

# National Clinical Assessment Framework for Children and Young People in OOHC

## The Dietitians Association of Australia (DAA) - as a member organisation of the National Primary Health Care Partnership - response to the Discussion Paper

March 2010



THINKING

DOING

LEADING



# 1 Recommendations

DAA recommends that the following changes be made:

- Physical health domain to include validated growth charts rather than BMI alone.
- Developmental domain to include a tool to measure appropriateness of dietary textures for ages 0-1 and 1-5s. (This may be covered in the suggested tools but DAA is not familiar with those listed). Children should be eating an age appropriate diet in terms of food texture.
- A dietary history should be taken as part of assessment at all age ranges not just 0-5s.
- Primary health check should measure weight, height and growth. Abnormalities in growth (overweight, obese or underweight/failure to thrive) should prompt a referral to an Accredited Practising Dietitian.
- Primary health check should also include blood pathology. Iron status would be appropriate to identify and treat at this stage.



## 2 Response to consultation questions

Consultation question	DAA response
1. Should the Framework identify specific measures that are appropriate for these diverse groups or should all measures identified be appropriate to all population groups? (Page 11)	Not all measures will be appropriate to all groups. For example, growth charts should be used to assess weight and height of all population groups but a specialised growth chart will be more appropriate for some groups eg. in disability.
2. Are the three key domains for assessments the right areas to focus on? Should mental health be a domain in its own right or continue to be combined with psychosocial health? (Page 11)	Key domains look right. Mental health fits well into psychosocial domain.
3. Should the Framework be prescriptive on the areas to be addressed for each assessment or provide guidance on the areas to be addressed and their applicability for the type of assessment being conducted? (Page 13)	Prescriptive approach preferred as this is likely to result in better consistency across users.  Dietary history should form part of the assessment for all age groups not just 0-1 and 1-5s. This whole population group is at risk of poor nutritional intake and poor eating habits.
4. Does the tiered approach provide the right structure for assessments? What other models can be identified? (Page 15)	The tiered approach looks like an appropriate structure. No other models identified.
5. How frequently should repeat assessments be conducted? Should the Framework including specific timings or should the implementation of the Framework be flexible to allow practitioners to determine the need and timing of assessment on a case by case basis? (Page 17)	Frequency of assessments should be age dependent as well as case dependent. A routine assessment schedule is recommended.  There should not be more than 12 months without some contact even if the child has no specific issues for follow up.



<p>6. Should the Framework be prescriptive on the tools to be used for each assessment or provide guidance on the range of tools available and their applicability for this group? (Page 21)</p>	<p>DAA agrees with the proposed principles for assessment tools: ie that they are validated and evidence based; age appropriate; cost effective and used accurately by the appropriate clinician.</p> <p>Standardised growth charts should be used to interpret weight and height measures rather than BMI alone for all age groups (0-18). Interpretation of growth charts should be considered carefully as some charts are based on the growth of breastfed babies and others are based on formula fed babies. The clinician assessing growth needs to be aware of this.</p> <p>BMI charts are required to interpret BMI calculated for children and can be complex to interpret.</p> <p>For children with a disability other charts may be available and more appropriate to interpret measures. For example, there are growth charts for Downs and Turners Syndrome and cerebral palsy.</p>
<p>7. Should the Framework be prescriptive on which clinician, health professional or health worker should undertake the assessments or be more flexible? (Page 22)</p>	<p>Yes the framework should be prescriptive on which health professional assesses some areas. All health professionals should operate in their own scopes of practice.</p> <p>Accredited Practising Dietitians are the appropriate health professionals to undertake a comprehensive assessment of dietary intake and participate in multidisciplinary team care. Nutritionists are not qualified to perform medical nutrition therapy.</p> <p>On page 21- spelling of 'dietitian' is incorrect and 'Nutritionists' should be removed.</p>
<p>8. How should the results of the assessments and any follow up care be documented? The Framework proposes preparation of a health plan for each child or young person entering out of home care. (Page 24)</p>	<p>A centralised health record is recommended. It may be best that care is coordinated by the GP but the record to be always accessible via the primary child protection agency case worker.</p> <p>The opportunity for health professionals to meet for case conferencing should be supported as this adds much value to individual health professional documentation of care, particularly in complex cases.</p>



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<p>9. How should implementation of the Framework be monitored and evaluated? (Page 25)</p>	<p>Monitoring and evaluation is essential but should not be burdensome.</p> <p>It should measure whether children receive appropriate referrals; whether they are assessed in the suggested timeframes; identify issues around access to appropriate health professionals for comprehensive assessments; whether the prescribed tools were used (and if not, why).</p> <p>Evaluation should also aim to determine whether children's health status/health outcomes improves – one measure may be appropriate growth for age.</p>
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