Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

THE NURTURE PROGRAMME
Infant Health and Wellbeing

National Guideline on the Use of the Ages & Stages Questionnaire™ for Developmental Screening of Children Between 1 month and 66 Months of Age

Is this document a:

Policy [ ] Procedure [ ] Protocol [ ] **Guideline** [x]

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http://www.hse.ie/eng/about/Who/qualityandpatientsafety/resourcesintelligence/Quality_and_Patient_Safety_Documents/PPPG_Document_Development_and_Inventory/

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Title of PPPG: National Guideline on the Use of the Ages & Stages Questionnaire™ for Developmental Screening of Children between 1 Month and 66 Months of Age

2.7 Outline of Guideline steps/recommendations:

2.7.1 Background

The ASQ-3™ is being introduced nationally as a parental reported developmental screening tool. The initial roll out will be for the 21-24 month public health nursing child health assessment.

Due to copyright and the licensing agreement the ASQ-3™ questionnaires can only be printed from the CD-ROM or photocopied from the master set that are both contained in the ASQ-3™ Starter Pack provided to each DPHN area. It cannot be shared electronically (e.g. by email) or reproduced in this guideline.

Parents of every child who is due to have their 21-24 month public health nursing child health assessment will be offered the relevant ASQ-3™ questionnaire to complete in advance of the public health nursing child health assessment. The recommended time frame for posting the relevant ASQ-3™ questionnaire to parents is two weeks in advance of the clinic appointment.

Consideration should be given to circumstances where it is prudent to omit the ASQ-3™; i.e. children who are already in **receipt** of Early Intervention Team (EIT) services or children with **diagnosed** global developmental delay. These parents can be given the option of deciding whether or not to complete the ASQ-3™ for their child. This should be done in discussion with the parents and by using professional judgement.

There are 22 ASQ-3™ questionnaires that cover children from 1 month to 66 months of age. It is envisaged that for the 21-24 month public health nursing child health assessment the 20, 22, 24, 27 and 30 month questionnaires are the most likely to be used. It is vitally important that the correct questionnaire is selected to ensure accurate use of the ASQ-3™.

A detailed flow chart of the process is included in Appendix V.

2.7.2 Choosing the correct age-appropriate ASQ-3™ questionnaire

In order for the RPHN/CMD to choose the correct age-appropriate questionnaire there are three steps:

Step 1: Calculate the child's age

Step 2: Convert the child's age into months and days

Step 3: Match the child's age to the age range on the front page of the ASQ-3™ questionnaires

Example 1

Emma was born on 6th August 2015. She has no known disability. She is due to have her developmental assessment with the RPHN on the 15th October 2017.

Step 1: Calculate child's age = Date of developmental assessment–Date of Birth

	Year	Month	Day
Date of Assessment	2017	10	15
Date of Birth	2015	8	6
Age	2	2	9

Step 2: Convert the child's age into months and days

- 2 years x 12 months = 24 months
- 24 months + 2 months + 9 days = **26 months and 9 days**

Step 3: Check which ASQ-3™ questionnaire should be used by matching the age to the age range on the front of the ASQ-3™ questionnaires. The 27 month questionnaire is to be used between 25 months and 16 days through to 28 months and 15 days. Therefore the 27 month questionnaire is the most appropriate one to use in this case.

There is a free online calculator available for ease of calculation of the child's chronological age and will indicate the correct ASQ-3™ questionnaire to use. It is available at http://bit.ly/ASQAgeCalc

It is also available as a free App on a smart phone:

- Apple iOS (http://bit.ly/CalcApp)
- Android (http://bit.ly/CalcAppAndroid)

Adjusting for prematurity

The ASQ-3™ requires you to adjust a child's age for prematurity if the child was born three or more weeks before his/her due date.

There is no need to adjust for prematurity once the child has reached the chronological age of two years old

Example 2

Zach was born on the 10th of December 2015 and will be having his developmental assessment on the 5th of December 2017. He was six weeks premature.

Step 1: Calculate child's age = Date of developmental assessment – Date of Birth

	Year	Month	Day
Date of Assessment	2017	12	5
Date of Birth	2015	12	10
Age	1	11	25

Step 2: Convert the child's age into months and days

- 1 years x 12 months = 12 months
- 12 months + 11 months + 25 days = **23 months and 25 days**
- Adjust for prematurity – 6 weeks
- It is recommended that the ASQ-3™ online calculator (http://bit.ly/ASQAgeCalc) or smart phone App is used when adjusting for prematurity
- Adjusted age = 22 months and 14 days

Step 3: Check which ASQ-3™ questionnaire should be used by matching the adjusted age to the age range on the front of the ASQ-3™ questionnaire. The 22 month questionnaire is to be used between 21 months and 0 days through to 22 months and 30 days. Therefore the 22 month questionnaire is the most appropriate one to use in this case.

Parents of premature children are often confused when they receive questionnaires younger than their child's chronological age. RPHNs must ensure to explain to the parent that the ASQ-3™ system adjusts for prematurity and that they are receiving the questionnaire that will most accurately reflect their child's stage of development.

2.7.3 Administration of the ASQ-3™

The full range of ASQ-3™ questionnaires can be accessed in three ways:

- by printing directly from the shared folder on the local network

- the 20, 22, 24, 27 and 30 month ASQ-3™ questionnaires can be bulk ordered by the designated staff member in each DPHN area through www.healthpromotion.ie

- by photocopying from the master set contained in each ASQ-3™ starter pack provided to designated staff in each DPHN area

- There is also a CD-ROM in each ASQ-3™ starter pack that contains PDF copies of the questionnaires that can be placed on individual PCs/laptops

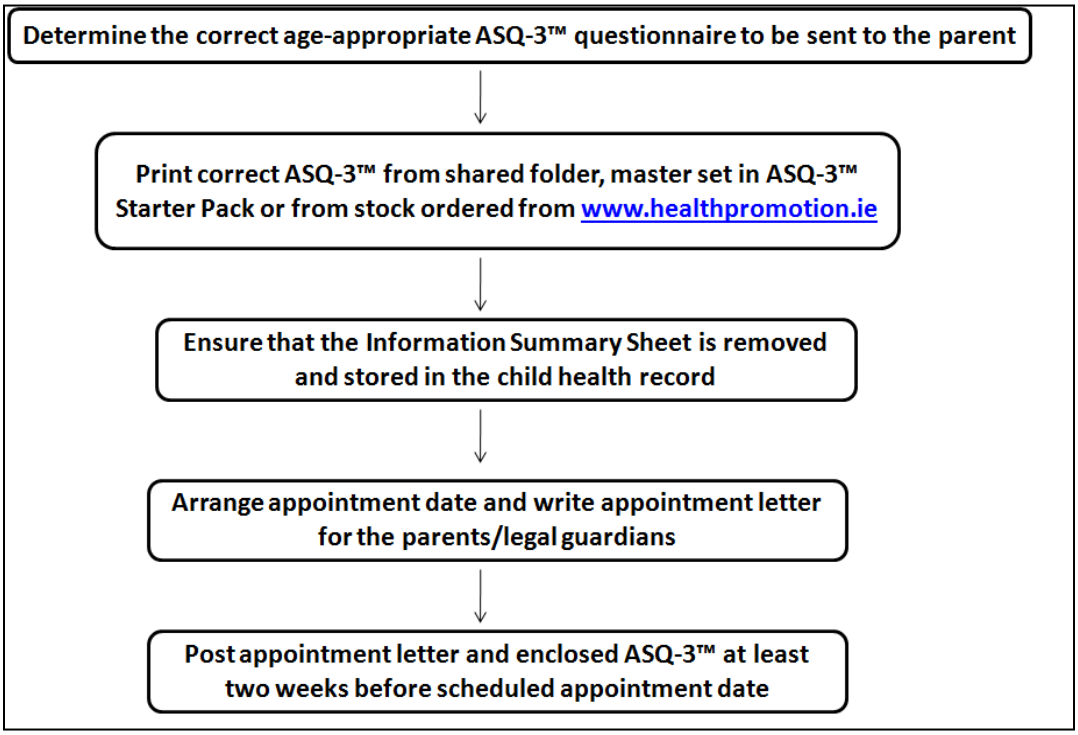
ASQ-3™ related resources such as intervention activities will be available for printing from the shared folder on the local network, the master set and the CD-ROM contained in each ASQ-3™ starter pack provided to designated staff in each DPHN area.

The parents of each child that is due their 21-24 month public health nursing child health assessment will have an appointment made and communicated by letter at least two weeks prior to the appointment date. The relevant ASQ-3™ questionnaire must be included with the letter.

The appointment letter will explain the purpose of the ASQ-3™ and ask the parents to complete the ASQ-3™ questionnaire with their child and to bring the completed questionnaire with them to the clinic appointment. (Sample appointment letter is included in Appendix VI).

Ensure that the Information Summary sheet is removed prior to postage and placed in the child health record.

Figure 1: ASQ-3™ Administration Flow Sheet



If the appointment is rescheduled for a later date, the RPHN must ensure that the correct age appropriate ASQ-3™ is sent to the parent for the date of the new appointment

2.7.4 Preparing for the public health nursing child health assessment appointment

RPHNs must check that the age range of the ASQ-3™ is correct for the age of the child.

Delayed or postponed appointments may mean that an incorrect questionnaire is being used. If this is the case, an appropriate ASQ-3™ will need to be sent to the parents with the letter confirming the new appointment date.

RPHNs must check that the age range on the ASQ-3™ information summary sheet matches the age range on the ASQ-3™ questionnaire being used. This is essential as threshold levels vary by age and developmental area; for example a score of 25 for fine motor skills falls below the threshold on the Information Summary sheet for a 24 month old, but is in the monitoring section on the 27 and 30 month Information Summary sheets.

2.7.5 Reviewing the questionnaire with parents

If the parents have not completed the questionnaire, the RPHN should provide guidance to the parents in completing the questionnaire in the health centre during the public health nursing child health assessment.

When reviewing the ASQ-3™ questionnaire with parents at the public health nursing child health assessment visit, RPHNs should:

- Ensure that parents understand the meaning of 'Yes', 'Sometimes' and 'Not Yet'

- Check that linked items are correct. Activities within each section of the ASQ-3™ increase in difficulty. Some sections contain two similar questions where one is identifying more advanced behaviour than the other. For example in the Gross Motor section of the 24 month questionnaire there are two questions about kicking:
  - Question 2 asks about walking into the ball
  - Question 6 asks about the child swinging his or her leg to kick the ball.

  If the more difficult item (Q6) is marked as 'Yes' or 'Sometimes', then Q2 should also be marked 'Yes'.

- Check with parents about any items which were untried
  - It can happen that a child may not have had the opportunity to try an activity in the home environment; i.e. a child living in a bungalow does not have the opportunity to climb stairs. In this case this activity should be left blank on the questionnaire.

- Provide the opportunity to the parent, where possible, for the child to try any untried activities during the public health nursing child health assessment.
  - Check some of the 'not yet' responses as children's abilities can develop quickly, even within a two week period.

- Be aware of cultural diversity. The RPHN should always consider cultural influences when analysing how a question is answered. The ASQ-3™ questionnaire is designed to cater for cultural variety – two questions can be left blank in any area and still get a valid result.
  - For example, some children do not play with footballs. You can omit the two questions within gross motor skills that relate to playing with a ball and still achieve a valid score.
  - For example, some children eat with their fingers up to the age of two years so their fine motor dexterity may not be as advanced as a child who uses a spoon.

- RPHNs should speak with the parents to learn about what experiences or developmental opportunities the child is exposed to.

Developmental Assessment Equipment Pack

As part of the national implementation of the ASQ-3 ™, each RPHN and CMD will be provided with a standardised developmental assessment equipment pack containing all the relevant items required to carry out a child health developmental assessment. Each item has been carefully selected and all items have the CE mark.

RPHNs and CMDs should ensure that the child is appropriately supervised in relation to the use of the items in the developmental assessment equipment pack from a child safety perspective.

2.7.6 Scoring the questionnaire

After the RPHN has reviewed the questionnaire with the parent, the questionnaire is scored by assigning a score for each answer as follows:

Yes	**=**	**10**
Sometimes	**=**	**5**
Not Yet	**=**	**0**

The RPHN completes the child health assessment which may include asking the child to carry out some of the activities contained in the questionnaire.

The total for each developmental area is calculated and noted on the ASQ-3™ questionnaire. The score, as based on the responses from the parents, is what is recorded as the ASQ-3™ score for the child in each developmental area.

Omitted items and unanswered questions

RPHNs can score the questionnaire even if some questions are not answered; for example if some activities remain untried. This is called adjusting the score.

If one or two items in a developmental area are blank or the parent reports that they were untried, the RPHN must adjust the total developmental area score so the child is not penalised for activities that they did not have the opportunity to try.

If more than two items in a developmental area are blank or the parent reports that they were untried, that developmental area cannot be scored. In these instances the RPHN should offer the parent guidance to complete the ASQ-3™ at the clinic visit.

Adjusting the score

To adjust the score, first divide the total area score (of items that have been tried), by the total number of items tried. This will produce an adjusted item score.

Then add the adjusted item score either once (for one missing item) or twice (for two missing items) to the total area score to get an adjusted total area score.

Example 3

Lucy has scored a total of 30 points from five items in the Problem Solving section of the ASQ-3™. She has not been able to try the other item.

To adjust Lucy's total, the RPHN must divide the total area score by the number of items tried to reach the adjusted item score – i.e. 30/5 = 6

The RPHN then adds the adjusted item score (for 1 missing item) to the total area score – i.e. 30 + 6 = 36.

Therefore 36 is the adjusted total area score for Lucy for the 'Problem Solving' section.

Information Summary Sheet

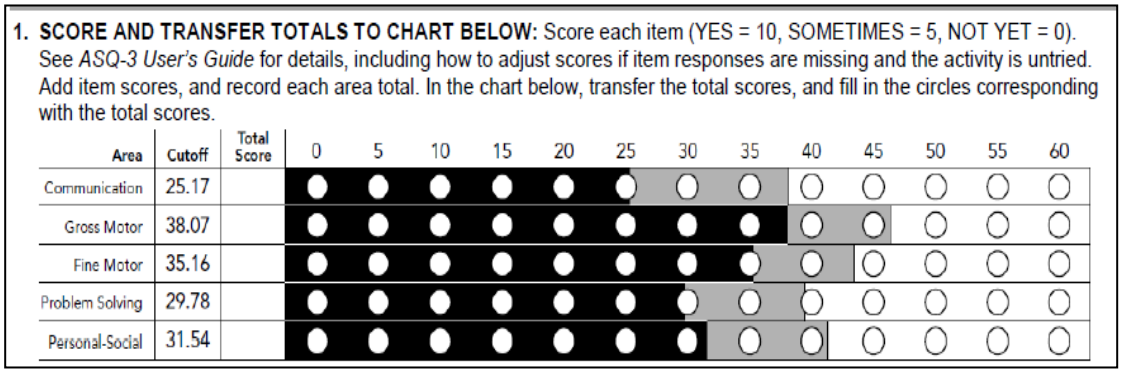
The scores for each section are then recorded on the Information Summary sheet.

The Information Summary sheet contains five parts.

Part 1: Score and transfer totals to the chart

The total scores for sections are noted in part 1 and the RPHN must fill in the circles that correspond with the total score – see Figure 2.

Figure 2: Part 1 from the 24 month ASQ-3™ Information Summary sheet



1. **SCORE AND TRANSFER TOTALS TO CHART BELOW:** Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing and the activity is untried. Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	25.17														
Gross Motor	38.07														
Fine Motor	35.16														
Problem Solving	29.78														
Personal-Social	31.54														

Part 2: Transfer overall responses

Transfer the answers from the 'Overall' section to this part of the Information Summary sheet. Any parental concerns that are recorded here must be noted and discussed with the parents. Any bolded uppercase responses require follow up – see Figure 3.

Figure 3: Part 2 from the 24 month ASQ-3™ Information Summary sheet

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. *See ASQ-3 User's Guide,* Chapter 6.

1. Hears well? Comments:	Yes	**NO**	6. Concerns about eyesight? Comments:	**YES**	No
2. Talks like other toddlers his age? Comments:	Yes	**NO**	7. Any medical/health problems? Comments:	**YES**	No
3. Understand most of what your child says? Comments:	Yes	**NO**	8. Concerns about behaviour? Comments:	**YES**	No
4. Walks, runs, and climbs like other toddlers? Comments:	Yes	**NO**	9. Other concerns? Comments:	**YES**	No
5. Family history of hearing problems? Comments:	**YES**	No			

Part 3: ASQ-3™ score interpretation and recommendation for follow up

The RPHN/CMD must consider the total area scores, overall responses and other considerations, such as opportunities to practice skills, to determine the most appropriate follow up.

- **Scores in 'white' area**
  If the child's total score is in the '***white***' area for a developmental area, it is above '*cut-offs'* and the child's development appears to be on schedule.

- **Scores in 'grey' area**
  If the child's total score is in the ***'grey'*** area for a developmental area, it is close to the '*cut-offs'*. The RPHN/CMD should provide intervention activities and monitor.

- **Scores in 'black' area**
  If the child's total score is in the **'black'** area for a developmental area, it is below the '*cut-offs*' and this indicates that a child may be at risk of developmental delay in that area and further professional assessment is indicated.

  See section 2.7.8 for further details on determining appropriate follow up.

Part 4: Follow -up Action Taken
This part outlines a checklist of follow-up actions that may be taken. The RPHN/CMD should tick all that apply.

Part 5: Optional
This table provides space to record responses to individual questions in each developmental area if required. However, the ASQ-3™ should be kept and filed in the child health record so this is optional.

Parent requests for the completed ASQ-3
If the parent wishes to have a copy of the ASQ-3™ they can be given a copy.

2.7.7 Recording in the Child Health Record

The ASQ-3™ score and any resulting findings, treatment or referral notes must be recorded in the child's health record.

If any follow up action from the ASQ-3™ is required, RPHNs must develop a nursing care plan.

If a child is being referred for further assessment, best practice would indicate that a copy of the ASQ-3™ should be included in the referral. However, this may depend on requirements from the service being referred to and may differ around the country.

2.7.8 Determining appropriate follow up

The RPHN/CMD should use the ASQ-3™ in conjunction with their professional judgement to support a referral for further assessment if deemed necessary. If ASQ-3™ scores, or any of the 'Overall' responses, raise a concern around possible developmental delay the RPHN/CMD should discuss this with the parents.

2.7.8.1 Children whose ASQ-3™ scores in the 'white' area in a developmental area - indicates typical development

It is important that the outcome of the ASQ-3™ is discussed with parents at the clinic visit. These children continue on the Best Health for Children Revisited (2005) schedule for public health nursing child health assessments.

2.7.8.2 Children whose ASQ-3™ scores in the 'grey' area in a developmental area - indicates a need for monitoring

If a child's score falls in the 'grey' area, RPHNs/CMDs should inform the parents that their child's score is close to *'cut-offs*'. RPHNs/CMDs should provide ASQ-3™ intervention activities and discuss the value of these with the parents.

RPHNs /CMDs should rescreen these children in 2 to 6 months, or earlier if deemed appropriate, and discuss this with the parents. It is essential that the RPHNs/CMDs use the relevant age appropriate ASQ-3™ questionnaire at any subsequent follow–up child health developmental assessments.

2.7.8.3 Children whose ASQ-3™ scores in the 'black' area in a developmental area - indicates possible risk of developmental delay

For children whose score falls into the 'black' area (below cut-off), this indicates a need for further assessment and some level of action should be taken by the RPHN/CMD.

2.7.8.3.1 Scoring in the 'black' area (below cut-off) for <u>one</u> developmental area only

On completion of the public health nursing child health assessment, the RPHN may be of the view that one or more of the referral considerations below may have influenced the ASQ-3™ score in that **<u>single</u>** developmental area. The RPHN/CMD should use their professional judgement and expertise to guide their actions, whilst taking into account parental concerns.

Referral considerations:

- **Opportunity**: Did the child have the opportunity to try the items or take the time to practice the skills? If not, it may be appropriate to provide the child further opportunity to try the items before making a referral
- **Health/biological factors**: Does the child have a health condition or medical factors that may have affected his or her performance?
- **Cultural factors**: are there cultural reasons that a child's performance on the questionnaire was not optimal?
- **Environmental factors**: Are there environmental factors that may have affected the child's performance
  (Squires et al, (2009) ASQ-3™ Users Guide; 3rd edition, page 77)

If the RPHN/CMD's child health assessment **<u>does not agree</u>** with the parents assessment for a score in any one of the black areas (below cut-off), and in their professional opinion the child scores in the grey area (near cut-off) or the white area (above cut-off), this should be discussed with the parents and the RPHN/CMD should provide the age appropriate ASQ-3™ intervention activity sheet and review in 1 to 2 months.

If the RPHN/CMD's child health assessment **<u>agrees</u>** with a score in any one of the black areas (below cut-off), but in the RPHN/CMD's

professional opinion, the score has been influenced by one or more of the referral considerations noted above, the RPHN/CMD may decide to provide the parents with the age appropriate ASQ-3™ intervention activities and review. The RPHN/CMD **must** review the child within 1 to 2 months.

If the score has not been influenced by any of the above referral considerations and the professional opinion of the RPHN/CMD is that the score is an accurate score then the child should be referred to the appropriate health professional.

If a child who scores in the 'black' area for **one** developmental area is not referred to an appropriate healthcare professional, RPHNs/CMDs must ensure that the rationale that informed the professional judgement for non-referral is documented in the child health record. In these instances the child must be reviewed again by the RPHN/CMD in 1 to 2 months.

2.7.8.3.2 Scoring in the 'black' area for two or more developmental areas

Children whose scores fall within the "black" area in **two or more developmental areas** should be referred for further assessment to the appropriate healthcare professional(s) following local area referral pathways for management of children with potential developmental delay. A copy of the ASQ-3™ should be included with the referral and the RPHN/CMD should provide the parents with age appropriate ASQ-3™ intervention activity sheets.

In cases where the child is placed on a waiting list for assessment for potential developmental delay, the RPHN/CMD should maintain contact (i.e. telephone) with the parents of any child that has been referred for further assessment until they have been accepted and assessed by the appropriate healthcare professional(s). If there are delays in a child being assessed this needs to be highlighted through local management/governance structures and placed on a risk register if deemed necessary.

Non Referral

If a child is not referred onwards the RPHN/CMD must record clearly the reasons for non-referral and an appropriate follow-up/care plan is actioned in the child's health record.

2.7.8.4 Communication with parents

The RPHN/CMD must communicate the requirement for an onward referral for further assessment for potential developmental delay to the parents in a sensitive manner. This should be done in person at a time

that is appropriate for the parents. If there are language difficulties an interpreter may be required.

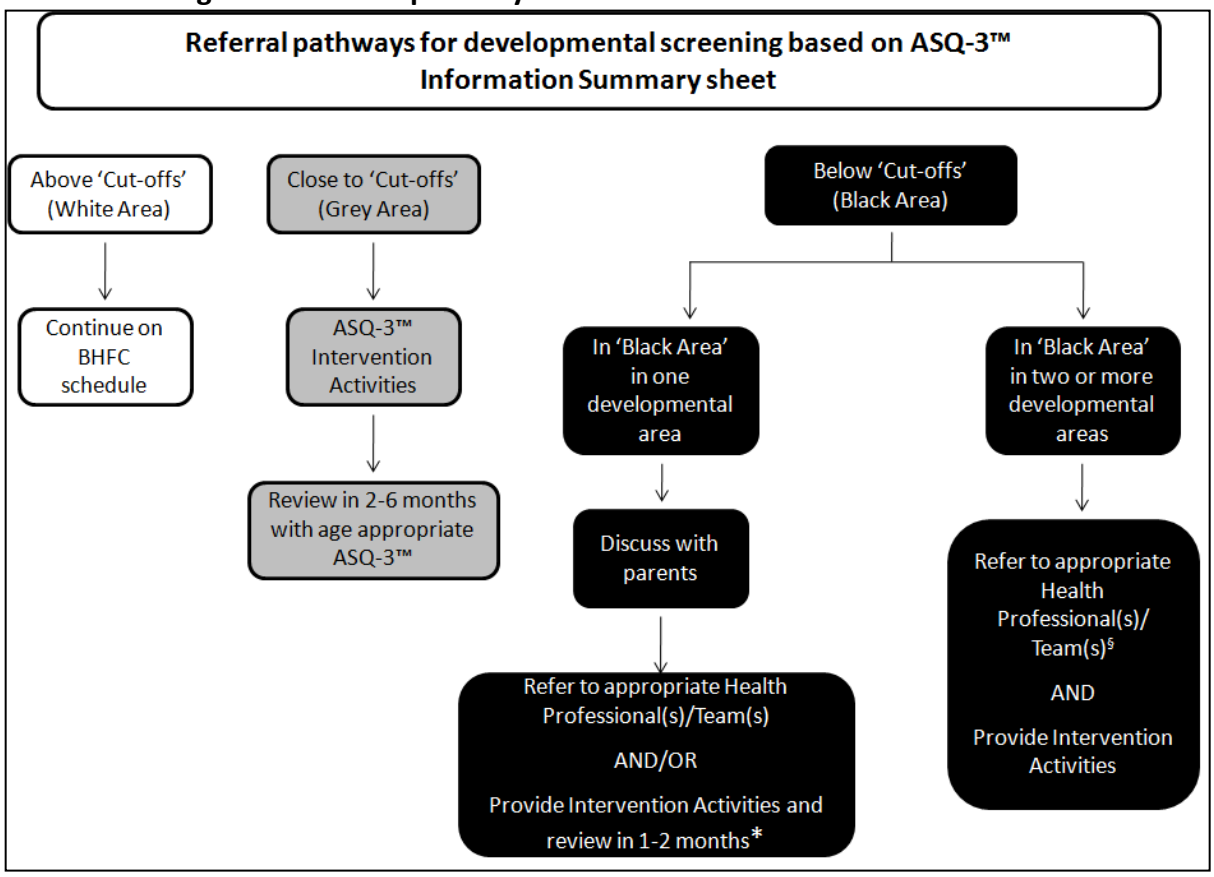
In communicating to parents that their child may be at risk of developmental delay it is important that the following points are adhered to:

- Assure parents that the conversation is confidential
- Remind parents as to the purpose of screening and ensure that they understand that screening only indicates the need for further assessment and does not constitute a diagnosis for a child
- When reviewing the ASQ-3™ results emphasise the child's strengths
- Avoid the use of terms such as *fail*, *test*, *normal* or *abnormal*
- Use language such as "*above cut-offs"*, "*close to cut-offs"* and "*below cut-offs"* when explaining cut off scores and a child's scores
- Discuss any factors that may have affected scores in particular areas of development (e.g. opportunity, health history, cultural or environmental factors)
- Listen to the parent's perceptions of their child and be open to any new ideas or viewpoints that they may have
- Discuss any concerns that the parents may have and provide specific examples of your concerns
- Emphasise the parents' current skills and resources
- If parents are interested, provide information about any relevant community resources and referral options
- Obtain appropriate consent for onward referrals as per HSE National Consent Policy (2017)
- Provide help and support to parents in accepting that an onward referral is necessary

If, following the RPHN/CMD holistic assessment, the assessment does not concur with the ASQ-3™ score the RPHN/CMD must record why and document any action taken in the child's health record and subsequent outcome.

2.7.9 Referral pathway for further assessment – Flow diagram

Figure 4: Referral pathway



* As per Section 2.7.8.3.1 - where your professional judgement and considerations do not support a score in the **'black'** area

§ As per Section 2.7.8.3.2 – if a child has been referred for further assessment the RPHN/CMD should maintain contact with the Parents/Guardians until the child has been accepted and assessed. Any delays to assessment should be highlighted through local management/governance structures and placed on a risk register if deemed necessary.

PART B: PPPG Development Cycle

1.0 INITIATION

1.1 Purpose

To inform all relevant staff, who use the Ages and Stages Questionnaire (ASQ-3™) for developmental screening and surveillance of children, of the requisite steps to be followed when using the ASQ-3™.

1.2 Scope

The scope of this National Guideline is as follows:

1.2.1 Target Audience

All Registered Public Health Nurses (RPHN) who carry out developmental assessments and surveillance of children at the core public health nursing child health assessments as per Best Health for Children Revisited (2005).

All relevant staff (e.g. Community Medical Doctors) that may employ the ASQ-3™ on receipt of a referral for a child at risk of developmental delay that requires further assessment and follow up.

1.2.2 Target Population

This National Guideline will apply to the population of all children who receive their core public health nursing child health assessments according to Best Health for Children Revisited (2005). The ASQ-3™ may also be employed at other time points outside the core public health nursing child health assessments if required.

Background

In 2014, the HSE Health and Wellbeing Division established a Child Public Health Group to commence a programme of work to review and update the existing child health programme – *Best Health for Children Revisited (2005)*. The evidence review completed by the Child Public Health Group provided the springboard for the work of the National Steering Group for the Revised Child Health Programme. Since October 2014, the national group and subgroups have worked diligently to develop the National Healthy Childhood Programme and the framework for its delivery. A fundamental principle of the National Healthy Childhood Programme is that it is evidence based and has a focus on prevention and early intervention – hence the initial roll out of the ASQ-3™ for all children at their 21-24 month public health nursing child health assessment visit. The implementation of the National Healthy Childhood Programme will follow the standardised approach established by the HSE Health and Wellbeing Division for each of the six policy priority programmes under its *Healthy Ireland in the Health Services National Implementation Plan* – one of which is *Healthy Childhood* which is a key enabler for the National Healthy Childhood Programme.

The review of *Best Health for Children Revisited (2005)* has provided an opportunity to

reflect on the current timing of contacts in the community based child health screening and surveillance service within the context of emerging evidence. Changes are proposed with respect to the timing of some of the contact points. Of relevance to this guideline are:

- 7 to 9 months contact will change to 9 to 11 months
- 18 to 24 months contact will change to 21 to 24 months
- 39 to 42 months contact will change to 46 to 48 months

These changes will be rolled out as part of the Implementation Plan for the National Healthy Childhood Programme during 2018.

1.3 Objective(s)

Developmental screening is an integral part of the National Healthy Childhood Programme. Evidence shows that early intervention is effective in improving outcomes in children with developmental delay. The ASQ-3™ is used internationally and is a validated parental reporting screening tool. This National Guideline will be used to:

- ensure that every child who was offered and who attends for their developmental assessment in Ireland has their development monitored in a standardised way as per current best practice

- facilitate early identification and onward referral of children who may be at risk of developmental delay and thus ensuring early intervention where indicated

1.4 Outcome(s)

The HSE Primary Care Division Operational Plan for 2018 specifies national implementation of the ASQ-3™, initially at the 21-24 month public health nursing child health assessment visit. This National Guideline will ensure that parents of all children who were offered and attended for their developmental assessment will be offered the ASQ-3™ at a minimum at this time point. It is envisaged that the ASQ-3™ will be employed at all core public health nursing child health assessment visits in the future but this will need further consultation and engagement. This national implementation of the ASQ-3™ will facilitate early identification and onward referral of children who may be at risk of developmental delay thus ensuring early therapeutic intervention where indicated and better outcomes for children.

1.5 Guideline Development Group

See Appendix II for Membership of the Guideline Development Group.
See Appendix III for Guideline Conflict of Interest Declaration Form.

1.6 Guideline Governance Group

1.6.1 See Appendix IV for Membership of the Approval Governance Group.

1.7 Supporting Evidence

1.7.1 Legislation

- Child and Family Relationship Act (2015)
- Child Care Act (1991) and amended Child and Family Agency Act (2013)
- Guardianship of the Infant Act (1964)
- Health Act (1970)

Policy

- Department of Children and Youth Affairs (2017) Children First, National Guidance for the Protection and Welfare of Children
- Department of Children and Youth Affairs (2014) Better Outcomes, Brighter Futures: The national policy framework for children and young people 2014-2020
- National Conjoint Child Health Committee (1999) Best Health for Children: Developing a Partnership with Families.
- National Core Child Health Programme Review Group (2005) Best Health for Children Revisited.
- Health Service Executive *(2005)* Best Health for Children Revisited Appendix 2. Training Programme for Public Health Nurses and Doctors in Child Health Screening, Surveillance and Health Promotion. Health Service Executive.
- Health Service Executive (2017) National Consent Policy
- Health Service Executive (2016) Child Protection and Welfare Policy
- Health Service Executive (2011) Risk Management in the HSE; An Information Handbook
- Health Service Executive (2011) Developing and Populating a Risk Register, Best Practice Guidance
- Health Service Executive (2011) Standards and Recommended Practices for Healthcare Records Management

Standards

- HIQA (2016) Supporting people's autonomy: a guidance document
- HIQA (2015) Guidance for providers of health and social care services. Communicating in Plain English
- HIQA (2012) National Standards for Better Safer Healthcare

Literature

- Squires J. and Bricker D. Ages and Stages Questionnaires®, Third Edition (ASQ-3™). A parent-completed child monitoring system. 2009 Paul H Brookes Publishing Co. Baltimore
- McBride L, Cawley T (2011). Introduction of the Ages and Stages Questionnaire (ASQ 3) at the 18-24 month developmental assessment. Regional Pilot HSE West Donegal, Sligo/Leitrim/West Cavan
- Fitzpatrick PM, Khan R, Sharif F (2006). Use of developmental screening tools in the detection of developmental delay in children. Department of Paediatrics Midland Regional Hospital Mullingar (Abstract published in Irish

Journal Medical Science 2006;175(4) es2:4)
- Bedford H, Walton S, Ahn J. (2013) Review of measures of child development. Policy Research Unit in the Health if Children. Young People and Families University College London Institute of Child Health
- American Academy of Paediatrics Committee on Children with Disabilities (2001). Developmental surveillance and screening of infants and young children. *Paediatrics* 2001;108:192-196

1.7.2 This is the first National Guideline of its kind on this topic. There may be a small number of local PPPGs in existence. This National Guideline on the use of the ASQ-3™ will replace any local guidelines that are in existence relating to this topic.

1.7.3 List related PPPGs.
- Nursing and Midwifery Board of Ireland (2015) Scope of Nursing and Midwifery Practice Framework
- Nursing and Midwifery Board of Ireland (2015) Recording Clinical Practice: Professional Guidance
- Nursing and Midwifery Board of Ireland (2015) Public Health Nursing Education Programme Standards and Requirements
- Nursing and Midwifery Board of Ireland (2014) Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives
- Health Service Executive (2017). Framework for the National Healthy Childhood Programme, HSE Health and Wellbeing and Primary Care Divisions
- Department of Health and Children, (1966) *Circular 27/66* District Nursing Service
- Department of Health and Children (2000) *Circular 41/2000*

1.8 Glossary of Terms

AAP	American Academy of Paediatrics	**EIT**	Early Intervention Team
ADPHN	Assistant Director of Public Health Nursing	**GP**	General Practitioner
AHP	Allied Health Professional	**HSE**	Health Service Executive
ASQ-3™	Aged and Stages Questionnaire (3rd edition)	**NMBI**	Nursing and Midwifery Board of Ireland
CHO	Community Healthcare Organisation	**RPHN**	Registered Public Health Nurse
CMD	Community Medical Doctor	**PMO**	Principal Medical Officer
DPHN	Director of Public Health Nursing	**PPPG**	Policy, Procedure, Protocol, Guideline
EIS	Early Intervention Service		

Definitions:

Appropriate	Matching the circumstances, meeting the needs of the individual, groups or situation (NMBI, Glossary of Nursing & Midwifery Terms https://www.nmbi.ie/Standards-Guidance/Glossary)
Chronological Age	This is the time elapsed after birth. It is usually described in days, weeks, months and years. (Reference: American Academy of Paediatrics: Age terminology during the perinatal period http://pediatrics.aappublications.org/content/114/5/1362#F1)
Corrected Age	An age correction is required for prematurity when the actual date of birth is 3 or more weeks earlier than the expected date of birth. It is calculated by subtracting the number of weeks prematurity from the chronological age – e.g. chronological age – number of weeks premature = corrected age (Reference: ASQ-3™ User Guide Glossary p143)
Consent	Consent is the giving of permission or agreement for an intervention, receipt or use of a service or participation in research following a process of communication about the proposed intervention (HSE National Consent Policy, 2017)
Cut-off scores	These are statistically derived scores for each of the five areas of development that guide users as regards the requisite follow up action. (Reference: ASQ-3 User Guide).
	Above cut-off scores: An ASQ-3™ score in any developmental area that falls above the statistically derived referral cut-off point (Reference: ASQ-3 User Guide, page 143). The above cut-off score is represented by the '**white'** area on the ASQ-3™ Information Summary sheet. A score in this area indicates that the child's development appears to be on schedule
	Close to cut-off scores or 'monitoring zone': On the ASQ-3™, scores that fall within the monitoring zone are between 1.0 and 2.0 standard deviations from the mean (Reference: ASQ-3 User Guide, page 144). The monitoring zone is represented by the '**grey**' area on the Information Summary sheet
	Below cut-off scores: An ASQ-3™ score in any developmental area that falls below the statistically derived referral cut-off point (Reference: ASQ-3 User Guide, page 143). The below cut-off score for onward referral is defined as two standard deviations below the mean for that area of development. This is represented by the '**black**' area on the ASQ-3™ Information Summary sheet
Must	Commands the action a nurse or midwife is obliged to take from which no deviation whatsoever is allowed (NMBI, Glossary of Nursing & Midwifery Terms https://www.nmbi.ie/Standards-Guidance/Glossary)
Parent	Refers to parent or legal guardian of the child
Premature Birth	A premature birth is a birth that takes place before 37 weeks of pregnancy are completed (Irish Neonatal Health Alliance http://www.inha.ie/definition-of-premature-birth/)
Professional Judgement	For the purpose of this guideline, a nurse/midwife's professional judgement is based on the principles of responsibility, accountability and autonomy as outlined within the NMBI's Scope of Nursing and Midwifery

	Practice Framework (2015, pages 17-18)
Referral	An act of referring someone for consultation, review, or further action if the required intervention is outside the scope of practice of the healthcare professional (NMBI, Glossary of Nursing & Midwifery Terms https://www.nmbi.ie/Standards-Guidance/Glossary
Should	Indicates a strong recommendation to perform a particular action from which deviation in particular circumstances must be justified (NMBI, Glossary of Nursing & Midwifery Terms https://www.nmbi.ie/Standards-Guidance/Glossary

2.0 DEVELOPMENT OF PPPG

2.1 List the questions

2.1.1 Why is early identification of developmental delay important?

Early childhood is a critical period in brain development and early identification of children who are at risk of developmental delay is essential for timely intervention and improved long-term outcomes. It has been estimated that only about half of the children with developmental problems are detected before they begin school.

Developmental surveillance and screening is important in the early identification of developmental delays in early childhood. The American Academy of Paediatrics and the British Joint Working Party on Child Health Services recommend developmental surveillance as an effective means to identify children with developmental delays. Parents' reports of attainment of developmental tasks has been shown to be reliable, and parent-completed screening tools such as the Parental Evaluation of Developmental Status (PEDS), the Ages and Stages Questionnaire (ASQ-3™) and the Child Development Inventories (CDI) are useful tools for identifying children who are in need of further evaluation.

2.1.2 What was the process of recommending a screening tool?

In 2014, a Developmental Assessment Subgroup of the National Steering Group for the revised child health programme was established to review the developmental assessment content of Best Health for Children Revisited (2005). The membership of the group included representation from Public Health Medicine, Community Paediatrics, Community Medicine and Public Health Nursing. The terms of reference of the group included the following:

- To review the developmental assessment content of Best Health for Children
- To review international evidence on optimal timing of assessments and make recommendations on appropriate content and timing of assessments in Ireland
- To review screening tools used for assessment and make recommendations on same

- To make recommendations on the developmental assessment content of training programmes to support the implementation of the revised model of child health

The group reported to the National Lead for Child Health and the National Steering Group for the Revised Child Health Programme.

2.1.3 What was the outcome of the review of Best Health for Children (1999) and Best Health for Children Revisited (2005)

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

A review of Best Health for Children was published in 2005 (National Core Child Health Programme Review Group (2005)). This report included recommendations for child health surveillance in each of eight working group areas. General recommendations included a reduction in the number of formal tests with a shift to observation of child behaviour and development by trained professionals. There was a continued emphasis on the value of parental observations and concern. The importance of determinants of child health and the need to work in partnership with parents to achieve positive health outcomes for children was recognised.

In relation to developmental assessment, the following observations and recommendations were made:

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

The review also made the following recommendations:

- Staff training in the recognition of childhood developmental delay and disorders needs to be provided to facilitate early referral and intervention
- Instruments that can identify parental concern in relation to any area of child development needs to be evaluated in the Irish context and introduced if found valid

- The role of specific tools to guide practitioners in the assessment of childhood development needs to be explored in the Irish context, as the use of individualised checklists is no longer in line with current evidence

2.2 Describe the literature search strategy

A desktop review of international policy and practice in relation to child developmental surveillance was undertaken to inform the work of the Developmental Assessment Subgroup. This was followed by a review of literature relating to the timing and content of developmental checks. Following review of screening tools which are currently in use in Ireland and internationally, the subgroup considered the Parents Evaluation of Developmental Status (PEDS) and the ASQ-3™ to be the most appropriate screening tools for use in Irish child health services. Grey and scientific literature relating to the use of screening tools was then reviewed. A number of online databases were examined including EBSCO, MEDLINE, PubMed and CINAHL. The subgroup also considered reports of pilot studies of the ASQ-3™ conducted in Ireland.

2.3 Describe the method of appraising evidence

The Developmental Assessment Subgroup reviewed published scientific and grey literature relating to the use of PEDS and ASQ-3™ screening tools in Ireland and presented their findings to the National Steering Group for the Implementation of a Revised Child Health Model. Presentations included the rationale for the group's recommendations, relevant literature reviews and a cost analysis relating to the introduction of the ASQ-3™ screening tool as a universal measure at the 21-24 month public health nursing child health assessment. The recommendations of the subgroup were discussed by the Steering Group and were incorporated into the new child health model.

2.4 Describe the process the Guideline Development Group used to formulate recommendations

The Guideline Development Group did not make the recommendations or take the decision to commence use of the ASQ-3™. As outlined in section 2.1, this work was carried out by the Developmental Assessment Subgroup who made recommendations to the National Steering Group for the Revised Child Health Programme. The ASQ-3™ screening tool was selected on the following basis:

- Internationally, the ASQ-3™ is the most widely used parental report child developmental screening tool
- The ASQ-3™ is recommended as a screening tool by the American Academy of Paediatrics
- The ASQ-3™ has a high sensitivity and specificity and there is a large body of evidence to support its use
- It is already in use in a number of areas in Ireland and is favoured by clinicians and parents (Fitzpatrick, Khan & Sharif (2006); McBride & Cawley (2011))
- The ASQ-3™ is also in use across much of the UK and was recently adopted as a population outcome measure in England
- The ASQ-3™ includes activity sheets for families to use in the home

- It is inexpensive and cost effective

2.5 Provide a summary of the evidence from the literature

In 2012, the Department of Health (UK) commissioned a team at University College London (UCL) to conduct a comprehensive review of the range of existing standardised instruments/tools that could be used to measure children's developmental progress at age 2–2½ years. The purpose of this work was to identify a population level outcome measure that met specific criteria. The team focussed on tools that could be used as part of the 2-2½ years Healthy Child Programme (HCP) review and included an analysis of the advantages and disadvantages of the different tools for the purpose of a population level outcome measure. The aspects of children's development which were considered were physical, social and emotional, cognitive and speech and language. This paper provided a very valuable analysis of the evidence to support the use of various parental report developmental screening tools (Bedford H, Walton S, Ahn J, 2013).

However, it is important to note that the universal use of the ASQ-3™ does not constitute a formal population screening programme. Screening for developmental delay, *"a child who does not meet developmental milestones at the expected age, even after allowing for the range of normality"* has been considered for inclusion as a population screening programme in UK (Rydz, D., et al. 2005). However, the lack of information about the nature of developmental delay, which is often a complex, imprecise condition, about definitive diagnostic tests and treatment/management options means that whole population screening does not currently meet the UK NSC criteria (UK National Screening Committee, 2012).

Results and recommendations of the UCL Review

The authors of the review searched PubMed, ERIC, Web of Knowledge, PsycInfo, and Embase databases and identified 20,554 relevant papers. Following three stages of filtering, 32 measures were identified for consideration.

Department of Health (UK) requirements for the measure:

- It can be updated on a regular basis (e.g. annually) and enables population level child development at age 2-2½ years to be tracked over time
- It is a valid and reliable measure of the aspects of child development we wish to measure
- It is applicable to different groups of the population with differing levels of development and needs
- It has standardised norms for an appropriate population that can be used to benchmark progress in England
- It can be aggregated at the national and local (local authority) level
- It is sensitive to changes at a population level
- It reflects influences on child development during pregnancy and first two years of life as well as being predictive of later life outcomes, especially school readiness
- It is simple to apply and is acceptable to families and professionals

- It minimises burdens on professionals and families
- It can be integrated with existing clinical contacts with all families around this age

Standardisation and psychometrics

The ASQ-3™ was standardised on 15,138 children (1,443 aged 24 months) whose parents completed 18,232 questionnaires (Squires, J. and D. Bricker. 2009). Families were educationally and economically diverse, and their ethnicities roughly matched estimates from the 2007 U.S. Census. Sensitivity was 0.86 and specificity was 0.85 overall. Figures for sensitivity and specificity at key ages between 24-30 months are given below:

- At 24 months: sensitivity 91.2%, specificity 71.9%
- At 27 months: sensitivity 77.8%, specificity 86.4%
- At 30 months: sensitivity 86.7%, specificity 93.3%

Strengths as a population measure

- ASQ-3™ covers the developmental areas of interest although it covers personal-social rather than social-emotional
- ASQ-3™ has been used as a population measure, and was already being used in the UK as part of the Healthy Child Programme (HCP), although the authors were not aware of any formal evaluations of its use.
- ASQ-3™ produces scores (out of 60) for each developmental area and an overall score. This may allow measurement of small changes longitudinally.
- Its format allows flexibility in administration. For example, it could be incorporated into the two year review in a number of ways: sent to parents in advance of the review, which would allow them to think about their child's development and to gather questions for the later review; adapted for inclusion in the Personal Child Health Record (PCHR), although its length would require a number of pages; for those parents who may have problems with literacy or with language barriers, the individual conducting the review could go through the items with the parent at the time of the review. This would be a useful way of widening access
- ASQ-3™ allows parents to be active participants in their child's development and encourages enjoyable interaction between parent and child
- The results of the ASQ-3™ provide a good basis for discussion about the child's current and future development
- The authors comment that an important difference between this and other screening tools is that it is designed to show what children can do, not just what they cannot do
- Acceptable sensitivity and specificity with figures for these rates among 2 year olds
- It has been used among children at high risk of developmental problems
- It is quick and easy to complete and to score
- Cost efficient as a one-off purchase with questionnaires and other materials being photocopied as required

Limitations and further questions about ASQ-3™

- There is a lack of standardised norms for the UK population – this is important as the socio-demographic characteristics of the UK population differ significantly from that of the USA where the measure has been normed
- Although ASQ-3™ covers all the developmental areas of interest, it focuses on 'personal-social' rather than 'social-emotional', thus issues such as relationships are less well covered. However, ASQ-SE-2™, which solely focuses on social and emotional development, could be used in conjunction with ASQ-3™. ASQ-SE-2™ focuses on a child's social and emotional behaviour in the areas of self-regulation, compliance, communication, adaptive behaviours, autonomy affect and interactions with people
- There is a lack of information about acceptability of ASQ-3™ among UK (English) parents and health professionals, other than anecdotal reports that 'they like it'
- There is a need to evaluate ASQ-3™ in the UK (English) population to determine if it can be used with parents with potential language barriers, cultural differences and with literacy problems
- Since the 2-2½ year review is currently being conducted at a range of ages between less than 24 months to just less than 36 months (personal communication with Programme Director ChiMat, January 2012), different age specific questionnaires would be used. It is not clear whether it is valid to combine the scores from age specific questionnaires into one overall score
- ASQ-3™ is designed as a system for developmental screening and the validity and usefulness of using it as a one-off measure is unclear
- Some of the language used in ASQ-3™ is 'Americanised'. Parents' understanding of this needs to be assessed and it possibly needs adapted for use in UK.

2.6 Detail resources necessary to implement the Guideline recommendations

Implementation of the ASQ-3™ in a universal roll out for every child's 21-24 month public health nursing child health assessment will have a number of resource implications. The main resource requirements:

- ASQ-3™ licence/starter pack have been purchased and are available
- Full set of ASQ-3™ questionnaires are available for local printing by individual RPHNs/clerical support from their local shared network and the relevant 21-24 months ASQ-3™ are also available through ordering from the national HSE storage and distribution service via www.healthpromotion.ie
- Developmental equipment packs/toys will be procured and made available for all RPHNs and CMDs
- Clerical support for the postage of the ASQ-3™ questionnaires with the appointment letters explaining the ASQ-3™
- Cost of postage of appointment letters and ASQ-3™ questionnaires
- Additional clinic time requirement to incorporate the review of the ASQ-3™ questionnaire into the public health nursing child health assessment and possible reassessments

- Potential for increased referral to other primary care services. No significant increases were noted in the North West pilot (McBride & Cawley, 2011)
- Access to interpreter services may be required in some areas of the country.

2.7 Outline of PPPG Steps/Recommendations

2.7.1 Background

The ASQ-3™ is being introduced nationally as a parental reported developmental screening tool. The initial roll out will be for the 21-24 month public health nursing child health assessment.

Due to copyright and the licensing agreement the ASQ-3™ questionnaires can only be printed from the CD-ROM or photocopied from the master set that are both contained in the ASQ-3™ Starter Pack provided to each DPHN area. It cannot be shared electronically (e.g. by email) or reproduced in this guideline.

Parents of every child who is due to have their 21-24 month public health nursing child health assessment will be offered the relevant ASQ-3™ questionnaire to complete in advance of the public health nursing child health assessment. The recommended time frame for posting the relevant ASQ-3™ questionnaire to parents is two weeks in advance of the clinic appointment.

Consideration should be given to circumstances where it is prudent to omit the ASQ-3™; i.e. children who are already in **receipt** of Early Intervention Team (EIT) services or children with **diagnosed** global developmental delay. These parents can be given the option of deciding whether or not to complete the ASQ-3™ for their child. This should be done in discussion with the parents and by using professional judgement.

There are 22 ASQ-3™ questionnaires that cover children from 1 month to 66 months of age. It is envisaged that for the 21-24 month public health nursing child health assessment the 20, 22, 24, 27 and 30 month questionnaires are the most likely to be used. It is vitally important that the correct questionnaire is selected to ensure accurate use of the ASQ-3™.

A detailed flow chart of the process is included in Appendix V.

2.7.2 Choosing the correct age-appropriate ASQ-3™ questionnaire

In order for the RPHN/CMD to choose the correct age-appropriate questionnaire there are three steps:

Step 1: Calculate the child's age

Step 2: Convert the child's age into months and days

Step 3: Match the child's age to the age range on the front page of the ASQ-3™ questionnaires

Example 1
Emma was born on 6th August 2015. She has no known disability. She is due to have her developmental assessment with the RPHN on the 15th October 2017.

Step 1: Calculate child's age = Date of developmental assessment–Date of Birth

	Year	Month	Day
Date of Assessment	2017	10	15
Date of Birth	2015	8	6
Age	2	2	9

Step 2: Convert the child's age into months and days

- 2 years x 12 months = 24 months
- 24 months + 2 months + 9 days = **26 months and 9 days**

Step 3: Check which ASQ-3™ questionnaire should be used by matching the age to the age range on the front of the ASQ-3™ questionnaires. The 27 month questionnaire is to be used between 25 months and 16 days through to 28 months and 15 days. Therefore the 27 month questionnaire is the most appropriate one to use in this case.

There is a free online calculator available for ease of calculation of the child's chronological age and will indicate the correct ASQ-3™ questionnaire to use. It is available at http://bit.ly/ASQAgeCalc

It is also available as a free App on a smart phone:

- Apple iOS (http://bit.ly/CalcApp)
- Android (http://bit.ly/CalcAppAndroid)

Adjusting for prematurity
The ASQ-3™ requires you to adjust a child's age for prematurity if the child was born three or more weeks before his/her due date.

There is no need to adjust for prematurity once the child has reached the chronological age of two years old

Example 2
Zach was born on the 10th of December 2015 and will be having his developmental assessment on the 5th of December 2017. He was six weeks premature.

Step 1: Calculate child's age = Date of developmental assessment – Date of Birth

	Year	Month	Day
Date of Assessment	2017	12	5
Date of Birth	2015	12	10
Age	1	11	25

Step 2: Convert the child's age into months and days

- 1 years x 12 months = 12 months
- 12 months + 11 months + 25 days = **23 months and 25 days**
- Adjust for prematurity – 6 weeks
- It is recommended that the ASQ-3™ online calculator (http://bit.ly/ASQAgeCalc) or smart phone App is used when adjusting for prematurity
- Adjusted age = 22 months and 14 days

Step 3: Check which ASQ-3™ questionnaire should be used by matching the adjusted age to the age range on the front of the ASQ-3™ questionnaire. The 22 month questionnaire is to be used between 21 months and 0 days through to 22 months and 30 days. Therefore the 22 month questionnaire is the most appropriate one to use in this case.

Parents of premature children are often confused when they receive questionnaires younger than their child's chronological age. RPHNs must ensure to explain to the parent that the ASQ-3™ system adjusts for prematurity and that they are receiving the questionnaire that will most accurately reflect their child's stage of development.

2.7.3 Administration of the ASQ-3™

The full range of ASQ-3™ questionnaires can be accessed in three ways:

- by printing directly from the shared folder on the local network
- the 20, 22, 24, 27 and 30 month ASQ-3™ questionnaires can be bulk ordered by the designated staff member in each DPHN area through www.healthpromotion.ie
- by photocopying from the master set contained in each ASQ-3™ starter pack provided to designated staff in each DPHN area

- There is also a CD-ROM in each ASQ-3™ starter pack that contains PDF copies of the questionnaires that can be placed on individual PCs/laptops

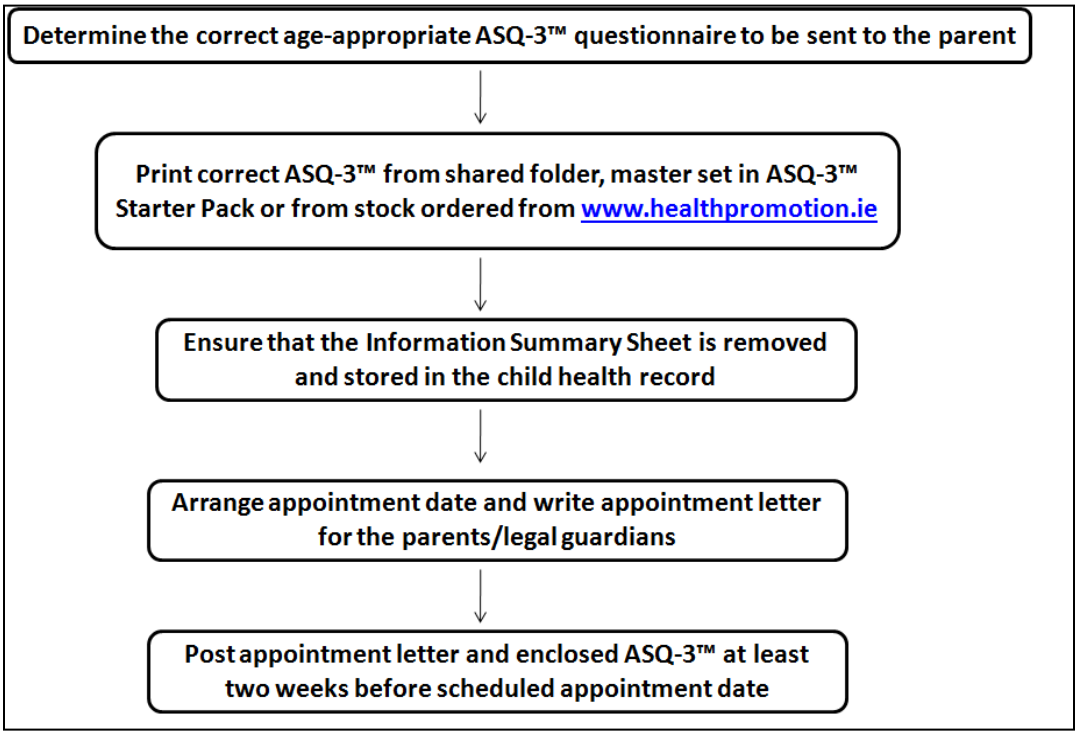
ASQ-3™ related resources such as intervention activities will be available for printing from the shared folder on the local network, the master set and the CD-ROM contained in each ASQ-3™ starter pack provided to designated staff in each DPHN area.

The parents of each child that is due their 21-24 month public health nursing child health assessment will have an appointment made and communicated by letter at least two weeks prior to the appointment date. The relevant ASQ-3™ questionnaire must be included with the letter.

The appointment letter will explain the purpose of the ASQ-3™ and ask the parents to complete the ASQ-3™ questionnaire with their child and to bring the completed questionnaire with them to the clinic appointment. (Sample appointment letter is included in Appendix VI).

Ensure that the Information Summary sheet is removed prior to postage and placed in the child health record.

Figure 1: ASQ-3™ Administration Flow Sheet



If the appointment is rescheduled for a later date, the RPHN must ensure that the correct age appropriate ASQ-3™ is sent to the parent for the date of the new appointment

2.7.4 Preparing for the public health nursing child health assessment appointment

RPHNs must check that the age range of the ASQ-3™ is correct for the age of the child.

Delayed or postponed appointments may mean that an incorrect questionnaire is being used. If this is the case, an appropriate ASQ-3™ will need to be sent to the parents with the letter confirming the new appointment date.

RPHNs must check that the age range on the ASQ-3™ information summary sheet matches the age range on the ASQ-3™ questionnaire being used. This is essential as threshold levels vary by age and developmental area; for example a score of 25 for fine motor skills falls below the threshold on the Information Summary sheet for a 24 month old, but is in the monitoring section on the 27 and 30 month Information Summary sheets.

2.7.5 Reviewing the questionnaire with parents

If the parents have not completed the questionnaire, the RPHN should provide guidance to the parents in completing the questionnaire in the health centre during the public health nursing child health assessment.

When reviewing the ASQ-3™ questionnaire with parents at the public health nursing child health assessment visit, RPHNs should:

- Ensure that parents understand the meaning of 'Yes', 'Sometimes' and 'Not Yet'

- Check that linked items are correct. Activities within each section of the ASQ-3™ increase in difficulty. Some sections contain two similar questions where one is identifying more advanced behaviour than the other. For example in the Gross Motor section of the 24 month questionnaire there are two questions about kicking:
    - Question 2 asks about walking into the ball
    - Question 6 asks about the child swinging his or her leg to kick the ball.

  If the more difficult item (Q6) is marked as 'Yes' or 'Sometimes', then Q2 should also be marked 'Yes'.

- Check with parents about any items which were untried
    - It can happen that a child may not have had the opportunity to try an activity in the home environment; i.e. a child living in a bungalow

does not have the opportunity to climb stairs. In this case this activity should be left blank on the questionnaire.

- Provide the opportunity to the parent, where possible, for the child to try any untried activities during the public health nursing child health assessment.
    - Check some of the 'not yet' responses as children's abilities can develop quickly, even within a two week period.

- Be aware of cultural diversity. The RPHN should always consider cultural influences when analysing how a question is answered. The ASQ-3™ questionnaire is designed to cater for cultural variety – two questions can be left blank in any area and still get a valid result.
    - For example, some children do not play with footballs. You can omit the two questions within gross motor skills that relate to playing with a ball and still achieve a valid score.
    - For example, some children eat with their fingers up to the age of two years so their fine motor dexterity may not be as advanced as a child who uses a spoon.
    - RPHNs should speak with the parents to learn about what experiences or developmental opportunities the child is exposed to.

Developmental Assessment Equipment Pack

As part of the national implementation of the ASQ-3 ™, each RPHN and CMD will be provided with a standardised developmental assessment equipment pack containing all the relevant items required to carry out a child health developmental assessment. Each item has been carefully selected and all items have the CE mark.

RPHNs and CMDs should ensure that the child is appropriately supervised in relation to the use of the items in the developmental assessment equipment pack from a child safety perspective.

2.7.6 Scoring the questionnaire

After the RPHN has reviewed the questionnaire with the parent, the questionnaire is scored by assigning a score for each answer as follows:

Yes	**=**	**10**
Sometimes	**=**	**5**
Not Yet	**=**	**0**

The RPHN completes the child health assessment which may include asking the child to carry out some of the activities contained in the questionnaire.

The total for each developmental area is calculated and noted on the ASQ-3™ questionnaire. The score, as based on the responses from the parents, is what is

recorded as the ASQ-3™ score for the child in each developmental area.

Omitted items and unanswered questions
RPHNs can score the questionnaire even if some questions are not answered; for example if some activities remain untried. This is called adjusting the score.

If one or two items in a developmental area are blank or the parent reports that they were untried, the RPHN must adjust the total developmental area score so the child is not penalised for activities that they did not have the opportunity to try.

If more than two items in a developmental area are blank or the parent reports that they were untried, that developmental area cannot be scored. In these instances the RPHN should offer the parent guidance to complete the ASQ-3™ at the clinic visit.

Adjusting the score
To adjust the score, first divide the total area score (of items that have been tried), by the total number of items tried. This will produce an adjusted item score.

Then add the adjusted item score either once (for one missing item) or twice (for two missing items) to the total area score to get an adjusted total area score.

Example 3
Lucy has scored a total of 30 points from five items in the Problem Solving section of the ASQ-3™. She has not been able to try the other item.

To adjust Lucy's total, the RPHN must divide the total area score by the number of items tried to reach the adjusted item score – i.e. 30/5 = 6

The RPHN then adds the adjusted item score (for 1 missing item) to the total area score – i.e. 30 + 6 = 36.

Therefore 36 is the adjusted total area score for Lucy for the 'Problem Solving' section.

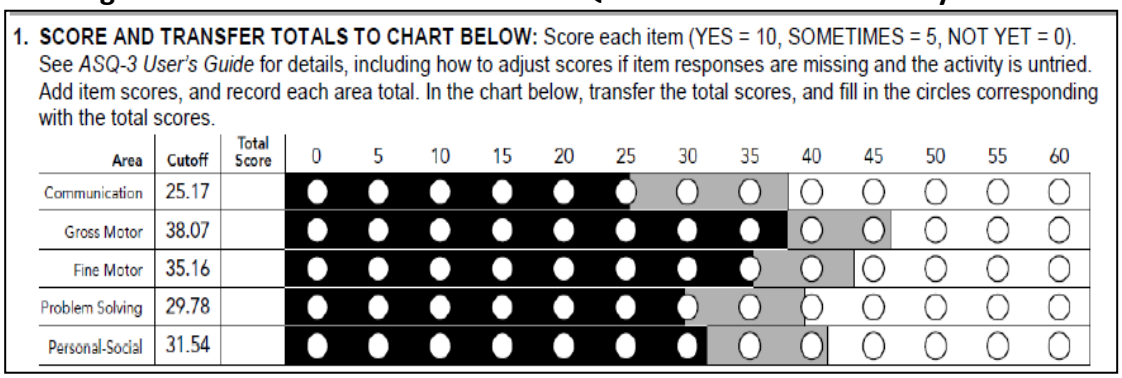
Information Summary Sheet
The scores for each section are then recorded on the Information Summary sheet.

The Information Summary sheet contains five parts.

Part 1: Score and transfer totals to the chart

The total scores for sections are noted in part 1 and the RPHN must fill in the circles that correspond with the total score – see Figure 2.

Figure 2: Part 1 from the 24 month ASQ-3™ Information Summary sheet



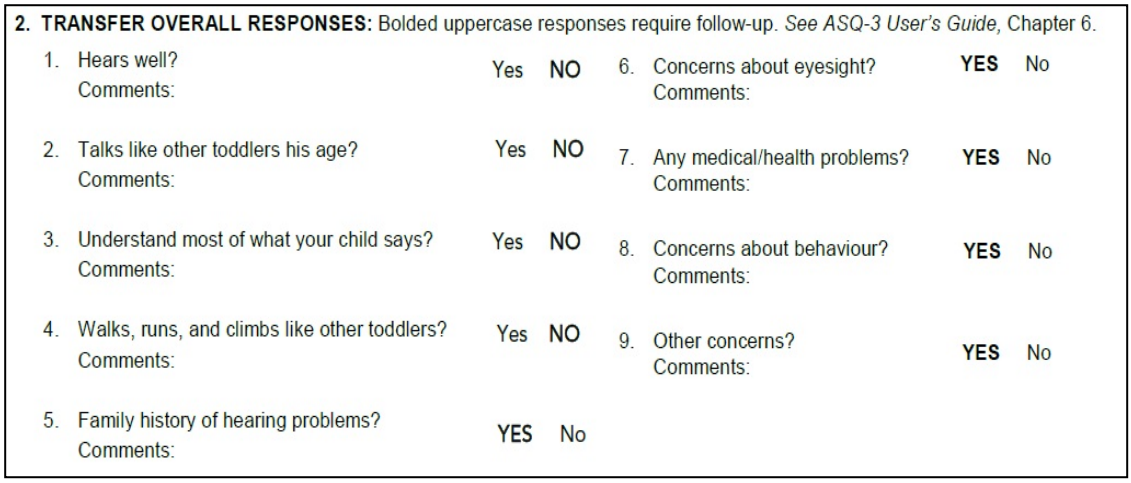
1. SCORE AND TRANSFER TOTALS TO CHART BELOW: Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing and the activity is untried. Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	25.17		●	●	●	●	●	●	○	○	○	○	○	○	○
Gross Motor	38.07		●	●	●	●	●	●	●	●	○	○	○	○	○
Fine Motor	35.16		●	●	●	●	●	●	●	●	○	○	○	○	○
Problem Solving	29.78		●	●	●	●	●	●	●	○	○	○	○	○	○
Personal-Social	31.54		●	●	●	●	●	●	●	○	○	○	○	○	○

Part 2: Transfer overall responses

Transfer the answers from the 'Overall' section to this part of the Information Summary sheet. Any parental concerns that are recorded here must be noted and discussed with the parents. Any bolded uppercase responses require follow up – see Figure 3.

Figure 3: Part 2 from the 24 month ASQ-3™ Information Summary sheet



2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. *See ASQ-3 User's Guide,* Chapter 6.

1.	Hears well? Comments:	Yes **NO**	6.	Concerns about eyesight? Comments:	**YES** No
2.	Talks like other toddlers his age? Comments:	Yes **NO**	7.	Any medical/health problems? Comments:	**YES** No
3.	Understand most of what your child says? Comments:	Yes **NO**	8.	Concerns about behaviour? Comments:	**YES** No
4.	Walks, runs, and climbs like other toddlers? Comments:	Yes **NO**	9.	Other concerns? Comments:	**YES** No
5.	Family history of hearing problems? Comments:	**YES** No			

Part 3: ASQ-3™ score interpretation and recommendation for follow up

The RPHN/CMD must consider the total area scores, overall responses and other considerations, such as opportunities to practice skills, to determine the most appropriate follow up.

- **Scores in 'white' area**

  If the child's total score is in the '***white***' area for a developmental area, it is above '*cut-offs'* and the child's development appears to be on schedule.

- **Scores in 'grey' area**
  If the child's total score is in the ***'grey'*** area for a developmental area, it is close to the '*cut-offs'*. The RPHN/CMD should provide intervention activities and monitor.

- **Scores in 'black' area**
  If the child's total score is in the **'black'** area for a developmental area, it is below the '*cut-offs*' and this indicates that a child may be at risk of developmental delay in that area and further professional assessment is indicated.

  See section 2.7.8 for further details on determining appropriate follow up.

Part 4: Follow -up Action Taken
This part outlines a checklist of follow-up actions that may be taken. The RPHN/CMD should tick all that apply.

Part 5: Optional
This table provides space to record responses to individual questions in each developmental area if required. However, the ASQ-3™ should be kept and filed in the child health record so this is optional.

Parent requests for the completed ASQ-3
If the parent wishes to have a copy of the ASQ-3™ they can be given a copy.

2.7.7 Recording in the Child Health Record

The ASQ-3™ score and any resulting findings, treatment or referral notes must be recorded in the child's health record.

If any follow up action from the ASQ-3™ is required, RPHNs must develop a nursing care plan.

If a child is being referred for further assessment, best practice would indicate that a copy of the ASQ-3™ should be included in the referral. However, this may depend on requirements from the service being referred to and may differ around the country.

2.7.8 Determining appropriate follow up

The RPHN/CMD should use the ASQ-3™ in conjunction with their professional judgement to support a referral for further assessment if deemed necessary. If ASQ-3™ scores or any of the 'Overall' responses raise a concern around possible developmental delay the RPHN/CMD should discuss this with the parents.

2.7.8.1 Children whose ASQ-3™ scores in the 'white' area in a developmental area - indicates typical development

It is important that the outcome of the ASQ-3™ is discussed with parents at the clinic visit. These children continue on the Best Health for Children Revisited (2005) schedule for public health nursing child health assessments.

2.7.8.2 Children whose ASQ-3™ scores in the 'grey' area in a developmental area - indicates a need for monitoring

If a child's score falls in the 'grey' area, RPHNs/CMDs should inform the parents that their child's score is close to *'cut-offs*'. RPHNs/CMDs will provide ASQ-3™ intervention activities and discuss the value of these with the parents.

RPHNs /CMDs should rescreen these children in 2 to 6 months, or earlier if deemed appropriate, and discuss this with the parents. It is essential that the RPHNs/CMDs use the relevant age appropriate ASQ-3™ questionnaire at any subsequent follow–up child health developmental assessments.

2.7.8.3 Children whose ASQ-3™ scores in the 'black' area in a developmental area - indicates possible risk of developmental delay

For children whose score falls into the 'black' area (below cut-off), this indicates a need for further assessment and some level of action should be taken by the RPHN/CMD.

2.7.8.3.1 Scoring in the 'black' area (below cut-off) for <u>one</u> developmental area only

On completion of the public health nursing child health assessment, the RPHN may be of the view that one or more of the referral considerations below may have influenced the ASQ-3™ score in that **<u>single</u>** developmental area. The RPHN/CMD should use their professional judgement and expertise to guide their actions, whilst taking into account parental concerns.

Referral considerations:

- **Opportunity**: Did the child have the opportunity to try the items or take the time to practice the skills? If not, it may be appropriate to provide the child further opportunity to try the items before making a referral
- **Health/biological factors**: Does the child have a health condition or medical factors that may have affected his or her performance?

- **Cultural factors**: are there cultural reasons that a child's performance on the questionnaire was not optimal?
- **Environmental factors**: Are there environmental factors that may have affected the child's performance
  (Squires et al, (2009) ASQ-3™ Users Guide; 3rd edition, page 77)

If the RPHN/CMD's child health assessment **does not agree** with the parents assessment for a score in any one of the black areas (below cut-off), and in their professional opinion the child scores in the grey area (near cut-off) or the white area (above cut-off), this should be discussed with the parents and the RPHN/CMD should provide the age appropriate ASQ-3™ intervention activity sheet and review in 1 to 2 months.

If the RPHN/CMD's child health assessment **agrees** with a score in any one of the black areas (below cut-off), but in the RPHN/CMD's professional opinion, the score has been influenced by one or more of the referral considerations noted above, the RPHN/CMD may decide to provide the parents with the age appropriate ASQ-3™ intervention activities and review. The RPHN/CMD **must** review the child within 1 to 2 months.

If the score has not been influenced by any of the above referral considerations and the professional opinion of the RPHN/CMD is that the score is an accurate score then the child should be referred to the appropriate health professional.

If a child who scores in the 'black' area for **one** developmental area is not referred to an appropriate healthcare professional, RPHNs/CMDs must ensure that the rationale that informed the professional judgement for non-referral is documented in the child health record. In these instances the child must be reviewed again by the RPHN/CMD in 1 to 2 months.

2.7.8.3.2 Scoring in the 'black' area for two or more developmental areas

Children whose scores fall within the "black" area in **two or more developmental areas** should be referred for further assessment to the appropriate healthcare professional(s) following local area referral pathways for management of children with potential developmental delay. A copy of the ASQ-3™ should be included with the referral and the RPHN/CMD should provide the parents with age appropriate ASQ-3™ intervention activity sheets.

In cases where the child is placed on a waiting list for assessment for potential developmental delay, the RPHN/CMD should maintain contact

(i.e. telephone) with the parents of any child that has been referred for further assessment until they have been accepted and assessed by the appropriate healthcare professional(s). If there are delays in a child being assessed this needs to be highlighted through local management/governance structures and placed on a risk register if deemed necessary.

Non Referral

If a child is not referred onwards the RPHN/CMD must record clearly the reasons for non-referral and an appropriate follow-up/care plan is actioned in the child's health record.

2.7.8.4 Communication with parents

The RPHN/CMD must communicate the requirement for an onward referral for further assessment for potential developmental delay to the parents in a sensitive manner. This should be done in person at a time that is appropriate for the parents. If there are language difficulties an interpreter may be required.

In communicating to parents that their child may be at risk of developmental delay it is important that the following points are adhered to:

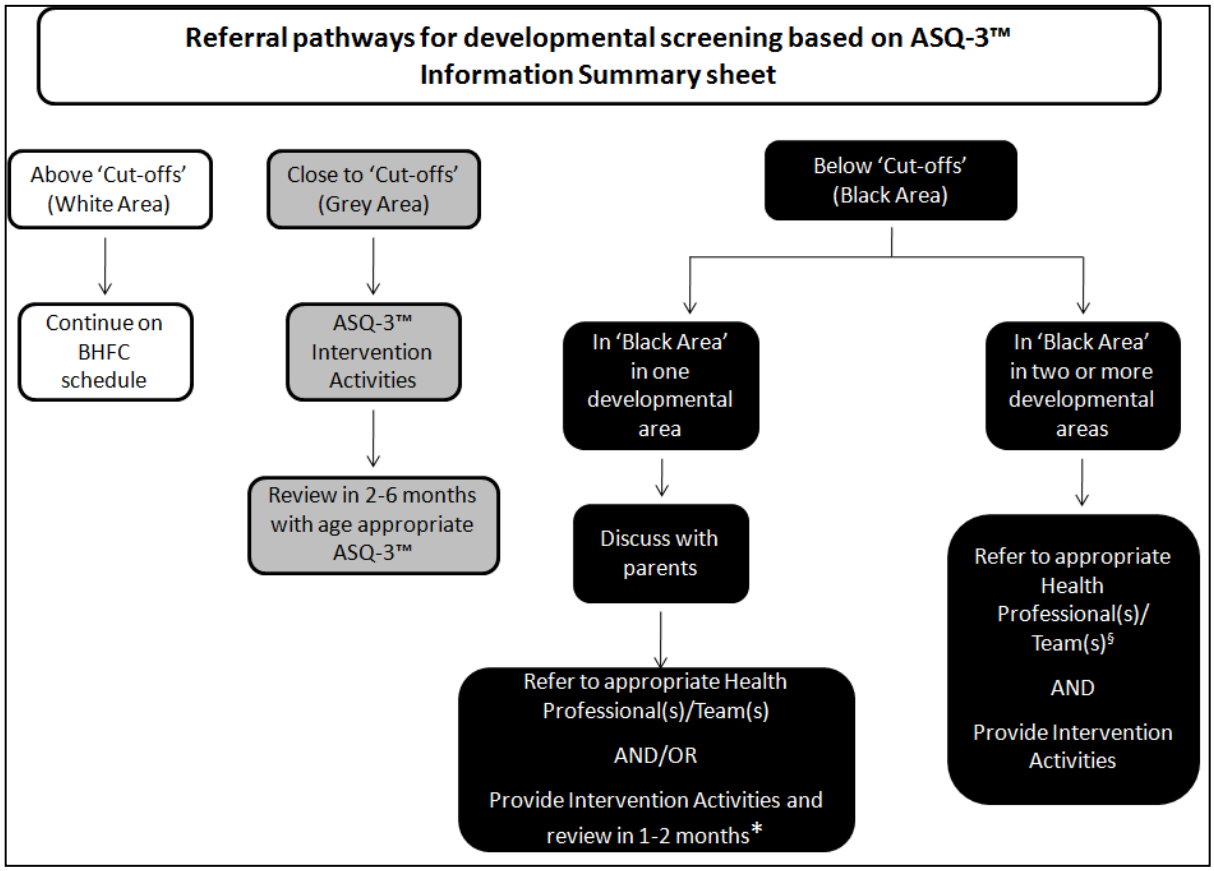
- Assure parents that the conversation is confidential
- Remind parents as to the purpose of screening and ensure that they understand that screening only indicates the need for further assessment and does not constitute a diagnosis for a child
- When reviewing the ASQ-3™ results emphasise the child's strengths
- Avoid the use of terms such as *fail*, *test*, *normal* or *abnormal*
- Use language such as "*above cut-offs"*, "*close to cut-offs"* and "*below cut-offs"* when explaining cut off scores and a child's scores
- Discuss any factors that may have affected scores in particular areas of development (e.g. opportunity, health history, cultural or environmental factors)
- Listen to the parent's perceptions of their child and be open to any new ideas or viewpoints that they may have
- Discuss any concerns that the parents may have and provide specific examples of your concerns
- Emphasise the parents' current skills and resources
- If parents are interested, provide information about any relevant community resources and referral options
- Obtain appropriate consent for onward referrals as per HSE National Consent Policy (2017)

- Provide help and support to parents in accepting that an onward referral is necessary

If, following the RPHN/CMD holistic assessment, the assessment does not concur with the ASQ-3™ score the RPHN/CMD must record why and document any action taken in the child's health record and subsequent outcome.

2.7.9 Referral pathway for further assessment – Flow diagram

Figure 4: Referral pathway



* As per Section 2.7.8.3.1 - where your professional judgement and considerations do not support a score in the **'black'** area

§ As per Section 2.7.8.3.2 – if a child has been referred for further assessment the RPHN/CMD should maintain contact with the Parents/Guardians until the child has been accepted and assessed. Any delays to assessment should be highlighted through local management/governance structures and placed on a risk register if deemed necessary.

3.0 GOVERNANCE AND APPROVAL

3.1 Outline Formal Governance Arrangements

3.1.1 Refer to Appendix IV for Membership of the Approval Governance Group.

3.1.2 The governance of this PPPG at Community Healthcare Organisation (CHO) level will be the responsibility of the Chief Officer. It is anticipated that the Chief Officer will delegate responsibility for the governance of this PPPG to the DPHN and PMO for the relevant area.

3.1.3 A National Governance Group for Child Health Developmental Surveillance is to be convened under the National Healthy Childhood Framework. This governance group will provide oversight on all child health developmental screening and surveillance, in particular the use of the ASQ-3™.

3.1.4 The National Governance Group for Child Health Screening and Surveillance Programmes, chaired by the Assistant National Director of Strategic Planning and Transformation, will have a national governance and oversight role of all child health screening and surveillance programmes. The chair of the National Governance Group for Child Health Developmental Surveillance will be a member of this governance group. Any governance issues that arise with regard to child health developmental screening and surveillance can be highlighted at the national group.

3.2 List method for assessing the PPPG in meeting the Standards outlined in the HSE National Framework for developing PPPGs.

This PPPG was drafted by the ASQ-3™ Implementation Group. This group are a sub group of the Nurture Programme Standardised Parent and Professional Health Record Implementation Team.

The membership of the ASQ-3™ Implementation Group includes health professionals that have extensive experience of implementing the ASQ-3™ in their local area – see Appendix II.

This PPPG was reviewed by key personnel within Community Operations, Strategic Planning and Transformation, Public Health Nursing, Principal Medical Officers and Consultant Paediatricians.

3.3 Attach any copyright/permission sought

Permission to use the ASQ-3™ was obtained through the purchase of ASQ-3™ starter packs which contains the licence for use.

3.4 Insert approved PPPG Checklist

Standards for developing Clinical PPPG	Checklist
Stage 1 Initiation	
The decision making approach relating to the type of PPPG guidance required (policy, procedure, protocol, guideline), coverage of the PPPG (national, regional, local) and applicable settings are described.	✔
Synergies/co-operations are maximised across departments/organisations (Hospitals/Hospital Groups/Community Healthcare Organisations (CHO)/National Ambulance Service (NAS)), to avoid duplication and to optimise value for money and use of staff time and expertise.	✔
The scope of the PPPG is clearly described, specifying what is included and what lies outside the scope of the PPPG.	✔
The target users and the population/patient group to whom the PPPG is meant to apply are specifically described.	✔
The views and preferences of the target population have been sought and taken into consideration (as required). *Note: CES carried out a parental survey in which there was a specific question asked in relation to use of developmental screening questionnaires*	✔
The overall objective(s) of the PPPGs are specifically described.	✔
The potential for improved health is described (e.g. clinical effectiveness, patient safety, quality improvement, health outcomes, quality of life, quality of care).	✔
Stakeholder identification and involvement: The PPPG Development Group includes individuals from all relevant stakeholders, staff and professional groups.	✔
Conflict of interest statements from all members of the PPPG Development Group are documented, with a description of mitigating actions if relevant.	✔
The PPPG is informed by the identified needs and priorities of service users and stakeholders.	✔
There is service user/lay representation on PPPG Development Group (as required).	**Not Required**
Information and support is available for staff on the development of evidence-based clinical practice guidance.	**Not Required**

Stage 2 Development	Checklist
The clinical question(s) covered by the PPPG are specifically described – ***Note:*** *The development of this PPPG was commenced after a detailed literature review was completed and signed off. The findings from this were used to populate this PPPG template as best as possible*.	✔

Systematic methods used to search for evidence are documented (for PPPGs which are adapted/adopted from international guidance, their methodology is appraised and documented) – ***Note****: The development of this PPPG was commenced after a detailed literature review was completed and signed off. The findings from this were used to populate this PPPG template as best as possible.*	✔
Critical appraisal/analysis of evidence using validated tools is documented (the strengths, limitations and methodological quality of the body of evidence are clearly described).	✔
The health benefits, side effects and risks have been considered and documented in formulating the PPPG.	✔
There is an explicit link between the PPPG and the supporting evidence.	✔
PPPG guidance/recommendations are specific and unambiguous.	✔
The potential resource implications of developing and implementing the PPPG are identified e.g. equipment, education/training, staff time and research.	✔
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care. ***Note:*** *there is national agreement for the ASQ-3 to be rolled out. Collaboration/consultation has been carried out already and move to implementation will have a collaborative approach locally.*	✔
Budget impact is documented (resources required). ***Note:*** *ASQ3 materials funded through Nurture programme, existing staff resources to be used as per current service provision*	✔
Education and training is provided for staff on the development and implementation of evidence-based clinical practice guidance (as appropriate).	✔
Three additional standards are applicable for a small number of more complex PPPGs: Cost effectiveness analysis is documented. A systematic literature review has been undertaken. Health Technology Assessment (HTA) has been undertaken.	**Not Required**
Stage 3 Governance and Approval	**Checklist**
Formal governance arrangements for PPPGs at local, regional and national level are established and documented.	**Local issue**
The PPPG has been reviewed by independent experts prior to publication (as required).	**Not Required**
Copyright and permissions are sought and documented. ***Note:*** *ASQ-3 user licences purchased*	✔
Stage 4 Communication and Dissemination	**Checklist**
A communication plan is developed to ensure effective communication and collaboration with all stakeholders throughout all stages.	✔
Plan and procedure for dissemination of the PPPG is described.	✔

The PPPG is easily accessible by all users e.g. PPPG repository.	✔ **Local issue**
Stage 5 Implementation	**Checklist**
Written implementation plan is provided with timelines, identification of responsible persons/units and integration into service planning process.	**Will be done as part of national roll out of ASQ-3™**
Barriers and facilitators for implementation are identified, and aligned with implementation levers.	✔
Education and training is provided for staff on the development and implementation of evidence-based PPPG (as required).	**Not Required**
There is collaboration across all stakeholders in the planning and implementation phases to optimise patient flow and integrated care. ***Note****: This will occur during implementation phase*	✔
Stage 6 Monitoring, Audit, Evaluation	**Checklist**
Process for monitoring and continuous improvement is documented.	✔
Audit criteria and audit process/plan are specified.	✔
Process for evaluation of implementation and (clinical) effectiveness is specified.	✔
Stage 7 Revision/Update	**Checklist**
Documented process for revisions/updating and review, including timeframe is provided.	✔
Documented process for version control is provided.	✔

4.0 COMMUNICATION AND DISSEMINATION

4.1 Describe communication and dissemination plans

After sign-off, this PPPG will be distributed to Chief Officers of each CHO for dissemination amongst relevant heads of service that are relevant to this PPPG for further dissemination amongst their staff. That should include but not limited to:

- Directors of Public Health Nursing
- Principal Medical Officers
- Community Paediatricians
- Allied Health Professionals

5.0 IMPLEMENTATION

5.1 Describe implementation plan listing actions, barriers and facilitators and timelines

Implementation of the ASQ-3™ on a national basis, which includes this PPPG, will be carried out using an implementation science framework across the following headings:

- Exploring and preparing
- Planning and resourcing
- Implementation and operationalising
- Full implementation (business as usual)

Exploring and preparing

Items under this heading include:

- Engagement with current users
- Identification of barriers and enablers
- Identification of required resources

Planning and resourcing

- Securing the licence to use the ASQ-3™
- Procurement of printing solution for ASQ-3™ questionnaires
- Identification and procurement of developmental screening equipment packs
- Development of this PPPG
- Designing an appropriate training plan including
    - 'Train the Trainer' course
    - Online e-learning module for HSE LAND
- Designing a monitoring and evaluation system

Initial Implementation

- Drafting of detailed implementation plan
- Identification of initial sites and local area implementation teams
- Monitor initial implementation by liaising with local area implementation teams
    - Ongoing coaching and assistance provided to staff
    - Regular communication
- Use feedback mechanisms to identify challenges and inform ingoing improvements
- Progress to subsequent sites

Full implementation

- Implement the ASQ-3™ across all CHOs
- Assess outcomes
- Business as usual

5.2 Describe education/training plans required to implement the PPPG

There is a three staged approached to training provision in relation to the full implementation of the ASQ-3™ into public health nursing and community medical

doctor services nationally.

- Nominees were sought from each Director of Public Health Nursing and Principal Medical Officer of staff willing to take on the role of 'trainer' in each DPHN Area. This person will be trained in a 'train the trainer' approach to be able to provide additional local support and information to staff in their DPHN area. Training was provided by a Consultant Paediatrician and an ADPHN who have extensive experience in rolling out and using the ASQ-3™ in their practice.

- A HSE LAND elearning module on 'Using the ASQ-3™' has been developed for RPHNs and CMDs. The aim of the module is to enable RPHNs and CMDs to support parents in using the ASQ-3™ and to use it effectively when undertaking a child health assessment. This module should be completed and a certificate obtained before any RPHN or CMD commences using the ASQ-3™ in their practice.

- If required or requested, practical workshop(s) may be held in each DPHN area, facilitated by the 'Trainer' to provide information and support to local RPHNs prior to commencing the use of the ASQ-3™ in their practice.

5.3 Identify lead person(s) responsible for the implementation of the PPPG.

Once embedded into practice, responsibility for the continued implementation of the ASQ-3™ will fall under the remit of the Chief Officer in each CHO. It is anticipated that the Chief Officer will delegate responsibility for the implementation of this PPPG to the DPHN and PMO for the relevant area.

5.4 Outline specific roles and responsibilities.

5.4.1 It is the responsibility of each Director of Public Health Nursing to ensure that all RPHNs who use the ASQ-3™ in their practice are aware of this PPPG.

5.4.2 It is the responsibility of all RPHNs who use the ASQ-3™ to have read the PPPG, signed and returned the signature sheet to the DPHN or designate.

5.4.3 It is the responsibility of each RPHN to ensure that they have completed the HSE LAND elearning module prior to using the ASQ-3™.

5.4.4 It is the responsibility of each RPHN to ensure that they take the appropriate steps to develop and maintain their competence and keep updated with regard to all aspects of child development in compliance with the NMBI Scope of Practice Framework

5.4.5 It is the responsibility of each PMO to ensure that all CMDs who use the ASQ-3™ in their practice are aware of this PPPG.

5.4.6 It is the responsibility of all CMDs who use the ASQ-3™ to have read the PPPG,

signed and returned the signature sheet to the PMO or designate.

5.4.7 It is the responsibility of each CMD to ensure that they have completed the online HSE LAND module prior to using the ASQ-3™.

5.4.8 It is the responsibility of the DPHN and PMO to ensure that risk management procedures are in place to report any adverse events that may arise through the use of the ASQ-3™.

6.0 MONITORING, AUDIT AND EVALUATION

6.1 Describe the plan and identify lead person(s) responsible for the following processes:

6.1.1 Monitoring - Key points:

- All children should be offered the ASQ-3™ at their 21-24 month developmental assessment visit
- How many children are identified as needing further assessment
  - the area the potential developmental delay was in
  - the healthcare professional(s)/team(s) they were referred to
- Are all parents attending with fully completed ASQ-3™ questionnaires

6.1.2 Audit

An audit of the use of this PPPG and compliance with it should be carried out by the relevant DPHN/designated person in each DPHN area. A sample documentation audit tool is contained in Appendix VII.

6.1.3 Evaluation

A detailed evaluation will be carried out during the implementation phase of the ASQ-3 ™ in each DPHN area. This will be carried out by the ASQ-3™ implementation sub-group and will be focussed on determining any major issues that need to be resolved and any good practice that could be employed for subsequent roll outs in other DPHN areas.

Once the ASQ-3™ is in full use in all areas there will be a national evaluation and this will include parent and PHN/AHP/CMD feedback utilising a methodology incorporating a survey and/or focus group approach. Any evaluation should also assess referrals, appropriateness of referrals and outcomes of children who had been identified as being at risk of developmental delay.

Once the ASQ-3™ is mainstreamed into regular practice the service in each DPHN area should be evaluated according to the local schedule.

7.0 REVISION/UPDATE

7.1 Describe procedure for the update of the PPPG

A formal review will be carried out on a three yearly basis unless there is a change required informed by legislation, best practice evidence or any relevant EU Directives which may indicate a requirement to update this PPPG sooner.

The responsibility for this review lies with the Community Operations Division. Any learning that arises from the ongoing monitoring and evaluation of the use of the ASQ-3™ that may impact on this PPPG will be used to amend and update the original PPPG version. Following the review process, the date and detail on the version tracking box on the front cover of the PPPG will be updated.

7.2 Identify method for amending PPPG if new evidence emerges.

Healthcare professionals using the ASQ-3™ will be aware, through continuous professional development activities, such as conferences, journal papers etc., of any new evidence regarding best practice that emerges in the area of child development. The healthcare professionals will be obliged to inform the relevant Child Health Lead/Line Manager/Professional Lead in their area of this change in evidence or best practice. The National Governance Group for Child Health Screening and Surveillance should also be informed through the Chairperson of the National Governance Group for Developmental Surveillance (Note: this group is yet to be convened).

7.3 Complete version control update on PPPG Template cover sheet.

This will be carried out as outlined in Section 7.1

8.0 REFERENCES

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9.0 APPENDICES

Appendix I Signature Sheet

Appendix II Membership of the PPPG Development Group Template

Appendix III Conflict of Interest Declaration Form Template

Appendix IV Membership of Approval Governance Group Template

Appendix V Flow chart for ASQ-3™ for RPHNs

Appendix VI Standard appointment letter to be sent with the ASQ-3™

Appendix VII Sample Documentation Audit Tool

Appendix I:

Signature Sheet - National Guideline on the Use of the Ages & Stages Questionnaire™ for Developmental Screening of Children between 1 month and 66 months of Age

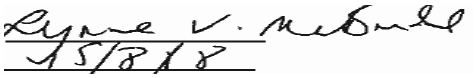
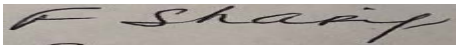
I have read, understand and agree to adhere to this Guideline:

Print Name	Signature	Area of Work	Date

Appendix II:

Membership of the Guideline Development Group

Please list all members of the development group (and title) involved in the development of the document.

Dr. Melissa Canny Specialist in Public Health Medicine	Signature:  Date: 19/07/2018
Jane Dare Assistant Director of Public Health Nursing	Signature:  Date: 24/07/2018
Dr. Lynne McBride Senior Medical Officer	Signature:  Date:
Ger McGoldrick Director of Public Health Nursing	Signature:  Date: 03/08/2018
Moira O'Reilly Implementation Specialist (CES)	Signature:  Date: 30/07/2018
Dr. Farhana Sharif Consultant Paediatrician	Signature:  Date: 26/07/2018
Catherine Whitty National Practice Development Co-Ordinator Public Health Nursing Services	Signature:  Date: 20/07/2018
Chairperson: Paul Marsden Project Manager, Child Health Screening Programmes	Signature:  Date: 24/08/2018

Appendix III: Conflict of Interest Declaration Form

CONFLICT OF INTEREST DECLARATION

This must be completed by each member of the Guideline Development Group as applicable

Title of PPPG being considered:

National Guideline on the Use of the Ages & Stages Questionnaire™ for Developmental Screening of Children between 1 month and 66 months of age

Please circle the statement that relates to you

1. I declare that I DO NOT have any conflicts of interest.

2. I declare that I DO have a conflict of interest.

Details of conflict (Please refer to specific PPPG)

_____

_____

_____

_____

(Append additional pages to this statement if required)

Signature

Printed name

Registration number (if applicable)

Date

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

A person who is covered by this PPPG is required to furnish a statement, in writing, of:

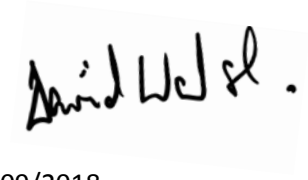
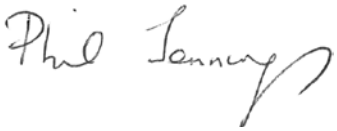
(i) The interests of the person, and

(ii) The interests, of which the person has actual knowledge, of his or her spouse or civil partner or a child of the person or of his or her spouse which could materially influence the person in, or in relation to, the performance of the person's official functions by reason of the fact that such performance could so affect those interests as to confer on, or withhold from, the person, or the spouse or civil partner or child, a substantial benefit.

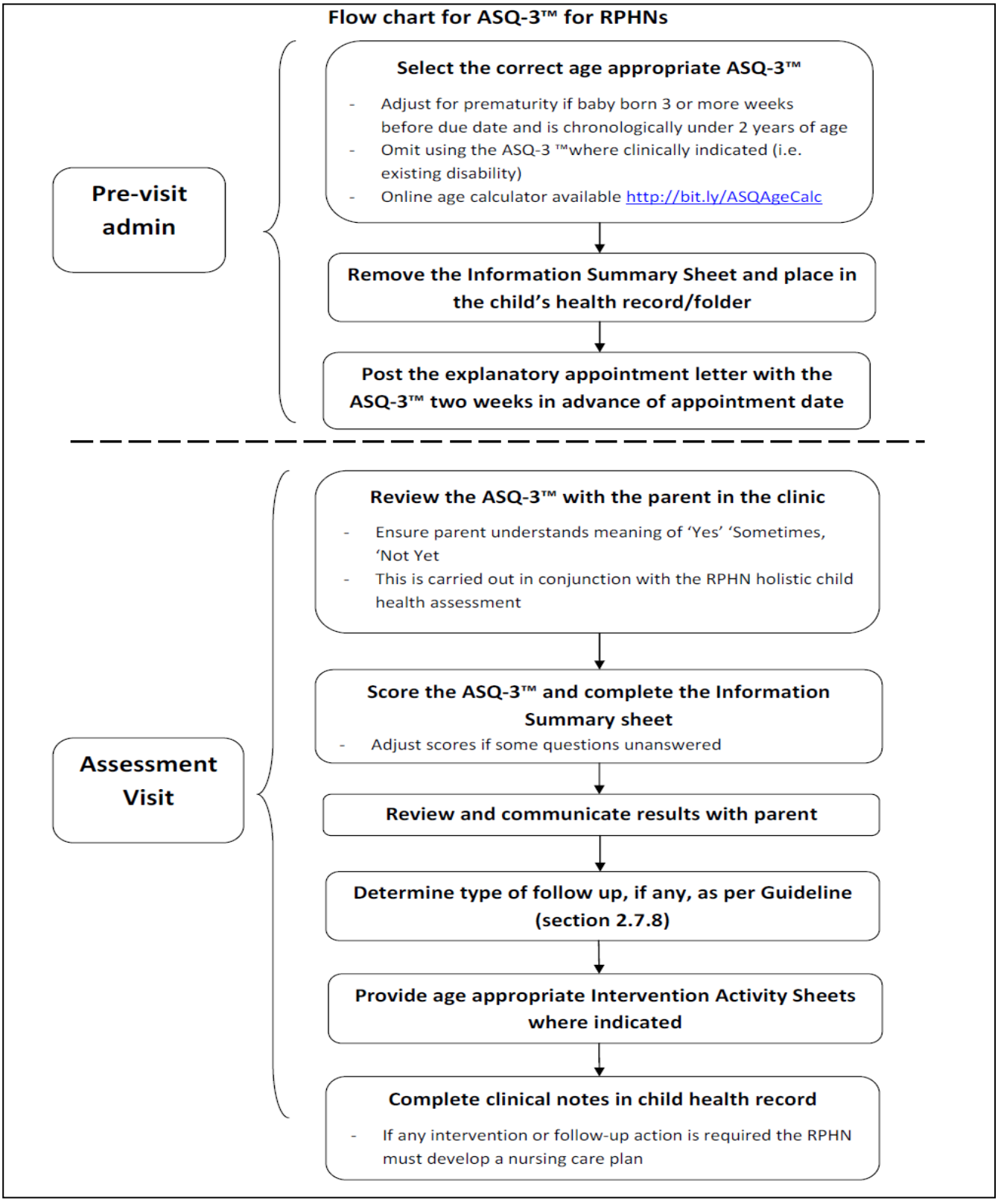
Appendix IV:

Membership of the Approval Governance Group (Template)

Please list all members of the relevant approval governance group (and title) who have final approval of the PPPG document.

David Walsh National Director – Community Operations	Signature:  Date: 12/09/2018
Dr. Kevin Kelleher Assistant National Director Public Health & Child Health Strategic Planning and Transformation	Signature:  Date: 24/08/2018
Dr. Phil Jennings Director of Public Health National Lead for the National Healthy Childhood Programme	Signature:  Date: 24/08/2018

Appendix V: Flow chart for ASQ-3™ for RPHNs



Appendix VI: Standard appointment letter to be sent with the ASQ-3™

PHN Service Address

Parents of
Address 1
Address 2
Address 3

Date:

Dear Parent/Guardian,

Your child is due their 21-24 month developmental visit at [LOCATION] on [DATE].

I am sending you a form called the Ages and Stages Questionnaire (ASQ-3™). It will help you to do a quick check of your child's development. It takes about 5 – 10 minutes to complete.

Your child may be able to do some but not all of the activities and this is to be expected. You are to answer each question either 'Yes', 'Sometimes', or 'Not Yet'.

You will be asked some important questions about your child's development and any concerns that you may have. The information that you give will help show your child's strengths and identify any areas that may need additional support.

Have fun completing the activities with your child. Make sure that they are rested, fed and ready to play before you try the activities.

Please be sure to bring the completed form with you on the day of the appointment and we can talk about how your child is progressing and any concerns that you may have.

If you have any questions or would like help to complete the questionnaire you can contact me at 08XXXXXXXX.

Thank you,

_____
NAME
Registered Public Health Nurse

Appendix VII: Sample Audit Tools

Sample Documentation Audit Tool

Question	Yes	No	Comment
Were you aware of the existence of this PPPG?			
Did you find this PPPG easy to understand?			
Did you find this PPPG easy to use?			
Did you use this PPPG to guide your practice?			

Sample Clinical Audit Tool

Question	Yes	No	Comment
Did the parent complete the ASQ-3 at the 21-24 month developmental assessment visit?			
If the child scored in the 'grey' area is it documented that the relevant activity sheets were provided to the parents?			
If the child scored in the 'grey' area were they rescreened in 2 to 6 months?			
If the child scored in the 'black' area was it documented that the child required onward referral?			
If the child scored in the 'black' area was there evidence of an appropriate care plan recorded in the child health record?			