GUIDELINE

Physical assessment 0-4 years

Scope (Staff):	Community health
Scope (Area):	CACH, 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

Contents

Aim

To conduct comprehensive and systematic physical assessments that focus on identifying key risk and protective factors and implementing early interventions according to client need, to maximise optimal health and developmental outcomes.

Risk

Failing to identify physical health concerns can negatively impact children's long term health outcomes by delaying identification of health issues, missing opportunities for early interventions, reducing opportunities to support parents/carers and failing to identify potential child abuse and neglect.[8-10]

Background

Childhood is an important time for healthy development, learning and establishing the building blocks for future wellbeing. It can also be a time where adverse circumstances can have consequences for the individual later in life.[11] Community health staff are uniquely placed to support families, enhance parenting and monitor physical and developmental progress at critical times in a child's early life.[9, 12, 13]

Physical health assessments give Community health staff the opportunity to[13]:

- Identify physical concerns that require and/or would benefit from early intervention or treatment.
- Identify delays and provide anticipatory guidance (and referral as appropriate).
- Recognise indicators of child abuse or neglect.
- Model appropriate and responsive handling and interaction with the child.
- Observe carers interactions with the child.

Physical assessments must prioritise the safety and well-being of every child accessing the health service in accordance with the National Principles for Child Safe Organisations and Standards. These standards are designed to promote a safe, respectful, and nurturing environment. During assessments the physical and emotional safety of the child should be prioritised by conducting assessments in a manner that is respectful and non-invasive.

Please note: In this document, the term "child" refers to children aged 0 to 4 years.

Identifying child abuse and neglect

Physical assessments of children are a critical opportunity to identify abuse and protect them from experiencing further injury. Bruising is the most common injury from physical child abuse. It is commonly overlooked or misdiagnosed. [14] Neglect may also be identified as part of a physical assessment.

Indicators for child abuse and/or neglect whilst completing a physical assessment are highlighted in relevant appendixes in this guideline. For other signs of abuse and neglect see *Guidelines for Protecting Children 2020*.

For more information, CAHS *Child Safeguarding and Protection* and WACHS Child Safety and Wellbeing Policy.

Key points

- Comprehensive physical assessments will be conducted at all Universal contacts.
- Targeted assessments should be offered when concerns are raised by a parent, carer, teacher, or health professional, and only proceed once consent has been obtained in accordance with the CACH Consent for Services Policy, WACHS Engagement Procedure or Universal Contact School Entry Health Assessment guideline.
- The child is the focus of care, and their best interest is the primary consideration in all decisions.
- Implied consent, which must be informed, should be obtained prior to proceeding with assessment in accordance with the CACH Consent for Services Policy or WACHS Engagement Procedure. Ensure ample time is provided for addressing any concerns or questions.
- Physical assessments must only be performed by community health staff who have undertaken the CACH Community Health Nurse Orientation or WACHS recommended training and have been deemed competent in the procedures.
    - After receiving training and prior to achieving competency, staff must work under the guidance of a clinician deemed competent.
- The *Guidelines for Protecting Children 2020 and* CAHS *Child Safety and Protection or* WACHS Child Safety and Wellbeing Policy will guide practice when nurses have concerns that a child is being, or has been, abused.[16]
- When performing the assessment, examiner considers own posture to minimise any risk of musculoskeletal injuries.
- Standard precautions are to be applied by all staff, for all clients and at all times when conducting assessment and/or when in contact (or likely to be in contact) with blood or body fluids, non-intact skin and mucous membranes.
- Community health staff must follow the organisation's overarching Infection Prevention and Control Policies and perform hand hygiene in accordance with WA Health guidelines at all appropriate stages of the procedure.

- All community health staff 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.
- Community health staff need to provide a culturally safe service delivery which demonstrates a welcoming environment that recognises the importance of cultural beliefs and practices of all clients.
- Staff provide care that is inclusive, and trauma informed to create a safe environment in partnership with children, and families.

Assessment

- Access electronic recording systems (e.g., CDIS/CHIS) prior to the assessment for documented history of concerns that may have already been identified.
- Explain procedures in age-appropriate terms to children and their parent or caregiver. This reduces anxiety, models positive consent behaviours, and fosters trust and informed participative care.
- Nurses should respect boundaries and use teachable moments to discuss consent and respect. [17, 18]
- Commence parts of the physical assessment that require the child to be in a quiet and alert state, prior to undertaking a comprehensive assessment.
- Elements of the physical assessment that require the child to be prone or supine must be conducted on a stable, firm surface such as a bench or examination table to ensure safety and accuracy. (Weighing scales are not considered a suitable surface.)
- Conduct assessment with actions and behaviours that show respect for child's age, gender, cultural values, and personal preferences. Privacy must always be considered. As per CAHS Child and Family Centred Care policy and WACHS Engagement Procedure.
- Adapt language and communication methods to align with the child's needs, considering their age and developmental stage.
- Staff must use the correct terminology (and correct names for body parts including genitalia) when discussing findings with the parent or caregiver.
- Community health staff maintain accurate, comprehensive, and contemporaneous documentation of assessments, planning, decision making and evaluations according to CACH and WACHS processes.
- Refer to Appendix 1-15 (links below) for comprehensive details on conducting assessments from head to toe, expected findings, indicators for further investigation, and available resources. (For ages not covered by the universal schedule listed in the table, please refer to the surrounding age groups for guidance on expected physical assessment.)

1. General Appearance	2. Neurological	3. Musculoskeletal
4. Hair, Skin, Nails	5. Head and face	6. Eyes
7. Ears	8. Nose	9. Mouth
10. Neck	11. Torso	12. Hips
13. Genitourinary system (male)	14. Genitourinary system (female)	15. Buttocks and rectal area

Follow up and Referral.

- Appendix 1-15 provide information on indicators for further investigation.
- As per matrix below, provide additional contacts for monitoring deviations. Refer to a General Practitioner or other appropriate services for further management as needed.
- If referral required, discuss, and seek consent for sharing of information from parent/caregiver. Adherence to CACH Clinical handover and WACHS Child Health Clinical handover of vulnerable children procedure is required when handing over, or referring a client within, or outside of the health service.
- Use clinical judgment to determine if referral has been actioned. Follow up must occur with parents/caregivers to determine if the referral has been actioned for the following groups: clients of concern, children in care, and those with urgent concern.
- Follow pathways as per below tables.

Pathway definitions:

- **Recognise indicators for child abuse and neglect pathway:**
  - there are observations or concerns relating to bruising or other indicators that have no reasonable explanation.
  - there are observations that may indicate either isolated incidents or a pattern of failure over time by the parent to provide for the child's development and wellbeing (neglect).
- **Urgent - Immediate concern pathway;** an immediate same day review is indicated i.e. the concern may be urgent and life threatening.
- Non-urgent concern pathway: an action must be taken, and concern is not life threatening.
  - Consult Nursing and Midwifery Board AHPRA Decision-making framework for guidance around need for escalation if unsure about timeframe.
  - See relevant policy documents for specific time frames.

Category	Follow up plan/action
Recognise indicators for child abuse and/or neglect pathway	**If community health staff identify a child with concerns related to abuse or neglect staff must take the following actions:** • **If abuse relates to bruising:** ○ **Consider the child's age, level of mobility and development. If there are observations or concerns relating to bruising without reasonable explanation (i.e., bruising in a non-mobile baby including facial, torso, ears, and neck bruising) or patterned bruising (i.e., slap, grab or loop marks).** • Identify any immediate safety concerns. • Discuss concerns with parent/caregiver if safe to do so. • If a belief is formed that the child has been harmed or is likely to be harmed a formal report to the Department of Communities is required as soon as possible. • Document discussion, actions, referrals, and plans in CDIS/CHIS, including discussions with relevant CNM/CNS and document further action and plan of follow up. Staff can use the TEN-4-FACESp tool to improve recognition of potentially abused children with bruising who require further evaluation. For further information around neglect see Wellbeing guide instructions and CHS470 Child Wellbeing Guide. See Guidelines for Protecting Children 2020, CAHS Child Safeguarding and Protection and WACHS Child Safety and Wellbeing Policy

Category	Follow up plan/action
Urgent - Immediate concern pathway	**If community health staff identify a child with urgent or immediate concerns, they should (as per CACH Recognising and responding to acute deterioration policy or WACHS Recognising and responding to acute deterioration):** • Advise parents /caregiver of clinical concerns and importance of immediate review.

	• Complete verbal or written handover as per CAHS Clinical Handover - Nursing or WACHS Child Health Clinical handover of vulnerable children to:
	  • Emergency services
	  • Hospital emergency department or
	  • GP
	• Plan follow up appointment as per Universal plus- Child Health. Follow up must occur with parents/caregivers to determine if the referral has been actioned.
	• Discuss with line manager or Clinical Nurse Specialist (CNS).
	• Document discussion, actions, referrals, and plans in CDIS/CHIS, (including discussions with relevant line manager or CNS) and document further action and plan for follow up.

Category	Follow up plan/action

Non – urgent concern pathway	If community health staff identify a child with non-urgent concern, they should:
	• Consider need for:
	  ○ Consultation with community health nurses or line manager/CNS
	  ○ Re-assessment or recheck as indicated (as per Universal Plus – Child health). Use clinical judgement to determine if referral has been actioned. Follow up must occur with parents/caregivers to determine if the referral has been actioned for the following groups: clients of concern and children in care.
	  ○ Referral to:
	  - Child Development Service
	  - GP or specialist referral (as per CAHS Clinical handover – nursing or WACHS Child Health Clinical handover of vulnerable children)
	• Advise parents/family of clinical concerns and the importance of follow up arrangements.
	• Provide verbal/written information as appropriate.
	• Document discussion, actions, referrals, and plans in CDIS/CHIS, clearly documenting further action and plan for

	follow up. (This should include discussions with senior practitioners if needed).

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Related internal policies, procedures and guidelines
The following documents can be accessed in the CACH Clinical Nursing Policy Manual HealthPoint link or CACH Clinical Nursing Policy Internet link
Universal contact guidelines (0-14 days, 8 weeks, 4 months, 12 months, 2 years, SEHA)
Ages and Stages Questionnaires (ASQ)
Breastfeeding protection, promotion and support
Growth – birth to 18 years
Hearing and Ear Health
Height Assessment 2 year and over and Length assessment 0-2 year
Hip assessment
Oral health assessment
Vision and eye health
Weight assessment 0-2 years and Weight assessment 2 years and over

The following documents can be accessed in the WACHS Policy Manual
Child Health Clinical handover of vulnerable children
Child Safety and Wellbeing
Engagement
WebPAS Child at Risk Alert
The following documents can be accessed in the CAHS Policy Manual
Child and Family Centred Care
Child Safeguarding and Protection
The following documents can be accessed in the CACH Operational Policy Manual
Clinical Handover

Related internal resources (including related forms)
Indicators of Need
Practice guide for Community Health Nurses

Useful external resources (including related forms)
Guidelines for Protecting Children 2020. Statewide Protection of Children Coordination Unit, Child and Adolescent Community Health.
Nursing and Midwifery Board of Australia – Decision Making Framework

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

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Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

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.

Appendix 1: General appearance

Key References: [19-23]

- **History**: Identify/discuss parental/carer concerns, note congenital or non-congenital conditions, genetic conditions, environmental conditions, birth trauma.
- **Observation**: Activity level and alertness, general behaviour and appearance, facial expressions, symmetry and proportion of body parts, posture of body and limbs, body movements, weight assessment, length/height assessment.
- **Palpation:** N/A.
- **Smell:** Note any body odour.
- **Other:** Cry/voice.
- **Relevant Policy Documents:** Weight assessment 0-2 years, weight assessment 2 years and over; Length assessment 0-2 years, Height assessment 2 years and over, Factors impacting child health and development, Ages and Stages Questionnaire,

Within normal limits:

All Ages	At all ages the child's: • body is symmetrical • position and movement are spontaneous • presentation is consistent with the situation (e.g. crying due to hunger) • alert and available for responsive interaction with caregivers.
0-14 days	At 0-14 days old the child's: • sleeping frequently and has brief periods of wakefulness • facial expressions are limited but can include basic reactions like grimacing or smiling

	• body and limbs are in a natural posture • body movements are generally reflexive and uncoordinated • interaction patterns with parents or caregivers are minimal but may include turning their head towards voices or attempting to focus on faces.
8 Weeks	At 8 weeks the child's: • activity levels and alertness are increased • curiosity about their surroundings is evident, and they have more frequent periods of wakefulness • facial expressions are varied, often including smiles and frowns • posture is improved and showing more controlled movements of the body and limbs • responses to voices and faces include coos, smiles, and displays of excitement or calmness when engaged.
4 Months	At 4 months the child's: • activity levels and alertness are high • behaviour includes active exploration and engagement with their environment • facial expressions are more diverse, often showing joy, curiosity, and surprise • posture is improved with more coordinated movements of the body and limbs • interactions are more interactive, including smiling, babbling, and reaching out to touch or grasp.
12 Months	At 12 months the child's: • activity levels and alertness are high • behaviour includes crawling or walking and exploring their surroundings • facial expressions are varied and expressive, often showing emotions like happiness, curiosity, and frustration

	• posture is good, and movements of the body and limbs are coordinated • interactions are highly interactive, responding with gestures, words, and emotional expressions, seeking attention, and engaging in simple play • stranger anxiety is appropriate.
2 Years	At 2 years the child's: • activity levels and alertness are high • general behaviour includes running, climbing, and exploring their environment • facial expressions are highly expressive, showing a wide range of emotions such as joy, curiosity, and frustration • posture is good, and movements of the body and limbs are coordinated • interactions are very engaging, responding with words, gestures, and emotional expressions, actively seeking interaction and participating in more complex play • cooperation can be expected with most aspects of assessment.
3 years +	At 3 years the child's: • activity levels and alertness are high • general behaviour includes running, jumping, and engaging in imaginative play • facial expressions are very expressive, showing a wide range of emotions such as joy, curiosity, and determination • posture is good, and movements of the body and limbs are coordinated • interactions are highly interactive; the child communicates with words, gestures, and emotional expressions, actively seeking social engagement and participating in more complex activities • cooperation can be expected with assessment.

Indications for further assessment and next steps

Indicators for child abuse	
Drowsiness, lethargy, or seizures in small babies (this may indicate a head injury)	**Manage as per recognising indicators for child abuse and/or neglect pathway.**
Repetitive and compulsive behaviours in attempts to self soothe, e.g. rocking, sucking, head-banging	
Lack of appropriate boundaries, overly compliant, or flat and superficial way of relating during assessment	
Becomes **startled** when an adult makes a sudden movement	
Moves or holds body in a way that indicates physical discomfort	
Indicators for child neglect	
Poor standard of hygiene including unwashed body/clothes/teeth not cleaned inappropriate clothing for age/weather/social conditions (including arms and legs are covered by clothing in hot weather)	**Manage as per recognising indicators for child abuse and/or neglect pathway.**
Appears **fearful** in the presence of the parent/carer	
Shows little or **no emotion when hurt**	

Urgent or Immediate concern	
Audible stridor or hoarseness (acute or prolonged)	**Seek urgent referral to medical practitioner for signs of respiratory distress or abnormal breathing sounds. Follow up as per urgent/immediate concern pathway.** If no respiratory distress or abnormal breathing sounds, follow up as per non-urgent concern pathway.
Unexpected growth downward trajectory (Length/height, weight) accompanied with acute illness (such as fever,	**See Growth – downward trajectory**

respiratory distress, vomiting, lethargy and or dehydration), chronic physical signs (reduced urine output, stool output, vomiting, decreased appetite) or psychosocial risk factors/concerns	**Follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
High pitch, continuous or excessive cry	Discuss comfort focused strategies and methods with parents as per Sleep guideline. Follow up as per non-urgent concern pathway.
Speech sounds inconsistent with developmental expectations	Consider Ages and Stages Questionnaire. Follow up as per non-urgent concern pathway. Consider referral to speech therapist.
Dysmorphic features	Follow up as per non-urgent concern pathway.
Unexpected growth trajectory (Length/height, weight)	See relevant procedure: - Growth – downward trajectory - Growth – Accelerated upward trajectory for further interpretation of measurements. Follow up as per non-urgent concern pathway.
Asymmetric movements	Follow up as per non-urgent concern pathway.
Concerns with behaviour, concentration, coordination	Consider examination of vision or hearing. Consider hearing/vision screening questions and cover test/ corneal light reflex/ distance vision (Lea symbols chart), / red reflex, /otoscopy,/ tympanometry as appropriate. Follow up as per non-urgent concern pathway.
Body odour	Some diseases and illnesses can cause a distinct smell. Follow up as per non-urgent concern pathway.

Appendix 2: Neurological

Key References: [21, 24]

- **History**: Identify/discuss parent/caregiver concerns.
- **Observation**: Cry, muscle tone, irritability, speech pattern, pitch of sounds, language acquisition.
- **Palpation:** Primitive reflexes (Asymmetrical tonic neck, Moro, Palmar grasp, Placing, Plantar grasp, Rooting, Stepping, Sucking, Truncal incurvation).
- **Smell:** N/A.
- **Other:** N/A.
- **Relevant Policy Documents:** N/A.

Within normal limits

All Ages	At all ages the child's: • initial presentation is consistent with the situation (e.g. crying due to hunger).
0-14 days	At 0-14 days the child's: • cry is strong, lusty, medium pitch, intermittent and in response to discomfort or need • primitive reflexes are symmetrical and indicative of central nervous system function.
8 Weeks	At 8 weeks the child's: • cry is strong, lusty and medium pitch • primitive reflexes are symmetrical and indicative of central nervous system function (Stepping and placing reflex start to disappear by 2 months) • communication is via cooing sounds, (soft, vowel-like noises).

4 Months	At 4 months the child's: • vocalisations are deliberate • vocalisations range in volume and pitch • vocalisations may include laughs, chuckles, or squeals when playing • annoyance is demonstrated by screams • primitive reflexes are symmetrical and indicative of central nervous system function. Rooting, and sucking start to disappear by 4 months. Truncal incurvation, asymmetrical tonic neck reflex and Moro reflex disappear by 4-6 months. Palmar grasp reflex disappears by 5-6 months.
12 Months	At 12 months the child's: • vocal cords are developing, and children often experiment with different sounds, which can include cooing, babbling, and crying • behaviour may include noncompliance and temper tantrums • plantar grasp reflex disappears by 9-12 months • primitive reflexes diminish, child develops postural reflexes and voluntary movements which support control of balance, posture, and movement in a gravity-based environment.
2 Years	At 2 years the child's: • language skills are developing, and their vocalisations reflect this growth • behaviour may include noncompliance and temper tantrums.
3 years +	At 3 years the child's: • language skills are developing, and their vocalisations reflect this growth • behaviour may include noncompliance and temper tantrums.

Indications for further assessment and next steps

Urgent or Immediate concern	
Weak or irritable cry or hoarseness (acute or prolonged)	**Seek urgent referral to medical practitioner for signs of respiratory distress or abnormal breathing sounds. Follow up as per urgent/immediate concern pathway.** If no respiratory distress or abnormal breathing sounds, follow up as per non-urgent concern pathway.

Non-Urgent Concern	Next Steps/Follow up/Referral
High pitch, continuous or excessive cry	Discuss comfort focused strategies and methods with parents. Follow up as per non-urgent concern pathway.
Absent/exaggerated reflexes or persistence of primitive reflexes past 6 months of age	Refer to medical practitioner as per non-urgent concern pathway where reflexes persist beyond expected time frame, especially in association with other concerns.
Delay in development of postural reflexes	Refer to medical practitioner as per non-urgent concern pathway.
Disruptive behaviours accompanied by functional impairment or significant distress	Explore behaviour further with parents/carer, enquiring about pattern and persistence of disruptive symptoms. Assist family to access resources to support parenting. Follow up as per non-urgent concern pathway.
Failure to be alert to environmental visual or auditory stimuli, no social smile (past 4 months), absent stranger anxiety (by 7 months)	Follow up as per non-urgent concern pathway.

Non-Urgent Concern	Next Steps/Follow up/Referral
Decreased muscle tone (Hypotonia)	Children who are born prematurely may have hypotonia lasting up to 12 months. Follow up as per non-urgent concern pathway.
Increased muscle tone (hypertonia), decreased range of movement, difficulty moving arms or legs, loss of balance and frequent falls, limited joint movement and little flexibility, muscle twitching or jerking	Hypertonia is less common then hypotonia. Follow up as per non-urgent concern pathway.
Abnormalities related to lower arousal, poorer quality of movement and self-regulation, higher excitability, jitteriness, and more non-optimal reflexes	Review history of intrauterine exposure to teratogens including alcohol or drugs. Consider finding from ASQ SE. Follow up as per non-urgent concern pathway.

Resources (For staff reference only – should not be distributed to parents)

- Royal Children's Hospital Melbourne: Voice Disorders

Appendix 3: Musculoskeletal

Key References: [21, 25, 26]

- **History**: Identify/discuss parent/caregiver concerns particularly regarding moving (joints/extremities) or with walking jumping or playing (spine, toes or hands), birth history, history of dislocated, broken bones.
- **Observation**: Range of movements of joints, muscles and extremities for size and symmetry, strength, stance, curvature of spine, flexibility, resting position, muscle tone, agility, balance and gait assess crawling/standing/ walking.
- **Palpation:** Joints for pain or swelling, range of movement noting flexion/extension, adduction/abduction, internal/external rotation (may be used to reinforce visual findings).
- **Smell:** N/A.
- **Other:** N/A.
- **Relevant Policy Documents:** Ages and Stages Questionnaire

Within normal limits

All Ages	At all ages the child's: • spine is straight and in midline • joints and muscles are symmetrical with no swelling, redness, or deformity • joints have a full range of motion without difficulty • movements are equal in flexibility and strength • foot is flexible with normal arch on tiptoeing.
0-14 days	At 0-14 days the child's: • spine is initially C-shaped and in midline • head should be aligned directly over the sacrum.

8 Weeks	At 8 weeks the child's: • spine is initially C-shaped and in midline • head should be aligned directly over the sacrum • legs may be bowed, and toes may be crooked with most resolving with weight bearing.
4 Months	At 4 months the child's: • spine gradually develops a cervical curve by 3-4 months and lumbar curve as the child bears weight • legs may be bowed, and toes may be crooked with most resolving with weight bearing.
12 Months	At 12 months the child's: • lumbar curve forms as the child begins to bear weight and begin to walk • gait is broad for support and appears to be flat footed and high stepped. • legs are often externally rotated with a degree of bowing • movements are equal in flexibility and strength • fine and gross motor have a gradual age appropriate increase in control and capacity.
2 Years	At 2 years the child's: • posture is erect with good balance and normal gait while walking • lumbar curve forms as the child begins to bear weight and begin to walk • gait is broad gait and appears to be flat footed and high stepped • legs are often externally rotated with a degree of bowing • movements are equal in flexibility and strength • fine and gross motor have a gradual age appropriate increase in control and capacity.

3 years +	At 3 years the child's: • posture is erect with good balance and normal gait while walking • normal spine curvature (S shaped) develops by 3- 4 years, including neck and inward curve of the lumbar spine, and spine curves outward in thoracic areas • gait is broad for support and appears to be flat footed and high stepped • legs are often externally rotated with a degree of bowing • pattern of muscle action and motion is mature.

Indications for further assessment and next steps

Indicators for child abuse	
Muscular pain or tenderness, bone or joint pain, palpable masses, movement limitation, oedema	Be alert to non-accidental injury (NAI), which may manifest with rib, clavicular, sternal, or spinal musculoskeletal injuries. **Manage as per recognising indicators for child abuse and/or neglect pathway.**
Bruising without reasonable explanation (i.e., bruising in a non-mobile baby including facial, torso, ears, and neck bruising) or patterned bruising (i.e. slap, grab or loop marks)	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Rigidity, particularly while sitting	Follow up as per non-urgent concern pathway.
Lateral curvature of the spine	
Pain (without NAI concerns)	
Pronounced curvature of spine	
Asymmetry of spine	
Masses or lesions on spine	

Non-Urgent Concern	Next Steps/Follow up/Referral
Dense tufts of hair/birthmarks in midline/ sacral dimple >0.5cm wide >2.5 mm from anal verge	
Abnormalities in gait (asymmetry, clumsy, excessive hip abduction as the leg swings forwards, stiff foot-dragging with foot inversion, instability with an alternating narrow to wide base of gait etc).	Consider findings from ASQ and hip assessment. Follow up as per non-urgent concern pathway. Consider referral to physiotherapist.
Toe walking is common in children up to 3 years of age. - It is not a concern unless child walks on their toes more than half of the time or has difficulty putting heel down	Encourage riding bike, balance bike or scooter, stomping and standing on one leg, squatting during play, balancing on a balance beam, going up or down stairs). Follow up as per non-urgent concern pathway. Consider referral to physiotherapist.
Outward curvature (Bowlegs) (Can be caused by diseases such as Blount's disease, rickets, or genetics)	Outward curvature - children normally grow out of bowlegs by age 2 years. Inward curvature - usually becomes apparent when a child is 2-3 years old. If changes are progressive or asymmetric, or if there is pain and functional limitation or evidence of neurological disease refer as per non-urgent concern pathway.
Inward curvature (knock knees) can be caused by genetic conditions or metabolic diseases. Usually becomes apparent when a child is 2-3 years old	
Flat feet	Flat feet usually resolve by the age of 6 years. If parental concerns, manage as per non-urgent concern pathway.

Non-Urgent Concern	Next Steps/Follow up/Referral
Crooked toes	If changes are progressive or asymmetric, or if there is pain and functional limitation or evidence of neurological disease refer as per non-urgent concern pathway.
Disproportionate limb or digit size, outside normal expectations	Follow up as per non-urgent concern pathway.
Hypomobility of joints	Give strategies to improve muscle tone and strength. Follow up as per non-urgent concern pathway.
Muscle tightening making joints stiff (Hypermobility of joints)	Follow up as per non-urgent concern pathway.
Rigidity of foot and inability to right itself from fixed position (foot or feet that turn in and under)	Touching and massaging babies' lower leg can help to stimulate and strengthen the muscles that need to work to reposition feet or foot in the correct position. Follow up as per non-urgent concern pathway.

Resources (For staff reference only – should not be distributed to parents)

- Child Development Service
  - Toe walking
  - Help me stand up and play
  - Help me stand, move and get ready to walk

Appendix 4: Hair, skin, nails

Key References: [21, 27-31]

- **History**: Identify/ discuss parental concerns, any recent changes, consider nutritional status.
- **Observation**: Skin colour and integrity, noting any rashes or anomalies (including changes in pigmentation and texture). Nail shape, colour, contour, cleanliness, and texture. Distribution, quantity, texture, growth pattern and condition of hair.
- **Palpation:** Warmth, perfusion, turgor of skin.
- **Smell:** Note any odour.
- **Other:** N/A.
- **Relevant Policy Documents:** N/A.

Within normal limits

All Ages	At all ages the child: • commonly has birthmarks either vascular, epidermal pigmented or other subtypes • may have dermal melancytosis (formerly Mongolian spots) which are flat blue or blue/grey birth marks. They are prevalent in Asian children and children with darker skin (including Polynesian, Indian and African children). They are commonly mistaken for bruises, however dermal melancytosis will not change colour size or shape over the course of a few days and are not painful to touch.
0-14 days	At 0-14 days the child's: • skin can be deep red or purple colour at birth, covered in vernix and may have lanugo • skin can be dry and flaky • nails are thin and soft • vellus (short, thin, and barely noticeable) type hair present on the scalp from birth is often present

	• hair may be fine and soft (downy lanugo).
8 Weeks	At 8 weeks the child's: • skin is typically, thicker, and more resilient, often appearing smooth and soft • nails are thin and soft • downy lanugo hair is present at birth and can persist for up to 3-4 months • vellus type hair may be present on the scalp from birth.
4 Months	At 4 months the child's: • skin is typically, thicker, and more resilient, often appearing smooth and soft • nails are thin and soft • intermediate scalp hair develops between 3-7 months.
12 Months	At 12 months the child's: • skin is typically, thicker, and more resilient, often appearing smooth and soft • nail beds are pink, flat or slightly convex with uniform thickness • nails are adherent to nail bed and capillary refill is 2-3 seconds or less • hair is pigmented, longer, thicker and replaces vellus hair on the scalp by 2 years of age.
2 Years	At 2 years the child's: • skin is typically, thicker, and more resilient, often appearing smooth and soft • nail beds are pink, flat, or slightly convex with uniform thickness • nails are adherent to nail bed and capillary refill is 2-3 seconds or less • hair is pigmented, longer, thicker.

3 years +	At 3 years the child's: • skin is typically, thicker, and more resilient, often appearing smooth and soft • nail beds are pink, flat, or slightly convex with uniform thickness • nails are adherent to nail bed and capillary refill is 2-3 seconds or less • hair is pigmented, longer, thicker.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation (i.e., bruising in a non-mobile baby including facial, torso, ears, and neck bruising) or patterned bruising (i.e. slap, grab, or loop marks)	**Manage as per recognising indicators for child abuse and/or neglect pathway.**
Indicators for child neglect	
Persistent skin infections	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent or Immediate concern	
Yellowing colour of skin and eyes	**Most jaundice in well children does not require investigation or management.** **Features that require prompt investigation and management include unwell baby, prolonged jaundice (2-3 weeks), pale stool. Further investigation including discussion of birth history, timing of jaundice, feeding history, output, behaviour (including any lethargy, cries becoming shrill, or arching of the body) will assist in determining urgency of referral.**

	If discussion leads to further concerns, referral to birth hospital may be needed or urgent referral to GP. Follow up as per urgent/immediate concern pathway. If no further concerns identified, follow up as per non-urgent concern pathway. If yellowing of skin occurs in older child, follow up as per non-urgent concern pathway.
Red or purple spotty rash	**If rash is accompanied by fever, irritability, drowsiness, vomiting, loss of appetite or headache. Follow up as per urgent/immediate concern pathway.**

Non-Urgent concern	Next Steps/Follow up/Referral
Birthmarks - A minority of birthmarks have complications or systemic associations, including: • More than 6 café-au-lait spots • Lesions located on the face, near the base of the spine or if a lesion seems to be growing larger. • Five or more haemangiomas anywhere on the body	In most cases parents can be reassured that that there are only cosmetic significance and appearance will change over time. If birthmarks meet criteria listed, or community health staff has concerns, follow up as per non-urgent concern pathway. Port wine stains (permanent red or blue-coloured birthmarks that are present from birth) often need no treatment; however, some port wine stains can become very dry, so it is important to apply moisturising cream to them once or twice a day.
Blotchy, red rash, with small bumps that can be filled with fluid (Erythema Toxicum Neonatorum)	Consider dryness, soreness, lumps, colour changes, exposure to new products (wipes or nappies used). Provide parental education: • The most common pustular eruption in newborns. • Aetiology is unknown.

Non-Urgent concern	Next Steps/Follow up/Referral
	• Usually appear day 2-3 and fade by day 7, although they may recur for several weeks. • Fluctuating generalised eruption. No treatment is needed.
Small white bumps (cysts) under the surface of skin (Milia)	Considering dryness, soreness, lumps, colour changes, exposure to new products (wipes or nappies used). Provide parental education: • Caused by retention of keratin within the dermis. • Occur mainly on the face (particularly nose and cheek) but can occur anywhere. • Usually disappear within the first month. No treatment is needed.
Small red bumps or pustules on a baby's cheeks, nose**,** and forehead (Neonatal Acne)	Provide parental education: • Stimulation of sebaceous glands by maternal or infant androgens. • Occurs around 3 weeks of age and usually resolves by 4 months of age. Treatment is not usually recommended but referral to GP may be necessary if extensive. Follow up as per non-urgent concern pathway.
Scaly patches on the skin, very itchy and uncomfortable (eczema)	Consider dryness, soreness, lumps, colour changes, exposure to new products (wipes or nappies used). Provide education to parents. Follow up as per non-urgent concern pathway. Referral to GP may be needed if parents are concerned, child is waking at night because of irritation, if skin looks infected.
Rashes	Enquire about other symptoms such as fever, sore throat, swollen lymph nodes.

Non-Urgent concern	Next Steps/Follow up/Referral
	Consult CAHS Exposure and outbreak management or WACHS Infection Prevention and Control - Patient management and healthcare worker exclusion periods policy if a belief is formed that child has a communicable disease (measles, chickenpox etc) or have recently been in contact with someone who has a communicable disease. For other rashes follow up as per non-urgent concern pathway.
Skin infections such as: • Scabies – scratches and sores between fingers on wrists elbows, knees ankles and bottom. Babies often have pustules on hands and feet • Skin sores – yellow/brown crusted sores may start as blisters • Tinea/ – scaly, well-defined patches that are itchy, sometimes skin is darker and tougher • Pityriasis versicolor– pale patches on darker skin, most common on upper trunk, shoulders, chest upper arms neck and occasionally face, no raised edges.	Consider symptoms and recognition of pattern skin signs. Carer education and support may include education and information. Skin infections can be reduced by the washing of children every day in the bath or shower or by swimming, and by the regular washing of clothes towels and bedding. Follow up as per non-urgent concern pathway.
Nail inflammation (including ingrown toe nails)	Often clears up without needing treatment. A small amount of antiseptic cream or liquid on the nail may be needed. If nail bed becomes red and swollen a GP referral may be needed - follow up as per non-urgent concern pathway.
Nails - Dry or brittle, convex**,** or concave, yellow or white colour thickened nail bed, transverse depression or grooves, nail biting, clubbing, prolonged refill	Parental education and support may include strategies related to nail care, behavioural deviations, or nutritional needs. Follow up as per non-urgent concern pathway.

Non-Urgent concern	Next Steps/Follow up/Referral
Extra digits, skin tags	In most cases parents can be reassured that they are only cosmetic significance. Follow up as per non-urgent concern pathway.
Absent hair or bald patches	The most common causes of paediatric alopecia are largely non-scarring. These include fungal infections of the scalp (tinea capitis), autoimmune disorders (alopecia areata), trauma due to repeatedly pulling on hair (traction alopecia or trichotillomania), and temporary hair loss due to stress (telogen effluvium). Follow up as per non-urgent concern pathway.
Greasy white or yellowish scales occurring over a patch of inflamed red skin or stubborn dandruff (Seborrheic Dermatitis is also known as 'cradle cap')	Provide education to parents: • can occur in hair or anywhere on the body. • usually resolves within the first 12 months. • emollients and shampoos are available and soft brushing can help remove scales. GP referral may be needed to keep condition under control (anti-fungal cream or corticosteroids). Follow up as per non-urgent concern pathway.
Change in growth pattern of hair	May indicate metabolic disorder: • Follow up as per non-urgent concern pathway.
Dryness, oiliness, irritation, or infestation of hair	Parent education and support may include strategies for management including: • Hygiene needs • Control of environmental factors

Resources (For staff reference only – should not be distributed to parents)

- Australian College of Dermatologists: A-Z of Skin – Your guide to skin hair and nail conditions
- Australian Family Physician: Birthmarks – identification and management
- Royal Children's Hospital Melbourne: Haemangiomas of infancy (strawberry naevus)
- Child and Adolescent Health Service: Baby - common presentations
- Telethon Kids Institute: National Healthy Skin Guideline
- Telethon Kids Institute: Healthy Skin Flip Chart
- WA Eczema Project: A practical guide to eczema care
- Raising Children Network: Nail infections: fingernails and toenails

Appendix 5: Head and Face

Key References: [7, 21, 32-35]

- **History**: Identify/discuss parent/caregiver concerns, newborn birth history, history of falls, head injuries or concussions, clumsiness, or unstable gait, head tilt or, neck pain or stiffness.
- **Observation**: Facial expressions, general shape, size, symmetry, alignment, range of movement, lacerations, abrasions, contusions. Definition, depression, and length of philtrum. Jaw size and shape, anomalies, or deformations.
- **Palpation:** Suture lines, scalp, bony structures, fontanelles.
- **Smell:** Note any odour.
- **Other:** N/A.
- **Relevant Policy Documents:** Head Circumference

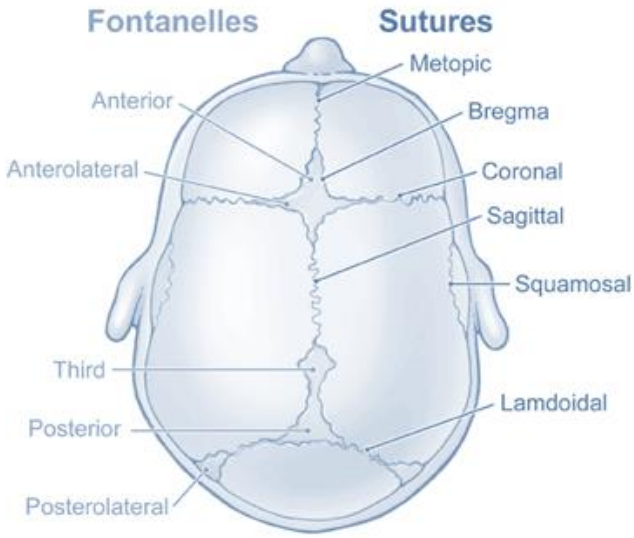

Figure 1: Anatomy of the head[7]

Within normal limits

All Ages	At all ages the child's: • head is rounded, symmetrical • head will comfortably sit in the midline when in supine position • scalp should be clean and free of lesions • philtrum is smooth, distinct**,** and well defined • facial features, ears and facial movements are symmetrical • facial nerves can be seen in their smile, laugh, facial creases and nasolabial folds and are symmetrical.

0-14 days	A 0-14 days the child's: • head shape symmetrical or asymmetrical • head circumference is greater than their chest circumference • anterior fontanelle is open, soft, flat with slight pulsation, has tension or bulging when child cries, flattening when child is calm, diamond shaped, average size is 2.1cm (can range from 0.6cm – 3.6cm) • posterior fontanelle is smaller, triangular and 0.5 -0.7 cm • suture lines are overlapping and protuberant.
8 Weeks	At 8 weeks the child's: • brain growth is symmetrical • anterior fontanelle is open, soft, flat with slight pulsation, has tension or bulging when child cries, flattening when child is calm, diamond shaped, average size is 2.1cm (can range from 0.6cm – 3.6cm) • posterior fontanelle is smaller, triangular and 0.5 -0.7 cm • suture lines is overlapping and protuberant.
4 Months	At 4 months the child's: • brain growth is symmetrical • head control is achieved, and when held sitting, head is firmly erect • anterior fontanelle is open, soft, flat with slight pulsation, has tension or bulging when child cries, flattening when child is calm, diamond shaped, average size is 2.1cm (can range from 0.6cm – 3.6cm) • posterior fontanelle closes by 4 months of age • suture lines are palpable until 6 months of age.

12 Months	At 12 months the child's: • chest circumference exceeds head circumference after 18 months • brain reaches approximately 80% of adult size • anterior fontanelle reduces in size by 9 months. • anterior fontanelle average closure ranges from 13-24 months • suture lines are proximate and immobile, skin is flush with scalp.
2 Years	At 2 years the child's: • chest circumference exceeds head circumference after 18 months • brain reaches approximately 80% of adult size • anterior fontanelle reduces in size by 9 months. • anterior fontanelle average closure ranges from 13-24 months • suture lines are proximate and immobile, skin is flush with scalp.
3 years +	At 3 years the child's: • suture lines are proximate and immobile, skin is flush with scalp.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation (i.e., bruising in a non-mobile baby including facial, torso, ears, and neck bruising) or patterned bruising (i.e. slap, grab, or loop marks)	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent or Immediate concern	
Enlarged, sunken or bulging fontanelle (in calm child)	**Urgent referral to medical practitioner where a sunken fontanelle is accompanied by other signs of dehydration, or illness such as fever, rashes, or gastrointestinal symptoms. Follow up as per urgent/immediate concern pathway.** **Bulging fontanelle can indicate a rise in intercranial pressure. Follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Head circumference measurements that deviate from the normal	See head circumference assessment procedure for interpretation of deviations of normal. Follow up as per non-urgent concern pathway.
Accelerated head growth in the first year of life	Is found in approximately 70% of children with autism spectrum disorder. See head circumference assessment procedure for interpretation of deviations of normal. Follow up as per non-urgent concern pathway.
Head is misshapen including elongated or asymmetrical	Refer to CHN Referral Guidelines for head shape. Follow up as per non-urgent concern pathway.
Positional head preference	
Persistent head tilt (lateral flexion)	
Lesions, nodules, masses, birth marks on head	For birthmarks see Hair, skin nails. Follow up as per non-urgent concern pathway.
Bruising on head relating to birth trauma, oedema, or pitting	Follow up as per non-urgent concern pathway.
Overriding sutures	Follow up as per non-urgent concern pathway. (Including palpable suture lines after 6 months of age).
Premature closure of sutures	Follow up as per non-urgent concern pathway.
Small receding chin	Follow up as per non-urgent concern pathway.
Asymmetrical nasolabial folds or facial expressions	Review birth history and any indication of damage to facial nerve before or during birth process.

Non-Urgent Concern	Next Steps/Follow up/Referral
	Follow up as per non-urgent concern pathway.
Unusual facies with disproportionate features, frontal bossing of the forehead and small low set ears	Potential genetic abnormality, follow up as per non-urgent concern pathway.
Smooth philtrum, thin upper lip, and short palpebral fissure (area between the open eyelids)	May indicate foetal alcohol syndrome (FASD). Follow up as per non-urgent concern pathway.
Flattened face, almond shape eyes, small ears, and short neck	May indicate a chromosomal anomaly Follow up as per non-urgent concern pathway.

Resources (For staff reference only – should not be distributed to parents)

CDIS consumer resources:

- Babys head shape,
- Roll to pick up

Appendix 6: Eyes

Key References: [4, 21]

- **History**: Vision surveillance questions, any noted family history of retinoblastoma, congenital, infantile, or juvenile cataracts, glaucoma, or retinal abnormalities. Parental reports of child having difficulties seeing, wearing glasses, or seeing an ophthalmologist/optometrist.
- **Observation**: (including eye, pupil, and iris) Shape, size, symmetry, spacing, position, colour, pupillary constriction, blinking, discharge.
- **Palpation:** N/A.
- **Smell:** N/A.
- **Other:** Assess gaze behaviour through observation of facial expressions, movements and attempts to attract attention from others.
- **Relevant Policy Documents:** Corneal light reflex, Cover Test, Distance Vision (LEA Symbols chart), Red Reflex, Vision and Eye Health

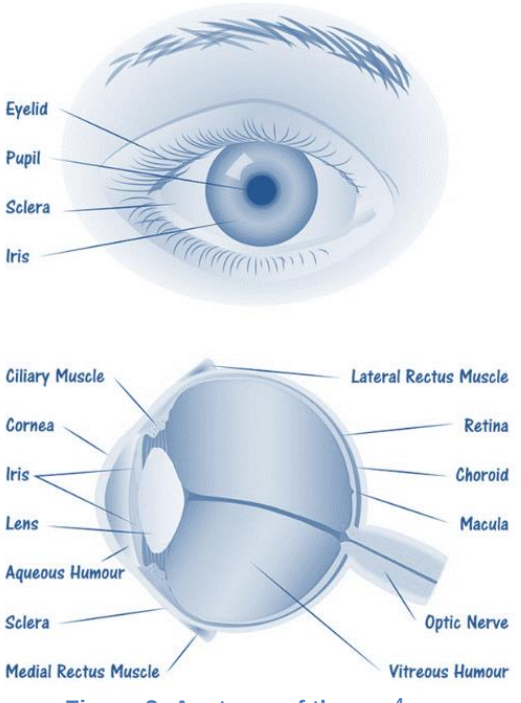

Figure 2: Anatomy of the eye[4]

Within normal limits

All Ages	At all ages the child's: • pupils should be round, clear, and equal • eyes are symmetrical, horizontal and in line with top of pinna • upper eyelids appear symmetrical • eyelids completely cover cornea and sclera when eyes are closed • pupils are round, clear, and equal • sclera is visible above and below the cornea

	• pupils react equally to light, movement, and patterns.
0-14 days	At 0-14 days the child's: • eyes may move independently, appearing to intermittently squint • attempt to engage with human faces, particularly caregivers, is through mutual gaze • eyes turn towards diffused light sources. (Pupils constrict with bright light) • eyes are turned away from bright light or neonate blinks in response to a flash of light • attracted to light, faces or objects approximately 20-25cm away • attention may be gained by large, bright shapes • benign scleral haemorrhage is often present at birth.
8 Weeks	At 8 weeks the child's: • head will move deliberately to gaze attentively around • eyes watch movement of parents/carer people, animals, or motor vehicles • recognition of familiar people approaching from a distance improves • extra ocular muscles coordination is usually occurs by 6 weeks and should be present by 3 months • eyes will follow an object at 15-30 cm distance through an arc of 90 degrees from midline • eyes observe objects 25-30cm away • lacrimation (tears) is present from 6 weeks • attracted to faces and black and white images and may stare.
4 Months	At 4 months the child's: • eye colour is established by around 6 months

	• watches their hands and reaches for nearby objects • can distinguish colour from 3 to 5 months of age • recognition of objects, looks at self in mirror improves • fixation and following a slowly moving object 15-30cm from the face in an arc 90° from midline improves • attracted to human faces and follows human movement (approx. 1.5 m away) • visually alert • sucking often stimulates child to open eyes and focus attention on surroundings • eyes look and follow smaller objects, people, animals and happenings and grasp objects between the thumb and forefinger by 9 months • depth perception develops • eyes move independently by 9 months.
12 Months	At 12 months the child's: • distance vision is clear with a Visual acuity of 6/18 • depth perception for objects is further than 0.5 meters away develops • eye movement is refined • recognition of self in mirror develops • interest in pictures and familiar people approaching from a distance improves • eyebrows extend to just beyond the outer canthus • raising and lowering of eyebrows is symmetrical • eyelashes are full and evenly distributed • upper and lower eyelids and palpebral fissures are symmetrical

	• gaze is symmetrical • gaze shifts between near and far vision tasks and they can track an object across 180°with eyes
2 Years	At 2 years the child's: • recognition of shapes and objects develops and they can perform match-the picture task • close vision skills, convergence and focusing, binocular vision at all distances improve • can change focus from distance to near depth perception • accommodation well developed.
3 years +	At 3 years the child: • recognises the orientation of letters and begins reading by 4 years • possess a mature sense of depth perception by 4 years • has clear single and comfortable vision at all distances by 4 years.

Indications for further assessment and next steps

Indicators for child abuse	
Reddened or bleeding in sclera **Bruising without reasonable explanation or patterned bruising.**	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent/Immediate concern pathway	
Cloudiness and opacity of pupil **Corneal cloudiness or opacity**	**Urgent referral to ophthalmologist through medical practitioner for opacities in the pupil or corneal abnormalities. Follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Fixed or unequal pupil size	Consider comprehensive examination including: • Vision screening questions and observations • Children < 3 years (as appropriate) - Red reflex; Corneal light reflex • Children >3 years (as appropriate) - Red reflex; Corneal light reflex; Distance vision (Lea Symbols Test) Follow up as per non-urgent concern pathway.
Sluggish reactivity to light	
Limitation in expected eye movements	
Misalignment of eyes either intermittent or constant (deviation from normal after 3 months of age)	
Pupils that are small, unequal, irregular, not round or are uneven	
Discolouration of sclera (white or greyish in colour)	
Sensitivity to light (or poor reaction to light)	
Epicanthal folds, inconsistent with ethnic origin	
Slow lateral movements	
Oedema	
Rapid, uncontrollable eye movements	
Eyelid drooping over eye (one or both eyes)	
Signs of discomfort or resistance during vision screening	
Not fixing on and following objects 20-25cm from face by 4 months	
Only using one eye to look at things (squinting)	
Child does not show an interest in their surroundings	
Not reaching for objects by 5-8 months	
Not showing interest or attempting to pick up small toys by 5 months	
Eye turn (when eye turns inward, outward up or down)	
No mutual gaze attempts made**,** or child does not show an interest in their surroundings	
Discharge (watery or purulent), sore, watery or itchy eyes or reported history of recurring eye infections (inflammation of the eyelid or conjunctivitis)	Parent education may include: • Eye toilet and hygiene • Techniques for blocked tear ducts including massage

	Review eye watering regularly at universal contacts (may take up to 12 months to resolve. If unresolved or escalating concerns, follow non-urgent concern pathway.
Yellowish green discharge, crusted mucus on eyelashes	Parental education including keeping eyes clean. Follow up as per non-urgent concern pathway.
Mild itching and irritation of eye with mucous or pus and eyelid swelling. May progress to blurring of vision and eye pain	Refer child to medical practitioner or where relevant to the local Aboriginal Medical Service or Public Health Units who provide screening for Trachoma in specific WACHS regions. Follow non-urgent concern pathway.
Not looking at carer's face or bright object when held close, by six weeks, or does not appear to recognise carer	Parent education and support may include strategies to promote bonding and attachment. Consider findings from ASQ SE. Follow up as per non-urgent concern pathway.

Appendix 7: Ears

Key References: [21, 36]

- **History:** Identify/discuss parent/caregiver concerns, screening questions as per universal child health contact schedules, neonatal hearing screen, previous ear problems (infections, pain, itchiness, discharge, hearing loss, dizziness, or balance problems), does child react to sound with startle response or change in activity? Does child make appropriate sounds (cooing, babbling, speech).
- **Observation:** Reaction to sound, shape, size, symmetry, patency, position, colour, deformity, placement, or discharge from ears.
- **Palpation:** Firmness of cartilage, noting lesions, masses, tenderness, inflammation.
- **Smell:** Note any odour.
- **Other:** N/A.

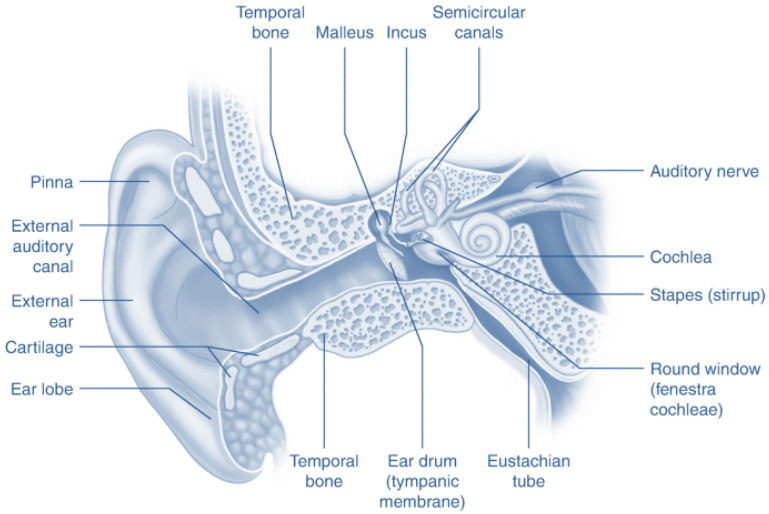

Figure 3: Anatomy of the ear[5]

- **Relevant Policy Documents:** Hearing and ear health guideline Otoscopy, Tympanometry, Audiometry

Within normal limits

All Ages	At all ages the child's: • pinna is soft, pliable, recoils when folded and released, is similar to facial skin colour and is vertical with no more than a 10-degree tilt • outer ear canal is covered with fine hair • balance is good and a has a coordinated gait

	• ear canal shows no drainage or cerumen • ears should be similarly symmetrical in size and shape and may have familial characteristics.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation or patterned bruising	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Discharge (pus or debris), swelling, inflammation, excessive wax, tenderness, foreign bodies, itching, suspected infection	Parent education and support related to external ear as per Hearing and Ear Health guideline Appendix A: Key health education messages for children, families, schools and communities to promote ear health and hearing. Follow up as per non-urgent concern pathway.
Dysmorphic deviation: low set ears, skin tag, accessory tragi, malformed auricles, auricular sinus, preauricular sinus	Follow up as per non-urgent concern pathway.
Poor balance or an uncoordinated gait	Follow Hearing and Ear Health guideline: • Appendix C: Hearing and ear health assessments – 0 to 3 years Aboriginal children and others with hearing and ear health risk factors. • Appendix D: Hearing and ear health assessments – 3 years and over Aboriginal children and others with hearing and ear health risk factors. Follow up as per non-urgent concern pathway.
Ear pain or redness, tugging or holding ear	
Scaling skin or scanty discharge	
Dizziness or vertigo	
Foreign bodies in ear canal	
Difficulty understanding spoken language, when in noisy backgrounds or speech is rapid	
Difficulty localising sound	

Resources (For staff reference only – should not be distributed to parents)

- Hearing Australia: Blow breath cough resource

Appendix 8: Nose

Key References: [21]

- **History**: Identify/discuss parent/caregiver concerns, feeding history, number of colds per year.
- **Observation**: Nasal cavity size and shape, obvious deviations at bridge, columella and tip symmetry, integrity, patency of nares, alignment, skin integrity. Note any discharge (colour consistency quantity and if its bilateral or unilateral).
- **Palpation:** N/A.
- **Smell:** N/A.
- **Other:** N/A.
- **Relevant Policy Documents:** N/A.

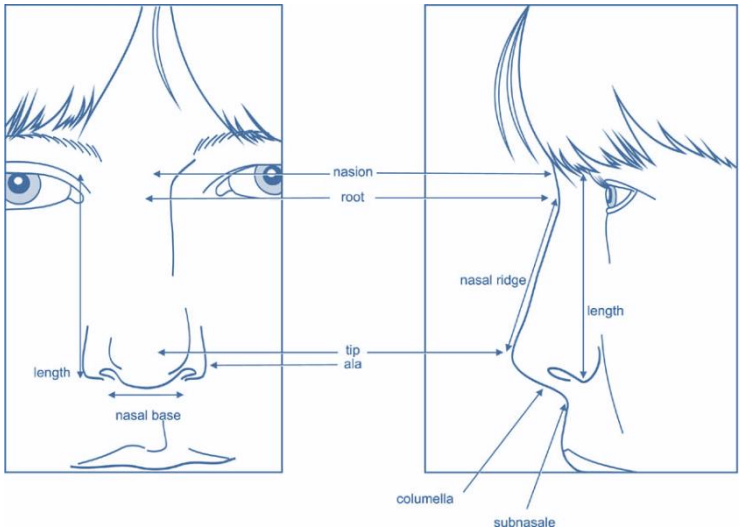

Figure 4: Anatomy of the nose[3]

Within normal limits

All Ages	At all ages the child's: • nose cartilage is soft, flattened, and malleable • nasal patency is demonstrated if neonate breathes easily with mouth closed • septum is relatively straight and in the midline of the nose • breathing is through their nose during feeding • removal obstructions by sneezing.
0-14 days	At 0-14 days the child's: • prone to increased airway resistance because of small passages.

8 Weeks	At 8 weeks the child's: • prone to increased airway resistance because of small passages.
4 Months	At 4 months the child's: • prone to increased airway resistance because of small passages.
12 Months	At 12 months the child's: • nasal passages enlarge in early childhood, allowing easier airflow.
2 Years	At 2 years the child's: • nasal passages enlarge in early childhood, allowing easier airflow.
3 years +	At 3 years the child's: • nasal passages enlarge in early childhood, allowing easier airflow.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation or patterned bruising	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent or Immediate concern	
Cyanosis when feeding	**Seek urgent referral to medical practitioner. Follow up as per urgent/immediate concern pathway.**
Nasal flaring	**Seek urgent referral to medical practitioner for signs of respiratory distress or abnormal breathing sounds. Follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Mucous and other nasal secretions	Provide parental education around strategies to clear nasal passages where patency is interfering with feeding. Discussion with parent around use of saline drops to clear nasal passages where appropriate. Parent education and support may include: • Hygiene practices for respiratory infection control • Range of expected normal mucosa secretions • Normal breath sounds Follow up as per non-urgent concern pathway.
Frequent detaching during feeding or slow or difficult feeding	Management of feeding difficulties associated with sub-optimal infant positioning impacting on breast attachment as per Breastfeeding protection, promotion and support. Follow up as per non-urgent concern pathway.
Oedema, lesions, upturned nose, discolouration, deviated septum, persistent snuffling, flattening of bridge, epistaxis, narrowing of the nares	Follow up as per non-urgent concern pathway.

Appendix 9: Mouth

Key References: [21, 37]

- **History**: Identify/discuss parent/caregiver concerns, feeding comfort for mother and child, difficulty feeding, sucking.
- **Observation**: Colour, symmetry, integrity, moisture of mouth. Colour, size and movement of tongue. Number, size, colour, and shape of teeth. Colour symmetry, lesions, swelling, dryness, or fissures on lips. Patency, and lesions on hard and soft palate.
- **Palpation:** N/A.
- **Smell:** Note any odour.
- **Other:** N/A.
- **Relevant Policy Documents:** Oral Health Assessment, Breastfeeding protection, promotion and support

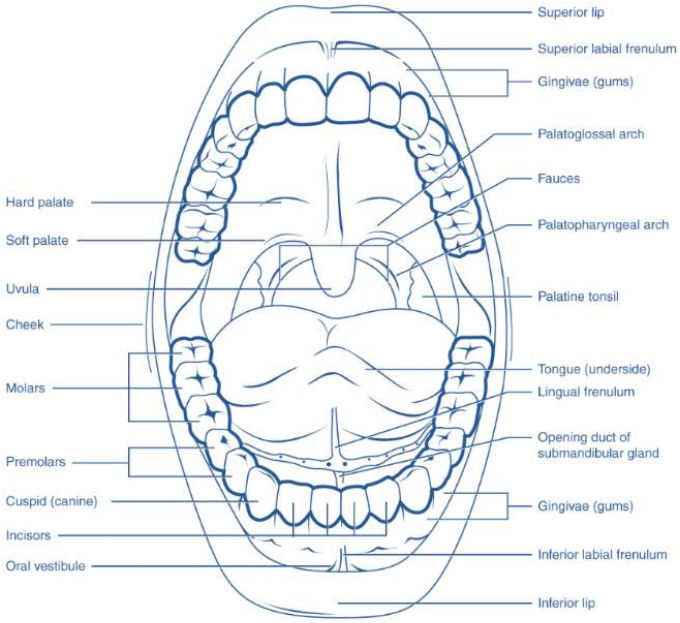

Figure 5: Anatomy of the mouth[6]

Within normal limits

All Ages	At all ages the child's: • oral mucosa is shiny, smooth, moist, and pink (bluish or pale in child with dark skin) • hard palate appears dome shaped, but not deeply indented, with transverse firm ridges • mucous membranes that line lip, cheeks, palate, and underside of tongue should be smooth, glistening, uniform and moist • gums are firm, and moist and not puffy or bleeding • hard palate is lighter in colour than the soft palate and buccal mucosa • tongue fills mouth to support effective feeding

	• lingual frenulum allows child to poke tongue out past lips and move from side to side • tongue surface is slightly rough, moist, and pink, sometimes patterned; ventral surface thin, with prominent vessels.
0-14 days	At 0-14 days the child's: • natal teeth or benign cysts (Epstein's pearls or Bohn nodules) may be present • rooting, gag, and sucking reflex are present • airway passages are anatomically small.
8 Weeks	At 0-14 days the child's: • rooting, gag and sucking reflex present • airway passages are anatomically small.
4 Months	At 4 months the child's: • deciduous teeth appear between 6 months to 24 months • airway passages are anatomically small • salivary gland production and drooling increases.
12 Months	At 12 months the child's: • teeth should have a whitish hue, be smooth and glossy, (except for the biting surfaces of the molar teeth, which will be grooved), plaque and food debris free • salivary gland production and drooling increases.
2 Years	At 2 years the child's: • teeth should have a whitish hue, be smooth and glossy, (except for the biting surfaces of the molar teeth, which will be grooved), plaque and food debris free

	• swallowing coordination improves • drooling decreases.
3 years +	At 3 years the child's: • teeth should have a whitish hue, be smooth and glossy, (except for the biting surfaces of the molar teeth, which will be grooved), plaque and food debris free • biting surface of their molar teeth is grooved and pitted • swallowing coordination improves • drooling decreases.

Indications for further assessment and next steps

Indicators for child abuse	
Contusions, bruising, burns, lacerations of the tongue, lips and buccal mucosa, palate, gingiva, frenulum, or fractured teeth	**Manage as per recognising indicators for child abuse and/or neglect pathway.**
Unexplained injury or petechiae of the palate, especially at the junction of the hard and soft palate	
Indicators for child neglect	
Untreated dental caries/severe tooth decay	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Teeth deviations (plaque, white, brown, or yellow spots, cavities)	Refer to Oral health assessment procedure – Follow up as per non urgent concern pathway.
Cleft deviations: such as cleft palate, narrow cleft, sub mucosal cleft	Follow up as per non-urgent concern pathway. Referral options include:

<table>
<tr><th>Non-Urgent Concern</th><th>Next Steps/Follow up/Referral</th></tr>
<tr><td>Lip deviations such as cleft lip, thin upper lip, swelling, dryness, lesions, loss in control of oral secretions and drooling, excessive upper lip frenulum</td><td rowspan="4">Dental Health Services.
School Dental Services.
Private general dentist.
Specialist paediatric dentist.
Oral Health Centre of Western Australia.
Perth Childrens Hospital or local hospital (if signs of significant/spreading infection).
For more information see: Oral Health Assessment Referral Options.</td></tr>
<tr><td>Gum deviations including swelling, lesions, reddened, friable, hematomas</td></tr>
<tr><td>Ulceration or other alteration in skin integrity</td></tr>
<tr><td>Tongue deviations including coating, unusual odour, smooth, red patches on the top or side, is larger than size of their mouth, or is smooth and glossy with a whitish hue</td></tr>
<tr><td>Oral anatomy concerns, including minimal protrusion or sideways movement of tongue, abnormal palate</td><td>Follow up as per non-urgent concern pathway.

Conduct a breastfeeding assessment for possible breastfeeding concerns using Breastfeeding assessment guide.

Consider different positioning and attachment strategies in breastfed child.</td></tr>
<tr><td>White plaques, bright white superficial lesions on tongue, and buccal mucosa of cheeks</td><td>If residue will scrape off, provide education about milk residue, and encourage parents to wipe mouth after every feed.

If residue will not scrape off, follow up as per non-urgent concern pathway.</td></tr>
</table>

Non-Urgent Concern	Next Steps/Follow up/Referral
Blisters or calluses on lips on breastfeeding child	Conduct a breastfeeding assessment for possible breastfeeding concerns using Breastfeeding assessment guide.

Resources (For staff reference only – should not be distributed to parents)

Dental Health Services:

- Dental Health resources
- Tooth eruption dates

Queensland Health:

- Tongue tie in babies

Appendix 10: Neck

Key References: [21]

- **History**: Birth history, identify/discuss parent/caregiver concerns including injury, head tilt, pain, stiffness, persistent lymph gland swelling and respiratory infection.
- **Observation**: Symmetry, shape, range of movement, musculature, head control.
- **Palpation:** Extraneous tissues or masses, lymph nodes, range of motion.
- **Smell:** Note any odour particularly in neck creases.
- **Other:** N/A.
- **Relevant Policy Documents:** N/A.

Within normal limits

All Ages	At all ages the child's: • lymph nodes are non-visible, mobile, non-tender and not warm to touch • trachea is aligned centrally.
0-14 days	At 0-14 days the child's: • head will fall forward in the sitting position, head lag is normal when pulled to sitting position • neck rotates freely as it cannot support the weight of the head.
8 Weeks	At 8 weeks the child's: • head will fall forward in the sitting position, head lag is normal when pulled to sitting position • neck rotates freely as it cannot support the weight of the head.

4 Months	At 4 moths the child's: • neck is shortened, and musculature is gradually developed • following a light or small toy with full range of head or neck movement.
12 Months	At 12 months the child's: • neck is shortened, and musculature is gradually developed • following a light or small toy with full range of head movement.
2 Years	At 2 years the child's: • neck lengthens, and neck to body proportion becomes closer to adult size • following a light or small toy with full range of head movement.
3 years +	At 3 years the child's: • neck lengthens, and neck to body proportion becomes closer to adult size • following a light or small toy with full range of head/neck movement.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation or patterned bruising	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent or Immediate concern	
Pain and restricted movement	**Urgent medical review when pain and stiffness in neck is accompanied by acute signs of illness. Follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Head bobbing, jerking, tremors, involuntary muscle contractions or spasms, webbed neck, persistent head lag after 3-4 months, head held erect	Follow up as per non-urgent concern pathway.
Persistent head tilt, positional head preference, limited range of motion, stiffness, resistance to movement	Refer to CHN Referral Guidelines for head shape. Follow up as per non-urgent concern pathway.
Swelling of lymph nodes	Follow up as per non-urgent concern pathway.
Positional shift of trachea	Follow up as per non-urgent concern pathway.

Resources (For staff reference only – not be distributed to parents)

Child development Service:

- Activities to encourage head turning to baby's left
- Activities to encourage head turning to baby's right
- Activities to encourage head tilting to baby's left
- Activities to encourage head tilting to baby's right
- Muscle stretches to tilt head to baby's left
- Muscle stretches to tilt head to baby's right
- Muscle stretches to turn head to baby's left
- Muscle stretches to turn head to baby's right

Appendix 11: Torso

Key References: [20, 21, 26]

- **History**: Identify/discuss parent/caregiver concerns, assessment of sleep patterns through parent report may give information related to respiratory tract, allergy, or infection.
- **Observation**: Chest shape, movement, respiratory rate, respiratory effort, breathing pattern and breathing sounds. Abdominal size shape, contours, movement, and symmetry. Umbilicus size, shape, contours, and skin integrity.
- **Palpation:** N/A.
- **Smell:** Note any odour particularly in the umbilicus.
- **Other:** N/A.
- **Relevant Policy Documents:** Nutrition for children- Birth-18 years

Within normal limits

All Ages	At all ages the child's: • breathing is regular including symmetrical rise and fall of chest • abdomen is protuberant and round, symmetrical, soft and moves with respiration.
0-14 days	At 0- 14 days the child's: • chest is symmetrical and compliant, and slightly barrel-shaped • sternum often drawn slightly inward on inspiration • chest circumference from nipple line is approximately 2-3cm less than head circumference • xiphoid process may be prominent • breath rate is 25 - 60 breaths per minute

	• umbilicus separates within 7-10 days and is healed within 2-3 weeks • umbilicus might have slight discharge/mild odour (shouldn't be large volumes of ongoing discharge) • breasts in both male and female may be swollen because of maternal oestrogen effect and may secrete milk like substance.
8 Weeks	At 8 weeks the child's: • chest is symmetrical and compliant, and slightly barrel-shaped • sternum often drawn slightly inward on inspiration • chest circumference from nipple line is approximately 2-3cm less than head circumference • regular breath rate is 25 - 60 breaths per minute.
4 Months	At 4 months the child's: • sternum forms a visible depression or protrusion on skin • chest shape is round, barrel like and equal to head circumference • regular breath rate is 20-55 breaths per minute • size shape, depth, length, and overall appearance of umbilicus is variable • umbilicus is dry and odorless.
12 Months	At 12 months the child's: • sternum forms a visible depression or protrusion on skin • chest shape is round, barrel like and equal to head circumference • regular breathing rate is 20-45 breaths per minute • size shape, depth, length, and overall appearance of umbilicus is variable • umbilicus is dry and odorless.

2 Years	At 2 years the child's: • chest becomes adult shaped, gradually exceeding head circumference by 5-7 cm • regular breathing rate is 20-45 breaths per minute • size shape, depth, length, and overall appearance of umbilicus is variable • umbilicus is dry and odorless.
3 years +	At 3 years the child's: • chest becomes adult shaped, gradually exceeding head circumference by 5-7cm • regular breathing rate is 20-40 breaths per minute • size shape, depth, length, and overall appearance of umbilicus is variable • umbilicus is dry and odorless.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation or patterned bruising	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent or Immediate concern	
Noisy breathing, including grunting or stridor, apnoea episodes, nasal flaring, intercostal retraction, or other breath sounds	**Seek urgent medical review for any signs of respiratory distress. Follow up as per urgent/immediate concern pathway.**
Abdomen is tense, distended, sunken, or scaphoid (inward concave) abdominal shape, asymmetrical, visible peristalsis	**Urgent referral to medical practitioner if accompanied with sustained vomiting or projectile vomiting. Follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Umbilicus or abdomen has intermittent or constant swelling which is more pronounced with increased abdominal pressure (i.e., with crying or defecation)	Discuss parental expectations for umbilical or epigastric herniation. Follow up as per non urgent concern pathway.
Umbilicus is swollen, moist, odorous, has significant bleeding or discharge	Parent education and support may include: • Routine umbilical care • Hygiene and infection control in relation to cord separation and healing Follow up as per non-urgent concern pathway. • Referral to GP may be needed if umbilical granuloma suspected or if purulent discharge noted.
Supernumerary nipples	Usually does not require treatment and tend to become imperceptible over time. In rare cases, females with supernumerary nipples may develop a small amount of breast tissue. Follow up as per non-urgent concern pathway.
Broad chest with widely spaced nipples	When seen with other indications such as webbed neck and low set ears, may indicate syndrome that needs investigation. Follow up as per non-urgent concern pathway.
Abnormalities in shape of chest such as funnel chest (with deep inspiration sternum appears to collapse into the chest cavity)	Follow up as per non-urgent concern pathway.

Appendix 12: Hips

Key References: [21]

- **History**: Identify/discuss parent/caregiver concerns, consider sex, birth history particularly breech presentation (in either sex), family history (first degree relative),tight wrapping with legs held straight and birthweight when assessing hips.
- **Observation**: Follow Hip Assessment procedure to assess hips for stability, limb length and symmetry, if walking independently, observe gait (over 2 years).
- **Palpation:** Follow Hip Assessment procedure to assess hips for stability, limb length and symmetry.
- **Smell:** N/A.
- **Other:** N/A.
- **Relevant Policy Documents:** N/A.

Within Normal limits

All Ages	At all ages the child's: • skin folds are symmetrical.
0-14 days	At 0-14 days the child's: • hips are commonly instable • soft tissue hip 'clicks' may be palpable or audible during early examinations.
8 Weeks	At 8 weeks the child's: • hips are stable and relaxed with thighs easily adducted and abducted.
4 Months	At four months the child's: • hips are stable and relaxed with thighs easily adducted and abducted.

12 Months	At 12 moths the child's: • hips are stable and relaxed with thighs easily adducted and abducted.
2 Years	
3 years +	

Indications for further assessment and next steps

Non-Urgent Concern	Next Steps/Follow up/Referral
Hip instability (normal in first few weeks)	Follow up as per non-urgent concern pathway. Note: PCH Orthopaedics Clinic accepts referrals for the abnormal findings of reduced abduction, positive Ortolani or Barlow, and/or leg length difference. Referrals for skin fold/crease asymmetry alone are not accepted. They are accepted only in conjunction with a second abnormal finding.
Asymmetrical skin creases	
Limb length discrepancy	
Clunking sounds	
Movement restriction	
Not crawling by 8 months, bottom shuffling, or alternative crawling method	Follow up as per non-urgent concern pathway. For any deviations from normal, refer to a General Practitioner.
Limping or waddling gait	
Unilateral toe walking	

Appendix 13: Genitourinary system (male)

Key References: [21, 38, 39]

- **History**: Identify/discuss parent/caregiver concerns. Ask parents if the testes have ever been in the scrotum. At 2 years enquire about testicular descent (If descent is confirmed, testicular assessment is not necessary. If parent is unsure, suggest testes examination). Assess urinary output through parental report (Noting volume, frequency, and colour).
- **Observation**: Position, size, and patency of urethra. Skin colour and integrity or groin area. Size, colour, and position of the scrotum.
- **Palpation:** Palpate both sides of the scrotum to assess the position and mobility of each testis. Start above the scrotum at the superior anterior iliac crest; apply consistent downward pressure while moving the hand obliquely towards the symphysis pubis, maintain gentle downward pressure towards the sacrum and use the opposite hand to palpate the scrotum, hold the testis in the scrotum for up to 30 seconds to fatigue the cremaster muscle, release the testis.

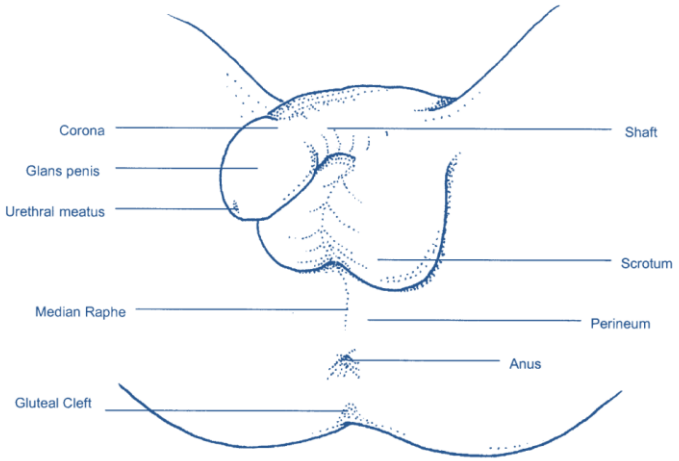

Figure 6: External male genitalia[1]

- **Smell:** Note any odour.
- **Other:** To assess testis a frog leg position for younger children, or standing, sitting or lying for older children**.** A squatting position helps the cremaster muscle to relax, enabling the testis to drop into the scrotum. **Do not attempt to forcibly retract the foreskin.**

NOTE: Assessments or discussions involving genitalia require consideration of the privacy of the venue and the appropriateness of those attending with the client.

Within Normal limits

All Ages	At all ages the child's: • urinary orifice is patent, uncovered by the prepuce, located at the tip of the glans penis • cremasteric reflex (elicited when the inner part of the thigh is stroked causing the muscle to contract and pull the testicle upward) can be activated by cold, emotion, or touch • scrotum is normally loose and wrinkled • initial sexual arousal and erection occur with normal sexual exploration or exposure of genitalia • foreskin does not retract until 2-3 years old • descended testis should be located well down in the scrotum.
0-14 days	At 0-14 days the child's: • length of penis in is 2.5 - 3cm • shaft may appear short or retracted in children with significant suprapubic fat pad.
8 Weeks	At 8 weeks the child's: • length of penis is 2.5 - 3cm • shaft may appear short or retracted in children with significant suprapubic fat pad
4 Months	At 4 months the child's: • testes is descended to scrotum
12 Months	At 12 months the child's: • testes is descended to scrotum

2 Years	At 2 years the child's • foreskin has complete separated from glans penis by 6 years.
3 years +	At 3 years the child's • foreskin has complete separated from glans penis by 6 years.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising, swelling, pain, lesions, or lacerations without reasonable explanation	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Urgent or Immediate concern	
Foreskin trapped behind glans penis due to swelling/oedema from restricted blood flow.	**May require surgical intervention. Follow up as per urgent/immediate concern pathway.**
Acute scrotal pain and swelling, nausea and vomiting, followed by scrotal oedema.	**Requires urgent surgical review, follow up as per urgent/immediate concern pathway.**
A truly ascended testis that cannot be manipulated into the scrotum	**Requires prompt medical review follow up as per urgent/immediate concern pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Penile deviations including abnormal position of urethral meatus, curvature of penis, micro-penis, redness, swelling, or penis concealed beneath scrotum	Parent education and support may include routine hygiene needs and age-appropriate expectations. Follow up as per non-urgent concern pathway.
Inguinal area deviations such as masses (either firm and reduced with pressure, or hard and immobile), tenderness or enlarged glands	Prompt medical review is indicated where any inguinal swelling is reddened, painful, or does not change size when the child cries, especially if accompanied by other signs of illness such as fever, vomiting or distended abdomen. Follow up as per non-urgent concern pathway.

Bilateral non-palpable testes	Require additional assessment for disorders of sexual development. Follow up as per non-urgent concern pathway.
Non-tender, soft, fluctuant scrotal swelling	Parent education may include information around congenital hydroceles most of which will resolve spontaneously within the first two years of life, without intervention. Refer if swelling is causing pain or enlarging or is still present after 2 years of age. Follow up as per non-urgent concern pathway.
Absent or incompletely descended testis after 3-4 months	Follow up as per non-urgent concern pathway. Child may need surgical intervention which is ideally done at 6–12 months.
Ambiguous genitals	Follow up as per non-urgent concern pathway.
Circumcision healing complications including bleeding, redness, cyanosis, discharge, or swelling	Follow up as per non-urgent concern pathway.
Retractile testis (stay in the scrotum for a short time when released but retracts when the cremasteric reflex is activated.) Retractile testes often descend during a warm bath	Children with a retractile testis are recommended to undergo a testicular examination at least annually. Follow up as per non-urgent concern pathway.
Acquired undescended testis (ascended testis), occurs when the spermatic cord fails to elongate as a child grows, causing the testis to retract back into the groin	Re-examination is recommended even if the testis were previously noted in the scrotum. If a truly ascended testis cannot be manipulated into the scrotum, medical review and referral are necessary. The optimal time for orchidopexy (surgical correction) is before puberty, usually around 7–8 years old. Follow up as per non-urgent concern pathway.

Decrease in volume and frequency, darker colour of urine	Parental education and support may include: • Expected fluid input and output for age. • Fluid requirements Follow up as per non-urgent concern pathway.
Bulging or tenderness in inguinal area	Follow up as per non-urgent concern pathway.
Where previously descended testis become either high-scrotal, retractile, or non-palpable	Follow up as per non-urgent concern pathway.
Maldescended testis (any abnormality in testicular descent that is not a normal variant)	Follow up as per non-urgent concern pathway.
Undescended testis (unable to be manipulated to the base of the scrotum or can be manipulated into the base of the scrotum under tension but will retract back quickly once released.) Note for 2-year-olds, if parents are unsure, proceed with assessment	Follow up as per non-urgent concern pathway.
Impalpable testis (Thirty per cent of testes not palpable in the scrotum (impalpable) are found in the inguinal region, 20% are intra-abdominal, and 10% are in an ectopic location. An impalpable testis may be absent in approximately 40% of boys as part of a testicular regression syndrome. This is usually secondary to intrauterine or perinatal torsion prior to fixation of the testis in the scrotum, and a testicular ‘nubbin’ or abnormal testicular remnant is the only tissue present. Hypertrophy of the contralateral testis is likely to occur. A useful comparison for the appropriate size of the testis is the size of the glans penis)	Follow up as per non-urgent concern pathway.

Resources (For staff reference only – should not be distributed to parents)

- CAHS Newsletter: Undescended testes
- Raising Children Network: Undescended testes
- Sydney Children's Hospital: Hydrocele
- The Royal Children's Hospital Melbourne – Undescended testes

Appendix 14: Genitourinary system (female)

Key References: [20, 21, 26, 40]

- **History**: Identify/discuss parent/caregiver concerns, assess urinary output through parental report (Noting volume, frequency, and colour).
- **Observation**: Presence and size of clitoris, patency of vaginal orifice, presence and location of urethra, distance between the posterior fourchette and anus. Shape, position, contours, skin integrity of labia, perianal area, inguinal area.
- **Palpation:** Labia majora for presence of gonads or hernias.
- **Smell:** Note any odour.
- **Other:** The perineum is best examined with the child supine (or semi-supine in a parent's lap) in a frog-leg position: heels together, knees flexed, and hips abducted; or lying on their side with knees drawn up to the chest.
- **Relevant Policy Documents:** N/A.

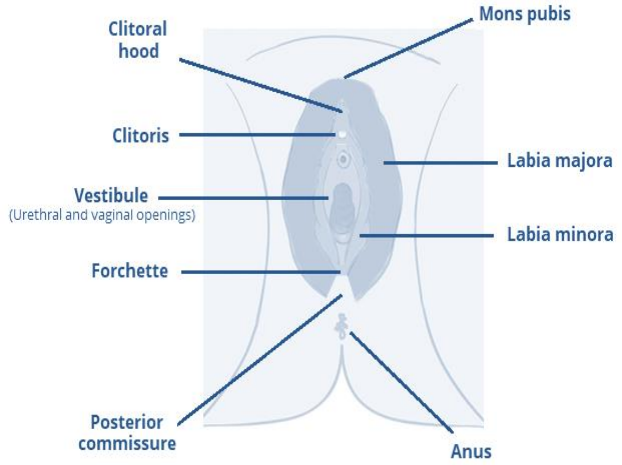

Figure 7: External female genitalia[2]

NOTE: Assessments or discussions involving genitalia require consideration of the privacy of the venue and the appropriateness of those attending with the client

Within Normal limits

All Ages	At all ages the child's: • hymen is thicker, pink white and may remain up until 2-4 years of age
0-14 days	At 0-14 days the child's • labia majora is enlarged and usually covers labia minora

	• clitoris is often disproportionately enlarged • labia minora is thickened, enlarged and dull pink • clitoris and labia minora may be more prominent in preterm children • hymen is pink, thick or wavy. Hymenal tag, white discharge, or a small amount of blood is normal • vaginal discharge may be creamy white, mucoid/blood - tinged in first 10 days • vaginal bleeding may be caused by withdrawal from maternal hormones.
8 Weeks	At 8 weeks the child's: • clitoris is about 3mm in length and 3mm in transverse diameter • labia minora are thin ridges of tissue which cover the urethral and vaginal orifices and meet at the clitoris • labia minora frequently protrude from the labia majora • urethral meatus may be difficult to visualise due to thickened hymen • vaginal orifice is patent, surrounded by hymen, with no discharge.
4 Months	At 4 months the child's: • vaginal discharge is usually minimal from 3 months of age until puberty, • clitoris is about 3mm in length and 3mm in transverse diameter • hormones wear off and vulva shrink in size and return to "normal" appearance.
12 Months	At 12 months the child's: • vaginal discharge is usually minimal • clitoris is about 3mm in length and 3mm in transverse diameter • external genitalia grow proportionately along with the rest of the body.

2 Years	At 2 years the child's: • vaginal discharge is usually minimal • clitoris is about 3mm in length and 3mm in transverse diameter • external genitalia grow proportionately along with the rest of the body.
3 years +	At 3 years the child's: • vaginal discharge is usually minimal • clitoris is about 3mm in length and 3mm in transverse diameter • external genitalia grow proportionately along with the rest of the body.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising, swelling, pain, lesions, or lacerations without reasonable explanation	**Manage as per recognising indicators for child abuse and/or neglect pathway.**
Hymenal irregularities or absence of hymen including notches, transections, thin round edge, or acute trauma to the hymen	
Partial or total removal of the external female genitalia, or other deliberate injury to the female genital organs for non-medical reasons (including "nicking" of the external genitalia)	

Non-Urgent Concern	Next Steps/Follow up/Referral
Decrease in volume and frequency, darker colour of urine	Parental education and support may include: • Expected fluid input and output for age. • Fluid requirements Follow up as per non-urgent concern pathway.
Rashes, redness, discharge, odour	This may indicate a fungal or bacterial infection. Parent support and education may include: • Routine hygiene needs • Age-appropriate expectations Follow up as per non-urgent concern pathway.
Foreign bodies – (Young preschool girls can be curious about their bodies, and it is not uncommon for girls to insert foreign objects (crayons, beads, coins, toys etc) into their vagina. It is also common for toilet paper to ball up and enter the vagina Inflammation and odour may be a sign that further investigation is needed if no object can be seen)	Follow up as per non-urgent concern pathway.
Bulging or tenderness in inguinal area	Follow up as per non-urgent concern pathway.
Ambiguous genitals	
Bulging, imperforated hymen or labial adhesions	
Clitoris >9mm length or >6mm width	
Fusion of labial majora	
Pigmented labia	
Single urogenital sinus (urethra and vagina should be seen separately)	
An inflamed “doughnut” of vascular tissue is visible at the urethral meatus	Can indicate a urethral prolapse. Follow up as per non-urgent concern pathway.

Vulval and vaginal pain	Common in prepubertal children and will usually resolve with simple measures (such as changes in hygiene practice). Follow up as per non-urgent concern pathway.
Nocturnal vaginal or perineal pain and/or itch	Consider pinworms – Follow up as per non-urgent concern pathway.

Resources (For staff reference only – should not be distributed to parents)

- The Royal Children's Hospital Melbourne: Vulva and vaginal conditions
- Royal Australasian College of Physicians: Female genital mutilation/cutting

Appendix 15: Buttocks and rectal area

Key References: [19, 21, 26]

- **History**: Identify/discuss parent/caregiver concerns, stool consistency, colour, and frequency, elimination patterns, toilet training (2 years and over).
- **Observation**: Anal position and patency, skin integrity, skin features.
- **Palpation:** N/A.
- **Smell:** Note offensive stools.
- **Other:** History of dietary intake and growth pattern may contribute to assessment.
- **Relevant Policy Documents**: Nutrition for children birth – 18 years

Within normal limits

All ages	At all ages**,** the child's: • anus is located behind the vagina in females and the scrotum in males • sphincter muscles normally maintain constriction of the anal orifice • anus patency is demonstrated by the passing of faeces.
0-14 days	At 0-14 days: • Human milk fed children have yellow faeces (brown and dark green may be normal in the absence of deviations) with texture from loose, granular to curdled. • Formula fed children have pale yellow to yellow, brown, green or grey with paste to semi formed texture.
8 Weeks	At 8 weeks: • Human milk fed children have yellow faeces (brown and dark green may be normal in the absence of deviations) with texture from loose, granular to curdled.

	• Formula fed children have pale yellow to yellow, brown, green or grey faeces with paste to semi formed texture.
4 Months	At 4 months the child's: • faeces become darker, more formed and odour increases with introduction of solid food.
12 Months	At 12 months the child's: • faeces become darker, more formed and odour increases with introduction of solid food.
2 Years	At 2 years the child's: • faeces become darker, more formed and may be odorous.
3 years +	At 3 years the child's: • faeces become darker, more formed and may be odorous.

Indications for further assessment and next steps

Indicators for child abuse	
Bruising without reasonable explanation or patterned bruising	**Manage as per recognising indicators for child abuse and/or neglect pathway.**

Non-Urgent Concern	Next Steps/Follow up/Referral
Lesions or rashes on buttocks	Parental education may include strategies for management of minor skin irritations or alterations in bowel actions. Follow up as per non-urgent concern pathway.
Sacral sinus, dimples, or tufts of hair	Follow up as per non-urgent concern pathway.
Inflammation, bleeding, small opening, evidence of pain or discomfort with anus	Follow up as per non-urgent concern pathway.

Changes in frequency (absence, reduction, explosive), colour, or consistency (loose or hard) of bowel motions	Parent education and support may include: • Dietary needs • Normal patterns of output • Strategies to address minor deviations. See Nutrition for children – Birth – 18 years) or Breastfeeding protection, promotion and support Follow up as per non-urgent concern pathway.

Resources (For staff reference only – should not be distributed to parents)

- Continence Association Australia: Bristol stool chart
- Continence foundation or Australia