STANDARDISED DEVELOPMENTAL ASSESSMENT GUIDELINES FOR OCCUPATIONAL THERAPY - CHW

PRACTICE GUIDELINE ©

DOCUMENT SUMMARY/KEY POINTS

- Developmental assessments are a key component of the occupational therapy (OT) framework and assist in identifying babies and children with developmental difficulties and guide intervention.
- Developmental assessment is a holistic child and family centred process that requires a skilled assessor and careful consideration of a range of factors.
- Includes the administration and interpretation of results and application to clinical practise for Occupational Therapists.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st August 2020	**Review Period**: 3 years
Team Leader:	Occupational Therapist	**Area/Dept**: Occupational Therapy - CHW

CHANGE SUMMARY

- N/A new CHW OT document

READ ACKNOWLEDGEMENT

This document is aimed at Occupational Therapist's working across The Sydney Children's Hospital Network who are required to conduct developmental assessments.

- All Occupational Therapists to read and acknowledge the document.
- Training Recommended:
  - Bayley's- III Accreditation
  - Peer supervision with experienced Bayley's –III Occupational Therapist to complete competency
  - Use of two therapists for assessments
  - Pre-requisite training – developmental, play and attachment

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1 Introduction

An infant or child's participation is often measured in observing and documenting their developmental skills, including their play skills. "The goal of occupational therapy services provided to children and families is to enable childhood participation. Occupational therapists collaborate with the child and family to identify occupational performance goals and provide appropriate interventions to achieve these goals". (OT Australia, 2016 p.13). "This requires understanding and assessment of purpose (doing). This may require assessment of the person (body structure and function level), the environment (barriers and facilitators), and an analysis of the occupation." (OT Australia, 2016 p.13)

Occupational Therapists (OTs) have in-depth knowledge of infant and child development and are equipped with skills and expertise in conducting developmental assessments. The interpretation of results, the impact of these skills and deficits on their participation in their roles and application of these findings are all critical components of the assessment process.

There are many components to developmental assessment, which may include the use of parent interview, clinical observations, and developmental screeners and standardised developmental assessments. The purpose of developmental assessment is to gain a baseline of developmental performance, to identify developmental skills and deficits, identify the need for early intervention and to guide intervention and recommendations. The results can also support targeted therapy goals and reassessment if indicated can be conducted after 6 months.

The OT uses a range of different models and theoretical frameworks to guide practice. In particular, principles of neurodevelopment and attachment theory provide clinical reasoning for early intervention for the infant, child and family. Regardless of their environment, the infant and young child's daily occupations continue to be bonding/ social interaction, play, sleep, feeding and self-regulation. Models of practice in paediatrics include the Occupational Performance Model (Chapparo and Ranka), and the Model of Human Occupation (Keilhofner). Based on current evidence, the Bayley Scales of Infant and Toddler Development, 3rd Edition (BSID III) is the gold standard for standardised developmental assessment of children aged 1 month – 42 months (3 ½ years) of age (Walker, K 2010, The Australian Educational and Developmental Psychologist, Vol 21, Issue 1, pg 54-58)

This document describes the occupational therapy clinical process for conducting the assessment, observations and the documentation required for standardised assessment conducted within CHW.

Occupational therapists are best placed to provide comprehensive holistic developmental assessment and management of children at risk of developmental delay within the multidisciplinary team. This contribution includes consideration of the environment, collaboration with the child and family, developmental considerations and utilises a range of frameworks.

SCOPE OF PRACTICE GUIDLINE

This practise guideline is developed for use within the Occupational Therapy department. It is acknowledged that therapists working with specific tertiary clinics will follow assessment procedures indicted as per clinic procedure.

2 Indicators for Developmental Assessment

A developmental assessment by an Occupational Therapist may be indicated where:

- two or more areas of development are considered delayed or at risk of delay
- a team member has concerns regarding the infant/ child's developmental presentation e.g. General Medicine referrals, Child Development Unit (CDU)
- there is an identified delay in reaching developmental milestones e.g. Community Outpatients
- an infant/ child is at risk due to a co-morbidity and/or long-term hospitalisation e.g. Liver transplant, Oncology diagnosis, Cardiac condition
- a baseline developmental level of a child/ infant is required prior to medication changes e.g. Neurology referrals
- there is suspicion of non-accidental injury and/or neglect, including children who are at risk of attachment difficulties
- the infant/ child has a history of congenital birth anomalies requiring surgical correction, neurological concerns, or a complex medical presentation e.g. Grace NICU, Grace Development Clinic (GDC) referrals

3 Referral Policy and Criteria

Inpatient Referral Policy:

- Referrals can be received via Power chart by the treating medical team. Referrals made through Power chart are acknowledged within 24 hours of referral.
- Patients may also be identified through ward or team meetings as requiring OT.
- Prioritisation as per Occupational Therapy department inpatient prioritisation policy (Appendix 2)
- If appropriate consider if this assessment should take place in a community setting.
- For outpatient referrals and criteria please refer to the Occupational Therapy Community Health Referral process (Appendix 1)

Inpatients seen may include children who are receiving occupational therapy services in the community. The treating occupational therapist will liaise with the referring team to clarify the purpose of the assessment and the OT will apply clinical reasoning as to the appropriateness and timing of the required assessment.

4 Purpose of Developmental Assessment

There is a range of clinical reasons and indicators that dictate the purpose of a developmental assessment. All factors need to be carefully considered and if required support from your Supervisor should be sought.

The purpose of the Occupational Therapy developmental assessment is to:

- Provide holistic assessment in the areas of cognition, motor (fine and gross), language (expressive and receptive), social and emotional development.
- Provide education and information to families and carers regarding child development and specifically developmental information relevant to the stage of their baby or child.
- Provide equipment and positioning to enhance their baby or child's development and enable them to engage in occupations such as feeding and play.
- Assist parents to understand the social and emotional needs of their baby or child and the impact of these skills on their overall development (this includes attachment patterns and a baby/child's arousal regulation capacity).
- Refer to other allied health professionals as required e.g. Physiotherapy for gross motor delay or impairment, Audiology for formal hearing assessment.
- Referral to outpatient therapy services as required, including referral to public services, referral to NDIS ECEI pathway and private providers.
- Provide clear, accurate documentation of the assessment conducted and service provided. Developmental reports are to be completed in line with department clinical documentation policy (Appendix 3)

The occupational therapist works in close collaboration with all members of the developmental care team including physiotherapist, speech pathologist, child life therapist, dietician, social worker and medical team/s.

5 Considerations for Assessment

The Occupational Therapy process as outlined by Occupational Therapy Australia, Occupational Therapy Guide to Good Practice: Working with Children (2016) includes:

1. Developing a positive therapeutic relationship
2. Analysing and identifying the occupational roles, strengths, needs and challenges necessary for babies and children to engage in their everyday activities and participation in life roles
3. Evaluating factors affecting occupational performance activities in the contexts and environments in which those activities and occupations occur
4. Planning appropriate occupation-based intervention to promote occupational performance
5. Evaluating outcomes.

It is acknowledged that the flow of OT process as outlined above is not always linear in an acute hospital environment. The OT role may also be transferred at varying stages along the outlined five steps e.g. Step 4 may be the role of the Community Occupational Therapist to provide intervention (and/or assessment).

There are a number of factors that need to be considered including:

- Timing: acute, in or outpatient, time of day (consideration of child's routines)
- Timing in child's/ families' patient/ hospital journey (how well is the child?)
- Number of therapists
- Environment: home, hospital, ward vs OT department
- Engaging parents
- Use of parental report
- Who is present during assessment? Child's key attachment figure?
- Other professional's involvement? (co-assessment with other disciplines)

6 The Occupational Therapy Developmental Assessment Process

Prior to assessment being conducted the purpose and goal of assessment needs to be established with the treating team, clinician and family.

The Occupational Therapists need to be able to clinically justify preforming a standardised assessment on a child. If other interventions or screening tools could be used to provide information and a formal standardised assessment is not indicated, over testing a child can be unhelpful. The decision making process that leads to a standardised assessment needs to be clearly documented.

The standardised assessment process is as follows:

- File review of electronic medical notes
- Discussion with referrer for more details if required.
- Liaison with other members of Multi-disciplinary team who are involved in the care of the child
- Initial contact with family/carer to provide an explanation of the role of occupational therapy, to explore parental concerns, to explain the assessment process and potential outcomes, and to obtain consent
- Liaison with external therapists if consent obtained – results of precious assessment, contraindications for assessment (eg repeated assessment within short time frame)
- Clinical Observations
- Screening Tools (Ages and Stages) if indicated, prior to in lieu of standardised assessment
- Standardised Developmental Assessment

6.1 Developmental Screening Tool

It may be deemed by the Occupational Therapist that a developmental screen is appropriate to use prior and/or instead of a full standardised developmental assessment. This is will be clinically justified and clearly documented by the therapist.

6.2 Standardised Developmental Assessments

Bayley Scales of Infant Development 3rd Edition (BSID III)

The Bayley Scales of Infant Development 3rd Edition (BSID III) assesses development across five domains: Cognition, Language, Motor, Social-Emotional and Adaptive behaviour. Language, Cognition and Motor domains are conducted using items administered to the child; assessment of the Social-Emotional and Adaptive domains are conducted using the primary caregiver responses to questionnaire.

The therapist administering, interpreting and reporting on this assessment is required to be competent in these skills, plus have current knowledge and experience on child development and attachment theory.

Best practise is to conduct the BSID III with a second therapist to ensure reliability. The second therapist preferably would be observing from the two way mirror room. As per the guidelines for the BSID III 'the number of individuals should be kept to a minimum, if possible avoid other children being present and one primary caregiver'. (BSID III technical Manual pg. 10) Access to a second therapist may be subject to operational demands and clinical need.

ADDITIONAL OBSERVATIONS:

Within the standardised assessment appointment the following areas of observation should be considered and commented on if relevant.

- Psychosocial
- Attachment relationship
- Arousal regulation and response to input (including sensory input)
- Mood
- Capacity of parents
- Dynamics/relationships between parents, child family unit
- Play and play skills
- Posture and muscle tone

7 Interpretation of results

7.1 Scoring Results

Scoring of the standardized assessment should be done in consultation with the second therapist if present. Scoring of the results need be conducted as per the BSID III Technical manual.

Best practice is to provide a classification along with all raw score, composite score and percentile. If there are clinical reasons as to why data is not represented this needs to be clearly documented.

Qualitative description of composite scores and equivalents is on pg. 114 of the Bayley-III Technical manual.

Interpreting the results for families and clinicians is essential in the standardized assessment process. This should be conducted with care and sensitivity.

7.2 Clinical Justification and Developmental Risk Indicators

The therapist's clinical justification and reasoning is essential to the standardized assessment process. The infant/child's behavior, attention, and quality of movement should be considered in conjunction with their scores. Within the standardised assessment appointment the following areas of observation should be considered and commented on if relevant.

- Psychosocial
- Attachment relationship
- Arousal regulation and response to input (including sensory input)
- Mood
- Capacity of parents
- Dynamics/ relationships between parents, child family unit
- Play and play skills
- Posture and muscle tone

'The Bayley –III items provided examiners with the opportunity to detect atypical behaviors, indicative of developmental risk'. These observations are essential to guide further evaluation and assist with planning intervention. pg. 131-136

These additional clinical observations and developmental risk factors need to be discussed in the report. There should be discussion of how these may have impacted on a child's performance and plan for intervention or further evaluation.

8 Recommendations and Intervention Planning

Following the assessment a formal report should be provided to the family and medical teams. This report should include any recommendations based on the assessment results and observations. There should also be a clear plan for the next steps required from the Occupational Therapist, family or medical team.

9 Documentation

Report Writing:

A formal Developmental Assessment Report will be provided to family, therapists and medical teams involved.

The template for documenting the Bayley Scales of Infant Development 3rd Edition can be found in the Occupational Therapy drive. All Bayley Assessments are to be written using this template.

Formal reports are required to be typed and saved into Power chart under the client's profile. A copy of the report should be sent to the carer and with the consent of carer to the treating team.

Based on the Occupational Therapy KIP for report writing, reports should be completed within 15 working days independent on employment status. (Appendix 3)

10 References

1. Bayley, N. (2006) Bayley's Scales of infant and Toddler Development (3rd Edition) San Antonio: The Psychological Corporation
2. Chinta, S., Walker, K., Halliday, R., *et al. Arch Dis Child* Published Online First: 6th Feb 2014 doi:10.1136/archdischild-2013-304834
3. DelCarmen-Wiggins, R. & Carter, A. (2004). *Handbook of Infant, Toddler and Preschool Mental Health Assessment.* Oxford University Press: New York
4. Walker, K Badawi, N, Halliday, R & Laing, S. (2010) *Brieft Report: Performnce of Australian children at one year of age on the Bayleys Scales of Infant and Toddler Development.* The Australian Educational and Developmental Psychologist, Vol 21, Issue 1, pg 54-58
5. Occupational Therapy Australia's National Paediatric Taskforce. (2016). *Occupational therapy guide to good practice: Working with children.* Occupational Therapy Australia http://www.otaus.com.au/sitebuilder/advocacy/knowledge/asset/files/87/guidetogoodpractice-workingwithchildren[may2016]-finalweb.pdf
6. Peter J. Anderson & Alice Burnett (2016): *Assessing developmental delay in early childhood- concerns with the Bayley-III scales*, The Clinical Neuropsychologist, DOI: 10.1080/13854046.2016.1216518
7. Stagnitti, K. (1998). Learn to Play: A practical program to develop a child's imaginative play skills. Coordinates Publications: Victoria

11 Appendices

Appendix 1:

the children's hospital at Westmead

Part of the Sydney Children's Hospitals Network

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Community Health
Occupational Therapy Service at CHW:
Referral Process

Referral Management

Referrals can be made by paediatricians, other health professionals and families. Referrals can be made via Powerchart (EMR), letter/written correspondence or direct telephone calls (02 9845 3369) or via email SCHN-CHW-IntakeOccupationalTherapy@health.nsw.gov.au

Inclusion Criteria

1. 0 to 8 years of age.

2. Children who reside within the Parramatta and Western portion of the Cumberland Council Areas.
- *This service is bound by a specific geographic area, corresponding to the Parramatta City Council and western portion of the Cumberland Council areas. The Division of Local Government's website is used to identify the LGA of the child's residence* www.olg.nsw.gov.au. Council maps are also used to identify LGA boundaries.

3. Children whose intellectual ability is within the normal to borderline impaired range.
- *Children whose intellectual functioning is within 2 standard deviations from the mean on a test of intelligence within the last 12 months. Children and adolescents with a mild, moderate to severe intellectual disability should be directed to NDIS funded services.*

Exclusion Criteria

1. Children over 8 years old.
2. Children who reside outside the specified LGA.
3. Children who are approved for NDIS funding.
4. Children with moderate OR severe intellectual impairment, according to developmental or psychometric assessment.
5. Children who require splinting, complex equipment (e.g. wheelchair, hoists) &/or home/school modifications where this is the only reason for referral.
6. Children receiving occupational therapy services elsewhere.

Appendix 2:

1.1.1 Prioritisation of Occupational Therapy Referrals

Policy Statement:
The Occupational Therapy (OT) service has clear clinical prioritisation guidelines that provide for equitable service provision to inpatients, and manageable and balanced workloads for therapists.

The referral prioritisation has been developed for use in times of low staffing and/or increased activity load. The system ensures that patients requiring Occupational Therapy assessment, intervention and discharge are seen in a timely manner.

Scope:
All Occupational Therapists employed by the Occupational Therapy department at CHW.

Expected Outcomes:
- Equitable service provision to inpatients
- Manageable and balanced workloads for all therapists
- Appropriate and timely service provision for all patients in order to expedite patient flow
- Provide direction for all OT staff regarding prioritisation of inpatients

Definitions:
Nil

Procedure:

- OT referrals should be received at least 24 hours prior to patient discharge. Referrals received after 4.00pm will be responded to on the following business day unless there are exceptional circumstances. For referrals received after 4.00pm where there is a request to be seen on the same day, these will be assessed on a case by case basis pending staffing availability and clinical need, and will be discussed with a senior member of staff.
- OT attends team talks on the wards daily. During these meetings, identification of new referrals and low staffing of Occupational Therapy should be acknowledge to the ward team.
- Inpatient Team meeting (Wednesday) is to be used to delegate and prioritise need of staff. In times of increased activity load or low staffing this policy is to be used to guide resources.
- Therapists will assess the priority of each patient's needs considering several factors, including the patient's medical condition, age, social situation and occupational performance. These are not exhaustive factors, and it must be emphasised that clinical reasoning will direct prioritisation of referrals.
- Priority 1 referrals are to be seen on day of referral if discharge is pending OT assessment, OR otherwise within 24 hours of referral
- Priority 2 referrals are to be seen within 48 hours of referral
- Priority 3 referrals are non-urgent, and seen within 72 hours.

- All referrals should be acknowledged on day of referral and a predicted response time documented in the medical history.
- A patient's level of priority is to be reviewed regularly and reprioritised by the allocated therapist. Priority 2 patients are likely to be upgraded to a priority 1 over time, depending upon patient needs and clinical caseload.
- Referrals from wards/caseloads without an allocated therapist are to be triaged and allocated by the deputy HOD.
- If a therapist is having difficulty prioritising and managing OT referrals, it is an expectation that the therapist will discuss their caseload with their supervisor. If the immediate supervisor is unavailable, the therapist should discuss matters with their stream leader and/or deputy HOD.
- All staff inpatient and outpatient are required to provide assistance. DHOD will assist with allocation and prioritisation.

Priority 1 criteria (within 24 hours of referral)
Clinical indicators

- Discharge is dependent upon OT assessment/intervention
- Discharge is anticipated within 24 hours
- Gate Leave is anticipated within 24 hours
- Same day intervention required, e.g. PTA testing, referrals from Emergency Department and Middleton Ward
- Prevention of acute complications, readmission or permanent disability (pressure care management, positioning for feeding risk of aspiration, splinting and casting of fractures)

Priority 2 criteria (within 48 hours of referral)
Clinical indicators

- Patient is medically stable or has been cleared by their medical consultant to receive safe and reasonable OT intervention; however is having continued medical investigations
- Patient requires OT service provision to assist discharge planning
- OT input is required for implementing/facilitating post-surgical plan e.g. transfers
- Pre-surgery assessment required
- Patients who require OT intervention as part of their rehabilitation or part of ongoing management to facilitate discharge
- Patients who do not have local therapists and requires OT assessment, advice or referral to services
- Education to patient / carer regarding imminent gate pass.

Priority 3 criteria: (non-urgent Occupational Therapy)
Clinical Indicators

- A patient who is medically unstable and requires OT input, but due to ongoing medical/surgical issues the discharge date is not directly affected by the initiation of OT.

- Patients that are progressing slowly and/or with no immediate prospect of discharge home from the acute setting.

Risk of policy non-compliance
Delayed discharges may occur as a result of this policy not being followed.

Appendices:

OT Service Provision examples

Priority One:

OT service provision may include:

- Assessment, planning and intervention to facilitate safe and timely discharge. This may include equipment prescription and home assessment if required.
- Seating consultation and recommendations if patient is identified as having high risk clinical needs e.g. for safe positioning whilst feeding.
- Upper limb management and intervention including splinting and positioning for patients at high risk of permanent deformity /complications (e.g. neuro rehab, hand therapy)
- Pressure care consultation and recommendations for patients at high risk

Priority Two:

OT service provision may include:

- Upper limb therapy
- Review of patient for potential discharge (>48 hours)
- Activities of daily living and transfer retraining
- Referrals to community services e.g. community health, disability services n, etc.
- Education to patient / carer regarding imminent gate pass

Priority Three:

OT service provision may include:

- Developmental screening assessments. All referrals for comprehensive developmental assessments that are not part of a protocol are recommended to be conducted when the patient is an outpatient.
- A patient who would benefit from ongoing therapy, however intervention is not essential for discharge e.g. developmental interventions

The use of two therapist:

Education Notes:
Regular discussion and review at the inpatient caseload meeting.

References/Bibliography:
N/A

Relevant Guidelines:
N/A

Appendix 3:

4.2.8 Report Writing KPI Policy

Policy Statement:
In response to the hospital requesting departmental Key Performance Indicators (KPIs), the Occupational Therapy department monitors time taken for report dispatch following completion of assessments. This involves monitoring the time to complete reports after conducting an assessment. Timeframes during which it is expected that reports will be written have been determined and a system for monitoring how staff meet these expectations has been implemented.

Scope: (In other words intended audience)
All Occupational Therapists, Administrative Assistants and Music Therapists employed at CHW.

Expected Outcomes:
All staff employed by the occupational therapy department will complete reports within the designated timeframes (below) as per the Report Writing KPI policy.

Definitions: (where relevant to the policy)

- ***Reports:*** These include reports, and also letters which serve a similar purpose, that are required to communicate the outcome of an assessment or to communicate recommendations. Reports do not include documentation of occasions of service with a patient or the routine documentation of assessments which aid direct intervention.

- ***Completed report:*** is one which has been ***dispatched to its recipients***.

Procedure:

1. **Expected timeframes for report writing**

Type of Report	FTE working days*
CPU	10
Developmental	15
Handwriting / technology incl Special Provisions	15
OT assessment / communication / outcome reporting	15
Equipment recommendations incl PADP, which require provision of quotes	20
School Modifications / access	30
Home Modifications	30

For example: If an assessment for CPU is completed on a Monday then it should be dispatched to its recipients on the Monday two weeks (10 working days) later.
Notes:

- If public holidays fall within this period the number of working days should be extended by the respective number of public holidays.
- If sick or annual leave falls within this period, this should be noted on monitoring sheet. Assessments should not be scheduled if annual leave is planned shortly afterwards and is likely to extend the report writing period.
- This criterion is not adjusted for part time staff as families should not be disadvantaged by being allocated part time occupational therapists.
- It is suggested that assessments not be scheduled unless a report writing time can also be scheduled within the time period suggested by the KPIs.

2. Procedures for monitoring completion of reports

The following procedures for collecting KPIs for report writing dispatch are on trial. These procedures are to be reviewed by the OT department following initial implementation. Potentially, this procedure will be repeated for 3 months in each 12 month period. (Period will alter within each 12/12 period to capture different trends in report writing activity.)

- A 3 month period each year (eg February, March, and April) will be selected. Record Sheets are to be kept of all assessments competed within the specified 3 month period. The Record Sheets will be collected 4 weeks after the 3 month period to allow time for reports to be completed for those assessments completed at the very end of the 3 month period.
- KPI Record Sheets are to be completed by the entire department. The form will be provided. All staff members must submit a record sheet even if no assessments requiring reports have been carried out for the monitoring period.
- It will be suggested that staff carry a Record Sheet in their diaries, recording: child's name, MRN, date of birth, nature of report, date of assessment, date of report dispatch and comments. This comments section may include issues which facilitate or challenge timely report completion and dispatch. The need for use of unpaid time for report writing should be noted here.
- The issue of KPIs for Report Dispatch will be placed on the agenda for staff meetings and stream meetings for the monitoring period, reminding staff to check diaries and place data relevant to reports on the Record Sheet.
- KPI managers will request all record sheets and compile a department report to summarise the results of the monitoring period.

3. Reporting the results of the KPIs for Report Dispatch

All staff: A summary report will be fed back to all staff via staff and stream meetings. These reports will be completely de-identified. Opportunities to discuss the results and any further strategies will be provided at these meeting.

Individual staff: The information regarding KPIs for individual staff will be provided only to the individual, HOD and stream leaders. Any staff member who is having difficulty achieving KPIs will be invited to discuss potential strategies to meet KPIs.

Summary reports will consist of:

- The numbers and nature of reports required and dispatched during the monitoring period
- Time taken to dispatch each type of report in working days (mean/median, range)
- Numbers
- of reports meeting and not meeting the KPI overall and by type of report.

Risk of policy non-compliance
Failure to meet the KPI's set out in this policy document may lead to failure to communicate plans around discharge and patient risk which could result in an adverse event.

Appendices:

Nil.

Education Notes:
Nil.

References/Bibliography:

Policy No: 06 – 0031 Minimum Documentation Standards

Clark, G & Youngstrom, M. (2008). Guidelines for Documentation of Occupational Therapy. American Journal of Occupational Therapy, November/December; 62 (6)

Relevant Guidelines:
N/A