted good clinical practice or requirements under a growth monitoring programme for children at risk of or with established growth disorders.

3.9 Oral and Dental Health

Working Group Membership

Dr. Anne O'Connell, Consultant in Paediatric Dentistry, Dublin Dental School

Rationale

- Oral disease is prevalent in young children, and can affect nutrition, speech, self esteem and appearance.
- Dental caries is a preventable transmissible infectious disease, leading to avoidable pain.
- Populations of children at high risk can be identified early, allowing focused prevention and early interventions.
- Inclusion of information on oral health within general health promotion can positively influence oral health.
- Epidemiological data can be generated as part of oral and dental screening programmes.

Recommendations

- Oral inspection as part of core child health programme examinations
- Establishment of a national programme of oral health surveillance and screening for all preschool children
- Staff training to non dental personnel in the provision of oral health promotion and education as part of general health promotion
- There is a need to establish best practice guidelines for the statutory school dental health screening programme in consultation with key professional organisations.

Equipment

- Reliable light source
- Age appropriate dental chart
- Risk assessment form



Oral and Dental Health

Timing	History	Examination	Equipment	Health promotion
Birth	General medical history	Inspection for early teeth, cleft lip and palate	Light source	CHISP, PHR
Postnatal visit				CHISP, PHR
6 to 8 weeks				CHISP, PHR
3 months				CHISP, PHR
7 to 9 months	Parental or professional concerns about dental or oral health	Inspection for erupting primary teeth	As above	CHISP, PHR
18 to 24 months	As above	Inspection for position and state of erupting primary teeth	As above	CHISP, PHR
3.25 to 3.5 years	As above	As above	As above	CHISP, PHR





Chapter 4 – Summary of Recommendations

Timing	History	Examination	Health Promotion	Recommended Health Care Staff
Birth	Antenatal, birth and family history Parental concerns	Physical examination, including eyes, ears, skin, mouth, cardiovascular system for CHD, hips for DDH and genitalia for UDT in boys, Developmental examination, Growth	Parental health and well-being Prevention of SIDS Transport in cars Feeding practice Sibling management Parent–infant interactions Child development Accident prevention Information about local support networks and contacts for additional advice and support when needed Identification of parents who may be in need of additional supports	Hospital Paediatrician or Community Midwife or General Practitioner
Postnatal visit	As above	Physical examination, developmental examination, growth, <i>“Can your baby hear you?”</i> , Guthrie test if not already taken	As above	Public Health Nurse
6 to 8 weeks	As above	Physical examination as for neonatal age, Developmental examination, growth, <i>“Can your baby hear you?”</i>	As above Family planning	General Practitioner and Practice Nurse
3 months	As above	Physical examination, Developmental assessment, growth, <i>“Can your baby hear you?”</i>	As above Oral health promotion Age appropriate play Return to work Child care Family planning	Public Health Nurse
7 to 9 months	As above	Examination for DDH, developmental assessment, growth, <i>“Can your baby hear you?”</i> , Distraction Hearing Test	As above	Public Health Nurses or Public Health Nurse and Area Medical Officer
18 to 24 months	As above	Observation of gait Developmental assessment Growth	As above Management of challenging behaviour Toilet training	Public Health Nurse
3.25 to 3.5 years	As above	Developmental assessment, growth	As above	Public Health Nurse
School entry (Junior Infants)	As above School entry questionnaire	Visual acuity testing Pure tone audiometry hearing screening Growth	As per SPHE programme Advisory and supporting role to teacher in SPHE	School Nurse
School leaving (5th or 6th class)	As above	Visual acuity testing <i>Colour vision screening</i>	As above	School Nurse

Please note: *Italics* indicate items not fulfilling screening criteria, but constituting accepted good clinical practice or requirements under a growth monitoring programme for children at risk of or with established growth disorders.

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Appendix 1

Academic and Professional Bodies for Consultation

Bord Altranais	Nursing Board, 31-32 Fitzwilliam Square, Dublin 2
Dental Health Foundation	26 Harcourt Street, Dublin 2
Faculty of Dentistry Royal College of Surgeons in Ireland (RCSI)	123 St Stephens Green, Dublin 2
Education Section of Irish Nurses Organisation	11 Fitzwilliam Place, Dublin 2
Faculty of Public Health Medicine Royal College of Physicians in Ireland (RCPI)	2 nd Floor, International House, 20-22 Lower Hatch Street, Dublin 2
Faculty Paediatrics RCPI	2 nd Floor, International House, 20 – 22 Lower Hatch Street, Dublin 2
Health Promotion Unit, DOHC	Hawkins House, Dublin 2
Health Promotion Dept, National University of Ireland (NUI) Galway	NUI Galway
Institute of Community Health Nursing	Baggot Street Community Hospital, 18 Upper Baggot Street, Dublin 4
IPPA – Early Childhood Organisation	Unit 4 Broomhill Business Complex, Broomhill, Tallaght, Dublin 24
Irish Association of Orthoptists	The Royal Victoria Eye & Ear Hospital, Adelaide Road, Dublin 2
Irish Association of Speech & Language Therapists	29 Gardiner Place, Dublin 1
Irish College of General Practitioners	4 -5 Lincoln Place, Dublin 2
Irish College of Ophthalmologists	121 St Stephens Green, Dublin 2
Irish Society of Audiology	c/o ISA Secretary Hannah Harlaar, OLHSC, Crumlin, Dublin 12
Irish Society of Public Health Medicine	c/o Dr Elaine Martin, Secretary Kilrush Health Centre, Kilrush, Co Clare
Mental Health Commission	St Martin's House, Waterloo Road Dublin 4
National Children's Office	St Martin's House, Waterloo Road Dublin 4
National Parents Council – Primary and Post Primary	12 Marlborough Court, Dublin 1 Unit 5 Glasnevin Business Centre, Balboggan Road, Dublin 11
Psychological Society of Ireland	CX House, 2a Corn Exchange Place, Poolbeg Street, Dublin 2