GUIDELINE

Physical Assessment 0-4 years

Scope (Staff):	Community health staff
Scope (Area):	CAHS-CH, WACHS

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this disclaimer

Aim

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

Risk

Where there are delays in identifying health and developmental concerns, this negatively impacts on children developing to the best of their ability.[1]

Background

There is compelling evidence that early childhood is a sensitive period for child development and functioning.[2] Community health nurses conduct comprehensive cephalocaudal physical assessments as a component of a holistic assessment, using evidence informed knowledge and skills, and clinical judgement through:

- Eliciting and responding to parental concerns
- Gathering information about the child's current abilities and functions
- Identifying risk and protective factors
- Using evidence informed assessment methods and tools that are age appropriate.[3] [4]

The *Pediatric Physical Examination: An Illustrated Handbook* and *Mary Sheridan's from birth to five years: Children's developmental progress,* have guided the content for specific body systems assessments for the following age parameters:

- Appendix A: Neonate – Birth to four weeks
- Appendix B: Infant – One month to twelve months
- Appendix C: Children – Twelve months to four years

Key points

- Comprehensive physical assessments will be conducted at Universal contacts according to *Universal Contact Guidelines* and at other times, as required.
- Commence parts of the physical assessment that require the child to be in a quiet and alert state, prior to undertaking a comprehensive assessment.
- Inspect visually, and further examination where indicated
- Standard precautions are to be applied by all staff, for all clients and at all times when conducting assessment and/or in contact (or likely to be in contact) with blood or body fluids, non-intact skin and mucous membranes.
- The child is the focus of care and their best interests are the primary consideration in all decisions.
- Nurses think critically and use the best available evidence and relevant policy documents, in making decisions and providing care that is safe, appropriate and responsive.
- Nurses will provide additional contacts for monitoring of deviations from normal and/or will refer to a General Practitioner or other appropriate medical service, for further management.
- The *Guidelines for Protecting Children 2020* publication will guide practice when nurses have concerns that a child is being, or has been, abused.[5]

Documentation

- Nurses maintain accurate, comprehensive and contemporaneous documentation of assessments, planning, decision making and evaluations; in electronic and/or MR600 child health records.

References

1. Sharma A, Cockerill, H.,. From Birth to Five Years: Children's Developmental Progress. 4th ed. Abingdon, Oxon: Routledge; 2014.
2. Department of Health. National Action Plan for the Health of Children and Young People: 2020-2030. Perth: Government of Western Australian 2019.

3. Duderstadt K. Pediatric Physical Examination: An Illustrated Handbook. 3rd Edition ed: Elsevier Health Sciences; 2019.
4. Sharma A, Cockerill H. From Birth to Five Years: Practical Developmental Examination: Taylor & Francis; 2014.
5. Department of Health: Child and Adolescent Health Services. Guidelines for Protecting Children: 2020. Perth: Government of Western Australia; 2020.
6. Dietitians of Canada, Canadian Paediatric Society, The College of Family Physicians of Canada, Community Health Nurses of Canada. Promoting optimal monitoring of child growth in Canada: Using the new World Health Organization growth charts – Executive Summary. Paediatrics & Child Health. 2010;15(2):77-9.

Related policies, procedures and guidelines
The following documents can be accessed in the **Clinical Nursing Manual** via the HealthPoint link, Internet link or for WACHS staff in the WACHS Policy link
Universal contact guidelines (0-14 days, 8 weeks, 4 months, 12 months, 2 years, SEHA)

Related CAHS-CH forms
The following forms can be accessed from the CAHS-Community Health Forms page on HealthPoint
Breastfeeding Assessment Guide form (CHS012)

Related CAHS-CH resources
The following resources can be accessed from the CAHS-Community Health Resources page on HealthPoint
Early Parenting Groups: Facilitator Guide
How children develop
Indicators of Need
Practice guide for Community Health Nurses

Related external resources

Advance Pediatric Assessment. 2019. Ellen M Chiocca.
Guidelines for Protecting Children 2020. Statewide Protection of Children Coordination Unit, Child and Adolescent Community Health.
Nursing and Midwifery Board of Australia. Code of conduct for nurses and Code of conduct for midwives. 2018
Nursing and Midwifery Board of Australia. Registered Nurses Standards for Practice. 2016.

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

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Healthy kids, healthy communities

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

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

Appendix A: Neonate - Birth to four weeks

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
General Appearance				
• Facial expressions • Posture • Hydration and nutritional health • Activity level • Temperament • Responsiveness • Interaction with others • Proportion of body parts • Symmetry of body parts • Movement and capacity • Skin integrity Observe appearance prior to-comprehensive assessment	• Initial presentation of the neonate is consistent with the situation (e.g. crying due to hunger) • Neonate is healthy and developing appropriately	• Deviations from the norm may be initially identified through assessing the general appearance of the neonate • Recognise indicators for child abuse, including but not limited to: injury, bruising, burns, retinal haemorrhages, bite marks, fractured bones, bleeding, pain or physical discomfort or poor standard of hygiene. • Assess appearance of child with consideration of their age, level of mobility and development. [1]	• Genetic conditions • Pregnancy complications • Birth trauma • Congenital or non-congenital conditions • Child abuse	Concerns will be documented and noted for additional monitoring and/or referral to a medical practitioner ⇒ Refer to the *Guidelines for protecting children 2020* publication for more information.

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Head (continued next page)				
Visual inspection with the neonate resting supine, and head in midline, noting: • General shape • Size • Circumference • Symmetry • Alignment	• Rounded • Symmetrical Head circumference averages: • males: 32-39.5cm • females: 31.5–39.cm[6] When in supine position, head will comfortably sit in the midline	• Elongated • Asymmetrical • Misshapen • Measurements outside of expected norm ○ Microcephaly ○ Macrocephaly • Lesions, nodules, masses, birth marks • Positional head preference • Persistent head tilt (lateral flexion)	• Birth trauma ○ Instrumental delivery • Genetic conditions ○ Achondroplasia ○ Noonan syndrome • Hydrocephalus • Craniosynostosis • Uterine placement • Intrauterine growth conditions and exposure to tetragons • Plagiocephaly	Parent education and support may include: • Postural exercises and repositioning • Handling strategies • Massage • Positioning of toys to non-favoured side • Variable positioning of head when put down to sleep
Visual inspection and palpation of: • Suture lines • Scalp • Bony structures • Fontanelles	• Anterior fontanelle should be open, soft, flat, an average of 2cm long by 2-3cm wide, but can be up to 5cm long [3] • Posterior fontanelle should be smaller, triangular and 0.5 cm long by 1 cm wide [3]	• Bulging anterior fontanelle • Sunken anterior fontanelle • Overriding sutures • Bruising • Oedema • Pitting	• Birth trauma ○ Caput succedaneum ○ Cephalohaematoma • Changes in intracranial pressure • Dehydration • Genetic conditions ○ Alpert's	Monitor premature closure of sutures

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Suture lines can be overlapping or protuberant	• Premature closure of sutures	○ Crouzon • Craniosynostosis	
Neck (continued next page)				
Visual inspection through the following process: • Controlled pulling up from the supine to sitting position • Observing supported in sitting position • Placing in the ventral suspension • Extending the head in all directions • Placing in prone position Noting: • Symmetry • Shape • Range of movement	• A short neck, which is creased with skin folds • The neck rotates freely as it cannot support the weight of the head • The head briefly stays erect, then lags when pulled up from a supine to a sitting position • In the prone position, the head can be raised slightly • The head will fall forward in the sitting position • The head will drop below or in line with	Movement deviations: • Limited range of motion • Head bobbing • Jerking • Tremors • Stiffness • Resistance to movement • Involuntary muscle contractions or spasms • Webbed neck Positional deviations: • Head held erect • Persistent head tilt	• Intrauterine growth conditions • Plagiocephaly • Torticollis • Genetic conditions ○ Turner syndrome ○ Noonan syndrome	Parent education and support may include: • Postural exercises and repositioning • Handling strategies • Massage • Positioning of toys to non-favoured side • Variable positioning of head when put down to sleep

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Head control	the plane of the body when in ventral suspension	• Positional head preference		
Face				

Through visual inspection observe facial features and expressions, noting:
• Spacing
• Size
• Symmetry of features
• Movement symmetry
	• Face is relaxed and symmetrical
	• Features are symmetrical during episodes of crying
	• Nasolabial folds are symmetrical
		• Low-set ears
		• Low-set hairline
		• Epicanthal folds inconsistent with ethnic origins
		• Frontal bossing
		• Absent philtrum
		• Deviated septum
		• Cleft lip
		• Unilateral flattening of nasolabial fold
		• Micrognathia
		• Lesions, nodules, masses
			• Genetic conditions
			  ○ Trisomy 21/Down Syndrome
			• Birth or other trauma
			• Neurological deficit
			• Milia
			• Preauricular sinus or tag
			• Birthmarks
			• Intrauterine conditions, including exposure to teratogens
			  ○ Syphilis
			  ○ Foetal alcohol spectrum disorder (FASD)
			• Congenital hypothyroidism
				⇒ Encourage medical practitioner or Breastfeeding Support Services review for any concerns, in particular feeding difficulties

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Philtrum				

Visual inspection, noting:
• Definition
• Depression
• Length
	• Philtrum is visible and can be pronounced
	• Can form a teardrop like shape
	• Can be in straight lines from septum to tubercule
		• Short
		• Smooth
		• Limited definition to no depression
			• Intrauterine conditions, including exposure to teratogens
			  ○ FASD
			  ○ Foetal valproate syndrome
			• Genetic conditions
			  ○ Pallister Killain
			  ○ Cornelia de Lange
			  ○ Wolf-Hirschhorn	

Eyes (continued next page)				

Visual inspection, noting:
• Shape
• Size
• Symmetry
• Spacing
• Position
• Colour
	• Eyes may move independently, appearing to intermittently squint
	• The upper eyelids appear symmetrical
	• When closed, eyelids completely cover cornea and sclera
		• Discharge
		• Reddened or yellow sclera
		• Eye watering, with or without infection
		• Bruising
		• Inflammation
		• Oedema
		• Subconjunctival haemorrhages
			• Acquired head injury
			• Trauma
			• Birth trauma
			• Infection
			• Immature tear ducts
			• Allergy
			• Genetic conditions
			  ○ Stickler syndrome
			  ○ Cri-du-chat
				Parent education and support for eye watering may include:
				• Massage techniques
				• Regular review at universal contacts
				• Discussion of signs of infection
				⇒ Urgent referral to ophthalmologist

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
		• Epicanthal folds (eyes), inconsistent with ethnic origin • Ptosis	○ syndrome ○ Prader-Willi syndrome • Jaundice • Myotonic	through medical practitioner for opacities in the pupil or corneal abnormalities
Gaze				
Assess gaze behavior through facial expressions, movements and attempts to attract attention from others	• Neonate attempts to engage with human faces, particularly caregivers, through mutual gaze	• No mutual gaze attempts made	• Trauma • Intraventricular insult • Interrupted bonding and attachment • Intrauterine exposure to teratogens	Parental education and support to promote bonding and attachment
Vision Behaviours (continued next page)				
Assess vision behaviours via examining pupil and iris by shining a light into the eyes, noting: • Size • Equality of size	• Pupils should be round, clear, and equal • Pupils react equally to light, movement, and patterns • Eyes turn towards diffused light sources	• Leukokoria • Coloboma • Fixed pupils • Cloudiness and opacity of cornea • Slow lateral movements	• Cataract • Scleral icterus • Esotropia • Exotropia • Hypertropia • Hypotropia	⇒ Prompt referral to medical practitioner, particularly for any: • Constant visual impairment • Opacity • Constant squint

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Colour • Clarity • Shape • Movement • Pupillary reaction • Blinking • Following the light to midline	• Eyes are turned away from bright light or neonate blinks in response to a flash of light • Increased alertness	• Nystagmus • Sundowning • Squint (intermittent or constant) • Differing pupil size • Refusal to open eyes after exposure to the light		
Ears (continued next page)				

Assess external ear including mastoid process, auricles, tragus and external auditory meatus, noting:
• Shape
• Size
• Symmetry
• Patency
• Position
• Firmness of cartilage
	• The superior portion of the auricle is equal in height to the outer canthus of the eye
	Pinna is:
	• Soft
	• Pliable
	• Recoils readily when folded and released
		• Discharge - pus/debris
		• Swelling
		• Inflammation
		• Foreign object
		• Excessive wax
		Dysmorphic deviations:
		• Low-set-ears
		• Skin tags
		• Accessory tragi
		• Malformed auricles
		• Auricular sinus
			• Infection Sebaceous cyst
			• Genetic conditions
			  ○ Trisomy 21/Down Syndrome
			  ○ Goldenhar
			  ○ Wolf-Hirchhorn
			  ○ Di George
			  ○ Trecher-Collins
			  ○ Nagar
			  ○ Usher
				Parent education and support may include ear care in relation to discharge and foreign objects

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
		• Preauricular sinus		
Assess neonatal hearing through observation of response to sounds N.B. Determine if Newborn Hearing Screen has been completed.	• Interested in sounds • Responds to calm and familiar voices • Eyes will 'corner' reflexively to the side of the noise • May startle at a loud noise beyond visual field	• Absence of startle reflex • Delay in response to voice stimulation • Signs of distress from exposure to loud noises	• Congenital infections: ○ Cytomegalovirus ○ rubella ○ toxoplasmosis ○ herpes ○ syphilis ○ varicella • Prematurity/low birth weight • Intrauterine exposure to teratogens or ototoxic drugs • Intrauterine conditions affecting audio processes • Trauma • Genetic conditions	Parent education and support for age appropriate auditory stimulation ⇒ Refer to hospital of birth or aligned medical professional for Newborn Hearing Screen follow up

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Nose				

Visual and auditory inspection, noting:
Patency:
• Nasal cavity size and shape
• Obvious deviations at bridge, columella and tip
Symmetry:
• Alignment
• Skin integrity
	• Small and narrow
	• Cartilage is soft and malleable
	• Septum is relatively straight and in the midline of the nose
	• Obligatory nose breathers
	• Nasal patency is demonstrated if neonate breathes easily with mouth closed
	• Removes obstructions by sneezing
		• Nasal secretions
		• Swelling
		• Frequent detachment, or slow or difficult feeding
		• Persistent snuffling
		• Cyanosis when feeding
		• Upturned nose
		• Flattening of bridge
			• Birth processes
			• Facial trauma
			• Choanal atresia
			• Polyps
			• Deviated septum
			• Intrauterine exposure to teratogens
			  ○ FASD
			• Genetic conditions
			  ○ Di George syndrome
			  ○ Achondroplasia
			  ○ Stickler syndrome
				Parent education and support may include:
				• Feeding strategies
				Discussion around use of saline drops to clear nasal passages where appropriate
				⇒ Encourage medical practitioner or Breastfeeding Support Services review for any concerns, in particular feeding difficulties

Mouth (continued next page)				
Visual inspection, and palpation where indicated, noting: • General appearance	• Healthy gums are firm, moist, and pink • The tongue surface appears rough but	Cleft deviations: • Cleft palate • Narrow cleft • Cleft lip	• Nerve damage • Infection, including Candidiasis • Epstein pearls	Parent education and support may include: • Management of precocious teeth

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Gums • Integrity of hard and soft palates • Mucosa • Pharynx • Fremulum • Maxillary labial and lingual Lips: • Colour • Symmetry • Integrity • Moisture Tongue: • Colour • Size • Movement Assess feeding comfort for mother and infant	moist and pink to pale pink • The lingual frenulum allows the tongue to protrude over gums to meet lips and to the roof of the palate • Upper lip can be lifted to touch the nose • Tongue fills mouth to support effective feeding • Lips are pink at rest, • Palate should appear dome shaped with transverse firm ridges • Palate is not deeply indented and is whiter than the buccal mucosa and soft palate	• Micrognathia • Sub mucosal cleft Lip deviations: • Thin lip • Loss of control of oral secretions Gum deviations: • Oedema • Lesions • Erythema • Friable • Hematomas Tongue and teeth deviations: • Coated • Plaque • Geographic tongue • Macroglossia • Precocious teeth • Short or inflexible maxillary labial or	• Nasal allergy • Dehydration • Fever • FASD • Genetic conditions ○ Wolf-Hirschorn ○ Beckwith-Wiedermann ○ Di George ○ Pierre Robin	• Feeding patterns and strategies where deviations exist ⇒ Referral to Breastfeeding Support Services regarding unresolved feeding concerns When blisters or calluses are present, conduct a breastfeeding assessment for possible breastfeeding concerns

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
		lingual frenulum impacting on function		
Vocal Behaviour				
Auditory observation, and parent report, noting the following: • Alertness • Cry	Cry is normally: • Strong • Lusty • Medium pitch • Intermittent, in response to discomfort or need	• High pitch • Continuous • Hoarseness • Excessive crying • Audible stridor	• Dehydration • Pain • Raised intracranial pressure • Gastro oesophageal reflux • Intrauterine exposure to teratogens including alcohol or drugs • Laryngeal trauma • Neurological condition • Laryngomalacia	Discuss provision of comfort measures with parents ⇒ Seek urgent referral to medical practitioner for signs of respiratory distress or abnormal breathing sounds
Chest and Respiratory Function (continued next page)				
Visual and auditory assessment, with neonate supine, noting: • Shape	• The chest is symmetrical and compliant, and slightly barrel-shaped	Respiratory deviations: • Stridor • Grunting	• Infection • Laryngomalacia • Trauma	Parent education and support may include:

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Size • Symmetry • Contour • Movement • Respiration functioning • Breath sounds	• Sternum often drawn slightly inward on inspiration • Chest rises and falls symmetrically • Chest circumference from nipple line is approximately 2-3cm less than head circumference • Circumference is very close in size to head circumference at birth • The xiphoid may be prominent • The regular breath rate is 30-60 breaths per minute	• Crackles • Rales • Wheezing • Rhonchi • Cough • Snoring • Apnoea • Nasal flaring • Head bobbing • Paradoxical breathing • Tachypnoea • Intercostal retractions • Use of accessory muscles • Chest deviations: • Engorged breast tissue • Nipple secretions • Supernumerary nipples • Pectus carinatum or excavatum	• Birth process • Pneumothorax • Cystic fibrosis • Intrauterine exposure to teratogens including alcohol, drugs, tobacco • Hormonal influences • Genetic conditions • Acute bronchiolitis • Acute epiglottitis • Foreign body aspiration • Gastroesophageal reflux	• Range of expected normal mucosa secretions • Normal breath sounds • Expectations and management of engorged breast tissue ⇒ Seek urgent referral to medical practitioner for signs of respiratory distress or abnormal breath sounds

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Musculoskeletal – General				
Placing neonate in supine, prone and supported sitting position, observe for overall: • Symmetry • Flexibility • Resting position • Muscle tone • Motor activity • Skin folds Observe range of movement, noting: • Flexion/extension • Adduction/abduction • Internal/external rotation Palpation and passive movement may be used where required to reinforce visual findings	• Muscles are in a flexed position, normotonic and symmetrical • In the supine position, arms and legs are in a semi flexed position with the hips slightly abducted	• Poor, increased or asymmetrical tone • Asymmetry • Flaccidity • Abnormal posture or positioning of extremities • Reluctance to use or move extremities • Evidence of pain on movement	• Trauma • Genetic conditions • Hypotonia • Hypertonia • Infection • Intrauterine exposure to teratogens	⇒ Urgent referral to a medical practitioner where muscle tone deviation is accompanied by other signs of illness

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Reflexes				
Assess alert neonate for presence of primitive reflexes, including: • Asymmetrical tonic neck • Moro reflex • Gallant's reflex • Placing reflex • Stepping reflex • Palmar grasp • Plantar grasp / Babinski reflex • Rooting reflex • Sucking reflex	• Primitive reflexes are symmetrical and indicative of central nervous system function	• Absence • Asymmetrical • Poor or delayed expression	• Genetic / congenital Conditions ○ Fragile X syndrome ○ Stickler syndrome ○ Cerebral palsy ○ Trisomy21/Down Syndrome • Trauma ○ Hemorrhage ○ Infection ○ Hypoxia ○ brachial injury • Prematurity – infant may have hypotonia lasting up to 12 months • Intrauterine exposure to teratogens including alcohol or drugs	
Back and Spine (continued next page)				
Assess general appearance of the back, noting: • Symmetry	• The infant has a C-shaped spinal curve • The secondary cervical curve is	• Sacral dimple and/or tufts of hair • Curvature	• Spina bifida • Intrauterine growth conditions	⇒ Ensure medical practitioner review and assessment of pilonidal dimple

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Flexibility • Skin integrity	present around 3-4 months • spine is straight, and in midline	• Asymmetry • Masses • Swelling • Lesions	• Nutritional status ○ Vitamin D, calcium and protein • Abnormalities in spinous processes • Genetic Conditions	
Upper Limbs (continued next page)				

Palpate the clavicles, and observe range of arm movement including:
• Shoulders
• Elbows
• Wrists
• Hands
Assess through observation of:
• Flexion/extension
• Adduction/abduction
• Internal/external rotation
• Strength
	• In the prone position, the arms are close to the chest and the elbows are fully flexed
	• In the supine position, the arms are kept semi-flexed, whilst the posture is symmetrical
	• Hands are relaxed and commonly held in a loose fist with/out thumb flex over finger
	• Hands open intermittently
		• Oedema
		• Flaccidity
		• Asymmetrical posture, positioning, tone or movement
		• Polydactyly
		• Syndactyly
		• Digital clubbing
		• Webbing
		• Persistent thumbs in fist
			• Trauma
			  ○ Fractures
			  ○ Brachial palsy
			  ○ Dislocations
			• Cerebral palsy
			• Intrauterine exposure to teratogens
			• Amniotic Banding Syndrome
			• Genetic conditions
			  ○ Edwards syndrome
			  ○ Neonatal Marfan syndrome
			  ○ Rubinstein-Taybi syndrome
			  ○ Achondroplasia	

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Flexibility	• Full range of movement when extending the arms • Movements are equal in flexibility and strength			
Hips				

Follow Hip Assessment procedure to assess hips for stability, limb length and symmetry.	• Skin folds are symmetrical
	• Hips are stable and relaxed with thighs easily adducted and abducted
		• Hip instability (normal in first few weeks)
		• Asymmetrical skin creases
		• Limb length discrepancy
		• Fine clicking sounds (normal)
		• Clunking sounds
			• Developmental Dysplasia of the Hip
			• Intrauterine growth conditions
			  ○ Breech presentation
			  ○ Birthweight over 4kg
			  ○ Oligohydramnios
			• Genetic conditions
			• Trauma
				⇒ Refer any hip concerns to medical practitioner, or directly to PCH Orthopaedic Clinic if the infant is less than 4 months of age

Lower Limbs (continued next page)				
With neonate in supine position, assess range of leg movement,	• Legs are equal in length, with knee and	• Asymmetrical skin folds	• Developmental Dysplasia of the Hip • Fractures	

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
including the knee and ankle through observation of: • Flexion/extension • Adduction/abduction • Internal/external rotation Assess symmetry of: • Leg Length • Muscle strength and tone • Flexibility • Skin folds	hip joints extended and aligned • Knees will naturally lie apart with soles of the feet turned slightly inward • Full range of movement in all directions • Legs are equal in tone, movement, strength and flexibility	• Asymmetrical movement or tone • Unequal length of legs	• Trauma • Genetic conditions ○ Edwards syndrome ○ Rubinstein-Taybi syndrome ○ Achondroplasia • Intrauterine growth conditions • Talipes	
Foot and heel: • Observe the position and alignment of forefoot and heel • Assess the range of motion in the ankle and plantar arch	• Supple foot • Normal angle to tibia • The plantar crease is visible	• Polydactyly • Absent plantar crease • Webbing • Rigidity of heel or limited range of movement • Adduction of the forefoot	• Intrauterine growth conditions • Trauma • Talipes • Developmental Dysplasia of the Hip • Lower leg deviation • Genetic conditions	Parent education and support may include: • Use of passive stretching exercises for minor positional deviations where feet can easily be returned to midline • Monitoring and review for resolution

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
				⇒ Referral to medical practitioner or allied health professional (Child Development Services) where an inflexible deviation exists
Abdomen				
Visual inspection, and palpation where indicated, noting: • Size • Shape • Contours • Movement • Symmetry • Bowel Sounds	• Protuberant and round • Symmetrical • Moves with respiration • Soft • Bowel sounds occur every 10 to 20 seconds	• Tension • Distension • Sunken or scaphoid abdominal shape • Asymmetry • Visible peristalsis • Hyperactive or absent bowel sounds • Vomiting	• Malrotation of the bowel • Obstruction • Diaphragmatic hernia • Paralytic ileus • Intussusception • Pyloric stenosis (usually between 2-6 weeks of age • Hirschsprung's disease	⇒ Urgent referral to medical practitioner for: • Sustained vomiting • Projectile vomiting • Reduced bowel sounds
Umbilicus (continued next page)				
Visual inspection, noting: • Separation of cord • Healing process	The umbilical cord is: • Odourless • Dry	• Delay in separation • Cord moisture, discharge or inflammation	• Infection Cyst • Umbilical polyp • Granuloma	Parental education and support may include:

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Separates in 7-10 days • Umbilicus heals within 2 to 3 weeks from birth and should be dry, intact and non- inflamed	• Discharge from umbilicus, including faeces • Swelling, persistent or intermittent occurring where abdominal pressure is increased (crying and defecation) • Lesions, Rashes, Masses	• Neonatal Omphalitis • Diastasis rectus • Urachal remnant • Omphalomesenteric duct remnant • Umbilical hernia • Environmental factors	• Hygiene and infection control in relation to cord separation and healing • Expectations for umbilical herniation • Referral to medical practitioner for: • Umbilical granuloma • Any purulent umbilical discharge ⇒ Urgent referral to medical practitioner if omphalomesenteric duct remnant
Buttocks and Rectal Area (continued next page)				
Visual inspection and discussion with parent, noting:	• Anus is located behind the vagina in	Buttock deviations: • Lesions or rashes	• Genetic conditions • Mongolian spot or other birthmarks	Parent education and support may include:

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Anal patency • Stool consistency, colour and frequency • Skin integrity • Skin features	females and the scrotum in males • Sphincter muscles normally maintain constriction of the anal orifice • Patency is demonstrated by the passing of faeces Neonate's faeces are: • Human milk fed – transitioning from meconium to yellow (brown and dark green may be normal in the absence of deviations) with texture from loose, granular to curdled • Infant formula fed - pale yellow to yellow, brown, green or grey with paste to semi-formed texture	• Sacral sinus, dimples or tufts of hair • Discolouration Anus deviations: • Inflammation • Bleeding • Small opening • Evidence of pain or discomfort Stool deviations: • Explosive • Absence • Reduction in bowel movements • Frequent and/or very loose bowel actions • Faecal matter in urine	• Spina bifida • Allergy or atopy • Infection, of skin or gastrointestinal tract • Normal adjustment to oral intake • Constipation • Trauma • Rectal tears • Fissures • Anal stenosis • Recto-urethral fistula	• Expected elimination patterns • Strategies for management of minor skin irritations or alterations in bowel actions • Referral to medical practitioner for: • Sacral sinus • Bleeding • Recto-urethral fistula ⇒ Consider referral to specialist services where child protection issues are suspected ⇒ Refer to Guidelines for Protecting Children 2020 for further information, including information on mandatory reporting

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Urinary System				
Assess urinary output through parental report, or visual inspection where possible, noting: • Volume • Frequency • Colour	• Normal neonatal urine output is 2 ml/kg/hour • Neonates are less able to concentrate urine	• Decrease in volume and frequency • Darker colour • Weight loss • Fever	• Dehydration • Altered feeding patterns • Infection • Jaundice • Congenital abnormalities of kidneys and urinary tract	Parental education and support may include: • Expected fluid input and output for age • Fluid requirements
Genitourinary – Male (continued next page)				
Visual inspection and palpation of external genitalia, noting: • Urinary meatus – position and patency • Foreskin • Scrotum • Testicular descent • Relative position of scrotum to anus N.B. Do not attempt to forcibly retract the	Urinary orifice is: • Clear • Uncovered by the foreskin • On the tip of the glans penis Foreskin: • Does not retract easily until 2- 3 years old, complete separation of the foreskin and glans	• Ambiguous genitals • Curvature of penis • Microphallus • Non-central position of urethral meatus, including hypospadias and epispadias • Phimosis • Paraphimosis • Chordee • Balanitis	• Genetic conditions • Intrauterine exposure to teratogens • Intrauterine growth conditions • Hydrocele	Parental support and education may include: • Strategies for routine hygiene and care • Referral to medical practitioner for: ○ Hypospadias ○ epispadias

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
foreskin	penis is usually complete by 6 years Scrotum: • Spontaneous testicular descent usually occurs prior to birth and may retract during the first 6 months of life	• Balanoposthitis • Retractable testis • Testis absent or palpable outside scrotal sac • Masses • Swelling		
Genitourinary – Female (continued next page)				
Visual inspection of external genitalia, noting: • Labia • Presence and size of clitoris • Vaginal orifice • Location and patency of urethral orifice • Relative position of posterior fourchette and anus	• Labia majora is enlarged and usually covers labia minora • Clitoris is often disproportionately enlarged • Labia minora is thickened, enlarged and dull pink • The clitoris and labia minora may be more prominent in preterm infants • Hymen is a thickened rim of tissue surrounding the	• Discharge • Swelling • Masses • Lesions • Rashes • Ambiguous genitals • Imperforate hymen • Hydrocolpos	• Genetic conditions • Maternal hormone influence • Pseudo menstruation • Infection: ○ commonly bacterial or fungal • Intrauterine exposure to teratogens • Skin tags • Polyps • Hernia	Parent support and education may include: • Expected range of normal • Strategies for routine hygiene and care • Strategies for management of minor skin irritations

Birth to 4 weeks - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	vaginal orifice, which is pink-white with a range of shapes • Creamy white, mucoid/ blood - tinged vaginal discharge is normal in first 10 days			
Inguinal Area				
Visual inspection, and palpation of inguinal area, noting: • Shape • Contours • Symmetry • Femoral pulses	• Equal, strong femoral pulses can be felt midpoint between the iliac crest and symphysis pubis • A horizontal chain of inguinal nodes run along the inferior groin	• Poor or unequal femoral pulses • Swelling • Masses – either firm and reduced with pressure, or hard and immobile • Enlarged nodes	• Circulatory deviation, including coarctation of the aorta • Inguinal herniation	⇒ Prompt medical review is indicated for any inguinal swelling that does not change size when the neonate cries

Appendix B: Infant - One month to twelve months

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
General Appearance				
• Facial expressions • Posture • Hydration and nutritional health • Activity level • Temperament • Responsiveness • Interaction with others • Proportion and symmetry of body parts • Movement • Skin integrity Observe appearance prior to comprehensive assessment	• Initial presentation of the infant is consistent with the situation (e.g. crying due to hunger) • Infant is healthy and developing appropriately	• Deviations from the norm may be initially identified through assessing the general appearance of the infant • Recognise indicators for child abuse, including but not limited to: injury, bruising, burns, retinal haemorrhages, bite marks, fractured bones, bleeding, pain or physical discomfort or poor standard of hygiene. • Assess appearance of child with consideration of their age, level of mobility and development.[1]	• A range of congenital or non-congenital conditions • Genetic conditions • Environmental conditions • Birth trauma • Intrauterine conditions	Observation of general appearance should be completed prior to a more detailed assessment. Any areas of concerns will be documented and noted for additional monitoring and/or referral to a medical practitioner ⇒ Refer to the *Guidelines for protecting children 2020* publication for more information.

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Head (continued next page)				

Visual inspection, noting:
• General shape
• Size
• Circumference
• Symmetry
• Alignment
• Range of movement
• Abnormal hair pattern
Head alignment is evaluated when infant is in supine and resting position
	• Rounded
	• Symmetrical
	Head circumference averages:
	• males: 35–48.5 cm
	• females: 34.5-47.5 cm[6]
	By 2 months, head is held in midline
	By 4 months head control is achieved, and when held sitting, head is firmly erect
		• Elongated
		• Asymmetrical
		• Misshapen
		• Circumference outside expected trajectory
		• Microcephaly
		• Macrocephaly
		• Positional head preference
			• Trauma
			• Plagiocephaly
			• Vision defect
			• Hearing defect
			• Intrauterine growth conditions
			• Intrauterine exposure to teratogens
			  ○ Alcohol (FASD), Syphilis, Herpes, Cytomegalovirus
			• Hydrocephalus
			• Craniosynostosis
			• Hypotonia
			• Genetic conditions
			  ○ Fragile X
			  ○ Noonan syndrome
			  ○ Trisomy 21/Down Syndrome
			  ○ Achondroplasia
				Parental education and support may include:
				• Postural exercises
				• Handling strategies
				• Massage
				• Positioning of toys to non-favoured side
				• Variable positioning of head in particular for sleep
				⇒ Refer to physiotherapist for assessment of any positional or symmetry deviations that do not resolve

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies

Visual inspection and palpation of:
• Suture lines
• Scalp
• Bony structures
• Fontanelles
Inspect and palpate anterior fontanelle, noting:
• Size
• Tension
• Pulsation
N.B. Nutritional assessment may provide relevant additional information where there are dehydration concerns
	• Suture lines can be overlapping or protuberant up to 2 months
	• Suture lines may be palpable until 6 months of age
	• Anterior fontanelle is flat with slight pulsation, and tension or bulging when infant cries, flattening when infant is calm
	• Anterior fontanelle begins to reduce in size by 9 months with full closure by 18 months
	• Posterior fontanelle closes by 4 months of age
		• Bulging or sunken anterior fontanelle
		• Overlapping sutures present after 2 months
		• Closure of sutures before 6 months
		• Palpable suture lines after 6 months
		• Separation of sagittal sutures
		• Caput succedaneum
		• Cephalhematoma
		• Subgaleal Hemmorrhage
		• Bruising
		• Swelling
		• Pitting
		• Lesions
			• Raised intracranial pressure
			• Dehydration
			• Genetic conditions
			  ○ Crouzon
			  ○ Apert's
			  ○ Trisomy 21/Down Syndrome
			• Craniosynostosis
			• Birthmarks
			• Intrauterine conditions
				⇒ Ensure medical practitioner review is in place for suture concerns, including palpable suture lines after 6 months of age
				
				⇒ Urgent referral to medical practitioner where a sunken fontanelle is accompanied by other signs of dehydration, or illness such as fever, rashes, or gastrointestinal symptoms

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Neck				

Visual inspection and palpation, noting the following:
• Symmetry
• Shape
• Range of movement
• Musculature
• Extraneous tissue or masses
Head control:
• For infants under 3 months head is moved passively whilst infant is in supine position
• For infants over 3 months observe the developing ability to follow light or an object
	• Neck is shortened, and musculature is gradually developed
	• Until 3-4 months, head lag is normal when pulled to sitting position
	• When in ventral suspension, the head is held well above the line of the body
	• When prone, infant is able to lift head and chest well up in midline by 4 months
		Movement deviation:
		• Persistent head lag after 3-4 months
		• Limited range of motion
		• Resistance to movement
		• Head bobbing
		• Jerking
		• Tremors
		• Stiffness
		• Involuntary muscle contractions or spasms
		• Flexion of lower extremities
		• Webbed neck
		Positional deviations:
		• Head held erect
		• Persistent head tilt
		• Positional head preference
			• Intrauterine growth conditions
			• Hypotonia
			• Vision defect
			• Hearing defect
			• Plagiocephaly
			• Torticollis
			• Pain
			• Meningismus or meningitis
			• Genetic conditions
			  ○ Turner syndrome
			  ○ Noonan syndrome
				Parent education and support may include:
				• Postural exercises and positioning
				• Handling strategies
				• Massage
				• Positioning of toys to non-favoured side
				• Variable positioning of head, particularly for sleep or for regular holding positions

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Face				

Through visual inspection observe facial features and expressions, noting:
• Symmetry
• Spacing and size
• Movement
• Emotional expression
	• Face is relaxed and symmetrical
	• Age appropriate development of a range of facial expressions and movements which are spontaneous and responsive to situation
	• Facial expressions and movement are symmetrical
		• Disproportionate features
		• Bossing or prominence of forehead
		• Epicanthal folds inconsistent with ethnic origins
		• Micrognathia
		• Lesions
		• Lumps, particularly on or around ears
		• Emotional expression inconsistent with expectations for age
			• Genetic conditions
			  ○ Russell-Silver syndrome
			• Intrauterine conditions including exposure to teratogens
			  ○ Fetal Alcohol Spectrum Disorder (FASD)
			• Trauma
			• Milia
			• Birthmarks
			• Neurological condition
				Parent education and support may include:
				• Feeding support where micrognathia exists
				• Features and management of birthmarks
				⇒ Refer to medical practitioner for facial birthmarks, particularly around lips, eyes, nose or scalp

Philtrum				

Visual inspection, noting:
• Definition
• Depression
• Length
	• Philtrum is visible and can be pronounced
	• Tear drop shaped
	• Can be in straight lines from septum to tubercule
		• Short or long
		• Smooth
		• Limited definition through to no depression
			• FASD
			• Genetic or Congenital conditions
			  ○ Foetal valproate syndrome
			  ○ Pallister-Killian
			  ○ Cornelia de Lange	

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
			○ Wolf-Hirschhorn ○ Achondroplasia	
Eyes (continued next page)				
Visual inspection, noting: • Shape • Size • Symmetry • Spacing • Position • Colour Examine pupil and iris by shining a light into the eyes, noting: • Size • Equality/symmetry of size • Colour • Clarity • Shape • Pupillary constriction	• Eyes are symmetrical, horizontal and in line with top of pinna • Eye spacing narrow or wider than expected • The upper eyelids are symmetrical • When closed, eyelid completely covers cornea and sclera • Pupils are round, clear, and equal • Pupils react equally to light, movement, and patterns • Eye colour is established by around 6 months • Sclera visible above and below the cornea	• Discharge, watery or purulent • Reddened sclera • Bruising or bleeding • Oedema • Epicanthal folds, inconsistent with ethnic origin • Strabismus • Ptosis • Leukokoria • Coloboma • Fixed pupils • Cloudiness and opacity of cornea • Nystagmus • Sundowning • Sensitivity to light	• Acquired head injury • Trauma • Infection • Subconjunctival haemorrhage • Immature blocked tear ducts • Allergy • Intrauterine conditions • Environmental conditions • Retinoblastoma (commonly linked with Leukokoria) • Cataract • Scleral icterus • Photophobia • Genetic conditions ○ Stickler syndrome ○ Cri-du-chat	Parent education may include: • Eye toilet and hygiene • Techniques for blocked tear ducts including massage Review eye watering regularly at universal contacts (may take up to 12 months to resolve)

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Refusal to open eyes after exposure to light			syndrome ○ Prader-Willi syndrome • Congenital glaucoma • Congenital Cataract • Dacryocystitis • Sundowning	
Gaze				
Assess gaze behaviour through observation of facial expressions, movements and attempts to attract attention from others	• Will move head to deliberately gaze attentively around • Watches movement of people, animals or motor vehicles • Recognises and enjoys the sight of familiar people approaching from a distance	• No mutual gaze attempts made • Infant does not show an interest in their surroundings	• Trauma • Interrupted bonding and attachment • Biochemical factors	Parent education and support may include strategies to promote bonding and attachment
Vision Behaviours (continued next page)				
Assess vision behaviours, noting: • Eye movements	• Eyes may move in unison until 3 months of age	• Slow lateral movements • Strabismus- constant	• Esotropia • Exotropia	⇒ Prompt referral to medical practitioner for constant visual

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Blinking • Increased alertness and attention to surroundings Assess also through presentation of an object or light source for infant to fixate and follow.	• Coordination of extra-ocular muscles is usually achieved by 6 weeks and should occur by 3 months • Infants can distinguish colour from 3 to 5 months of age • Will follow an object at 15-30 cm distance through an arc of 30 degrees from midline at 6-8 weeks, increasing to 90 degrees by 4 months	• Strabismus - intermittent (deviation from normal after 3 months of age)	• Hypertropia • Hypotropia • Trauma • Refractive error • Strabismus • Haemorrhage • Hyphema	impairment or evident squint over 3 months of age ⇒ Urgent referral to ophthalmologist through medical practitioner for opacities in the pupil or corneal abnormalities
Ears (continued next page)				
Assess external ear including mastoid process, auricles, tragus and external auditory meatus, noting: • Shape • Size	• Pinna is soft, pliable, and recoils readily when folded and released • The superior portion of the auricle should be equal in height to	• Pus/debris • Sebaceous cyst • Inflammation • Excessive wax formation	• Congenital Infection ○ Rubella ○ cytomegalovirus ○ toxoplasmosis ○ syphilis • Foreign objects	Parental education and support for ear care in particular to: • Discharge • Foreign objects • Excessive wax

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Symmetry • Patency • Position • Colour • Firmness of ear cartilage • Obstruction/foreign bodies	the outer canthus of the eye • Auricles are vertical with no more than a 10-degree tilt • Auricles are similar to facial skin colour • Outer ear canal is covered with fine hair • Cerumen is a normal protective secretion, ranging from grey, dry and flaky to honey-coloured to dark brown and wet • Tympanic membrane is pearl-grey, sometimes pink or red tinged, translucent, intact, and in neutral position	• Evidence of fluid in middle ear • Tympanic membrane deviations • Bruising around ear Dysmorphic deviations: • Low-set ears • Skin tags • Accessory tragi • Malformed auricles • Auricular sinus • Preauricular sinus	• Trauma related to child abuse • Genetic conditions ○ Trisomy 21/Down Syndrome ○ Goldenhar syndrome ○ Wolf-Hischhorn syndrome ○ Di George syndrome ○ Treacher Collins syndrome ○ Nagar Syndrome • Intrauterine exposure to teratogens or ototoxic drugs • Myringitis	⇒ Refer to medical practitioner for any suspected infection Child Abuse - consider indicators outside of what may be expected given the child's age and development ⇒ Refer to the *Guidelines for protecting children 2020* publication for more information
Assess infant hearing as a component of ear health assessment, through discussion with	• Attentive to everyday sounds, in particular will turn eyes and/or	• Startle reflex persistent after 3 months of age	• Intrauterine conditions affecting audiometric processes	Parent education and support may include strategies to promote

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
parent, and observation of the following: • Vocalisation • Response to auditory stimuli	head towards voices by 3 months • Develops recognition and response to own name around 6-10 months • Vocalisations are appropriate for age • Age-appropriate response to sounds	• Delay in response to voice stimulation • Language delay • Decrease in age-appropriate response to range of sounds	• Trauma • Congenital Syndromes • Alport, Trisomy 21/Down Syndrome, Jervell, Treacher Collins, Lange-Nielson, Usher • Congenital Infection ○ Rubella ○ cytomegalovirus ○ toxoplasmosis ○ syphilis ○ herpes • Environmental conditions • Prematurity/low birth weight	appropriate auditory stimulation
Nose (continued next page)				
Visual and auditory inspection, of nasal bridge, nares, columella and septum, noting: • Symmetry • Shape	• Nose is flattened and malleable • Prone to increased airway resistance because of small passages	• Mucous and other nasal secretions • Epistaxis • Narrowing of the nares	• Facial trauma • Intrauterine exposure to teratogens ○ FASD • Infection	Parent education and support may include: • Strategies to clear nasal passages where patency is interfering with feeding

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies

• Size
• Integrity
• Patency of nares
• Alignment
• Skin integrity
	• Infant removes obstructions by sneezing
	• Septum is relatively straight and in the midline of the nose
	• Infant nose breathes during feeding
		• Infant frequently detaching during feeding
		• Nasal flaring
		• Oedema
		• Lesions
		• Upturned nose
		• Discolouration
		• Deviated septum
			• Polyps
			• Inflammation
			• Environmental factors
			• Genetic conditions
			  ○ Di George syndrome
			  ○ Achondroplasia
			  ○ Stickler syndrome
			  ○ Choanal atresia
				• Management of feeding difficulties associated with nasal deviations

Mouth (continued next page)				

Visually inspect:
• Gums
• Hard and soft palates
• Mucosa
• Lips
• Tongue
• Teeth
Note the following:
• Tooth eruption
	• Gums are firm, moist and pink
	• The tongue surface appears slightly rough, but moist, and pink to pale pink
	• The lingual frenulum allows the tongue to protrude over gums to meet lips and to reach the roof of the palate
		Cleft deviations:
		• Cleft palate
		• Narrow cleft
		• Sub mucosal cleft
		Lip deviations:
		• Cleft lip
		• Thin upper lip
		• Swelling
		• Dryness
			• Neurological deficit
			• Infection
			• Genetic conditions
			  ○ Wolf-Hirschhorn syndrome
			  ○ Beckwith-Wiedermann syndrome
			  ○ Di George syndrome
			  ○ Pierre Robin syndrome
				Parent education and support may include management of deviations such as:
				• Precocious teeth
				• Teething processes
				• Drooling
				• Minor lesions
				⇒ Refer to Breastfeeding

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Odour Lips and mucosa: • Colour • Symmetry • Integrity • Moisture Tongue: • Colour • Size • Movement • Symmetry Assessment of feeding patterns and feeding comfort may be relevant where oral deviations exist.	• Tongue fills mouth to support effective feeding • Hard Palate appears dome shaped, but not deeply indented, with transverse firm ridges • Hard Palate is lighter in colour than the soft palate and buccal mucosa • Deciduous teeth erupt from 6 – 24 months • Anterior permanent teeth begin to calcify at 3 to 12 months • Drooling increases as objects are taken into mouth • Infant develops capacity to hold, bite and chew a small piece of food by 9 months	• Lesions • Loss in control of oral secretions and drooling • Excessive upper lip frenulum Gum deviations: • Swelling • Lesions • Reddening • Friable • Hematomas Tongue and teeth deviations: • Coated • Plaque • Unusual odour • Geographic tongue • Macroglossia • Ankyloglossia	• Intrauterine conditions • Environmental factors • Dehydration • Fever • Hematoma • Trauma • Tooth eruption • Allergy	Support Services or other relevant health professional for unresolved feeding concerns

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Deciduous teeth are smooth and glossy with a whitish hue • The biting surface of the molar teeth is grooved and pitted	• Ulceration or other alteration in skin integrity • Excessive lingual frenulum • Precocious teeth • Lesions, including white, yellow or brown spots • Tooth cavities		
Vocal Behaviour (continued next page)				
Auditory observation, and parent report, noting the following: • Alertness • Cry • Pitch of sounds • Language acquisition	• Strong, lusty and of medium pitch • Will develop deliberate vocalisation as a means of interpersonal communication • Screams in annoyance • Laughs, chuckles or squeals during play	• High pitch • Continuous • Hoarseness • Monotonous vocalisation or inconsistency with developmental expectations • Excessive crying • Audible stridor	• Dehydration • Pain • Raised intracranial pressure • Gastro oesophageal reflux • Laryngeal trauma • Neurological condition • Croup	Parent education and support may include: • Discussion of comfort measures • Expected vocal development for age

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Gradual development of a range of vocal sounds		• Infant of narcotic, or other substance-dependent mother • Hearing impairment	
Chest and Respiratory Function (continued next page)				

Visual and auditory assessment, with infant supported in upright position, noting:
• Chest shape
• Movement
• Respiratory rate
• Respiratory effort
• Breathing pattern
• Breathing sounds
• Assessment of sleep patterns through parent report may offer additional information related to respiratory tract, allergy or infection
	• The chest is symmetrical and slightly barrel-shaped
	• Chest circumference is close in size to head circumference up to 2 years of age
	• Chest then gradually develops adult shape
	• Rhythm of breaths is regular including symmetrical rise and fall of chest
	• The regular breath rate is 24-55 breaths per minute (between birth and 12 months with higher rates for younger infants)
		• Oral/nasal mucosal secretions
		• Stridor
		• Grunting
		• Crackles
		• Rales
		• Wheezing
		• Rhonchi
		• Cough
		• Snoring
		• Apnoea
		• Nasal flaring
		• Head bobbing
		• Paradoxical breathing
		• Tachypnoea
			• Infection, including; bronchiolitis and epiglottitis
			• Laryngomalacia
			• Trauma
			• Foreign body aspiration
			• Asthma
			• Croup
			• Gastroesophageal reflux
			• Pneumothorax
			• Genetic or congenital conditions
			  ○ Cystic fibrosis
			  ○ Joubert syndrome
				Parent education and support may include:
				• The range of normal mucosal secretions
				• Strategies for management of specific deviations
				• Signs to alert parent to need for further review
				⇒ Seek urgent medical review for any signs of respiratory distress including stridor, grunting, apnoea episodes, nasal flaring and intercostal retraction or

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Infant may use oral airway spontaneously or in response to nasal occlusion	• Intercostal retraction • Use of accessory muscles • Cyanosis central or extremities		other altered breathing sounds
Musculoskeletal – General (continued next page)				

Through placing infant in prone, sitting and standing position if child is walking, observe for overall:
• Symmetry
• Flexibility
• Resting position
• Muscle tone
• Motor activity
• Skin folds
Assess range of movement through observation of age-appropriate activity, noting:
• Flexion/extension
	• Muscles are in a flexed position, normotonic and symmetrical
	• In the supine position, arms and legs are in a semi flexed position with the hips slightly abducted
	• Infant will start to transition from a 'bear walk' crawl to pulling up to standing position
	• When hands are held, will purposefully step on alternating feet and may start to walk alone
		• Asymmetry in tone
		• Flaccidity
		• Abnormal posture or positioning of extremities
		• Movement limitation or reluctance to use limbs
		• Unbalanced gait
		• Evidence of pain or tenderness on movement
		• Swelling
		• Masses
		• Inflammation
			• Trauma
			• Infection
			• Genetic or congenital conditions
			  ○ Trisomy 21/Down Syndrome
			  ○ Cerebral Palsy
			• Hypotonia
			• Hypertonia
				Parent education and support may include:
				• Safety
				• Avoidance of common injuries related to developmental milestones
				• Strategies to improve muscle tone and strength

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Adduction/abduction • Internal/external rotation Palpation and/or passive movement may be used to reinforce visual findings Assess crawling, standing or walking, noting: • Balance and pivots • Agility • Gait				
Reflexes (continued next page)				
Assess alert infant for presence and gradual diminishing of primitive reflexes, including: • Palmar grasp • Asymmetrical tonic neck reflex • Moro reflex	• Primitive reflexes are symmetrical and indicative of central nervous system function • Primitive reflexes diminish from 3-4 months of age with cerebral cortex	• Asymmetrical • Poor expression or delay in response • Persistence of primitive reflexes beyond 4-6 months • Delay in development of postural reflexes	• Genetic conditions ○ Fragile X syndrome ○ Stickler syndrome ○ Cerebral palsy ○ Trisomy 21/Down Syndrome • Trauma • Brachial palsy	⇒ Refer to medical practitioner where reflexes persist beyond expected time frame, especially in association with other concerns

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Stepping reflex • Rooting response • Sucking response Assess gradual age-appropriate development of postural and voluntary movement, including: • Head control • Facial expressions • Grasp • Reach • Weight bearing capacity	maturity, and disappear by 4-6 months • As primitive reflexes diminish, infant develops postural reflexes and voluntary movements which support control of balance, posture and movement in a gravity based environment	and voluntary movements by 9 months of age	• Hypotonia	
Back and Spine (continued next page)				
Assess general appearance of the back, noting: • Symmetry • Flexibility • Curvature • Skin	• The spine is initially C-shaped and in midline • The head should be aligned directly over the sacrum • Spine gradually develops a cervical	• Sacral dimple or sinus • Tufts of hair, particularly in sacral area • Pronounced curvature • Swelling • Asymmetry	• Intrauterine growth conditions • Spina bifida • Genetic conditions • Abnormalities in spinous processes	⇒ Ensure medical practitioner review of any pilonidal dimple or sinus

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	curve by 3-4 months and lumbar curve as the infant bears weight and begins to walk	• Masses • Lesions		
Upper Limbs (continued next page)				

Palpate the clavicles, and observe range of arm movement including:
• Hands
• Elbows
• Wrists
• Shoulders
Assess through observation of:
• Flexion/extension
• Adduction/abduction
• Internal/external rotation
• Symmetry
• Strength
• Flexibility
	• Infant will gradually develop capacity to lift chest up when lying on abdomen, supporting at first on forearm, and later on extended arms and flattened palms
	• Age-appropriate development in use of both hands. May show a preference for one by 18 months
	• Develops capacity to pick up small objects with a pincer grasp by 12 months
	• Limbs gradually become more pliable and movements
		• Swelling
		• Distortion
		• Bruising
		• Limited, reluctance or discomfort on movement
		• Erythema
		• Extra digits
		• Syndactyl
		• Webbing
		• Digital clubbing
		• Persistent clenched fists or thumbs in fist beyond 3 months
		• Early preference for one hand
			• Trauma including, fracture, subluxation, or dislocation
			• Brachial palsy
			• Intrauterine exposure to teratogens
			• Cerebral palsy
			• Environmental conditions
			• Genetic conditions
			  ○ Edwards syndrome
			  ○ Marfan syndrome
			  ○ Rubinstein-Taybi syndrome
			  ○ Achondroplasia	

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	become smoother and continuous • Should have full range of movement when extending the arms in all directions • Movements are equal in flexibility and in strength	• Asymmetrical movement or muscle tone		
Hips				
Follow Hip Assessment procedure to assess hips for stability, abduction, limb length and symmetry.	• Skin folds are symmetrical • Hips are stable, and thighs are easily adducted and abducted • Knees are equally aligned	• Uneven leg length • Asymmetrical buttock folds and thigh creases • Movement restriction • Reluctance to move • Not crawling by 8 months • Bottom shuffling or alternative crawling method • Limping or waddling gait	• Intrauterine growth conditions • Genetic conditions • Developmental Dysplasia of Hip • Trauma • Environmental conditions, including constrictive wrapping	⇒ Refer any hip concerns to medical practitioner, or directly to PCH Orthopaedic Clinic if the infant is less than 4 months of age

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Lower Limbs (continued next page)				
Assess while infant is supine or in standing position, noting: • length • strength • flexibility • movement • skin folds Through observation of: • flexion/extension • adduction/abduction • internal/external rotation	• Legs are equal in length with symmetry in skin folds • Legs are equal in movement, strength and flexibility • Knee and hip joints extended and aligned • Knees will naturally lie apart with soles of the feet turned slightly inward • Bow leggedness is common until 4-5 years • As the ability to walk is developed, the infant's stance is wide with small steps and rapid cadence	• Unequal leg length • Asymmetry in skin folds • Asymmetrical movement • Asymmetrical muscle tone • Genu varum • Genu valgum • Talipes – positional or genetic •	• Birth trauma • Trauma, including fractures or dislocations • Intrauterine growth conditions • Tibial torsion • Nutritional deficiency • Genetic conditions ○ Edwards syndrome ○ Rubinstein-Taybi syndrome ○ Achondroplasia ○ Duchenne muscular dystrophy	
Foot and heel	• Foot is supple • Visible plantar crease	• Rigidity or limited range of movement, including:	• Intrauterine growth conditions • Genetic conditions	Parent education and support may include: • Use of passive stretching

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Assess forefoot and heel for position and alignment • Assess ankle and plantar arch for range of motion	• In the supine position, the medial and lateral malleoli are parallel	• Limited dorsiflexion • Adduction of forefoot • Fixed position of hindfoot • Polydactyly • Absent plantar crease • Webbing	○ Talipes • Metatarsus adductus • Trauma	exercises for minor positional deviations where feet can easily be returned to midline • Monitoring and review for resolution ⇒ Referral to medical practitioner or allied health professional where an inflexible deviation exists
Abdomen (continued next page)				
Visual inspection, and palpation where indicated, noting: • Size • Shape • Symmetry • Sounds • Contours • Skin integrity	• Protuberant and round (pot-bellied) • Symmetrical • Moves with respiration • Soft • Bowel sounds are present and generally heard every 10-20 seconds	• Tension • Distension • Sunken or scaphoid shape • Asymmetry • Visible peristalsis • Vomiting • Hyperactive or absent bowel sounds	• Changes in oral intake • Infection • Constipation • Intolerance or atopy • Malrotation of bowel • Obstruction • Intussusception • Paralytic ileus	⇒ Urgent referral to medical practitioner for: • Sustained vomiting • Projectile vomiting • Reduced bowel sounds

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
		• Evidence of pain or discomfort	• Pyloric stenosis (usually between 2-6 weeks of age • Hirschsprung's disease	
Umbilicus (continued next page)				
Visual inspection, noting: • Size • Shape • Integrity • Separation of cord • Healing of cord stump	• The umbilical cord has separated and is dry and healed • Lies at vertical level corresponding to between L3 and L5 • Size, shape, depth, length, and overall appearance is variable • Forms a visible depression on skin in 90% of infants • Protrusion may occur in10% of infants • Underlying abdominal muscles surrounding umbilicus are concave	• Intermittent or constant bulging or swelling, more pronounced with increased abdominal pressure (crying and defecation) • Discharge from umbilicus • Erythema • Inflammation • Lesions • Masses • Omphalitis • Umbilical lint	• Umbilical hernia • Diastasis rectus • Infection • Omphalomesenteric duct remnant • Urachal remnant • Cyst • Umbilical polyp • Granuloma • Cellulitis • Environmental conditions	Parent education and support may include: • Routine umbilical care • Strategies for management of minor infections ⇒ Prompt referral to medical practitioner for umbilical discharge

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Buttocks and Rectal Area (continued next page)				
Visual inspection and discussion with parent, noting: • Anal patency • Stool consistency, colour and frequency • Skin integrity • Skin features	Patency demonstrated through passing of faeces which is normally: • Human milk fed – yellow (brown and dark green may be normal in the absence of deviations) with texture from loose, granular to curdled • Infant formula fed - pale yellow to yellow, brown, green or grey with paste to semi-formed texture • Infant faeces become darker, more formed and odour increases with introduction of solid food	Buttock deviations: • Lesions or rashes • Discolouration • Sacral sinus, dimples or tufts of hair • Rectal deviations: • Changes in frequency of bowel motions • Changes in colour or consistency of bowel motions • Bleeding	• Birthmarks • Trauma • Genetic conditions • Response to change in dietary and fluid intake • Constipation • Infection: bacterial, viral or parasitic • Fissures • Rectal tears • Allergy or Atopy	Parent education and support may include: • Dietary needs • Normal patterns of output • Strategies to address minor deviations • Referral to medical practitioner for: • Sacral sinus • Bleeding • Recto-urethral fistula ⇒ Consider referral to specialist services where child protection issues are suspected ⇒ Refer to *Guidelines for Protecting Children 2020* for further information, including

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
				information on mandatory reporting
Urinary System				
Assess urinary output through parental report, or visual inspection where possible, noting: • Volume • Frequency • Colour Note: Nutritional assessment may contribute to findings	• Normal urine output is >2 ml/kg/hour in infants • Infants void an average of 20 times per day/once per hour • Infant bladder will completely empty at least once during a four hour period	• Change in urine: ○ Volume ○ Frequency ○ Colour • Presence of blood • Weight loss • Behavioural irritability	• Urinary Tract Infection • Pyelonephritis • Dehydration • Changes in fluid intake • Urinary reflux • Jaundice • Diabetes • Congenital abnormalities of kidneys and urinary tract	Parental education and support may include: • Expected urinary output for age and how to monitor • Fluid requirements
Genitourinary – Male (continued next page)				
Visual inspection of penis, scrotum and inguinal areas, and palpation of testes, noting: • Position • Size	• Urinary orifice is patent, uncovered by the prepuce, located at the tip of the glans penis • Foreskin does not retract until 2-3 years old. Complete	• Ambiguous genitals • Curvature of penis • Microphallus • Deviation in position of urethral meatus, including hypospadias and epispadias	• Genetic conditions • Intrauterine exposure to teratogens • Infection • Testicular torsion	Parent education and support may include routine hygiene needs and age appropriate expectations ⇒ Urgent referral to emergency department for

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Patency of urethra • Skin • Testicular descent N.B. Do not attempt to forcibly retract the foreskin	separation of the foreskin and glans penis is usually complete by 6 years • Spontaneous testicular descent usually occurs before birth and may retract during the first 6 months • Cremasteric reflex can be activated by cold, emotion, or touch	• Phimosis (tight foreskin) • Paraphimosis • Chordee • Balanitis • Balanoposthitis • Scrotal swelling, acute or persistent • Abnormal distance from scrotum to anus • Circumcision – healing complications include bleeding, redness, cyanosis, discharge, or swelling • Testis absent or outside of scrotal sac	• Intrauterine growth conditions • Hydrocele	paediatric surgical review for signs of torsion ⇒ Refer to medical practitioner for review of any deviation in testicular descent over 4 months of age

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Genitourinary – Female				
Visual inspection of: • Labia • Vaginal orifice • Urethral meatus • Perianal area • Clitoris Noting the following: • Shape • Position • Contours • Patency • Skin integrity N.B. Careful examination should be conducted where discharge exists	• Clitoris is about 3mm in length and 3mm in transverse diameter • The labia minora are thin ridges of tissue which cover the urethral and vaginal orifices and meet at the clitoris • Labia minora frequently protrude from the labia majora • Urethral meatus may be difficult to visualise due to thickened hymen • Vaginal orifice is patent, surrounded by hymen, with no discharge	• Rashes • Lesions • Redness • Lacerations • Bruising • Swelling • Pain • Discharge • Odour • Hydrocolpos • Ambiguous genitals	• Trauma • Allergy or atopy • Environmental conditions or irritants • Infection, commonly bacterial or fungal • Genetic conditions ○ Imperforate hymen • Hernia	Parent support and education may include routine hygiene needs and age appropriate expectations ⇒ Consider referral to specialist services where child protection issues are suspected Refer to *Guidelines for Protecting Children 2020* for further information, including information on mandatory reporting

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Inguinal Area				
Visual inspection, and palpation of inguinal area along the: • Juncture of the thigh and abdomen • Along the inguinal ligament and the saphenous vein	• A horizontal chain of inguinal nodes run along the inferior groin • Regular femoral pulses can be felt midpoint between the iliac crest and symphysis pubis	• Masses – either firm and reduced with pressure, or hard and immobile • Tenderness • Enlarged glands • Poor, unequal or absence of femoral pulses	• Prematurity • Genetic conditions ○ Coarctation of the aorta • Lymphadenopathy • Infection • Inguinal hernia	⇒ Prompt medical review is indicated where any inguinal swelling is reddened, painful, or does not change size when the infant cries, especially if accompanied by other signs of illness such as fever, vomiting or distended abdomen
Skin (continued next page)				
Visual inspection, and palpation where required, noting the following: • Colour • Texture • Integrity • Turgor	• The skin is smooth, even, clear and intact • Mucous membranes are moist • Normal colour according to race • Skin is elastic and returns rapidly to original shape following gentle pinching	• Pallor, redness, cyanosis • Unusual pigmentation or discolouration • Plethora of protein • Bruising • Rashes, lesions, scars • Thickening, drying, cracking, flaking or scaling of skin	• Jaundice • Erythema toxicum neonatorum • Milia • Trauma • Genetic conditions ○ Congenital dermal melanocytosis (Mongolian blue spot)	Parent education and support may include strategies for management of deviations such as: • Minor infections • Infestation • Allergy and eczema (atopic dermatitis)

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Hydration of exposed skin and mucous membranes • Temperature N.B. Skin should be inspected in areas of natural light, or a well-lit space with fluorescent lighting where possible	• Capillary refill is under 2 seconds • Pigmentation variations occur in darker skinned infants in nail-bed, palm, sole and genital areas	• Blistering • Itching • Papules, Plaques, Vesicles, Nodules • Skin tags, dimples, cysts • Hydration deviations: • Reduction in skin elasticity • Flushed appearance • Xerosis (dry skin) • Skin takes > 3 secs to return to original shape	○ Cutis marmorata • Macular or cavernous haemangioma • Nevus vasculosus • Telangiectatic nevi • Dehydration • Allergy • Eczema (atopic dermatitis) • Infection - bacterial, viral or fungal • Fever or overheating • Infestation, including scabies • Intrauterine exposure to teratogens	• Environmental influences • Expected fluid intake and output for age ⇒ Referral to a medical practitioner for birthmarks and rashes, particularly where birthmarks are located on face, head or buttock areas ⇒ Prompt referral to a medical practitioner where deviations are accompanied by other signs of illness
Hair (continued next page)				
Visual inspection, noting: • Distribution • Colour	• Fine soft, downy lanugo hair is present at birth and can persist for up to 3-4 months	• Absent hair or bald patches • Dryness • Oiliness	• Seborrheic dermatitis (cradle cap)	Parent education and support may include strategies for management of:

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Hair line • Quantity • Texture • Growth pattern	• Lanugo is gradually shed and replaced by vellus hair which is short, fine, soft, poorly pigmented and covers most of body • Vellus type hair is also present on the scalp from birth, gradually replaced from 3-7 months of age by intermediate scalp hair • Terminal hair is pigmented, longer, thicker and replaces vellus hair on the scalp by 2 years of age • Growth is uniform, and specific to body area	• Infestation • Coarse texture • Change in growth rate • Irritation, dryness, lesions or scaling of scalp	• Environmental conditions, including friction on surfaces • Infection, e.g. tinea capitus (ringworm) or impetigo • Trauma • Nutritional deficiency • Stress or recent illness • Pallister-Killian syndrome	• Seborrhic dermatitis • Hygiene needs • Control of environmental factors
Nails (continued next page)				
Visual inspection, noting:	• Nails are soft, pliable and fast growing	• Short and thick	• Infection: bacterial, viral or fungal	Parent education and support may include:

1-12 months - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Colour • Contour • Shape • Texture • Cleanliness	• Nails are adherent to nail bed • Nail beds are pink, smooth, flat or slightly convex, with uniform thickness	• Fragile or thin • Nail shedding (onychomadesis) • Dryness • Transverse depressions or grooves (Beau's lines) • Pruritus • Clubbing • Paronychia • Odour • Cyanosis • Nail atrophy/ absence	• Environmental conditions, including exposure to moisture • Psoriasis • Ectodermal dysplasia • Trauma • Stress or significant illness	• Routine care and hygiene strategies • Expected growth patterns

Appendix C: Children - Twelve months to four years

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
General Appearance				
• Facial expressions • Posture • Activity level • Temperament • Responsiveness • Interaction with others • Proportion and symmetry of body parts • Movement • Nutritional status • Skin Integrity Observe appearance prior to comprehensive assessment	• Initial presentation of the child is consistent with the situation (e.g. crying due to tiredness or pain) • Child appears healthy and appropriately developed	• Deviations from the norm may be initially identified through overall assessment of general appearance of the child • Recognise indicators for child abuse, including but not limited to: injury, bruising, burns, retinal haemorrhages, bite marks, fractured bones, bleeding, pain or physical discomfort or poor standard of hygiene. • Assess appearance of child with consideration of their age, level of mobility and development.[1]	• A range of congenital or non-congenital conditions • Genetic conditions • Environmental conditions • Child abuse – consider indicators outside of what may be expected given the child's age and development	Observation of general appearance should be completed prior to a more detailed assessment. Any areas of concerns will be documented and noted for additional monitoring and/or referral to a medical practitioner ⇒ Refer to the *Guidelines for protecting children 2020* publication for more information.

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Head				

Visual inspection with the head at midline, while sitting supported, noting:
• General shape
• Size
• Circumference
• Symmetry
• Alignment
• Range of, movement, tone and flexibility
	• Rounded
	• Symmetrical
	• When child is upright, head will comfortably sit in the midline
	Head circumference averages:
	• males: 43.5–53 cm
	• females: 42.5-52cm[6]
	• Brain reaches 80% of adult size by 2 years
	• Sutures are proximate and immobile
	• Skin is flush with scalp
	• Anterior fontanelle closes by around 18 months of age
		• Asymmetrical
		• Circumference outside expected trajectory
		• Microcephaly
		• Macrocephaly
		• Bruising
		• Swelling
		• Lesions
		• Positional head preference or tilt
		• Jerking, tremors or involuntary spasms
		• Persistence or premature closure of anterior fontanelle
		• Bulging or sunken anterior fontanelle in younger child
			• Plagiocephaly
			• Dehydration- more easily observed in younger child
			• Trauma
			• Space-occupying intracranial lesions
			• Gastro-oesophageal reflux disease (GORD) where overfeeding contributes to torticollis
			• Intrauterine growth conditions and exposure to tetragons
			• FASD
			• Craniosynostosis
			• Neurological condition
			  ○ Epilepsy
			  ○ Brain injury
			• Visual or hearing deficit
			• Hydrocephaly	

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Neck				

Visual inspection, noting the following:
• Symmetry
• Shape
• Mobility
• Musculature
• Lymph nodes
Consider relevant history from parent report, including: injury, head tilt, pain, stiffness, persistent lymph gland swelling and respiratory infection
	• Neck lengthens at 3-4 years, and neck to body proportion becomes closer to adult size
	• Trachea is at midline
	• Lymph nodes are non-visible, mobile, non-tender and not warm to touch
		• Stiffness or resistance to movement or range of motion
		• Pain
		• Lateral inclination of the head
		• Lymphadenopathy
		• Positional shift of Trachea
			• Torticollis
			• GORD
			• Raised intracranial pressure
			• Meningitis
			• Infection
			• Cerebral palsy
			• Hypotonia
			• Genetic conditions
			  ○ Turner's syndrome
			  ○ Trisomy 21/Down Syndrome
				⇒ Urgent referral for medical review of any child with neck stiffness accompanied by signs of acute illness

Face (continued next page)				
Through visual inspection observe facial features and expressions, noting: • Symmetry • Spacing and size	• Face is relaxed and symmetrical • Nose should be symmetric and in centre of child's face	• Bruising • Swelling or oedema • Alteration in skin integrity • Asymmetry	• Trauma ○ child abuse • Fatigue • Allergy • Environmental conditions	Child Abuse - consider indicators outside of what may be expected given the child's age and development

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies

• Movement
• Emotional expression
	• Facial expressions are spontaneous and responsive to situation
	• Symmetry of smile, laugh, creases and wrinkles reveal normal function/ innervation
		• Lesions
		• Dark circles under eyes
		• Neurological deficit
		• Lack of, or inappropriate, emotional expression
		• Involuntary movements
			• Infection
			• Genetic conditions
			  ○ Russell-Silver
			  ○ Trecher-Collins
			• Medication side effect
			• Mental illness
			• Myotonia
				⇒ Refer to the *Guidelines for protecting children 2020* publication for more information

Eyes (continued next page)				
Visual inspection, noting: • Shape • Size • Symmetry • Position and spacing • Visual engagement	• Eyebrows extend to just beyond the outer canthus • Raising and lowering of eyebrows is symmetrical • Eyelashes are full and evenly distributed • Upper and lower eyelids and palpebral fissures symmetrical • Gaze is symmetrical	• Discharge, watery or purulent • Conjunctival redness or inflammation • Crusting or scaling • Eyelid inflammation, swelling, lesions, or discoloration • Sunken eyelids • Ptosis • Loss of hair - eyelashes or eyebrows	• Acquired head injury • Infection, bacterial, viral or fungal • Allergy • Dehydration • Trauma	Parent education and support for infection control measures and hygiene where eye infection is suspected

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Eyes are symmetrical, horizontal and in line with top of pinna • Conjunctiva and sclera are smooth, clear, whitish and glistening (yellow tinge normal in children with dark skin)	• Subconjunctival haemorrhage		
Vision Behaviours (continued next page)				
Assess by examining the pupil and iris, and by shining a light into the eyes, noting: • Size • Symmetry • Colour • Clarity • Shape • Movement • Pupillary constriction	• Pupils are round, clear, equal in size and reactivity to light • Pupils may be larger than adults • Irises are circular • Eyes move in unison • Shifts between near and far vision tasks and tracks an object across 180° from 12 months	• Fixed or unequal pupil size • Sluggish reactivity to light • Corneal cloudiness or opacity • Strabismus ○ Hypertropia ○ Hypotropia • Limitation in expected eye movements • Coloboma	• Retinoblastoma • Cataract • Scleral icterus • Photophobia • Glaucoma • Optic nerve deficit • Neurological deficit • Trauma • Nystagmus • Strabismus – intermittent or constant	⇒ Prompt referral to medical practitioner for any visual impairment, opacity or strabismus ⇒ Urgent referral to ophthalmologist through medical practitioner for opacities in the pupil or corneal abnormalities

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Light sensitivity • Ability to fix and follow		• Discolouration of sclera		
Ears (continued next page)				
Assess external ear including mastoid process, auricles, tragi and external auditory meatus, noting: • Position • Size • Shape • Symmetry • Colour • Skin integrity • Patency • Firmness of ear cartilage • Observe for infection or discharge of preauricular sinus/	• The superior portion of the auricle is equal in height to the outer canthus of the eye • Auricles are vertical with less than 10° tilt • The pinna is 80% of adult size by 4 – 5 years of age • The pinna is soft and pliable and recoils readily when folded and released • Colour is similar to facial skin	• Inflammation • Erythema • Oedema • Tenderness • Discharge • Lesions or masses • Abrasions • Piercings – deviations may include inflammation, scar tissue, trauma • Bruising around ear	• Otitis Externa • Mastoiditis • Other infection • Sebaceous cysts • Trauma • Environmental conditions	Parent education and support related to external ear may include: • Wax production • Hygiene • Infection control ⇒ Refer to medical practitioner for any suspected infection Child Abuse - consider indicators outside of what may be expected given the child's age and development

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Examine ear canal and visualise tympanic membrane using otoscopy Visible tympanic membrane landmarks include cone of light, umbo, and handle of malleus	• Skin of distal two thirds of ear canal is similar to external ear, and is covered with fine hair • Tympanic membrane is thin oval shaped and concave • Cerumen is a normal protective secretion, ranging from grey, dry and flaky to wet, honey to dark brown colour and texture • Cone of light position: 4-6 o'clock on the right and 6-8 o'clock on the left	• Erythema • Bulging • Retracted • Perforated • Discharge • Grommet • Thickening and scarring of membrane typically appears as white area	• External ear infection • Trauma • Foreign objects, which may precipitate wax production or discharge • Inadequate middle ear drainage • Middle ear infection	⇒ Referral options and parent education and support for: • Foreign bodies • Discharge • Excessive wax or suspected infection

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Nose				
Visual and auditory inspection, noting in relation to nasal bridge, nares, columella and septum: • Symmetry • Shape • Size • Skin integrity • Alignment • Patency of nares	• Septum is straight and in midline of the nose • Nasal passages enlarge in early childhood, allowing easier airflow • Nares can be easily occluded • Child removes obstructions by sneezing	• Mucous or other nasal secretions • Oedema • Epistaxis • Nasal flaring • Asymmetry • Narrowing of the nares • Flattening • Discolouration or lesions	• Infection • Inflammation • Foreign body • Allergy • Nasal polyps • Trauma • FASD	
Mouth (continued next page)				
Using the Oral health examination procedure and ‘Lift the Lip’, inspect: • Gums • Mucosa • Lips	• Oral mucosa is shiny, smooth, moist, and pink (bluish or pale in child with dark skin) • Upper frenulum gradually disappears with growth of maxilla	Gum deviations: • oedema • Lesions • Inflammation • Friable • Halitosis	• Dehydration • Infection: bacterial, viral or fungal • Trauma • Allergy • Environmental conditions	Parental support and education for minor deviations may include: • Teething processes • Drooling

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies

• Tongue
• Teeth
Noting the following:
• Colour
• Symmetry
• Integrity
• Moisture
• Movement of tongue
• Tooth eruption
• Odour
The 'Lift the Lip' resource should be used from 12 months of age, to assess oral health.
	• Lingual frenulum allows child to poke tongue out past lips and move from side to side
	• Deciduous teeth appear between 6–24 months
	• Drooling is normal between 3 and 15 months of age
	• Dorsal surface of tongue is slightly rough, moist and pink, sometimes patterned; ventral surface thin, with prominent vessels
		Lip deviations:
		• Oedema
		• Dryness
		• Lesions
		• Fissures
		• Persistent drooling
		• Persistence of upper frenulum
		Tongue deviations:
		• Coated
		• Plaque or lesions
		• Geographic tongue
		• Macroglossia
		• Ankyloglossia
		• Difficulty swallowing
		Tooth deviations:
		• Plaque
		• Lesions
		• Trauma
			• Poor hygiene
			• Neurological impairment
			• Tooth eruption
			• Nutritional deficiency
			• FASD
			• Myotonia
			• Medications
			• Congenital and genetic abnormalities
			  ○ Trisomy 21/Down Syndrome
			  ○ Hypothyroidism
				• Minor lesions or infections
				• Dental hygiene
				• Healthy eating
				⇒ Direct referral to Dental practitioner is recommended for parental or professional concerns regarding teeth

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Vocal Behaviour				
Auditory observation, and parent report, noting the following: • Speech patterns • Pitch of sounds • Language acquisition	• Will vocalise deliberately using a range of volume and pitch as a means of interpersonal communication • May scream in annoyance • Gradual age-appropriate development of speech and language	• High pitch • Continuous • Hoarseness, acute or prolonged • Excessive crying • Speech sounds inconsistent with developmental expectations	• Raised intracranial pressure • Infection, particularly in upper respiratory tract • Allergy • Hypothyroidism • Dehydration • Pain • GORD • Laryngeal trauma • Neurological condition • Hearing impairment	Parental education and support for minor deviations, may include: • Croup and other upper respiratory infection strategies • Allergy control ⇒Consider further assessment and referral to speech therapist for parental or professional concerns with speech
Chest and Respiratory Function (continued next page)				
Visual and auditory assessment, with child sitting upright, noting: • Chest shape • Movement • Respiratory rate	• Chest shape is round, barrel like and equal to head circumference until about 2 years • After 2 years, chest becomes adult shaped, gradually	• Noisy breathing, including grunting or stridor • Snoring • Crackles • Wheezing	• Infection, including bronchiolitis and epiglottitis • Laryngomalacia • Trauma • Foreign body aspiration • Asthma	Parent education and support may include: • Hygiene practices for respiratory infection control

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Respiratory effort • Breathing pattern • Breathing sounds N.B. Assessment of sleep patterns through parent report may give information related to respiratory tract, allergy or infection	exceeding head circumference by 5-7 cm • Respirations regular at rate of 20-30 per minute from 1-5 years • Symmetrical chest rise and fall • Child may use oral airway spontaneously or in response to nasal occlusion	• Rhonchi • Stridor • Cough • Apnoea • Breath-holding • Cheyne-Stokes breathing • Tachypnoea • Intercostal retraction • Accessory muscle use • Persistent barrel chest	• Croup • Pneumothorax • Increased intracranial pressure • Adenoid or tonsillar hypertrophy • Cardiac conditions • Genetic conditions ○ Cystic fibrosis ○ Joubert syndrome	• Asthma education and action plan as appropriate ⇒ Seek urgent medical review for any signs of respiratory distress which may include stridor, grunting and wheezing, intercostal retraction
Musculoskeletal – General (continued next page)				
Observe for overall symmetry, including: • Length • Strength and tone • Flexibility • Skin folds • Range of motion • Mobility of joints	• Movements are equal in flexibility and strength • Upper and lower limbs are symmetrical in length • Laxity of ligaments predisposes to musculoskeletal	• Muscular pain or tenderness • Bone or joint pain • Oedema • Warmth • Movement limitation • Unilateral weakness	• Trauma ○ Sprain, Strain, Fracture ○ Subluxation/dislocation • Synovitis • Neurological disorder • Scoliosis • Spina bifida	Parent education and support regarding safety, and avoidance of common injuries related to developmental milestones Be alert to non-accidental injury, which may manifest commonly with rib,

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Circulation • Sensation Assess range of movement through observation of activity or play, noting: • Flexion and extension • Adduction and abduction • Internal/external rotation Palpation and passive movement assessment may be required to reinforce visual findings	injury in young children • Movements gradually become smoother and continuous • Mature pattern of muscle action and motion by 3 years of age • Gradual age-appropriate increase in fine and gross motor control and capacity	• Disproportionate limb or digit size, outside normal expectations • Hypermobility of joints • Palpable masses • Muscle contracture	• Rheumatoid arthritis • Haemophilia • Genetic conditions ○ Trisomy 21/Down Syndrome ○ Duchenne muscular dystrophy ○ Marfan syndrome ○ Osteogenesis imperfecta • FASD • Osteomalacia • Tumour • Leukaemia	clavicular, sternal or spinal musculoskeletal injuries ⇒ Consider referral to specialist services where child protection issues are suspected Refer to *Guidelines for Protecting Children 2020* for further information, including information on mandatory reporting
Back and Spine (continued next page)				
Assess general appearance of back while the child is standing erect, noting: • Symmetry, including hips, shoulders and rib cage	• Lumbar curve forms as the infant begins to bear weight and begin to walk • Exaggerated lumbar lordosis is normal in young children	• Rigidity, particularly while sitting • Lateral curvature • Pronounced curvature • Pain	• Genetics • Trauma • Kyphosis • Scoliosis	

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Curvature • Flexibility • Range of movement • Skin	• Normal curvature (C-shaped) develops by 3- 4 years, including neck and lumbar lordosis, and thoracic kyphosis • Bending and stretching should be without resistance			
Upper Limbs (continued next page)				

Assess range of movement in:
• Hands
• Elbow
• Wrists
• Shoulders
Noting the following:
• Strength
• Flexibility
	• Able to use both hands and arms equal in strength and flexibility
	• May show hand preference by 18 months of age
	• Development and ossification of the hands continues until 11-12 years of age
	• Normal arm swing begins from 18 months and arms
		• Oedema
		• Distortion
		• Limited or reluctance with movement
		• Pain or discomfort on movement
		• Asymmetrical tone on movement, including limpness
		• Digital clubbing
		• Persistent fist formation
			• Trauma
			  ○ fracture, subluxation, or soft tissue injury
			• Neurological deficit
			• Genetic conditions
			  ○ Edwards syndrome
			  ○ Marfan syndrome
			  ○ Rubinstein-Taybi syndrome
			  ○ Achondroplasia
			  ○ Cerebral palsy
			• Environmental conditions
			• Child Abuse
				Parent education and support for:
				• Expected range of movement and ability for age
				• Injury prevention e.g. radial-ulnar joint subluxation and shoulder dislocation are common from 2-4 years of age
				Child Abuse - Consider sign of child

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	move reciprocally with legs by 2 years			abuse and conduct further assessment Refer to *Guidelines for Protecting Children 2020* for further information.
Hips				
Follow Hip Assessment procedure to assess gait and toe walking	• Gait is symmetrical, though may be disjointed in toddler	• Waddling or limping gait • Unilateral toe walking	• Conditions which may be associated with hip deviations include: • Genetic conditions ○ Trisomy 21/Down Syndrome ○ Larson's syndrome • Congenital Arthrogryposis • Spina bifida • Scoliosis • Developmental Dysplasia of Hips	⇒ Referral for medical review where any previously undiagnosed hip dysplasia is suspected

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Lower Limbs (continued next page)				

Assess lower limbs through observation of child standing and gait, noting:
• Muscle tone
• Strength
 	
Observe for symmetry in;
• Length
• Strength
• Flexibility
• Movement
• Skin folds
	• Legs are equal in length, movement, strength and flexibility
	• Stance includes wide base of support, hyperextension of knees and hips, and disjointed (toddling) pattern when walking. Stance is slightly apart by 2 years and in line with body by 4 years. which gradually becomes more smooth
	• In-toeing normal from 15 months and usually resolves by 4 years
	• Genu varum (Bowleggedness) - normal to 2.5–3 years
		• Asymmetrical
		  • skin folds
		  • Movement
		  • Tone
		  • Rotation
		• Unequal limb length
		• Bowed legs with space greater than 5 cm between knees after 2.5–3 years
		• In-toeing affecting mobilisation
			• Trauma, including fractures or subluxation
			• Talipes
			• Tibial torsion
			• Nutritional deficiency
			  ○ Vitamin D, calcium and protein
			• Genetic Conditions
			  ○ Edwards syndrome
			  ○ Rubinstein-Taybi syndrome
			  ○ Achondroplasia
				Parent education and reassurance of common deviations which should resolve spontaneously, including:
				• Tibial torsion by 4-5 years
				• Genu valgum by 7 years
				• Genu varum by 2.5–3 years
				
				⇒ Consider referral to GP relevant allied health services for specialised treatment of positioning or movement deviations

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	• Genu valgum (Knock knees) - common until 7 years			
Assess foot and heel, noting: • Position and alignment • Range of motion	• Feet are supple • Plantar crease is visible on each foot • When supine, the lateral malleoli may normally rotate up to 20 degrees posteriorly • Pes planus (flat feet) are normal in early walking phase • Longitudinal arch develops by 2-3 years • Walking mostly with heal toe gait and toe walking lessens 6 months after walking and resolves by 3 years	• Rigidity or limited range of movement, including dorsiflexion • Flat feet (Pes planus) persistent after 2-3 years • Heel or arch pain • Toe-walking most of the time 6 months after started walking or persisting beyond 3 years	• Trauma • Genetics ○ Duchenne muscular dystrophy • Cerebral palsy • Short Achilles tendon • Autism	Parent education and support may include: • Discourage the use of equipment such as walkers and jolly jumpers ⇒ Consider referral to relevant allied health services for specialised treatment of positioning or movement deviations

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Abdomen				
Visual inspection and palpation where required, noting: • Size • Shape • Symmetry • Contours • Bowel sounds • Skin texture, colour and integrity • Nutritional status	• Protuberant and round (pot-bellied) normal until 4 years • Abdomen moves with respiration • Soft • Symmetrical • Bowel sounds present	• Reduction or increase in bowel motions, including consistency, or colour • Vomiting • Pain, tenderness or guarding • Distension • Tension or rigidity • Visible peristalsis • Palpable masses or protrusions • Swelling or lesions • Hyperactive or absent bowel sounds	• Gastrointestinal infection • Constipation • Normal response to dietary changes • Peritonitis • Full bladder • Obstruction • Paralytic ileus • Trauma • Malnutrition • Foreign body • Coeliac disease • Cystic fibrosis • Hirschsprung's disease	⇒ Urgent referral to medical practitioner for: • Sustained vomiting • Reduced bowel sounds • Pain on palpitation and/or guarding/rigidity
Umbilicus (continued next page)				
Visual inspection, noting: • Size • Shape	• Forms a visible depression or protrusion on skin	• Swelling • Masses • Lesions	• Herniation • Polyp • Granuloma	Parent education and support may include: • Routine umbilical care

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
• Contours • Skin integrity	• Size shape, depth, length, and overall appearance is variable	• Discharge • Lint	• Dermoid Cyst • Diastasis recti abdominis	
Buttocks and Rectal Area				
Inspection should include discussion with parent, noting: • Anal patency • Skin • Elimination patterns • Toilet training History of dietary intake and growth pattern may contribute to assessment	• Stools may be passed normally from 1-3 times per day through to 2-3 times per week • Stool consistency is highly variable, but should be soft, formed, and easy to pass without pain or trauma • Continence develops from 2 years of age with an average of 3 years	• Lesions • Lacerations or tears • Bruising • Discolouration • Tufts of hair, particularly in crease • Evidence of itching • Erythema • Inflammation • Fissures • Skin Tags • Changes in frequency or consistency of bowel motions	• Response to change in nutritional intake • Genetics • Infestation • Constipation • Infection • Polyps • Trauma • Child Abuse	Parental support and education may include strategies to address minor deviations with • Elimination patterns • Nutritional needs • Physical activity needs for normal bowel function • Hygiene • Toilet training ⇒ Consider referral to specialist services where child protection issues are suspected ⇒ Refer to *Guidelines for Protecting Children 2020* for

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
				further information, including information on mandatory reporting
Urinary System				
Assess fluid intake and urinary output by parental report, noting: • Frequency • Volume • Colour • Bladder control Visual assessment and dip stick analysis of urine sample where relevant	• Young child's urine output is >1 ml/kg/h • Bladder capacity is about 1% of child's body weight • Toddlers and pre-schoolers will void on average between 8-14 times per day • Kidneys immature until 2 years, predisposing child to dehydration and hypovolaemia • Urine colour is clear, and pale yellow to amber	• Decrease in volume and frequency • Cloudy urine • Weight loss • Signs of dehydration • Haematuria • Strong smelling urine • Behavioural irritability • Fever • Vomiting	• Diabetes • Urinary tract infection • Urinary reflux • Pyelonephritis • Glomerulonephritis • Other infection • Changes in fluid intake	Parental education and support may include: • Fluid requirements • Expected urinary output • Timing and strategies for developing bladder control ⇒ Refer for medical review of any signs of urinary tract infection

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Genitourinary – Male				
Use visual inspection of penis and scrotum and inguinal areas, and palpation of testes, noting: • Position • Size • Patency of urethra • Skin • Testicular descent (At 2 years enquire about testicular descent) N.B. Do not attempt to forcibly retract the foreskin	• Urinary orifice is patent, uncovered by the prepuce, located at the tip of the glans penis • Retraction of foreskin is possible by 3 years of age • Scrotum is normally loose and wrinkled • Testes descended • Cremasteric reflex is strong in early childhood initiated in response to cold, wet or anxiety	• Balinitis • Hypospadias • Chordee • Phimosis (tight foreskin) • Deviations in position of testes • Small flat scrotum • Enlarged scrotum • Absent cremasteric reflex • Scrotal pain • Lymphadenopathy • Inguinal swelling • Circumcision – post surgical deviations may include bleeding, redness, cyanosis, discharge or swelling	• Genetics • Infection • Undescended testis • Retractile testis • Hydrocele • Testicular torsion • Inguinal herniation	⇒ Urgent referral for paediatric surgical review of signs of torsion which may include: pain, scrotal swelling, unilateral absence of cremasteric reflex, nausea and/or vomiting and later, scrotal oedema ⇒ Refer to medical practitioner for review of any deviations in testicular descent

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Genitourinary – Female				
Visual inspection of: • Labia • Vaginal orifice • Urethral meatus • Perianal area • Inguinal area Noting the following: • Shape • Position • Contours • Patency • Skin integrity	• Labia minora is thin, covers the urethral and vaginal orifices • Labia minora frequently protrudes from the labia majora • The vaginal orifice is partly covered by the hymen membrane, which varies but is normally annular and crescent shaped • No vaginal discharge • Urethral meatus is small	• Rashes • Lesions • Erythema • Lacerations • Bruising • Oedema • Pain • Discharge • Odour • Labial adhesion or partial fusion • Tenderness in the lower abdomen • Bulging or tenderness in inguinal area • Lymphadenopathy	• Allergy • Infection, including fungal, viral or bacterial • Trauma • Child abuse • Foreign body • Allergy or atopy • Infestation, e.g. pinworm	Parental education and support may include: • Normal age appropriate developmental expectations • Hygiene requirements ⇒ Refer the child for immediate specialised assessment where there are any child protection concerns Refer to *Guidelines for Protecting Children 2020* for further information, including information on mandatory reporting

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
Skin (continued next page)				
Visual inspection, and palpation where required, noting the following: • Colour • Texture • Integrity • Turgor • Hydration of exposed skin and mucous membranes • Temperature N.B. • Skin should be inspected in areas of natural light, or a well-lit space with fluorescent lighting where possible • Where colour change is suspected, inspect skin in an area	• Exposed skin areas normally feel dryer than body creases • Mucous membranes are moist • A child's skin is normally smooth and even • Skin colour variation occurs between and within races and affects assessment findings • Darker skin is often normally drier	• Pallor • Redness • Plethora of protein • Bruising- consider signs of child abuse • Rashes, lesions, scars • Thickening, drying, cracking, flaking or scaling, Blistering of skin • Itching • Clamminess • Hairy patches, or dimpling in the lumbosacral area • Cyanosis, either extremities or central • Jaundice • Clustered pigmentation	• Syncope • Anaemia • Hypo or hyperthermia • Trauma • Child Abuse • Stress • Dehydration • Burns • Infection, including fungal, viral or bacterial • Eczema (atopic dermatitis) • Infestation • Nutritional deficit • Raynaud's phenomenon • Exposure to environmental extremes • Behavioural deviations, such as thumb or finger sucking • Neurological disorder	Parental education and support may include strategies for: • Minor rashes, infections or infestations • Allergy and eczema (atopic dermatitis) • Hygiene • Safety and avoidance of common skin injuries related to developmental milestones, including sun safety Child Abuse - consider indicators outside of what may be expected given the child's age and development

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
where there is less melanin, and use palpation and temperature assessment to add to findings			• Endocrine disorders • Liver disease • Congenital heart or lung disease	• Refer to *Guidelines for Protecting Children 2020* for further information, including information on mandatory reporting
Nails (continued next page)				
Visual inspection, noting: • Colour • Contour • Thickness • Texture Assess time of capillary refill (in relevant settings)	• Nail beds are pink, smooth, flat or slightly convex, with uniform thickness • Nails are adherent to nail bed • Capillary refill is 2-3 seconds or less	• Dry or brittle nails • Paronychia (inflammation of surrounding skin) • Tenderness • Convex or concave curving • Cyanosis • Pallor • Yellow or white colour • Thickened nail bed	• Anaemia • Nutritional deficiency • Trauma • Infection, commonly bacterial or fungal • Hypoxia • Endocrine disorder • Trachonychia • Ectodermal dysplasia • Chronic respiratory or cardiac disease	Parental education and support may include strategies related to: • Nail care • Behavioural deviations • Localised infections • Nutritional needs

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
		• Transverse depressions or grooves (Beau's lines) • Splinter haemorrhages • Nail-biting or picking • Clubbing • Prolonged capillary refill	• Behavioural deviations such as nail-biting, thumb sucking • Stress or significant illness • Genetic conditions	
Hair (continued next page)				
Visual inspection, noting: • Colour • Quality • Texture • Quantity • Distribution	• Short, fine, poorly pigmented vellus hair covers all but the palms, soles and mucous membrane areas • Thick, mature terminal hair replaces intermediate vellus hair on scalp by 2 years of age • Terminal hair is more coarse, thick longer and pigmented and	• Coarse • Dull, dry or brittle • Delayed growth • Thin distribution • Alopecia • Irritation, dryness, lesions or scaling of scalp • Infestation • Matting • Oily or dirty hair	• Infection, e.g. tinea capitus (ringworm) or impetigo • Infestation • Seborrheic dermatitis • Nutritional deficiency • Thyroid disorder • Immune disorder • Hormonal disorder • Behavioural disorder, such as hair pulling • Ectodermal dysplasia	Parental education and support may be provided for common deviations such as: • Infestation • Infection • Dermatitis • Hygiene needs • Age appropriate behavioural management related to hair

1 to 4 years - Area	Within the Norm	Common Deviations	Possible Causes	Specific Strategies
	grows on the scalp and eyebrows	• Precocious or delay in body hair distribution	• Neglect • Stress or recent illness • Environmental exposure e.g. chlorine, frequent washing	