Saskatchewan Child Health Clinic Guidelines for Standard Practice

Appendices 180

Purpose:
The Saskatchewan Child Health Clinic (CHC) Guidelines for Standard Practice are based on prevention principles and population health strategies. They outline the services provided by Public Health Nurses (PHNs) to promote, protect, and preserve the health of children and families in Saskatchewan.

Goal:
The goal of the Saskatchewan CHC Guidelines for Standard Practice is to support families in the growth, and development of their children and to prevent communicable disease.

To provide a standard of practice for CHC services in Saskatchewan to facilitate the collection of consistent information for a future electronic family health record which may be applied to population based health promotion strategies.

Saskatchewan PHNs will utilize the CHC Guidelines for Standard Practice to provide a consistent evidence based assessment, early identification, and referral to improve the health of the population.

Objectives:
- To provide standardized services to infants, preschool children and their families.
- To provide evidence based guidelines for all CHC assessments.
- To continue interdisciplinary consultation with health care providers in order to maintain evidence based practice.
- To implement the Saskatchewan CHC Guidelines for Standard Practice in each regional health authority (RHA) across Saskatchewan.

Philosophy of Child Health Clinics:
The *Saskatchewan Plan for Growth - Vision 2020 and Beyond* looks to the future of Saskatchewan and 1.2 million residents. The *Saskatchewan Plan for Growth* is to secure a better life for all the people of Saskatchewan. (Government of Saskatchewan, 2013) In support of the Saskatchewan Plan for Growth, a Cabinet Committee called the Child and Family Agenda has been developed to respond to important issues facing Saskatchewan children, youth and families. The goals of this committee are: children get a good start in life; youth are prepared for their future; families are strong; communities are supportive.

The Inter-Ministerial approach of the Child and Family Agenda acknowledges that complex interactions between individual characteristics, social and economic factors and physical environments determine a child's health. Healthy child development is in itself a powerful determinant of health. The early identification of priority risks to a child's optimal health and development may influence the health outcome of children and their potential contribution to society. Opportunity exists for PHNs to help families take action on priority risk factors that impact a child's growth and development during the first five years of life. Interventions in partnership with the family and other service providers are essential. The CHC is an appropriate setting where potential risk factors may be identified and planning for interventions can begin. The PHN possesses the knowledge and skills necessary to identify potential risk factors and identify possible interventions to enhance the health and well being of the child and family.

Guiding Principles:

When providing services in the CHC setting, the PHN uses the nursing process (assessment, diagnosis, plan, implement, and evaluate) and provides a service that:

- focuses on the needs of the child and family;
- builds on parent's knowledge and skills to increase family capacity and self-reliance;
- recognizes that the client is the one who decides to engage in care and who will participate in his/her care;
- safeguards the best interests of children;
- follow principles of primary and secondary prevention;
- focuses on improving outcomes for the child and family;
- ensures referral and follow-up with the appropriate services;
- understands that health inequities are caused by disparities in income, education, social supports, housing and physical environments, access to health services, as well as healthy child development, personal health practices, and coping skills;
- considers the root causes of ill health by recognizing that improving a client's health may also require focusing on changing the conditions and environments in which people live, work and play;
- considers the values and practices of client centred care and therapeutic relationships as the basis of nursing practice; and
- is sensitive to social, linguistic and cultural diversity of families and communities.

Values and Beliefs:

The following values and beliefs are the foundation of client centred care (RNAO, 2006). These are presented as factors to be considered as influences in organizations when determining policy and practice guidelines. These values and beliefs are not directive but suggestive of how service should be provided. Some are similar to the Code of Ethics of the Canadian Nurses Association (CNA).

***Respect*:** Respect clients' wishes, concerns, values, priorities, perspectives, and strengths.

***Human Dignity*:** Care for clients as whole and unique human beings, not as problems or diagnoses.

***Clients as Leaders*:** Follow the lead of clients with respect to information giving, decision-making, care in general and involvement of others.

***Clients' Goals Coordinate Care of the Health Care Providers*:** Clients identify their needs that coordinate the practices of the health care providers. All health care providers work toward facilitating the achievement of these goals.

***Continuity and Consistency of Care and Caregiver*:** Continuity and consistency of care and caregiver provides a foundation for client centred care.

***Timeliness*:** The needs of clients and communities deserve a prompt response.

***Responsiveness & Universal Access*:** Care that is offered to clients is universally accessible and responsive to their wishes, values, priorities, perspectives, and concerns.

Child Health Clinic Procedure:
Every family attending CHCs is offered standard assessment services in the areas of parental concern, immunization, nutrition, and growth assessments within a recommended 30 minute allotted appointment time. Additional assessments will be provided based on parental concern or at the discretion of the PHN. Regional Health Authorities have the discretion to adjust the CHC time but are encouraged to support the Standard Work recommendations from the PHN Managers committee. The PHN partners with the family to facilitate follow-up and/or referrals as needed. Standard documents at CHCs include the Growing Up Healthy[1] series and Saskatchewan Ministry of Health immunization fact sheets.[2]

[1] http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/children-health-and-parenting/growing-up-healthy
[2] http://www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/support-programs-and-services/immunization-programs-and-services

Principles:

- Child Health Clinics are family centered and parental concerns are the priority of the CHC assessments.
- Immunization protects the population from vaccine-preventable disease and is a cornerstone of Public Health. Immunization services will be offered according to the most current recommendations in the Saskatchewan Immunization Manual.[3]
- Healthy lifestyles across a lifespan will reduce the risk of chronic disease. Growth, dental (oral health) and nutrition assessments will be provided based on the attached protocols.
- Standard Assessments will be provided at the current targeted age groups as follows:
  - 2 month assessments for ages 6 weeks to 4 months;
  - 4 month assessments for ages 4 months to 6 months;
  - 6 month assessments for ages 6 months to 12 months;
    - Assessment indicators broken into 3 month periods as appropriate (6 – 9 months; 9 – 12 months).
  - 12 month assessments for ages 12 months to 18 months;
    - Assessment indicators broken into 3 month periods as appropriate (12 – 15 months; 15 – 18 months).
  - 18 month assessments for ages 18 months to 4 years of age;
    - Assessment indicators broken down into 6 or 12 month periods as appropriate.
  - 4 year old assessments for ages 4 to 6 years of age;
    - Assessment indicators broken into 12 month periods as appropriate.

- The Standard Assessments are to be conducted by PHNs with every client and family attending a CHC in Saskatchewan. The following are considered Standard Assessments for CHCs:
  - Assessment of parental concerns.
  - Assessment of eligibility and provision of publicly funded vaccines.
  - Assessment of child growth.
  - Assessment of child nutrition which includes the feeding relationship and oral health.
- Along with these Standard Assessments, there are targeted questions that are specific to the age categories to which PHNs provide service.
- Review of key developmental milestones may be included in the targeted questions.
- Standard Assessments must be offered consistently to ensure provincial standardization of service and data collection.

[3] http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx

- Additional Assessments are those assessment services provided when identified through parental concern or by PHN lead questioning. The following assessments may be included as Additional Assessments for CHCs:
  - Physical – sleep/cry, head to toe, hearing and vision;
  - developmental assessment/speech and language/sexual health;
  - maternal mental health;
  - health education/ injury prevention (anticipatory guidance);
  - family dynamics;
  - violence/ abuse;
  - seasonal concerns; and
  - second hand smoke.
- It is expected that PHNs will have knowledge and resources required to provide the Standard and Additional Assessments.
- Public Health Nurses are to use their acquired knowledge of children's growth and development through previous learning and skill development.
- Parents/caregivers expect that PHNs will share their knowledge of growth and development to assist in the parent/caregiver's assessment of how their child is doing and what to expect in the coming months as their child continues to grow and develop. This provision of information and anticipatory guidance are considered inherent to PHN practice and will be documented under targeted questions or the developmental section if a full screen is required.
- Regional Health Authorities/First Nations Jurisdictions may offer Additional Assessments or include other regional special programs as required but standardized recording and data collection will not be available.
- These CHC Guidelines for Standard Practice including Protocols will be reviewed on an ongoing basis to maintain evidence informed practice or provincial direction. The reviewing experts will be a sub-committee of the Managers of Public Health Nursing in Saskatchewan Committee.

Request for Assessments from others

Any agency, organization or professional group wanting access to the time in CHCs from a provincial perspective for the purpose of survey, data collection, education or other will be asked to submit in writing a letter to the Ministry of Health requesting the time or service, the purpose of it, its relevance to CHCs and the length of time required to initiate, provide and complete the project or assessment. The PHN Consultant responsible for the CHCs will bring the request forward to the Managers of Public Health Nursing in Saskatchewan Committee meeting as a discussion and recommendation item.

A request for more information to the requesting group or decision will be sent out within four weeks of the meeting. The recommendation from the Mangers of Public Health Nursing will affect CHC services in Saskatchewan.

If a request comes for a special project in a specific RHA, the PHN Manager from that RHA may bring the request to the Managers of Public Health Nursing for discussion and recommendation, however, the PHN Manager in the requesting RHA will make recommendations for that particular RHA.

Procedure:
The protocols for the assessments are contained in the age related assessments. Standard Assessments are listed first then Additional Assessments.

Documentation of the assessments will be by exception on the Early Childhood Assessment Form (may be referred to as the chart or client record throughout this document). If the assessment is determined to be within normal limits and there is no apparent problem (NAP), circle NAP in the appropriate box. If the assessment is not completed, circle NA (not assessed) in the box. If the assessment results indicate there is a need to observe (OBS), refer (REF) or under continued care (UCC), write the appropriate abbreviation in the box. If the assessment has been followed up from a referral or observation and is no longer a concern, write Closed (CLS) in the box. Nurses' Notes will be brief and concise statements about the concern. Please see Appendix 1, Child Health Clinic Charting Tool and Appendix 2 for Guidelines for Child Health Clinic Charting Tool for further explanations and details.

Guidelines for Referrals
If a referral is required following the assessment of a child/family, here are suggested parameters for the PHN to follow-up:

- Follow-up for the referral should be done at the next CHC. Parents/caregivers should be asked about follow through with the referral and results of any interventions.
- If a client has not heard from the agency they are referred to, the client is encouraged to contact the PHN for assistance and direction.
- When a PHN receives a report from a referred agency, a summary of the information should be recorded on the client's record. The file is then stored or shredded as per the RHA policy.
- The PHN will use her discretion in determining if follow-up of a referral needs to occur prior to the next CHC visit.

Standard Assessments

Demographics

Purpose:
To ensure contact information on clients is current and up-to-date.

Goal:
To have updated demographic information such as address, phone number and correct names in case of the need for follow-up or access to other health services.

Standards:
Parent/caregiver is asked to confirm current demographic information and provide updates as needed. PHN to determine client's age or adjusted age as required.

Principles:
Updated information allows for the correct person to be provided the right services at the right time. If required, referrals and follow-up services will also be provided in a timely manner based on correct demographic information.

Procedure:
The parent/caregiver is asked to confirm information on name, address and phone number at each visit by the PHN or administrative support person.

Determination of age of child:
Take the date the child is to be seen and subtract the child's date of birth to determine child's age in years/months/days

E.g. Encounter date (Jan. 14, 2014)	2014 01 14
Child's date of birth (June 10, 2012)	2012 06 10
	01 07 04

Child's age is; 1-7-4 which reads one year, seven months and four days. This age can be recorded on the charting tool in this manner: 1-7-4.

For children born < 37 weeks gestation or earlier, calculate adjusted age and assess development and growth based on adjusted age until the child is 24 months of age chronologically.

For adjusted age in weeks, subtract the difference between 40 weeks gestation and actual weeks gestation at birth, to arrive at the corrected age in weeks. E.g. if an infant is 16 weeks postnatal age, and was born at 30 weeks gestational age, her corrected postnatal age is: 16 – (40-30) = 6 weeks corrected age.

Growth and development assessments need to be based on the corrected age until 24 months of age. Document the adjusted age of the child on the WHO Growth Chart in the comment section as adjusted aged (A. A. ###) and chart.

Time Required:
Approximately one minute if changes are required.

Indicators:
Parents/caregivers are consistently asked for updated demographics when they present at CHC.

PHN Resources:
n/a

Suggested resources/handouts for parent/caregiver as needed:
To update or apply for a Saskatchewan Health Card, go to this link**:**
http://www.saskatchewan.ca/live/health-and-healthy-living/health-cards/replace-or-update-a-health-card

In person applications are no longer accepted.
Phone number for contact is **1-800-667-7551.**

References:
Saskatchewan Registered Nurses Association Standard of Practice
www.srna.org

Canadian Nursing Association Code of Ethics
http://www.cna-aiic.ca/en

General Health

Purpose:
To determine the general health status of the client (child) including allergies, chronic and acute illnesses, and congenital anomalies.

Goal:
To ensure the child is healthy to receive immunization.

To identify children with any allergies, chronic health conditions, congenital anomalies, or with any significant previous and/or current health concerns. In relation to Immunization services, particular attention needs to be on those disease processes that may affect the immune system.

Standards:
Child's health status is assessed generally and as part of the immunization assessment.

Principles:
A child's physical health affects their development and growth. Early detection and proper management of health issues will improve a child's potential for optimal growth and development.

Procedure:
Ask parent/caregiver if the child has:

- developed any new allergies since the last visit;
- if the child has been well;
- if they have had any change in their medication or have needed new medication;
- if the child has had a fever in the last 24 hours;
- if the child has been diagnosed with any medical conditions or congenital anomalies; or
- if the child had any recent hospitalizations.

Answers to this inquiry should be recorded on the child's record.

Documentation:
If there is no change in the child's health status circle apparent problem (NAP. If a change in health status has occurred (new allergy, disease process, hospitalization), provide a concise statement in the Nurses' Notes. Indicate if this change is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS). If these questions are not asked, circle NA (not assessed) and provide reason why in Nurses' Notes.

Example: If a child has a previous diagnosis of seizures, on the next visit a notation of Under Continued Care (UCC) would be marked if the child continues on medication or is being followed by another health professional. Observe (OBS) could also be used depending on the context of the situation. Either reference would be appropriate with accompanying Nurses' Notes.

Time Required:
Dependent on concerns; less than one minute.

Indicators:
n/a

PHN Resources:
Saskatchewan Immunization Manual

Suggested resources/handouts for parent/caregiver as needed:
Ministry of Health Immunization Fact Sheets (refers to health status and when not to immunize)

References:
n/a

Parent Concern/Targeted Questions

Purpose:
To address parent/caregiver concerns and have the clinics be client focused.

Goal:
To address concerns parents/caregivers have about their child's health, growth, development, behaviour or other concerns.

Standards:
The child and his parent/caregiver concerns and questions are the priority of the CHC visit. These concerns and questions should be addressed based on priority of the parent/caregiver whether it is within the time of CHC or if another time/appointment is more appropriate.

Principles:
Public Health Nurses provide client centered care. This is the priority and base of all services.

Procedure:
Parents/caregivers are asked if they have any questions or concerns about their child's physical growth, health, behaviour or development.

Parents/caregivers are asked key targeted questions that are specific to each age. Further additional assessments or referrals may be provided as needed.

Documentation:
Charting of parent questions or concerns will be done in the assessment area that the concern is in whether it is a standard and additional assessments. Example: if the concern is around the child getting enough milk, the concern will be charted under the Nutrition Assessment and in the Nurses' Notes.

Targeted questions are asked in the Parental Concern section. When targeted questions are asked of the parent, document answers in the targeted questions box. If no apparent problem (NAP), circle NAP. If concerns are expressed, indicate OBS, REF, UCC or CLS and document in the Nurses' Notes. If these questions are not asked, circle NA and provide reason why in Nurses' Notes.

Time Required:
Two to five minutes or more may be required.

Indicators:

- number and type of concerns expressed by parent; and
- number of referrals made for parent concerns (This will be dependent on ability to develop a report).

Resources for PHNs:

- Saskatchewan Child Health Clinic Guidelines for Standard Practice procedures and protocols for standard and additional assessments.

Suggested resources/handout for parent/caregiver as needed:

- Additional handouts will be based on parental concern and may be found under the specific assessment area listed in this document.
- Suggested parenting resources:
  - Parents Matter: www.parentsmatter.ca
  - Healthy Parenting Home Study Program (Saskatchewan Prevention Institute: www.skprevention.ca
  - Healthy Parents Healthy Children: www.healthyparentshealthychildren.ca
  - Canadian Paediatric Society Patient Education Materials: www.cps.ca
- Areas of parent concern: child care, preschool information, and community activities. These resources may be RHA dependent.

References

References and resources are dependent upon the concern and/or question presented.

Growth Assessment

Purpose:
To identify children who are at risk due to deviations from normal growth patterns.

Goal:
To weigh and measure each child attending CHC and provide interpretation of the results to the parent/caregiver.

To provide parents/caregivers with anticipatory guidance, knowledge, and support needed to affect factors that impact the growth of their child such as physical activity, nutrition, the feeding relationship, mental health and environment.

Standard:
A child is assessed for growth at all ages when they present at CHC by the PHN. When a child's measurements are outside the healthy weight percentiles, the PHN will refer to the child's primary care provider or other healthcare professional.

Principles:
- Growth is the best indicator of infant and child nutritional status.
- Growth assessment, in addition to medical and dietary history and laboratory findings, can help identify feeding, congenital, cognitive or other physical concerns.
- Poor nutrition for infants and children impacts weight gain as well as possible poor growth in length, head circumference and possible failure to thrive.
- Over nutrition adversely impacts growth, as early childhood/infancy is a sensitive period of time in the development of obesity.
- Substantive increases in obesity rates among young children points to the need for early growth monitoring as a part of a comprehensive and integrated health promotion strategy including the promotion, protection and support of breastfeeding and establishment of positive feeding relationships.
- Children at risk for growth deficits are those who have one or more of the following:
  - born to women under duress i.e. poverty, decreased family support systems, decreased access to quality health care, mental or physical health concerns which interfere with the establishment or maintenance of a healthy relationship with the child;
  - children born <2500gms or >4000 gms;
  - children who have feeding difficulties related to genetics (metabolic disorders) or biology (cleft-palate);
  - attachment disorders; or
  - who are not exclusively breastfed for the first six months of life.

- For children born <37 weeks gestation or earlier, calculate adjusted age and assess development and growth based on adjusted age until the child is 24 months of age chronologically. For adjusted age in weeks, subtract the difference between 40 weeks gestation and actual weeks gestation at birth, to arrive at the corrected age in weeks. E.g. if an infant is 16 weeks postnatal age, and was born at 30 weeks gestational age, her corrected postnatal age is: 16 – (40-30) = 6 weeks corrected age.

Note: Growth monitoring charts alone should not be used to make a diagnosis.
Parent's size, infant feeding methods and knowledge of health problems are equally important factors to be considered.

Procedure:
How to obtain measurements:

- Head circumference - should be measured prior to undressing the child.
  - Use a flexible, not stretchable tape.
  - Position the tape just above the eyebrow, above the ears and around the biggest part on the back of the head.
  - Measure to the nearest 0.1 cm.
- Weighing Infants.
  - The infant, up to 12 months of age, should be weighed nude on a balance beam or electronic (digital) scale. (Child may be weighed in a dry diaper if concerned about potential contamination of scale. A note is to be made on the WHO Growth Chart that the infant was weighed in a dry diaper).
  - The scale should be accurate and reliable with a maximum weight of 20kg in one gram or 10g increments and easily "zeroed" and recently calibrated. (calibration should be done to manufacturer's standards) The "average weight" feature is desirable on an electronic scale to accommodate those infants who do not remain still during the weight measuring.
  - Weight is recorded to the nearest 0.1kg.
- Weighing Children.
  - A child one year and older may be weighed with a dry diaper, light under garments, or light clothing on.
  - A child 24 months or older is weighed standing on a balance beam or digital scale, provided they can stand on their own.
  - Weight is recorded to the nearest 0.1kg.

Note: Children unable to stand unsupported may need to be held by someone, with the weight of the person holding the child subtracted from their combined weight.

- Measuring Infant Length.
  - Use a calibrated length board or infantometer, with fixed headpiece and movable foot piece which is perpendicular to the surface of the table.
  - The PHN and the parent/caregiver are needed to get an accurate measurement.
  - Infant or child is in a recumbent position, i.e. knees straight, eyes facing the ceiling. Keeping legs straight, place infantometer alongside the infant and close the instrument until it touches the head and feet. At this point, tighten the small thumbscrew on the bottom of the infantometer to hold sliding points firmly in position until measurement is taken in centimeters.
  - Measure length to nearest 0.1cm.

**** For those toddlers (up to 24 months) who will not lie down to be measured, height can be measured. **Remember to add 0.7cm to the height and record the result as length on the chart.** (Weight for length is calculated for children less than 24 months)
Measuring Child Height.

- Young children from 24 to 36 months may have either length or height measured. For children three years of age or older, height should be measured. Children with physical disabilities (unable to stand) may require a recumbent length measurement.
- A stadiometer for height measurements requires:
  - a wall mounted vertical board with an attached metric rule;
  - a horizontal headpiece that can be brought into contact with the superior part of the head;
  - height may also be measured using a measuring tape attached to a wall and a Staedtler Square; and
  - the metal attachment on a stand up scale is not considered an accurate method of measuring height.
- Child stands against the stadiometer without shoes, with heels together, legs straight, arms at sides, shoulders relaxed.
- Ensure that the child is looking straight ahead.
- Bring perpendicular headpiece down to touch the crown of the head.
- Measurer's eyes are parallel with the headpiece.
- Measure to the nearest 0.1cm.

**** Talk with parents/caregivers about trends in growth as opposed to using individual measurements as a diagnostic indicator.

See Nutrition and Growth Assessment Manual for Healthy Full Term Infants and Children (NAMIC) Guidelines for Referral Resources.

Calculation of Body Mass Index (BMI):

- After measuring a child's height and weight (age two years and older) the BMI is calculated before documenting on the growth chart.
- BMI is calculated using the following formula:

  BMI = Weight (kg) ÷ Height (cm) ÷ Height (cm) x 10,000

  Example: 4 year old boy; weight 15 kg, height 103 cm

  BMI= 15 kg ÷ 103 cm ÷ 103 cm x 10,000

  BMI = 14

When to refer:

1. Any sharp decline in the growth line needs further investigation. A referral should be made to the primary care provider when:

- This is a very significant change in the child's growth.
- A sharp decline in a normal or undernourished child indicates a growth disturbance.
- A sharp decline in an overweight child could indicate an undesirable rapid weight loss.
- Changes in weight or length/height should be investigated before a child crosses two major percentile lines.

2. Any sharp incline in the growth line needs further investigation. A referral should be made to the primary care provider when:

- This is a very significant change in the child's growth.
- An unexplained sharp incline may signal a change in feeding practices that may lead to a child being overweight.
- A sharp incline in a previously ill or undernourished child may be "catch up" growth and expected in re-feeding period. (this is not a cause for referral but PHN may want to observe).
- Changes in weight or length/height should be investigated before a child crosses two major percentile lines.

Documentation:

- Refer to WHO Growth Chart orientation or the Dietitians of Canada WHO Growth Chart Training Modules at www.dietitians.ca/Knowledge-Center/Events-and-Learning/Online-Courses/WHO-Growth-Chart-Training.aspx
- Record and plot measurements on the appropriate WHO Growth Chart.
  - Choose the appropriate growth chart based on the client's age and gender.
- Calculate age of client (adjust for actual or corrected age) and round age (to nearest completed half month for children < 24 months and to the complete quarter year for children > two years) to plot.
  - 12 months and 1 week = 12 months.

- Parents' height (biological mother and father) should be recorded, on the gender appropriate WHO Growth Chart, the first time the client is seen. This will usually occur with a postnatal visit or at the two month CHC visit.
- If client is being measured more frequently than scheduled CHC visits, the health care provider will need to add rows to the existing documentation area to capture ongoing measurements.

Time Required:
Three minutes – explanation and discussion with client – carried out concurrently during the procedure.

Indicators:
- Number of infants/toddlers that are weighed, measured for length and head circumference under the age of two years.
- Percent of children that are weighed, measured for height and have BMI calculated over the age of two years. (denominator based on those who attend CHC)
- Percent of infants/toddlers with weight/length ratio <97th percentile or >3rd percentile.
- Number of infants/toddlers with head circumference for age <97th percentile or >3rd percentile. (denominator based on those who attend CHC)
- Number of referrals to professionals for over or under weight.
- Number of children with BMI ratio <97th percentile or >3rd percentile.

PHN Resources:
- 2014 WHO Revised Growth Charts for Canada (Appendix 18)
- Reliable infant and stand on weigh scales (calibrated according to manufacturer's requirement and agency policy).
- Standard measuring device recorded in centimeters. (Infantometer and Stadiometer).
- Stadiometer or Measuring tape.
- *Trouble Shooting Guide for Children 12 months and Older* when growth falls outside the predictable range for children 12 months and older.
- A Health Professional Guide to using the WHO Revised Growth Charts for Canada (www.whogrowthcharts.ca)
- WHO Growth Chart Assessment and Counselling – Key Messages and Actions (www.whogrowthcharts.ca)

Suggested resources/handouts for parent/caregiver as needed:
- Growing Up Healthy.
- Tips to Help Your Child and Teen Grow Well (Dietitians of Canada).
- Caring for Kids - www.caringforkids.cps.ca

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Immunization

Purpose:
To assess a child's eligibility for and provide publicly funded immunization against vaccine preventable diseases.

Goal:
To protect Saskatchewan residents from vaccine preventable diseases. Immunization will be offered according to the Saskatchewan Immunization Schedule.

Standard:
Immunization will be provided according to the Saskatchewan Immunization Schedule for publicly funded vaccines.

Principles:
Immunization is one of the cornerstones of public health. Immunization programs demonstrate greater benefits than risks to the population.

Procedure:
Please refer to the Saskatchewan Immunization Manual.

Documentation:
As per the Saskatchewan Immunization Manual.

Time required:
Seven minutes for the first vaccine and three to five minutes for subsequent ones. Time will vary due to nursing experience, cooperation of parent/child, and prior documentation given around immunization. This time will cover screening, administration and documentation of the vaccine.

Indicators:
- Immunization coverage rates two year old children.
- Immunization coverage rates for seven year old children.

PHN Resources:
Saskatchewan Immunization Manual
http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx

Saskatchewan Immunization Schedule
http://www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/support-programs-and-services/immunization-programs-and-services

Suggested resources/handouts for parent/caregiver as needed:
Vaccine Fact sheet relevant to immunization being given in English and French.
www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/support-programs-and-services/immunization-programs-and-services.

Caring for your child's fever
www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/support-programs-and-services/immunization-programs-and-services/immunization-information-and-fact-sheets

Protecting the Privacy of Your Immunization Record
www.saskatchewan.ca/live/health-and-healthy-living/manage-your-health-needs/support-programs-and-services/immunization-programs-and-services/Immunization-records

References:
Saskatchewan Immunization Manual
www.ehealthsask.ca/services/manuals/Pages/SIM.aspx

Nutrition Assessment/Elimination

Purpose:
To support the establishment of positive eating patterns and feeding relationships in children.

To prevent, detect early and/or provide intervention for deviations from normal nutrition and positive feeding relationship.

To provide oral health and dental care accounting to the Oral Health Screening Guidelines for Child Health Clinics.

Goal
To provide parents and caregivers with the information and support needed to promote optimal child nutrition, oral health and growth outcomes.

To reinforce healthy eating practices for infants, toddlers and preschool children as part of a responsive feeding relationship.

Standard:
A child is assessed for nutrition, the feeding relationship, and oral health at all ages, when they present at CHC, and when deemed necessary or appropriate by the PHN, parent/caregiver or other referral.

Principles:
- The establishment of positive eating patterns begins in early childhood and has significant and long term health benefits.
- Professional practice indicates that, when parents have followed recommendations, improvements in eating and growth patterns are demonstrated.
- Non-judgmental and respectful professional support, influences positive breastfeeding practices (including exclusive and sustained breastfeeding) which impacts maternal and infant health outcomes during the first year and beyond.
- Parents have a major influence on reinforcing and modeling healthy attitudes and eating behaviours by recognizing and appropriately responding to a child's normal social and developmental milestones.
- A healthy feeding relationship respects the division of responsibility associated with eating. Parents are responsive to feeding cues, promote autonomy and trust in the child to self regulate food intake. Parents also provide structure around eating, sleeping, activity and screen times which contribute to optimal nutrition and predictable growth. Children are responsible to identify their hunger and self-regulate food intake.

- Restricted feeding due to food insecurity or perceived need to restrict calorie intake, contributes to accelerated weight gain leading to childhood obesity and other chronic conditions.
- Early identification of nutrition and growth concerns helps to prevent inappropriate feeding practices which may have negative physical, mental, or emotional consequences.

Procedure:
- Refer to the Standard Assessment Appendices in each age category for the appropriate Nutrition Assessments.
- Refer to the NAMIC for information and resources.

Documentation:
Indicate in each of the assessment areas the appropriate response:
See ***Saskatchewan Child Health Clinic Guidelines for Standard Practice*** for descriptions and definitions of assessment areas.
- Breastfeeding: circle EXB (exclusive breastfeeding), NEX (non-exclusive breastfeeding), or NBF (no breastfeeding)
- Formula Feeding/ Milk: write the type of formula or milk child is consuming (other than breast milk)

Provide indication of the overall assessment of the nutritional status by marking the appropriate abbreviation for the assessment result, (NAP, NA, OBS, REF, UCC, or CLS) which includes the assessment of elimination. If any abbreviation other than NAP is used, write a concise and relevant to any concerns or referrals in the Nurses' Notes.

Time Required:
Discussions can take place concurrently with other activities. In-depth discussion may take five to seven minutes including referral and follow-up.

Indicators:
- Percent of children said to be in a positive feeding relationship. (self-report/assessment)
- Percent of children breastfeeding exclusively at two, four, six months of age.
- Percent of children receiving some breast milk at 12 months of age.
- Percent of children who have received complementary feeds (solid food) prior to four months and six months of age.
- Percent of children who receive iron rich food as some of the first foods offered.
- Percent of children receiving Vitamin D supplement during the first year of life.
- Percent of four year olds meeting the nutrition standards.
- See Growth Assessment for other indicators of nutrition.

(Denominator is number of children attending CHC).

PHN Resources:

- Nutrition and Growth Assessment Manual for Healthy Full Term Infants and Children. (NAMIC 2013) Public Health Nutritionists' Working Group (PHNWG)
- Growing Up Healthy series (Government of Saskatchewan)[4]

Suggested resources/handouts for parent/caregiver as needed:

- Growing Up Healthy series (Government of Saskatchewan)[4]

The following resources as indicated: (These documents are current as of May 2015)

- Ellyn Satter: Division of Responsibility in Feeding http://ellynsatterinstitute.org/dor/divisionofresponsibilityinfeeding.php
- 10 Valuable Tips for Successful Breastfeeding (PHAC 2009)
- Breastfeeding Your Baby: Mother's Milk, Babies' Choice (Saskatoon Breastfeeding Matters, 2013)
- Infant Formula Feeding (Government of Saskatchewan)[5]
- Preparing and Handling Powdered Infant Formula (Healthy Canadians); http://www.healthycanadians.gc.ca/eating-nutrition/safety-salubrite/milk-lait/formula-nourrisson-eng.php
- Healthy Bowel Habits of Children (www.caringforkids.cps.ca)
- Dehydration and Diarrhea in Children: Prevention and Treatment (www.caringforkids.cps.ca)
- Pregnancy, Parenting and the Workplace (www.shrc.gov.sk.ca/pdfPPW-2.pdf)
- Eating Well with Canada's food Guide (Health Canada)
- Mealtime Mentoring: Canada's Food Guide A Focus on Children (Ministry of Education)
- Mealtime Mentoring: Encouraging a Competent Eater (Ministry of Education)
- Mealtime Mentoring; Children with Food Preferences (Ministry of Education)

[4] http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/children-health-and-parenting/growing-up-healthy
[5] http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/children-health-and-parenting/feeding-your-baby

References:

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Dietitians of Canada. Infant Nutrition-Infant Formula: Practice Questions. Practice-based Evidence in Nutrition [PEN]. Last updated: *May 25, 2012* <November 2012> Available from www.dieteticsatwork.com/PEN/index.asp?msg Access only by subscription.

Dietitians of Canada. Infant Nutrition-Complementary Feeding: Practice Questions. Practice-based Evidence in Nutrition [PEN]. Last updated: *August 23, 2012* <November 2012> Available from www.dieteticsatwork.com/PEN/index.asp?msg Access only by subscription.

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Health Canada, Canadian Paediatric Society, Dietitians of Canada, and Breastfeeding Committee for Canada. Nutrition for Healthy Term Infants: Recommendations from Birth to Six Months. (2012). Available from http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/recom/index-eng.php

Saskatchewan Public Health Nutritionists (2014). Nutrition and Growth Assessment Manual for Healthy Term Infants and Children.

Satter E. Satter Feeding Dynamics Model of Child Overweight Prevention and Treatment. Available from http://www.ellynsatter.com/resources/childoverweightprevention.pdf

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Whitlock, E.P., Orleans, T., Pender, N., Allan, J. Evaluating primary care behavioral counseling interventions: An evidence based approach. Am. J Prev Med. 2002; *22*(4): 267–264.

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World Health Organization. (2003). *Global strategy for infants and young child feeding*. Retrieved April 2015 from www.paho.org/english/ad/fch/ca/GSIYCF_infantfeeding_eng.pdf

Oral Health Assessment

Purpose:
To screen children from two months to five years for factors which would indicate risk for early childhood tooth decay (ECTD).

Goal:
To reduce the prevalence of ECTD.

To reduce the number of children requiring general anesthetic for dental treatment.

To identify ECTD at an early stage and make appropriate referral for treatment.

Standard:
Education on oral health is provided to parents of children attending CHCs. PHNs provide an oral health assessment to screen and train parents/caregivers at two, four, six, 12, 18 months, and four - six years. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity.

Principles:
- Dental decay is almost 100% preventable and predictable.
- There is a growing body of evidence that indicates that oral health is directly linked to general health. Oral health affects general health in the following categories:
  - the oral cavity as a portal for nutrients for the body;
  - the oral cavity is important for communication;
  - medical links between oral disease and other health conditions;
  - the importance of the oral cavity for self-esteem and social connectedness; and
  - the importance of good oral health to support proper growth and development of the face and jaw.
- It is important that parents understand the following:
  - the importance of oral health and the need to initiate oral health practices for their children;
  - decay is caused by bacteria in the mouth and is passed from parent/caregiver to the child through saliva; and
  - other risk factors regarding the development of early childhood dental caries.

Procedure:
- See Appendix 6 - Oral Health Screening Guidelines for CHCs as developed by the Saskatchewan Dental Public Health Network.
- Assess for risk factors in tooth decay (form from oral health or in Oral Health Screening Guidelines for CHCs).
- Referrals are to be made to the appropriate oral health care professional. Follow the guidelines as established in the Oral Health Screening Guidelines for CHCs.

Documentation:

- If these questions are not asked, circle NA (not assessed) and write rationale for not assessing in the Nurses' Notes.
- If there is no concern, circle NAP (no apparent problem).
- If a concern exists, indicate in the assessment box if the concern is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS).
- Nurses' Notes should be concise and relevant to any concerns or referrals. Indicate whether the referral is to a dentist or oral health professional external to public health or to the Dental Health Educator/provider in public health in the Nurses' Notes.

Time required:

Less than one minute to lift the lip and look.

Indicators:

- Number of individuals screened at CHC.
- Number of individuals referred to an oral health professional.

For population health data:

- Number of referrals made to an oral health professional.

PHN and Parent Resources:

- Growing Up Healthy series (Government of Saskatchewan).[6]
- Dental Health Educators/ providers name and contact number.
- Regional Health Authorities list of dentists who will see children (please check with your Regional Dental Health Educator/provider to see if a list is available for your region).
- Toothpaste Use for Children Under 3.
- Fluoride Varnish Protects Teeth.
- Thumb, Finger and Pacifier Habits.
- Drinking From A Cup.
- Early Childhood Tooth Decay.
- A Parent's Guide to Oral Health.

References:

Government of Saskatchewan (2015). Oral Health Screening Guidelines for Child Health Clinics 2015. See Appendix 6.

[6] http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/children-health-and-parenting/growing-up-healthy

Additional Assessments

Physical
Sleep/Cry, Head to Toe, Hearing and Vision

Purpose:
To identify physical health concerns of the child.

To assist parent/caregivers in understanding their child's needs and when to access the services of additional healthcare providers.

Goal:
Use anticipatory guidance to address parent/caregiver concerns regarding their child's health.

To provide early identification of physical health concerns of children and encourage appropriate referrals to primary care providers as needed.

Standard:
A child is assessed for their physical health if a parent concern is raised or at the discretion of the PHN. A referral will be made to the child's primary care provider if any anomaly or concern is identified.

Principles:
To provide support to parents regarding health concerns.
To assist parents to determine need for further intervention for their child.

Procedure:
When weighing and measuring the infant, the PHN will observe the child for any physical concerns. Questions will also be asked if the parent/caregiver have any concern about the child's vision and hearing. Follow the additional assessment for head to toe, vision and hearing assessments for each age category. Referrals are to be made to the appropriate health care provider dependent on parental concern or at the PHN discretion. Parental/caregiver consent is required for any referrals. The PHN needs to be aware of any emerging issues such as sleep training. Education and response to these issues will be dependent on the RHA as the concern may differ in each RHA.

Documentation:
Documentation of the physical assessment will be by exception. If the client passes the assessment, circle no apparent problem (NAP). If there are concerns about the client, (ongoing issues, anomalies, history of illness or hospitalization), write the abbreviation that indicates that the client will be observed (OBS), was referred (REF), or under continuing care (UCC).

The rationale for the follow-up is to be recorded in the comments section of the specific assessment. When the concern is resolved, the chart should be marked closed (CLS).

Time required:
Two minutes required to review and identify concerns.

Indicators:
Percentage of children referred < one year of age and >1 year of age for primary care services.
(Denominator – children receiving additional screen for physical assessment)

PHN Resources:
- Physical Examination and Health Assessment (2009 or 2014) by Carolyn Jarvis et al.
- Text and assessment CD-Rom. The Publisher may change the link in the future. http://www.elsevier.ca/product.jsp?isbn=9781437756852

Resources/handouts for parent/caregiver:
n/a

References:
See resources for reference.

Development
Speech and Language, Sexual Health

Purpose:
To screen and identify children who have developmental delays or behavioural problems in order to provide early intervention and maximize the child's potential.

Goal:
To provide parents/caregivers with anticipatory guidance and support needed to encourage optimal development of their child through the use of milestones and screening.

To identify and refer children with mild to severe communication disorders/delays as early as possible.

To provide parents/caregivers with anticipatory guidance and support for the development of functional communication skills in their child.

Standards:
Children aged six weeks to five years will be assessed for developmental milestones if a concern or question is expressed by the parent/caregiver or at the discretion of the PHN. The Nipissing District Developmental Screen (NDDS) will serve as a base for milestone indicators and further developmental assessments.

Principles:
- Development delays over and above congenital issues are usually not seen in young infants. Most often specific challenges become evident over time as the appropriate growth patterns and milestones are noted to be incomplete or delayed in some manner or degree.
- Early identification of specific problems or health challenges greatly increases the chances of overcoming and minimizing any limitation that may arise for a child as he/she enters school and grows into adulthood.
- As health problems continue to expand, intensify and/or solidify, the limits to a child's growth, adaptability and potential become increasingly entrenched and more extensive. The resulting state of health, learning, behavioural and social complications begin to limit a young person's situation, independence and ability to be part of his/her community.
- Developmental assessment also allows assessment of a child's mental health.
- Children have functional communication skills that allow for optimal social, academic, and vocational outcomes.

- Early identification of communication delays or disruptions in child-parent interactions is vital to how the child develops socially, emotionally, academically and whether or not he/she has joyful relationships with others. Communication delays and parent-child interaction disruptions can be identified early. Identifying and treating communication issues early goes far in minimizing the impact of these challenges while preserving the parent-child relationship.
- "The greatest predictor of a child's school success is their communication skills at three years of age" (Dr. Louis Rosetti, 2005). The better a child's speech and language skills are at three years of age, the better he will do in school both academically and socially.
- Communication skills directly impact on all areas of life throughout the life cycle. At least 10% of any children's population will have communication delays or be at significant risk for delays. This incidence can increase to up to 30% of the children in certain high-risk groups: young moms, premature babies, lower socioeconomic status, drug/alcohol use in the home, and maternal metal health issues.
- The World Health Organization defines sexual health as a state of physical, mental and social well-being in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.
- Parents and caregivers are the first and primary sexual health educators of children. Public Health Nursing supports parents and caregivers by providing accurate information and support.
- Although attachment, child behaviour and parenting are all aspects of child development and supporting children, it is not expected that the PHN be an expert in these areas or have in depth knowledge. Listed under PHN and Parent resources are a number of websites with information about these areas. PHNs are invited to explore these resources and share them with parents as indicated by parental concern or interest.

Procedure:

Development

Developmental milestones specific to the child's age are reviewed with parents within the context of targeted questions in order to assess child's developmental level. Key tasks are also identified in the CHC procedures under Additional Assessments/ Developmental Screening. If a child does not meet two or more of the milestones identified for their age, the PHN can use the age appropriate NDDS tool.

When the NDDS tool is completed, the PHN will review it and address any parental questions or concerns. If two or more "No" responses are marked, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "No" may be influenced by culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.**

While the NDDS was designed to be completed by a parent or caregiver, the Screen Forms are not meant to be a substitute for professional advice, assessment and/or treatment from a health care and/ or child care professional.

Speech and Language

Targeted questions at the 18 month visit are a preliminary speech and language screen. If there is a "No" response to any of the three questions, a referral to the speech and language pathologist in the regional health authority should be made. Additional questions may be required before referral as per RHA policy.

The three targeted questions are:

1. Is your child using at least 25 words that the parent recognizes? Yes/No
2. Is your child able to follow simple directions like "give me the ball" or "bring your shoes" or "find the doll" without you looking or pointing at it? Yes/No
3. Does your child come to you to play, show you things, and seek your help? Yes/No

Please see Appendix 12 for the Vocabulary List if parents or PHN require assistance in counting or determining child's vocabulary.

Sexual Health Development

The sexual health development area is not as much an assessment as it is anticipatory guidance. Through discussions with parents around development and behaviours, questions may arise regarding why a child may be behaving in a particular way. The PHN is able to answer questions about sexual development and provide anticipatory guidance for parents on how to respond to normal sexual behaviours. Resources developed by the Saskatchewan Prevention Institute (SPI) and information found on the www.sexualityandu.ca/parents website can be shared with parents and caregivers. If a parent's concerns persist, referral to their primary care provider or early childhood psychologist should be made.

Documentation:

- For development, speech and language and sexual health, circle NAP if the client passes the assessment. If there are concerns about the client, indicate with the appropriate abbreviation that the client will be observed (OBS), was referred (REF), or under continuing care (UCC). The rationale for the follow-up needs to be recorded in the Nurses' Notes. When the concern is resolved, the chart should be marked closed (CLS).

Time required:

- Public Health Nurse reviewing milestones and providing anticipatory guidance is about two minutes.

- Parent completing the Nipissing tool should take approximately five to seven minutes.
- Scoring of the Nipissing tool should take approximately two minutes. Discussion of concerns may take longer. Public Health Nurses are encouraged to follow-up outside of the clinic at their discretion.

Indicators:

- Number of children who have been screened and referred for further assessment. (Denominator is all who are screened for development at CHC).
- Percent of children referred to Speech and Language Pathologists (SLP) at 18 months. (Denominator = all screened).
- Percent of children referred to SLP at 18 months whose parents refuse follow-up. (Denominator = number referred).
- Percent of children referred to an Early Childhood Psychologist (ECP) or mental health professional. (Denominator = all screened).

PHN Resources:

- Saskatchewan CHC Guidelines for Standard Practice procedures and protocols.
- Nipissing District Developmental Screening Tools.
- Regional referral form.
- Sexual Health Developmental Chart.

Suggested resources/hand outs for parent/caregiver as needed:

- Growing Up Healthy series (Government of Saskatchewan).[7]
- Will I grow out of it? (Government of Saskatchewan).
- Appendix 12 Vocabulary List
- Fact Sheet Series and Literature Review from Prevention Institute available: http://www.skprevention.ca/early-childhood-mental-health/ (go to bottom of the page)
- **Infant Mental Health Promotion. Sick Kids Hospital – Toronto** http://www.sickkids.ca/imp/
- **Zero to Three** http://www.zerotothree.org/
- Connection for Life Resource Guide, DVD, and Activity Sheets http://www.skprevention.ca/shop/connections-for-life-attachment-resource-kit-guide/ http://www.skprevention.ca/shop/connections-for-life-dvd-45-min-loan-only/
- Healthy Baby Healthy Brains http://www.healthybabyhealthybrain.ca/love-builds-brains.htm

[7] http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/children-health-and-parenting/growing-up-healthy

- Resiliency:
  - Reaching in Reaching Out
    http://www.reachinginreachingout.com/
  - I am safe and secure: promoting resiliency in your children
    http://www.naeyc.org/files/yc/file/201103/PromotingResilience_Pizzolongo0311.pdf
  - Growing up Resilient
    http://www.camh.ca/en/education/teachers_school_programs/resources_for_teachers_and_schools/growing_up_resilient_ways_to_build_resilience_in_children_and_youth/Pages/growing_up_resilient_ways_to_build_resilience_in_children_and_youth.aspx

- Healthy Parenting Home Study Manual
  http://www.skprevention.ca/shop/healthy-parenting-home-study-manual/
- Challenging Behaviors in Young Children
  http://www.skprevention.ca/shop/challenging-behaviours-in-young-children-techniques-and-solutions-dvd-50-min-loan-only/

References:

Nipissing District Developmental Screening tool: www.ndds.ca
Sexuality and U: www.sexualityandu.ca/parents
Saskatchewan Prevention Institute: www.skprevention.ca

Maternal Mental Health

Purpose:
To identify women experiencing postpartum anxiety or depression.

To create awareness about maternal mental health for new mothers, families, and other caregivers.

To provide early detection of postpartum depression and refer to appropriate resources and supports.

Goal:
To screen moms at two and six months postpartum for postpartum depression.

To identify women scoring 10 or higher on the Edinburgh Postpartum Depression Scale (EPDS) and provide appropriate referrals.

Standard:
Mothers attending the two and six month CHC visit will be screened using the EPDS as the targeted questions for these age groups. The PHN will score the EPDS and refer to the primary care provider, mental health clinician and/or HealthLine Maternal Wellness Program* as indicated by the EPDS Screening and Care Guide following procedures in the Saskatchewan CHC Guidelines for Standard Practice and resources in the RHA.

* The HealthLine Maternal Wellness Program will only be available for referral to in designated RHAs initially until capacity is built to extend province-wide. PHNs are encouraged to have moms with postpartum concerns call HealthLine for assistance whether or not their RHA is part of the Maternal Wellness Program.

Principles:
Maternal Mental Health is important because:

- Pregnancy, birth, and early parenthood are periods of significant change for the whole family and can be affected by stress, anxiety, and depression.
- Every child deserves, and every parent wants to provide, the best beginning in life.
- A mother's mental health can have a significant impact on the quality of care provided to her child and, therefore, on the child's development.
- Early childhood development, particularly in the first months of life, is critical to the long-term health and well being of children.
- Maternal depression is common, affecting 20% of mothers, their babies, and families. Prevalence of depression among women peaks during pregnancy and the postpartum period.

- Partners of depressed mothers are more likely to suffer from depression themselves.
- Effective prevention and intervention can reduce the suffering of women and the negative effects on child development and family function.

Procedure:
Mothers attending the two and six month CHC visit will be screened using the EPDS. The mother will be given the tool to fill out herself or may be assisted in filling it out by the PHN or family member. The PHN will score the tool and refer as indicated by the tool. Edinburgh Postpartum Depression Scale Care Pathway referrals are as follows: if questions 3, 4, and 5 have a score >4 probable anxiety; EPDS score 10-11 possible depression; EPDS score >12 probable depression; these are indicators that a referral is required. The EPDS and Screening Guide indicates that when the mothers' score is >12, the EPDS is offered to the mother's partner to screen for depression. It is not an expectation of the PHN to screen the partner but to encourage discussion with the primary care provider.

The PHN can administer the EPDS anytime outside of the target times if there is a concern. The PHN will score the tool and refer to the woman's primary care provider, mental health services, HealthLine, or crisis intervention as determined by the score of the tool and/or the PHNs discretion. Consider notification of the woman's family member if immediate intervention is needed.

If the mother scores less than 10 on the EPDS, positive reinforcement and suggestions for maintaining good mental health should be offered. Positive mental health messaging includes:

- Providing information on maintaining good mental health:
  - be kind to yourself;
  - ask for and accept help with baby and housework;
  - keep active – go for a walk;
  - get enough sleep – at least six hours in a 24 hour period;
  - eat healthy and regularly;
  - avoid alcohol, tobacco and other drugs;
  - take medications as prescribed;
  - try yoga or other activities to help you relax;
  - look for a support group or other supports in your community; or
  - talk to a health care provider.
- Suggestions for partners and family to help:
  - listen to her and support her feelings;
  - ask her how you can help;
  - encourage her to seek professional help if she has frequent feelings of sadness or depression;

  - develop a relationship with the baby; or
  - educate yourself about maternal mental health.
- Partners can also experience depression – it is important that they also get the support they need.

Documentation:
At two and six months, screening of the mother with the EPDS is part of the targeted questions. Document the screening, and the acceptance or refusal of the referral by the mother on the mother's record or other document as per RHA policy. Document the results of the Maternal Mental Health screening as part of the targeted questions on the Early Childhood Assessment Form as follows:

- If these questions are not asked, circle NA (not assessed).
- If there is no concern expressed, circle NAP (no apparent problem). No further documentation is required in the mother's record.
- If a concern is expressed by a score higher than 9 on the EPDS, mark an XM in the box and document the screening, and the acceptance or refusal of the referral by the mother on the mother's record or other document as per RHA policy.

Screening with the EPDS can be used anytime as an Additional Assessment if the mother or PHN has concerns about the mother's mental well- being. Documentation is to occur on the mother's record or as per RHA policy.

Time required:
When EPDS screening tool used it may take five to 10 minutes to review the mother's answer on the EPDS. Longer if a referral is required.

Indicators:

- Number of women screened at CHC with EPDS.
  - Number of EPDS screens done at:
    - 2 months
    - 6 months
    - Other
- Number of women scoring 10 or higher on the EPDS.
- Number of women scoring positive on question 10 (thoughts of harming self or others).
- Number of referrals to primary care provider or other service.
- Number of referrals from PHN to HealthLine at:
  - 2 months
  - 6 months
  - Other
- Percent of women referred.

PHN Resources:

- Edinburgh Postnatal Depression Scale (EPDS) and Maternal Mental Health Care Pathways .
  https://sites.google.com/site/maternalmentalhealthsk/home

Suggested resources/handouts for parent/caregiver as needed:

- Maternal Mental Health – Information Card.
- Maternal Mental Health – Fact Sheet.

References:

- Maternal Mental Health Working Group (2010), MotherFirst - Maternal Mental Health Strategy: Building Capacity in Saskatchewan. Retrieved from https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxtYXRlcm5hbG1lbnRhbGhlYWx0aHNrfGd4Ojg4OTNhZjZiYjA4MzUwYw

Health Education
Injury Prevention, Family Dynamics, Violence/Abuse, Seasonal

Purpose:
To provide parents/caregivers with information and guidance on development, behaviour, growth, and injury prevention that is age/seasonally appropriate.

Goal:
To have parents/caregivers be aware of upcoming developmental milestones and their impact on safety issues.

Standard:
Age appropriate information about injury prevention, screen time, physical activity, and seasonal concerns is shared with parents/caregivers. Information, health teaching is provided in anticipation of the next developmental milestones and activities.

Principles:
- Injuries are predictable and preventable.
- In Saskatchewan injuries cause 69% of deaths of children and youth from 1 – 20 years.

Procedure:
The documentation procedure for health education is located in the CHC protocol document for each assessment and category. The Growing Up Healthy pamphlet series should be provided at age appropriate times as messaging around injury prevention, seasonal concerns, screen time, and physical activity are included in the pamphlets.

Documentation:
Documentation of the provision of anticipatory guidance will be noted in specific assessments completed. If the assessment is completed and there are no concerns, circle NAP (no apparent problem). If a concern exists, indicate in the assessment box if the concern is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS). Rationale about the need for anticipatory guidance is be written in the Nurses' Notes.

Time required: One to two minutes

Indicators:
Percentage of parents receiving information about injury prevention and safety. (Number of children seen at CHC = denominator)

PHN Resources:

- Growing Up Healthy pamphlet for age specific from Government of Saskatchewan.[8]

Suggested resources/handouts for parents/caregivers as needed:

- Growing Up Healthy series (Government of Saskatchewan) [7]
- Canadian Physical Activity Guidelines

References:

Canadian Physical Activity Guidelines: http://www.csep.ca/english/view.asp?x=804

Saskatchewan Prevention Institute: http://www.preventioninstitute.sk.ca

Albert, T. & Cloutrer, E. (2001). *The economic burden of unintentional injury in Saskatchewan*. The SMARTRISK Foundation.

Safe Kids Canada. (2006). *Child & youth unintentional injury: 10 year review*, 1994-2003.

Saskatchewan Comprehensive Injury Report (2005) available at: http://www.saskatchewan.ca/government/news-and-media/2008/july/04/saskatchewan-injury-report-released

[8] http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/children-health-and-parenting/growing-up-healthy

Second-Hand Smoke/Smoke Free Homes

Purpose:
To provide information to parents about the risks to their child from exposure to second-hand smoke.

Goal:
To identify those children at risk for the effects of second-hand smoke and assist in changing behaviour.

To decrease the exposure of preschool population to second-hand smoke.

To reduce the possible health effects on children and their families related to second-hand smoke exposure.

Standard:
At the two and 12 month CHC visits, parents will be asked if their children are exposed to second-hand smoke. Education around the risks of exposure and offering resources for smoking cessation will be provided as needed.

Principles:
Second-hand smoke hurts everyone, but is particularly dangerous to babies and children because their lungs are still developing. With small lungs, babies and children breathe more quickly and take in more harmful chemicals for their size than adults do. In addition, their immune systems are less developed and cannot protect them as much from tobacco smoke.

The health effects to babies and children from exposure to second-hand smoke include.
- a higher risk of dying from Sudden Infant Death Syndrome (SIDS);
- more frequent lower respiratory tract problems, such as coughs, pneumonia, bronchitis and croup;
- increases the number of ear infections; and
- recent studies have shown children exposed to tobacco smoke scored lower on tests than children who were not exposed.

Procedure:
If a concern is expressed or the PHN is concerned at the two month CHC visit, the PHN will ask the parent/caregiver, “does anyone smoke around your child (ren)?” If smoke free, there is no need to address this issue again until the child is 12 months old, when they may be in a child care outside the home. The PHN would then repeat the question to reinforce the need for a smoke-free environment even when not in the home.

If it is determined at the two month visit or 12 month visit, that the child is exposed to second-hand smoke in the home, the PHN can assess the readiness for further information concerning smoking cessation and/or providing a smoke free environment for their child. Written materials and community resource information should be made available for those who are interested. Expressed concern and actions are to be noted in the Nurses' Notes.

Documentation:
If the client is not exposed to second-hand smoke, NAP (no apparent problem) is written in the assessment box. If a concern exists, indicate in the assessment box if the concern is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS). If handouts are given to parents/caregivers on smoking cessation document this in the Nurses' Notes.

Time required: Two minutes.

Indicators:
Percentage of children attending CHC at two and 12 months who are screened. (Denominator is all who come to CHC)

Percentage of children attending CHC at two and 12 months that are reportedly exposed to circulating second-hand smoke at home and/or at child care. (Denominator is # of children screened)

Percentage of parents/caregivers referred to primary care provider for smoking cessation.

Percentage of referrals accepted/refused.

PHN Resources:
- Procedures for the 5 A's of Tobacco Intervention (Appendix 13)
- Smoking in Vehicles Reference List (Appendix 16)

Suggested resources/handouts for parents/caregivers as needed:
- Smoking Cessation pamphlets.
- A smoke-free home. (Saskatchewan Prevention Institute)
- Building on Success: Celebrating Smoke Free Homes. (Métis Nation and University of Saskatchewan)
- Environmental Tobacco Smoke. (Saskatchewan Prevention Institute)

References:
Government of Saskatchewan Tobacco and Your Health
http://www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/tobacco/tobacco-and-your-health

Protocols

Child Health Clinic – 2 month
Standard Assessments

Expected Standards	Client-based Support	Red Flags
Demographics • Confirmation of Demographic information (e.g. name, address, date of birth, gender and HSN number). • This can be done by PHN or support staff. • Client identifiers (right child).	• Updated information allows for improved contact and follow-up. • Confirmation of client identifier contributes to zero immunization errors.	• Any errors or changes to be updated on the child record and reported to the Ministry of Health by the parents.
Parent Support • Parents are able to ask questions about their child's health, growth, development, behaviour or other concerns. • Tell me if you have any questions or concerns about your child's health, development, behavior or growth?	**Counseling** • Parents are asked if they have any questions or concerns about their child's physical growth, health or development. • If parent is concerned about the child, the PHN could offer a home visit or phone call for further follow-up. • Address any concerns that parent has or provide further assessment as indicated.	
Targeted questions: **Maternal Mental Health** • EPDS is given to each mom attending CHC with their child at 2 month visit and asked to complete the questionnaire. • Assistance by the PHN/staff/ or family member can be given to the mom to complete the EPDS. • Mom has the right to refuse to complete the questionnaire.	• The EPDS is a tool used to assess risk for postnatal depression. • Once the questionnaire is completed by the parent, the PHN scores the answers and totals them. • It is normal to have baby blues but if there is the presence of five or more of the following symptoms over a two week period most of the	• If the score is <10, affirm positive findings and promote positive mental health. • If the score is 10 or 11, discuss concerns and offer referral to primary care provider, mental health services, or HealthLine. Promote positive mental health and increase contact with mom if possible.

Expected Standards	Client-based Support	Red Flags
	day and nearly every day, postpartum depression may exist. Refer to the appropriate health care provider. ➢ Depressed mood; ➢ Diminished interest or pleasure in all or most activities; ➢ Significant weight loss when not dieting, or weight gain, or decrease/increase in appetite; ➢ Insomnia or hypersomnia; ➢ Excessive or lowered physical expression/activity; ➢ Fatigue or loss of energy; ➢ Feelings of worthlessness or excessive or inappropriate guilt; ➢ Diminished ability to think or concentrate, or indecisiveness; ➢ Recurrent thoughts of death, recurrent suicidal ideation or suicide attempt; ➢ Preoccupation with infant well-being which can range from over-concern to delusions; ➢ Severe anxiety; ➢ Disinterest in the infant; ➢ Fear of being left alone with the infant; or ➢ Over-intrusiveness that prevents adequate infant rest. • Degree of support for women and families will vary in each community. Determine most appropriate referral and community resources based on RHA information.	• If the score is 12 or greater, discuss concerns and take action; make a referral to the primary care provider or mental health services or HealthLine; increase contact; promote positive mental health. • Anxiety Items (3, 4, 5) score >4 Discuss concerns and repeat in two weeks; offer referral and promote positive mental health. • Positive score on item #10: Assess harm risk to self and others; intervene with Emergency, Crisis Intervention, Harm Contract or other appropriate referral • If mom refuses to complete the EPDS, document in chart. Encourage mom to contact PHN or primary care provider if she has concerns about her mental health.

Expected Standards	Client-based Support	Red Flags
	• Provide information on maintaining good mental health; ➢ Be kind to yourself ➢ Ask for and accept help with baby and housework ➢ Keep active – go for a walk ➢ Get enough sleep – at least 6 hours in a 24 hour period ➢ Eat healthy and regularly ➢ Avoid alcohol, tobacco and other drugs ➢ Take medications as prescribed ➢ Try yoga or other activities to help you relax ➢ Look for a support group or other supports in your community ➢ Talk to a health care provider • Partners and family suggestions to help; ➢ Listen to her and support her feelings ➢ Ask her how you can help ➢ Encourage her to seek professional help if she has frequent feelings of sadness or depression ➢ Develop a relationship with the baby ➢ Educate yourself about maternal mental health • Partners can also experience depression – it is important that they also get the support they need.	

Expected Standards	Client-based Support	Red Flags
	For more information: www.skmaternalmentalhealth.ca **Resources for parents:** • Provide HealthLine number: 811 • Maternal Depression Online: https://www.onlinetherapyuser.ca/intro/mdo/	
Developmental Milestones: • Coos – throaty gurgling sounds. • Lifts head up while lying on tummy. • Holds head steady while upright. • Can be comforted and calmed by touching/rocking. • Smiles responsively. • Have different cries for different needs. Parental Strengths	• Parent is asked if the child is able to do these milestones and/or PHN observes at least 3. • Parents are encouraged to give their child opportunities to play, learn and observe. Acknowledge and give positive feedback.	• If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.
Growth ** For children born <37 weeks gestation or earlier, calculate adjusted age and assess growth based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details.	**Counseling**	

Expected Standards	Client-based Support	Red Flags
• Infant's growth is progressing normally. • Serial measurements of length, weight, and head circumference are recorded and plotted on the appropriate WHO growth chart (i.e. weight-for-age, length-for-age, weight-for-length, head circumference-for-age). • Measurements are to be recorded in metric. • **Parental height is recorded** – should be recorded at postnatal visit. • Age of child is identified and plotted to the nearest completed half month. • Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and tracks parallel to the 50th percentile.	• Assess infant's growth pattern based on recorded and plotted measurements and using *A Health Professional's Guide for using the new WHO Growth Charts* (www.whogrowthcharts.ca). • Advise parents that measurements help confirm that their infant is growing and developing well and that it is important to look at patterns as opposed to any one single measurement. • Advise parents that the infant's rate of growth directly affects the infant's appetite and that appetite is the best indicator of adequate energy. When appetite picks up it usually means the infant is going through a growth spurt. • Advise that parental size has a big impact on the size to which their infant may grow. • Advise parents that the number of wet and soiled diapers over 24 hours is an indication of the adequacy of intake. See **NAMIC Standard:** Infant exhibits normal elimination patterns.	**When growth pattern is outside of expected parameters: re-measure, verify age and re-plot.** • Growth pattern remains **flat** ➢ Obtain consent for referral to primary care provider or pediatrician. Primary care provider notified. • **Sharp incline or decline** in growth pattern ➢ Further investigation and follow-up required. ➢ Based on assessment of all growth measures consider appropriate referral. See NAMIC Guide to Referral Resources. • **Growth measures plotted at <3rd or >85th percentile** ➢ This growth pattern may be normal, but children in these extremes should be assessed for whether this pattern is appropriate for them or due to a pathological situation and requires referral. See NAMIC Guide to Referral Resources. • **Head circumference** for age <3rd percentile and growing slowly or >97th percentile and growing rapidly. ➢ Rapidly increasing head circumference requires immediate referral.

Expected Standards	Client-based Support	Red Flags
	• Assist parents in identifying any issues or concerns they may have about their feeding relationship, the infant's nutrition intake, elimination patterns, and other health concerns related to development and behaviour all of which have an impact on growth. • Assist parents with any information they may need for corrective action and connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support. **Resources:** • Growing Up Healthy 2 to 4 months • WHO Growth Chart (appropriate for age and gender)	
Immunization • Assessment of the individual's health. • Determination of which vaccines to provide. • Discussion of follow-up care. • Obtain informed consent for immunization. • Administration of those vaccines. • Documentation within 24 hours into the provincial immunization registry.	**Counseling** • **See Saskatchewan Immunization Manual for recommended vaccines, counseling, procedures, and parental resources.** www.ehealthsask.ca/services/manuals/Pages/SIM.aspx Immunize Canada: http://immunize.ca Caring for Kids (resources to share with parents): www.caringforkids.cps.ca See Appendix 3.1 in the Saskatchewan Immunization Manual for other reliable websites.	• Unable to obtain consent as legal guardianship in question. • Contraindications to immunization.

Expected Standards	Client-based Support	Red Flags
Nutrition **Parental Support** • Parents are aware of resources they can access if family is food insecure. • Parent is aware of resources they can access to sustain breastfeeding while returning to work or school.	**Counseling** • Assist food insecure families by connecting them to local community resources they can access. • See **NAMIC Standards**: Mother and Family have access to enough healthy foods. • Advise parents of resources available to sustain breastfeeding while returning to work or school (refer to *Pregnancy, Parenting and the Workplace* at http://www.shrc.gov.sk.ca/pdfs/publications/PPW-v2.pdf).	• Family is unable to access enough healthy food to meet their needs. • Mother returning to work or school does not have information to support sustained breastfeeding.
Feeding Relationship • Mother expresses satisfaction with the feeding relationship. • Parent identifies and responds to early feeding cues. • Parents are responsive to night time feeds as well as day time. • Parent understands signs that infant is getting enough milk.	• Assess if parent identifies infant's early feeding cues: sucking movements, sucking sounds, hand-to-mouth movements, rapid eye movements, soft cooing or sighing sounds, restlessness. • Assess whether mother is breastfeeding without time restriction, eight and often more times in 24 hours, including night feeds. This responsive parenting style is critical to the development of an adequate milk supply and healthy weight gain. (i.e., cue-based feeding). See **NAMIC Standards**: Mother recognizes and responds to early feeding cues from infant; Mother understands the sign that the infant is getting enough breast milk.	• Mother expresses dissatisfaction with the feeding relationship. • Infant's feedings are scheduled at specific times. • Infant is not easily accessible at night.

Expected Standards	Client-based Support	Red Flags
	• If bottle feeding, remind parents about responsive feeding and to allow their infant's cues of hunger and satiety guide the amount of formula to provide (i.e., cue-based feeding rather than ensuring that the infant is consuming a prescribed amount of breast milk or formula.	
	Handouts • 10 Valuable Tips for Successful Breastfeeding http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/nutrition/tips-cons-eng.php • Breastfeeding Your Baby: Mother's Milk Babies' Choice (revised) (Check first to see if previously received in hospital.) http://www.saskatoonbreastfeedingmatters.ca/breastfeeding/index.html • See Public Health Nutritionist for list of resources and websites for parents.	
Breastfed Infant • Infant is exclusively breastfed for six months. • Infant does not receive formula unless medically indicated.	• Assist mothers to continue to exclusively breastfeed for six months by providing information about local breastfeeding support groups.	• Breastfed infant receives formula.

Expected Standards	Client-based Support	Red Flags
• Breastfeeding is defined as: Exclusive breastfeeding – infant receives breast milk (including expressed milk, donor milk) and allows the infant to receive oral rehydration solution (ORS), syrups (vitamins, minerals, medicines) but does not allow the infant to receive anything else (from birth). ➢ Non-exclusive breastfeeding – infant has received breast milk (includes expressed milk, donor milk) and water, water-based drinks, fruit juice, ritual fluids (water infused with herbs or water mixed with different grains/cereals into a thin paste. They may be used as part of a religious ceremony, provided regularly (e.g., 1x per day) or only given during a disease state) or any other liquids including non-human milk or solids. ➢ No breastfeeding – the infant receives no breast milk. • Mother and infant achieve a comfortable and effective latch. • Mother has the skill to hand express breast milk.		

Expected Standards	Client-based Support	Red Flags
• Mother understands what to do about common breastfeeding problems or concerns.	• Ask mother if she is comfortable with hand expression of breast milk. For instructions on hand expression, see Breastfeeding Your Baby: *Mother's Milk Babies' Choice.* www.saskatoonbreastfeedingmatters.ca/breastfeeding/index.html ➢ For management of breastfeeding concerns refer to **NAMIC Standard:** Infant is exclusively breastfed for 6 months with continued breastfeeding up to 2 years and beyond. ➢ Breastfeeding Your Baby: Mother's Milk Baby's Choice. www.saskatoonbreastfeedingmatters.ca/breastfeeding/index.html ➢ Breastfeeding Committee for Saskatchewan Fact Sheets available at: http://www.thebcs.ca	• Mother does not have the skill to hand express breast milk. • Mother does not know what to do about breastfeeding problems or concerns. • Mother identifies that she does not have enough milk and/or that she is experiencing engorgement.
Non-breastfed Infant • Parent indicates that infant is always held for feeding. • Infant receives a commercial infant formula which meets nutritional needs. • Infant is receiving the quantity of formula which best meets her needs. • Infant receives formula in the proper concentration.	• Advise parents that their infant should be held for feeding as the use of a propped bottle increases the risk for aspiration, choking and ear infection. • Remind parents about responsive feeding. See **NAMIC Standard:** Mother recognizes and responds to early feeding cues from infant; • Advise parents that a regular cow's milk-based commercial formula meets the need of healthy term infants.	• Infant is fed with a propped bottle. • Inappropriate formula given such as regular cow's milk, goat's milk or homemade formula. • Inappropriate quantity or concentration of formula offered.

Expected Standards	Client-based Support	Red Flags
• Sanitary and safe procedures are followed when preparing, storing formula and feeding the infant. • Water used in the preparation of infant feeds meets current safety standards.	See your Public Health Nutritionist for more information on infant formulas. See **NAMIC Standard:** Infant is receiving a commercial formula which meets their nutritional needs. • For sanitary and safe procedures in the preparation and storage of formula see **NAMIC Standard:** Safe and sanitary procedures are followed when preparing and storing food and feeding the infant. • Boiled water should be used in preparation of infant formula. • Advise parents that powdered infant formula (PIF) is not a sterile product and must be prepared according to Health Canada recommendations. See *Recommendations for the Preparation and Handling of PIF* www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/pif-ppn-recommandations-eng.php Sask H2O - Nitrates www.saskh2o.ca/PDF-WaterCommittee/nitrate.pdf www.saskh2o.ca/WaterServices_WaterTesting.asp **Handouts** Infant Formula Feeding	• Inappropriate safety precautions. • Mother is taking potentially harmful over-the-counter drugs or herbs and is breastfeeding.

Expected Standards	Client-based Support	Red Flags
Nutrients of Concern • Infant receives adequate vitamin D. • Mother takes only medically indicated supplements including over-the-counter medications and herbs.	• All infants who are breastfed or receiving breast milk should be provided with a daily vitamin D supplement of 400 IU. • Non-breastfed infants who are receiving a commercial infant formula do not require a vitamin D supplement. • See Public Health Nutritionist for **BACKGROUND PAPER**: *Vitamin D for Healthy term Infants (0-12 months of age)* • Ask mother if she is aware of the potential increase in health risks from taking over-the-counter drugs and herbs. See *Breastfeeding and Drugs – Prescribed, Over-the-counter, Herbs, Illegal* www.ibreastfeeding.com/content/free-stuff-14	• Breastfed or partially breastfed infant is not receiving a daily vitamin D supplement.
Elimination • Infant has at least five wet diapers a day. Urine is clear or pale yellow. • Infant has yellow, soft, curdy bowel movements. • Infant passes stools without difficulty.	• Advise parents that stool of breastfed infants are yellow, soft and curdy. • Breastfed babies are rarely constipated. There may be a shift in frequency of stools from many a day to one every few days. • Advise parents of non-breastfed infants that the colour of stools varies with composition of the formula.	• Stool that is not yellow, soft and curdy.

Expected Standards	Client-based Support	Red Flags
	• Advise parents re: signs of dehydration and when to seek medical assistance**:** child has bloody or black stools, continues to vomit after four to six hours, has diarrhea and a fever with a temperature higher than 38.5°C (101.5°F), has dehydration, stomach pains getting worse. See **NAMIC Standard:** Infant exhibits normal elimination patterns **Handouts** Refer to www.caringforkids.cps.ca for handouts: ➢ Healthy Bowel Habits for Children ➢ Dehydration and Diarrhea in Children: Prevention and Treatment	• Non-breastfed infant has a change in consistency of the stool, this may be the infant's normal pattern however, it may signal a need for further assessment. • Infant has green watery stools. • Infant has less than five wet diapers a day.
Oral Health • Oral health assessment. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity. • Mother indicates breast or bottle nipple is removed from the mouth when infant falls asleep. • Presence of sucking reflex. • Risk for developing tooth decay is assessed.	• Advise parents to remove breast or bottle if infant falls asleep. • Clean your baby's mouth after feeding, at least once per day, with a moist cloth or toothbrush. • If pacifier is used, the nipple should be soft enough to flatten out against the roof of the mouth. • Keep pacifier clean. Limit its use. • Never put baby's pacifier in your mouth to clean it; this passes decay-causing germs to baby. **References** Oral Screening Guidelines for Child Health Clinics	• Infant continues to feed while sleeping. • Presence of thrush. • Presence of tongue tie. • Absence of sucking reflex. • Amount of pacifier use (most of the time). • Parent or sibling is observed putting infant's pacifier in own mouth. • Damaged or worn pacifier is used. • Refer to Oral Health Professional if any concerns or risk factors identified

Expected Standards	Client-based Support	Red Flags
	Resources • Thumb, Finger and Pacifier Habits • Parent's Guide to Oral Health	
• Advise to book next appointment. • Discuss public health/community services. • Parenting program (if available in your area). • Provincial HealthLine - 811		
Standard Handouts Immunization Fact Sheets Caring for Your Child's Fever Growing Up Healthy 2-4 months		

Child Health Clinic – 2 month
Additional Assessments

Expected Standards	Client-based Support	Red Flags
Offer and discuss the highlights of the 2 -4 month Growing Up Healthy **Physical** **Sleep/Cry** Average amount of sleep is 16 hours (3-4 hours at a time).	• Encourage routines for bedtime to foster healthy child development and parenting. • Baby's sleep patterns. • Reality vs. expectations. • Affirm family's sleep/room sharing choices. • Coping strategies. **Resource:** Caring for Kids: www.caringforkids.cps.ca/handouts/healthy_sleep_for_your_baby_and_child	• Parents indicate they are not coping. • Parents express concern about their child's sleep. • Parent has unreasonable expectations of baby's sleep. • Co-sleeping with parents.
Head to Toe Symmetry of body and movement.	**Counseling** • Referral to the primary care practitioner if appropriate. • Prevention of plagiocephaly (flattening of the head) - change the position of your baby's head each day when she is laying down. Because babies like to have something interesting to look at, they tend to turn their head to look out into their room rather than toward the wall.	• Asymmetrical appearance. • Asymmetry of muscle tone, rigid posture. • Plagiocephaly.

Expected Standards	Client-based Support	Red Flags
• Muscle tone present and strong, coordinated movement. • Fontanels – frontal - flat and one to three cm in size; posterior fontanel should be closed. • Skin – colour – ethnic appropriate, turgor – indicates hydration and elasticity, clear – blemish free, smooth.	**Resource:** Canadian Paediatric Society: www.cps.ca Suggested Reference: Jarvis, C. (2009 or 2014) Physical Examination and Health Assessment; Mosby's	• Floppy movement: lack of muscle tone. • Fontanel is bulging or depressed; hydrocephalus will present with a bulging fontanel in the sitting position; asymmetry to the head including craniosynostosis. • Early closure is not an indication of any problem in the absence of other signs of cranial abnormality. • Presence of rash, inconsistent skin colour, cradle cap, unusual marks, bruises or hemangiomas.
Hearing • Ask if child's hearing has been tested in hospital, if available in RHA. • No high-risk factors in family history for deafness. • No high-risk factors in child's history for hearing loss. • Infant startles to loud and unusual noises.	**Counseling** • Review of family or child history for risk factors for deafness. • Parents are asked if they have any concerns about their child's hearing. • In RHAs where the universal hearing screening is not provided, assess for high-risk factors.	• In RHAs where universal hearing screening is provided and the infant has not been tested or if initial test was abnormal, refer back to RHA within the first six months. High-risk factor for deafness is identified: • Mechanical ventilation for > 5 days. • Bacterial meningitis. • Congenital perinatal infection. • Defects of head or neck. • Hyperbilirubinemia requiring transfusion. • Family history of childhood deafness. • Birth weight <1500 gms.

Expected Standards	Client-based Support	Red Flags
		• History of ototoxic medication use (ie. Salicylates, Non Steroidal Anti-Inflammatory Drugs, Antibiotics, Diuretics, Chemotherapeutic Agents, Quinine, Mucosal Protectant, Narcotic Analgesics: see http://chchearing.org/nyc/otology/ototoxic-medications and www.merckmanual.com for detailed medications list) See Appendix 8 – Ototoxic Medication • History of ear infections. • Concerns expressed by parents/ caregivers. • Refer to audiologist or primary care provider.
Vision • Eyes symmetrically positioned on face. • Follows objects with eyes. • Focuses on object.	**Counseling** • Advise parents that some amblyopia is common in young infants. • The Optometry Association of Saskatchewan encourages parents to have their child's eyes assessed by an optometrist at six months and then again at three years of age, earlier if there are any concerns. • Parents to consult their optometrist for further direction on when the child is to be seen. • Ministry of Health covers yearly eye exams for children up to their 18th birthday.	• If any concerns expressed by parent or any unusual eye movements noted, refer to the Optometrist or primary care provider.

Expected Standards	Client-based Support	Red Flags
Developmental Screening ** For children born < 37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See CHC Guidelines for Standard Practice for calculation details in the Demographics Standard (page 8). • Coos – throaty gurgling sounds. • Lifts head up while lying on tummy. • Holds head steady while upright. • Can be comforted and calmed by touching/rocking. • Smiles responsively. • Have different cries for different needs.	**Counseling** • Anticipatory guidance re: ➢ Promoting development; and ➢ Stimulation. • Encouraging tummy time. **Resource:** Promoting infant attachment: Saskatchewan Prevention Institute www.skprevention.ca Early childhood mental health attachment Rourke Record 2011 – www.rourke.ca Nipissing District Developmental Scale - www.ndds.ca	• If there is a parental concern or if more than two of the milestones are not being met, use the age appropriate NDDS. If two or more "No" responses are marked on the screen, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "no" may be influenced by culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.**

Expected Standards	Client-based Support	Red Flags
Sexual Health Development • Infant has skin to skin contact with parent. • Parent uses correct name of body parts including genitals.	**Anticipatory guidance for four months:** • Follows a moving toy or person with eyes. • Responds to people with excitement. • Holds head steady when supported at the chest. • Holds an object briefly when placed in hand. • Laughs/smiles responsively. • It is normal for children to explore their own bodies including their genitals. • Children enjoy appropriate touch as well as skin to skin contact. • Children like to be naked. Saskatchewan Prevention Institute: www.skprevention.ca Sexual and Reproductive Health Resources	• Concerns expressed by parent that they suspect their child has been abused. • Possible signs of sexual, physical abuse or neglect.
Maternal Mental Health • In two month Standard Assessment, all counseling and criteria are found under "Targeted Questions". • Provide EPDS screen to any mom who is at risk for or indicates concerns about postpartum anxiety or depression. • Public Health Nurse assists in scoring the EPDS.	**Counseling**	

Expected Standards	Client-based Support	Red Flags
Health Education / Injury Prevention Anticipatory guidance for health education and prevention.	**Counseling**	• Information in this section supports the previous assessments. Refer back to assessments for red flag identification and appropriate referral.
Child restraints	• Infants must use a rear-facing car seat until they are one year old and 10 kg (22 lbs) and can walk. Saskatchewan Prevention Institute: www.skprevention.ca - child injury prevention car seats.	
Shaken Baby Syndrome	• Many caregivers and parents become frustrated and angry when caring for a crying baby. Have a plan to recognize and deal with frustration. It is more important to stay calm than to stop the crying. Never Shake a Baby. Saskatchewan Prevention Institute: www.skprevention.ca Child injury prevention shaken baby syndrome	
Drowning and suffocation	• Never leave a baby alone while he or she is being bathed. • Remove the plastic wrapping on cribs, make sure the mattress fits snugly, and do not place pillows, stuffed toys, or bumper pads in the crib.	
Burns and scalds	• Always test the temperature of bath water with your elbow and make sure the hot water temperature at the taps is set at no more than 49°C (120°F).	

Expected Standards	Client-based Support	Red Flags
SIDS	• Infants should be placed on their backs when sleeping. • Make sure that nobody smokes around your baby. • Avoid putting too many clothes and covers on your baby. • Breastfeed your baby, it may give some protection against SIDS.	
Screen time/Physical Activity	• Canadian Physical Activity Guidelines recommend physical activity several times daily – particularly through interactive floor-based play. • Being active as an infant means: ➢ tummy time; ➢ reaching for or grasping balls or other toys; and ➢ playing or rolling on the floor. • Canadian Sedentary Behaviour Guidelines recommend for healthy growth and development, caregivers should minimize the time infants spend being sedentary during waking hours. This includes prolonged sitting or being restrained for more than one hour at a time. (stroller, car seat) • Limit use of playpens and infant seats when baby is awake. • Explore and play with your child. • Stop during long car trips for playtime. Canadian Society for Exercise Physiology: www.csep.ca	

Expected Standards	Client-based Support	Red Flags
Family dynamics	• Discuss sibling rivalry, grandparents, and changes in family dynamics related to parents as needed.	• Parent expresses concern over family members' actions since birth of child.
Violence and abuse	• Assess for concerns or presence of domestic violence or child abuse (see page 64 of the RNAO guidelines for possible action).	• See the Ministry of Social Service brochure for child abuse indicators: Social Services Child Protection www.socialservices.gov.sk.ca/child-protection.pdf. • Signs and symptoms of domestic violence or child abuse. See the Registered Nurses Association of Ontario (RNAO) best practice guidelines for a list of signs of abuse: rnao.ca/sites/rnao-ca/files/Guideline__Supplement_PDF.pdf . • Parents experiencing domestic violence should consider a safety plan and also have a copy of important documents in a safe place outside the home (HSN, tax return, driver's license).
Seasonal concerns Mosquitoes	• Protect your baby from mosquitoes by providing netting around strollers and other areas where immobile children are placed. • Protective light-coloured clothing with long cuffed sleeves, long pants, tucked into socks or shoes, and hats.	

Expected Standards	Client-based Support	Red Flags
	• Do not apply insect repellent to children under six months of age. • Keep infants inside during dusk and dawn when mosquitoes are out. • Use of DEET is restricted. See Caring for Kids Insect Repellent hand out. Caring for Kids: www.caringforkids.cps.ca/handouts/insect_repellents	
Sun	• Keep young children in the shade. • Use long sleeves and long pants to protect your baby from the sun. • Sunscreen with a minimum of 15 UV protection should be used. • Do not apply sunscreen on babies less than six months old. Canadian Cancer Society www.cancer.ca/en/prevention-and-screening/live-well/healthy-habits-for-families/sun-safety-and-children/?region=sk	
Frost bite	• Use of proper clothing. • Dressing the child in layers. • Cover head with a warm, close-fitting hat that protects the ear lobes. • Be aware of wind chill as it greatly speeds up the process of body heat loss.	

Expected Standards	Client-based Support	Red Flags
	• Remove wet clothes as soon as possible to avoid additional chilling. For more information: Saskatchewan Prevention Institute: www.skprevention.ca Child injury prevention seasonal.	
Second-hand smoke	• Ask if the infant is ever exposed to second-hand smoke in the home or vehicle. Reinforce benefits of smoke free air and reduced risk of SIDS, asthma, lung cancer, heart disease and tooth decay. • Assess where and who may be exposing the child to secondhand smoke. • Assist in offering information on protecting the child from second-hand smoke. • Arrange for more information or contacts to assist in eliminating second-hand smoke. If the presenting parent is a smoker: • Ask what type of tobacco they use. • Advise them that quitting is best. • Assess if they are thinking about quitting tobacco use. • Assist them by reviewing the risks, relevance, roadblocks, rewards and the need for repetition (resource information available on cessation). • Arrange: refer to cessation contacts or their primary care provider.	• Child is exposed to second-hand smoke on a regular basis. • History of ear infection/respiratory problems. • History of irritability, cough, congestion or phlegm production, allergies or asthma.

Expected Standards	Client-based Support	Red Flags
	(Record in child record that child is exposed to second-hand smoke, discussion and handout given to parent on cessation). See Appendix 13 – Procedure for the 5A's of Tobacco Intervention. **Resource** Prevention of Gestational and Neonatal Exposure to Tobacco Smoke: www.pregnets.org Smoker's Help Line 1-877-513-5333 Government of Saskatchewan: www.saskatchewan.ca/live/health-and-healthy-living/health-topics-awareness-and-prevention/tobacco/tobacco-and-your-health	
• Advise to book next appointment. • Discuss public health/community services. • Provincial HealthLine - 811 • Parenting program (if available in your area).		

Child Health Clinic – 4 month
Standard Assessments

Expected Standards	Client-based Support	Red Flags
Demographics • Confirmation of Demographic information (e.g. name, address, date of birth, gender and HSN number). • This can be done by PHN or support. • Client identifiers (right child).	• Updated information allows for improved contact and follow-up.	• Any errors or changes to be updated on the child record and reported to Ministry of Health by the parents.
Parent Support • Parents are able to ask questions about their child's health, growth, development, behaviour or other concerns. • Tell me if you have any questions or concerns about your child's health, development, behaviour or growth? **Targeted Questions:** **Nutrition** Focus on delaying complementary feeding until six months of age. See Nutrition Assessment.	**Counseling** • Parents are asked if they have any questions or concerns about their child's physical growth, health, behaviour, or development. • If parent is concerned about the child, the PHN could offer a home visit or phone call for further follow-up. • Children at this age should be consuming only breast milk or formula. • Encourage parents not to give complementary foods until the child is developmentally ready at about six months of age. • Encourage the introduction of iron-rich foods beginning at six months of age.	

Expected Standards	Client-based Support	Red Flags
Developmental Milestones: • Follows a moving toy or person with eyes. • Responds to people with excitement (leg movement/ panting/ vocalizing). • Holds head steady when supported at the chest or waist in a sitting position. • Laughs/ smiles responsively. • No parental concerns. Parental Strengths	• See Nutrition Assessment for more information and details. • Parent is asked if the child is able to do these milestones or PHN observes at least 3. • Parents are encouraged to give their child opportunities to play, learn and observe. • Acknowledge and give positive feedback.	• If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.
Growth ** For children born <37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. • Infant's growth is progressing normally. • Serial measurements of length, weight, and head circumference are recorded and plotted on the appropriate WHO growth chart (i.e. weight-for-age, length-for-age, weight-for-length, head circumference-for-age). • Age of child is identified and plotted to the nearest completed half month.	**Counseling** • Assess infant's growth pattern based on recorded and plotted measurements and using *A Health Professional's Guide for using the new WHO Growth Charts* (www.dietitians.ca/growthcharts). • Advise parents that measurements help confirm that their infant is growing and developing well and that it is important to look at patterns as opposed to any one single measurement.	**When growth pattern is outside of expected parameters: re-measure, verify age and re-plot.** • Growth pattern remains **flat** ➢ Obtain consent for referral to primary care provider or paediatrician. Primary care provider notified**.**

Expected Standards	Client-based Support	Red Flags
• Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and tracks parallel to the 50th percentile. • Record growth measurements in metric.	• Advise parents that the infant's rate of growth directly affects the infant's appetite and that appetite is the best indicator of adequate energy. When appetite picks up it usually means the infant is going through a growth spurt. Advise that parental size has a big impact on the size to which their infant may grow. • Advise parents that the number of wet and soiled diapers over 24 hours is an indication of the adequacy of intake. See Nutrition Standard – Elimination. • Assist parents in identifying any issues or concerns they may have about their feeding relationship, the infant's nutrition intake, elimination patterns, and other health concerns related to development and behaviour all of which have an impact on growth. • Assist parents with any information they may need for corrective action and connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support.	• **Sharp incline or decline** in growth pattern ➢ Further investigation and follow-up required. ➢ Based on assessment of all growth measures consider appropriate referral. See **NAMIC** Guide to Referral Resources. • **Growth measures plotted at <3rd or >85th percentile** ➢ This growth pattern may be normal, but children in these extremes should be assessed for whether this pattern is appropriate for them or due to a pathological situation and requires referral. See **NAMIC** Guide to Referral Resources. • **Head circumference** for age <3rd percentile and growing slowly or >97th percentile and growing rapidly. ➢ Rapidly increasing head circumference requires immediate referral.

Expected Standards	Client-based Support	Red Flags
Immunization • Assessment of the individual's health • Determination of which vaccines to provide. • Discussion of follow-up care. • Obtain informed consent for immunization. • Administration of those vaccines. • Documentation within 24 hours into the provincial immunization registry.	**Counseling** • **See Saskatchewan Immunization Manual for recommended vaccines, counseling, procedures, and parental resources.** www.ehealthsask.ca/services/manuals/Pages/SIM.aspx Immunize Canada: http://immunize.ca Caring for Kids (resources to share with parents): www.caringforkids.cps.ca See Appendix 3.1 in the Saskatchewan Immunization Manual for other reliable websites.	• Unable to obtain consent as legal guardianship in question. • Contraindications to immunization.
Nutrition **Targeted Questions:** 1. In the past seven days has your baby received anything other than breast milk? (**If no**, continue to question 4) 2. What type of milk is your baby drinking? 3. How much? How often? 4. Have you given your baby any solid foods? If so what kind? How did they react? 5. What was the reason for introducing solid foods?	**See Counseling supports below**	

Expected Standards	Client-based Support	Red Flags
Parental Support • Parents are aware of resources they can access if family is food insecure. • Parent is aware of resources she can access to sustain breastfeeding while returning to work or school.	**Counseling** • Assist food insecure families by connecting them to community resources they can access locally. See **NAMIC Standard**: Mother and family have access to enough healthy foods. • Advise parents of resources available to sustain breastfeeding while returning to work or school (refer to *Pregnancy, Parenting and the Workplace* handbook found at: http://www.shrc.gov.sk.ca/pdfs/publications/PPW-v2.pdf).	• Family is unable to access enough healthy food to meet their needs. • Mother returning to work or school does not have information to support sustained breastfeeding.
Feeding Relationship • Mother and infant express satisfaction with the feeding relationship. • Parents are responsive to night time feeds as well as day time.	**Counseling** • Assess mother's satisfaction with breastfeeding and provide any necessary guidance. See **NAMIC Standards:** Mother recognizes and responds to early feeding cue from infant; Mother understands the signs that her infant is getting enough breast milk. • Assess whether parents are responsive to night time feeds. A responsive parenting style is critical to maintenance of an adequate milk supply as well as meeting the nutrient and energy needs of non-breastfed infants for healthy weight gain See **NAMIC Standard:** Mother is responsive to feeding cue during nighttime as well as daytime.	• Mother expresses dissatisfaction with feeding relationship. • Parents expect infant to sleep through the night and may use training to promote this behaviour.

Expected Standards	Client-based Support	Red Flags
	• If bottle feeding, remind parents about responsive feeding and to allow infant's cues of hunger and satiety to guide the amount of formula to provide (i.e., cue-based feeding) rather than ensuring that the infant is consuming a prescribed amount of breast milk or formula. See **NAMIC Standard**: Mother recognizes and responds to early feeding cues from infant.	
Breastfed Infant • Infant is exclusively breastfed for six months. • Infant does not receive formula unless medically indicated • Breastfeeding is defined as: ➢ Exclusive breastfeeding – infant receives breast milk (including expressed milk, donor milk) and allows the infant to receive oral rehydration solution (ORS), syrups (vitamins, minerals, medicines) but does not allow the infant to receive anything else (from birth). ➢ Non-exclusive breastfeeding – infant has received breast milk (includes expressed milk, donor milk) and water, water-based drinks, fruit juice, ritual fluids (water infused with herbs or water mixed with different grains/cereals into a thin paste.	**Counseling** • Assist mothers to continue to exclusively breastfeed for six months by providing information about local breastfeeding support groups.	• Breastfed infant receives formula. • Infant cereal or other pureed foods given before 17 weeks of age. • Mother does not have the skill to hand express breast milk.

Expected Standards	Client-based Support	Red Flags
They may be used as part of a religious ceremony, provided regularly (e.g., 1x per day) or only given during a disease state) or any other liquids including non-human milk or solids. ➢ No breastfeeding – the infant receives no breast milk.		
• Mother has skill to hand express breast milk. • Mother understands what to do about common breastfeeding problems and concerns.	• Ask mother if she is comfortable with hand expression of breast milk. For instructions on hand expression, see: Breastfeeding Your Baby: *Mother's Milk Babies' Choice**.*** ➢ For management of breastfeeding concerns refer to **NAMIC Standard**: Infant is exclusively breastfed for 6 months with continued breastfeeding up to 2 years and beyond; and ➢ Breastfeeding Your Baby: *Mother's Milk Babies' Choice* ➢ Breastfeeding Committee for Saskatchewan Fact Sheets available at: http://www.thebcs.ca/ ➢ Lactation Consultant	• Mother does not know what to do about breastfeeding problems or concerns. ➢ Mother **identifies** that she does not have enough milk and/or that she is experiencing engorgement. • Infant cereal or other pureed foods given before 17 weeks of age (four months).
• Mother understands signs that infant is ready for solids at about six months.	• Remind parents that at 4 months, infants may be interested in seeing, smelling and touching food but are not ready to eat food. • At about six months, infants are physiologically and developmentally ready for new foods, textures and modes of eating.	

Expected Standards	Client-based Support	Red Flags
	See **NAMIC Standard**s: Infants show signs or readiness for solids; Child exhibits age appropriate development as it pertains to feeding. **Handouts** • 10 Valuable Tips for Successful Breastfeeding • Breastfeeding Your Baby: Mother's Milk Babies' Choice • Growing Up Healthy 6-12 months contains information on introducing solids. Only give this out if parent insists on feeding solids.	
<u>Non-breastfed Infant</u> • Parent indicates that infant is always held for feeding. • Infant receives a commercial infant formula which meets her nutritional needs. • Infant is receiving the quantity of formula that best meets her need. • Infant receives formula in the proper concentration. • Sanitary and safe procedures are followed when preparing and storing formula and feeding the infant. • Water used in the preparation of infant feeds meets current safety standards.	**Counseling** • Advise parents that infant should be held while feeding as the use of a propped bottle increases the risk for aspiration, choking and ear infection. • Advise parents that a regular cow milk-based commercial formula meets the needs of most healthy term infants. See your Public Health Nutritionist for more information about commercial infant formulas. See **NAMIC Standard:** Infant is receiving a commercial infant formula that meets their nutritional needs. • For sanitary and safe procedures in the preparation and storage of formula and current safety standards on water used in the preparation of formula see **NAMIC Standard:** Safe and Sanitizing Procedures. • Boiled water should be used in preparation of infant formula.	• Infant is fed with a propped bottle; bottle in crib. • Inappropriate formula given such as regular cow's milk, goat's milk or homemade formula. • Inappropriate quantity or concentration of formula offered. • Inappropriate safety precautions. • Inappropriate formula preparation.

Expected Standards	Client-based Support	Red Flags
• Mother understands signs that infant is ready for solids at about six months.	• Advise parents that powdered infant formula (PIF) is not a sterile product and must be prepared according to Health Canada recommendations. • See *Recommendations for the Preparation and Handling of PIF* http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/pif-ppn-recommandations-eng.php • Remind parents that at 4 months infants may be interested in seeing, smelling and touching food but are not ready to eat food. • At about six months, infants are physiologically and developmentally ready for new foods, textures and modes of eating. See **NAMIC Standard:** children exhibit age appropriate development as it pertains to feeding. **Handouts** • Infant Formula Feeding • Feeding Baby Introducing Solids	• Infant cereal, other pureed foods or liquids given before 17 weeks of age (four months).
Nutrients of Concern • Infant receives adequate vitamin D. • Mother takes only medically indicated supplements including over-the-counter medications and herbs.	**Counseling** • All infants who are breastfed or receiving breast milk should be provided with a daily vitamin D supplement of 400 IU. • Non-breastfed infants who are receiving a commercial infant formula do not require a vitamin D supplement.	• Breastfed or partially breastfed infant is not receiving a daily vitamin D supplement. • Mother is taking potentially harmful over-the-counter drugs or herbs and is breastfeeding.

Expected Standards	Client-based Support	Red Flags
	• See Public Health Nutritionist for **BACKGROUND PAPER**: *Vitamin D for Healthy Term Infants (0-12 months of age)* • Ask mother if she is aware of the potential increase in health risks from taking over-the-counter drugs and herbs. See *Breastfeeding and Drugs – Prescribed, Over-the-counter, Herbs, Illegal* (http://www.ibreastfeeding.com/content/free-stuff-14).	
Elimination • Infant has clear or pale yellow urine. • Infant has at least five wet diapers a day. • Infant passes stools without difficulty.	• Advise parents that constipation is hard stools that often make stooling difficult (**NAMIC Standard:** Infant exhibits normal elimination patterns). • Advise parents of non-breastfed infants that the colour of stools varies with the composition of the formula. • Infrequent stooling may be an indication of inadequate calorie and fluid intake. • Advise parents re: signs of dehydration and when to seek medical assistance**:** child has bloody or black stools, is still vomiting after four to six hours, has diarrhea and a fever with a temperature higher than 38.5°C (101.5°F), has dehydration, stomach pains getting worse (**NAMIC Standard:** Infant exhibits normal elimination patterns).	• Stools that are not yellow, soft and curdy. • Non-breastfed infant has a change in consistency of the stool, this may be the infant's normal pattern however, it may signal a need for further assessment. • Infant has green watery stools. • Infant has less than five wet diapers a day. • Constipation or diarrhea. • Dehydration.

Expected Standards	Client-based Support	Red Flags
	Handouts Refer to Caring for Kids: www.caringforkids.cps.ca for handouts: • Healthy Bowel Habits for Children • Dehydration and Diarrhea in Children: Prevention and Treatment	
Oral Health • Oral health assessment. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity. • Mother indicates breast or bottle nipple is removed from the mouth when infant falls asleep. • Indication of teething (i.e. chewing on objects, increased saliva, increased fussiness while feeding). • Risk for developing tooth decay is assessed	• Advise parents to remove breast or bottle if infant falls asleep. • If no teeth are present: clean your baby's mouth after feeding, at least once per day, with a moist cloth. • If teeth are present: teeth/gums should be cleaned with moistened soft bristled toothbrush twice a day. Bedtime is most important. • If the child is at risk for tooth decay, use fluoridated toothpaste, the size of a grain of rice. (See page 2 of the Oral Screening Guidelines for risks for tooth decay – Appendix 6). • Keep pacifier clean. Limit use. • Never put baby's pacifier in your mouth to clean it; this passes decay causing germs to your baby. • Lift the lip and look for plaque and early signs of tooth decay if teeth are present. • Thumb and finger sucking is normal for infants. • Tooth Eruption: Lower incisors (6 – 10 months)	• Infant continues to feed while sleeping. • Referral to an oral health professional if there are any concerns or risk factors identified.

Expected Standards	Client-based Support	Red Flags
	References: Oral Screening Guidelines for Child Health Clinics **Resources:** • Early Childhood Tooth Decay Thumb, Finger and Pacifier Habits	
Standard Handouts Immunization Fact Sheets Caring for Your Child's Fever Growing Up Healthy 4-6 months		

Child Health Clinic – 4 month
Additional Assessments

Expected Standards	Client-based Support	Red Flags
Offer and discuss highlights of the 4 -6 months Growing Up Healthy resource. **Physical** **Sleep/Cry** • Average amount of sleep 14 hours per day (three to four hours at a time).	• Routines for bedtime foster health child development and parenting. • Baby's sleep patterns. • Reality vs. expectations. • Affirm family's sleep/room sharing choices. • Coping: what helps? **Resources:** Caring for Kids www.caringforkids.cps.ca/handouts/healthy_sleep_for_your_baby_and_child	• No bedtime routine established. • Parent has unreasonable expectations of baby's sleep. • Baby is co-sleeping with parents.
Head to Toe • Symmetry of body and movement. • Fontanels are flat and one to two cm in size.	**Counseling** • Referral to the primary care practitioner if appropriate. • Prevention of plagiocephaly - change the position of your baby's head each day when she is laying down. Because babies like to have something interesting to look at, they tend to turn their head to look out into their room rather than toward the wall.	• Fontanel is bulging or depressed; hydrocephalus will present with a bulging fontanel in the sitting position; asymmetry to the head including craniosynostosis. • Early closure is not an indication of any problem in the absence of other signs of cranial abnormality.

Expected Standards	Client-based Support	Red Flags
	Resource Canadian Paediatric Society - www.cps.ca Jarvis, C. (2009 or 2014) Physical Examination and Health Assessment; Mosby's	• Presence of plagiocephaly. • Presence of rash, cradle cap, unusual marks, bruises or hemangiomas.
• Skin: colour, turgor, appearance. • Muscle tone present and strong with coordinated movement. • No head lag. Podiatry • Hip in partial flexion. • Knee in flexion. • Bow legs. • Apparent flat feet- lack of arches.		• If poor muscle tone, lack of muscle tone or hyper muscle tone present, refer to primary care practitioner. • Refer to podiatrist or primary care practitioner for ingrown toenails or signs of pressure on nails, hips not in partial flexion, knees not flexed, legs not bowed, arched feet.
Hearing *if hearing risk assessment questions not asked at a previous visit, assessment should be done here. • Ask parents if they have any concerns about their child's hearing. • Infant startles to loud, unusual noise.	**Counseling** • Review of family or child history for risk factors for deafness. • Parents are asked if they have any concerns about their child's hearing.	High-risk factor for deafness is identified. • Mechanical ventilation for > 5 days. • Bacterial meningitis. • Congenital perinatal infection. • Defects of head or neck. • Hyperbilirubinemia requiring transfusion. • Family history of childhood deafness. • Birth weight <1500 gms.

Expected Standards	Client-based Support	Red Flags
		• History of ototoxic medication use (ie. Salicylates, Non Steroidal Anti-Inflammatory Drugs, Antibiotics, Diuretics, Chemotherapeutic Agents, Quinine, Mucosal Protectant, Narcotic Analgesics: see http://chchearing.org/nyc/otology/ototoxic-medications and www.merckmanual.com for detailed medications list) See Appendix 8. • History of ear infections. • Concerns expressed by parents/ caregivers • Refer to audiologist or primary care provider.
Vision • Eyes symmetrically positioned on face. • Follows objects with eyes. • Advise parents regarding Optometric Association recommendations.	**Counseling** • Advise parents that some amblyopia is common in young infants. • The Optometric Association of Saskatchewan encourages parents to have their child's eyes assessed by an optometrist at six months and then again at three years of age, earlier if there are any concerns.	• Refer to Optometrist if any concerns.

Expected Standards	Client-based Support	Red Flags
Development ** For children born at 37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. • Follows a moving toy or person with eyes. • Responds to people with excitement (leg movement/ panting/ vocalizing). • Holds head steady when supported at the chest or waist in a sitting position. • Laughs/ smiles responsively. • No parental concerns.	**Counseling** • Anticipatory guidance re: ➢ Promoting development ➢ Stimulation • Encouraging tummy time. • Promoting infant attachment. **Anticipatory guidance for the six months:** • Turns head towards sounds. • Makes sounds while you talk to him/her. • Vocalizes pleasure and displeasure. • Rolls from back to side. • Sits with support (e.g. pillows). • Reaches/ grasps objects.	• If there is a parental concern or if two or more of the milestones are not being met, use the age appropriate Nipissing District Developmental Screen (NDDS). If two or more "No" responses are marked, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "no" may be influenced by culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.**

Expected Standards	Client-based Support	Red Flags
Sexual Health Development • Infant has skin to skin contact with parent. • Parent uses correct name of body parts including genitals.	• It is normal for children to explore their own bodies including their genitals. • Children enjoy touch as well as skin to skin contact. • Children like to be naked. Saskatchewan Prevention Institute www.skprevention.ca Sexual and Reproductive Health Resources	• Concerns expressed by parent that they suspect their child has been abused. • Possible signs of sexual, physical abuse or neglect.
Maternal Mental Health • If mom has not been screened at the two month visit, follow assessment. If mom has been screened, this assessment is not done at four months unless a mom presents with concerns about anxiety or depression, the maternal mental health assessment should be done.	**Counseling** • It is normal to have baby blues but if there is the presence of five or more of the following symptoms over a two week period most of the day and nearly every day, postpartum depression may exist. Refer to the appropriate health care provider. ➢ Depressed mood. ➢ Diminished interest or pleasure in all or most activities. ➢ Significant weight loss when not dieting or weight gain, or decrease or increase in appetite. ➢ Insomnia or hypersomnia. ➢ Excessive or lowered physical expression/activity. ➢ Fatigue or loss of energy. ➢ Feelings of worthlessness or excessive or inappropriate guilt. ➢ Diminished ability to think or concentrate, or indecisiveness.	• If the score is <10, affirm positive findings and promote positive mental health. • If the score is 10 or 11, discuss concerns and offer referral to primary care provider or mental health services, or HealthLine. Promote positive mental health; increase contact. • If the score is 12 or greater, discuss concerns and take action; make a referral to the primary care provider or mental health services, and HealthLine; increase contact; promote positive mental health. • Anxiety Items (3, 4, 5) score >4. • Discuss concerns and repeat in two weeks; offer referral and promote positive mental health. • Positive score on item #10: Assess harm risk to self and others; intervene with Emergency, Crisis Intervention, Harm Contract or other appropriate referral.

Expected Standards	Client-based Support	Red Flags
	➢ Recurrent thoughts of death, recurrent suicidal ideation or suicide attempt. ➢ Preoccupation with infant well-being which can range from over-concern to delusions. ➢ Severe anxiety. ➢ Disinterest in the infant. ➢ Fear of being left alone with the infant. ➢ Over-intrusiveness that prevents adequate infant rest. • Degree of support for women and families will vary in each community. Determine most appropriate referral and community resources based on RHA information. • Provide information on maintaining good mental health; ➢ be kind to yourself; ➢ ask for and accept help with baby and housework; ➢ keep active – go for a walk; ➢ get enough sleep – at least 6 hours in a 24 hour period; ➢ eat healthy and regularly; ➢ avoid alcohol, tobacco and other drugs; ➢ take medications as prescribed; ➢ try yoga or other activities to help you relax; ➢ look for a support group or other supports in your community; or ➢ talk to a health care provider.	

Expected Standards	Client-based Support	Red Flags
	• Partners and family suggestions to help; ➢ listen to her and support her feelings; ➢ ask her how you can help; ➢ encourage her to seek professional help if she has frequent feelings of sadness or depression; ➢ develop a relationship with the baby; ➢ educate yourself about maternal mental health. • Partners can also experience depression – it is important that they also get the support they need. www.skmaternalmentalhealth.ca **Resources:** Maternal Mental Health Committee of Saskatchewan www.skmaternalmentalhealth.ca HealthLine 811 Maternal Depression Online: https://www.onlinetherapyuser.ca/intro/mdo/	

Expected Standards	Client-based Support	Red Flags
Health Education / Injury Prevention Anticipatory guidance for health education and prevention.	**Counseling**	
Child restraints	• Infants must use a rear-facing car seat until they are one year old and 10 kg (22 lbs) and can walk. • Many caregivers and parents become frustrated and angry when caring for a crying baby. Saskatchewan Prevention Institute: www.skprevention.ca child safety	• Information in this section supports the previous assessments. Refer back to assessments for red flag identification and appropriate referral.
Shaken Baby Syndrome	• Encourage parents to have a plan to recognize and deal with frustration. It is more important to stay calm than to stop the crying. Never Shake a Baby.	
Drowning and suffocation	• Never leave a baby alone while he or she is being bathed. • Remove the plastic wrapping on cribs, make sure the mattress fits snugly, and do not place pillows, stuffed toys, or bumper pads in the crib.	
Burns and scalds	• Always test the temperature of bath water with your elbow and make sure the hot water temperature at the taps is set at no more than 49°C (120°F).	

Expected Standards	Client-based Support	Red Flags
Falls	• Children begin to roll at this age, use safety straps on change tables and keep a hand on child at all times.	
SIDS	• Infants should be placed on their backs when sleeping. • Make sure that nobody smokes around your baby. • Avoid putting too many clothes and covers on your baby. • Breastfeed your baby, it may give some protection against SIDS.	
Screen time/Physical Activity	• Canadian Physical Activity Guidelines recommend physical activity several times daily – particularly through interactive floor-based play. • Being active as an infant means: ➢ tummy time; ➢ reaching for or grasping balls or other toys; ➢ playing or rolling on the floor. • Canadian Sedentary Behaviour Guidelines recommend for healthy growth and development, caregivers should minimize the time infants spend being sedentary during waking hours. This includes prolonged sitting or being restrained for more than one hour at a time. (stroller, high chair, car seat) • Limit use of playpens and infant seats when baby is awake. • Explore and play with your child. • Stop during long car trips for playtime.	

Expected Standards	Client-based Support	Red Flags
	Canadian Society of Exercise Physiologists: www.csep.ca	
Family Dynamics	• Discuss sibling rivalry, grandparents, and changes in family dynamics related to parents as needed.	• Parent expresses concern over family members' actions since birth of child.
Violence and abuse	• Assess for concerns or presence of domestic violence or child abuse (see page 64 of the RNAO guidelines for possible action).	• Signs and symptoms of domestic violence or child abuse. See the Registered Nurses Association of Ontario (RNAO) best practice guidelines for a list of signs of abuse: http://rnao.ca/sites/rnao-ca/files/Guideline__Supplement_PDF.pdf . See the Ministry of Social Service brochure for child abuse indicators: www.socialservices.gov.sk.ca/child-protection.pdf • Parents experiencing domestic violence should consider a safety plan and also have a copy of important documents in a safe place outside the home (HSN, tax return, driver's license).

Expected Standards	Client-based Support	Red Flags
Seasonal Concerns		
Mosquitoes	• Protect your baby from mosquitoes by providing netting around strollers and other areas where immobile children are placed. • Protective light-coloured clothing with long cuffed sleeves, long pants, tucked into socks or shoes, and hats. • Do not apply insect repellent to children under six months of age. • Keep infants inside during dusk and dawn when mosquitoes are out. Caring for Kids www.caringforkids.cps.ca/handouts/insect_repellents	
Sun	• Keep young children in the shade. • Use long sleeves and long pants to protect your baby from the sun. • Do not apply sunscreen on babies less than six months old.	
Frostbite/Winter	• Use of proper clothing. • Dressing the child in layers. Cover head with a warm, close-fitting hat that protects the ear lobes. • Be aware of wind chill as it greatly speeds up the process of body heat loss. • Remove wet clothes as soon as possible to avoid additional chilling.	

Expected Standards	Client-based Support	Red Flags
Second-hand smoke This assessment should be delivered at the two month visit, if not provided then, assess at the four month visit.	Resources : Saskatchewan Prevention Institute www.skprevention.ca seasonal safety	• Child is exposed to second-hand smoke on a regular basis.
• Advise to book next appointment. • Discuss public health/community services. • Provincial HealthLine 811. • Parenting program (if available in your area).		

Child Health Clinic – 6 month
Standard Assessment

Expected Standards	Client-based Support	Red Flags
Demographics • Confirmation of Demographic information (e.g. name, address, date of birth, gender and HSN number). • This can be done by PHN or support staff. • Client identifiers (right child).	• Updated information allows for improved contact and follow-up. • Confirmation of client identifier contributes to zero immunization errors.	• Any errors or changes to be updated on the child record and reported to Ministry of Health by the parents.
Parent Support • Parents are able to ask questions about their child's health, growth, development, behaviour or other concerns. • Tell me if you have any questions or concerns about your child's health, development, behaviour or growth?	**Counseling** • Parents are asked if they have any questions or concerns about their child's physical growth, health or development. • If parent is concerned about the child, the PHN could offer a home visit or phone call for further follow-up. • Address any concerns that parent has or provide further assessment with indicated additional assessment.	
Targeted questions: **Maternal Mental Health** EPDS is given to each mom attending CHC with their child at 6 months and asked to complete the questionnaire. Assistance by the PHN/staff/ or family member can be given to the mom to complete the EPDS. Mom has the right to refuse to complete the questionnaire.	• The Edinburgh Postnatal Depression Scale (EPDS) is a tool used to assess risk for postnatal depression. • Once the questionnaire is completed by the parent, the PHN scores the answers and totals them.	• If the score is <10 affirm positive findings and promote positive mental health. • If the score is 10 or 11, discuss concerns and offer referral to primary care provider or mental health services, promote positive mental health; increase contact.

Expected Standards	Client-based Support	Red Flags
	• It is normal to have baby blues but if there is the presence of five or more of the following symptoms over a two week period most of the day and nearly every day, postpartum depression may exist. Refer to the appropriate health care provider. • Depressed mood. • Diminished interest or pleasure in all or most activities. • Significant weight loss when not dieting or weight gain, or decrease/increase in appetite. • Insomnia or hypersomnia. • Excessive or lowered physical expression/activity. • Fatigue or loss of energy. • Feelings of worthlessness or excessive or inappropriate guilt. • Diminished ability to think or concentrate, or indecisiveness. • Recurrent thoughts of death, recurrent suicidal ideation or suicide attempt. • Preoccupation with infant well-being which can range from over-concern to delusions. • Severe anxiety. • Disinterest in the infant. • Fear of being left alone with the infant. • Over-intrusiveness that prevents adequate infant rest. • Degree of support for women and families will vary in each community. Determine most appropriate referral and community resources based on RHA information.	• If the score is 12 or greater, discuss concerns and take action; make a referral to the primary care provider or mental health services; increase contact; promote positive mental health. Screen partner. • Anxiety Items (3, 4, 5) score >4. • Discuss concerns and repeat in two weeks; offer referral and promote positive mental health. • Positive score on item #10: Assess harm risk to self and others; intervene with Emergency, Crisis Intervention, Harm contract. • Provide HealthLine number: 811. • If mom refuses to complete EPDS, chart the refusal. Encourage mom to talk with her primary care provider, mental health clinician or HealthLine if she has concerns about her mental health.

Expected Standards	Client-based Support	Red Flags
	• Provide information on maintaining good mental health; ➢ be kind to yourself; ➢ ask for and accept help with baby and housework; ➢ keep active – go for a walk; ➢ get enough sleep – at least 6 hours in a 24 hour period; ➢ eat healthy and regularly; ➢ avoid alcohol, tobacco and other drugs; ➢ take medications as prescribed; ➢ try yoga or other activities to help you relax; ➢ look for a support group or other supports in your community; or ➢ talk to a health care provider. • Partners and family suggestions to help; ➢ listen to her and support her feelings; ➢ ask her how you can help; ➢ encourage her to seek professional help if she has frequent feelings of sadness or depression; ➢ develop a relationship with the baby; ➢ educate yourself about maternal mental health. • Partners can also experience depression – it is important that they also get the support they need. For more information: www.skmaternalmentalhealth.ca	

Expected Standards	Client-based Support	Red Flags
	Resources for parents: • Provide HealthLine number: 811 Maternal Depression Online: https://www.onlinetherapyuser.ca/intro/mdo/	
Developmental Milestones: • Turns head towards sounds. • Makes sounds while you talk to him/her. • Vocalizes pleasure and displeasure. • Rolls from back to side. • Sits with support (e.g. pillows). • Reaches/ grasps objects. Parental Strengths	• Parent is asked if the child is able to do these milestones or PHN observes at least 3. • Parents are encouraged to give their child opportunities to play, learn and observe. • Acknowledge and give positive feedback.	• If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.
Growth *** For children born <37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. • Infant's growth is progressing normally. • Serial measurements of length, weight, and head circumference are recorded and plotted on the appropriate WHO growth chart (i.e. weight-for-age, length-for-age, weight-for-length, head circumference-for-age).	**Counseling** • Assess infant's growth pattern based on recorded and plotted measurements and using *A Health Professional's Guide for using the new WHO Growth Charts* (www.whogrowthcharts.ca).	**When growth pattern is outside of expected parameters: re-measure, verify age and re-plot.** • Growth pattern remains **flat** ➢ Obtain consent for referral to primary care provider or pediatrician. Primary care provider notified.

Expected Standards	Client-based Support	Red Flags
• Age of child is identified and plotted to the nearest completed half month. • Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and tracks parallel to the 50th percentile. • Record all measurements in metric.	• Advise parents that measurements help confirm that their infant is growing and developing well and that it is important to look at patterns as opposed to any one single measurement. • Advise parents that the infant's rate of growth directly affects the infant's appetite and that appetite is the best indicator of adequate energy. When appetite picks up it usually means the infant is going through a growth spurt. Advise that parental size has a big impact on the size to which their infant may grow. • Advise parents that the number of wet and soiled diapers over 24 hours is an indication of the adequacy of intake. See Elimination. • Assist parents in identifying any issues or concerns they may have about their feeding relationship, the infant's nutrition intake, elimination patterns, and other health concerns related to development and behaviour all of which have an impact on growth. • Assist parents with any information they may need for corrective action and connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support.	• Sharp **incline or decline** in growth pattern ➢ Further investigation and follow-up required. ➢ Based on assessment of all growth measures consider appropriate referral. **NAMIC** Guide to Referral Resources. • Growth **measures plotted at <3rd or >85th percentile** ➢ This growth pattern may be normal, but children in these extremes should be assessed for whether this pattern is appropriate for them or due to a pathological situation and requires referral. **NAMIC** Guide to Referral Resources. • **Head circumference** for age <3rd percentile and growing slowly or >97th percentile and growing rapidly. ➢ Rapidly increasing head circumference requires immediate referral.

Expected Standards	Client-based Support	Red Flags
Immunization • Assessment of the individual's health. • Determination of which vaccines to provide. • Discussion of follow-up care. • Obtain informed consent for immunization. • Administration of those vaccines. • Documentation within 24 hours into the provincial immunization registry.	**Counseling** • **See Saskatchewan Immunization Manual for** recommended vaccines, counseling, procedures, and parental resources. www.ehealthsask.ca/services/manuals/Pages/SIM.aspx Immunize Canada: http://immunize.ca Caring for Kids (resources to share with parents): www.caringforkids.cps.ca See Appendix 3.1 in the Saskatchewan Immunization Manual for other reliable websites.	• Unable to obtain consent as legal guardianship in question. • Contraindications to immunization.
Nutrition **Parental Support** • Parents are aware of resources they can access if family is food insecure. • Parent is aware of resources she can access to sustain breastfeeding while returning to work or school.	**Counseling** • Assist food insecure families by connecting them to community resources they can access locally. See **NAMIC Standard**: Mother and family have access to enough healthy foods. • Advise parents of resources available to sustain breastfeeding while returning to work or school (refer to *Pregnancy, Parenting and the Workplace* handbook found at www.shrc.gov.sk.ca/pdfs/publications/PPW-v2.pdf).	• Family is unable to access enough healthy food to meet their needs. • Mother returning to work or school does not have information to support sustained breastfeeding.
Feeding Relationship • Mother and child exhibit satisfaction with the feeding relationship. • Parents are responsive to night time feeds as well as day time.	**Counseling** • Assess satisfaction with sustained breastfeeding while gradually introducing solids reminding parents of what to expect. For example: breast milk is the main source of nutrients during the first year, the frequency of nursing may not change until infant receives enough calories from family foods at about 12 months.	• Dissatisfaction with feeding relationship.

Expected Standards	Client-based Support	Red Flags
• A quality feeding relationship exists within the context of a supportive family environment where child joins the family at mealtimes. • Infant takes the lead when learning to eat solids. • Infant shows cues of hunger and fullness and parents can identify these cues and respond appropriately. • Child is offered a variety of healthy foods but is given the responsibility for how much to eat.	• Assess whether parents are responsive to night time feeds. A responsive parenting style is critical to maintenance of an adequate milk supply as well as meeting the nutrient and energy needs of non-breastfed infants for healthy weight gain. See **NAMIC Standard:** Mother is responsive to continued feeding night time and day time. • Assess parenting style and discuss positive ways to respond to infant feeding cues. See **NAMIC Standard:** A quality feeding relationship exists within the context of a supportive family environment (complementary feeding). For example: let child take the lead on how much to eat, encourage child to self-feed, include child at meals. • Advise the parent to provide opportunities to self-feed.	• Parent expects infant to sleep through the night and may use training to promote this behaviour. • Eating behaviour problems. • Excess or inadequate energy intake. • Inadequate nutrient intake. • Sustained breastfeeding diminished.
Breastfed Infant • Infant continues to be breastfed for up to two years and beyond with the addition of energy and nutrient rich complementary food being offered at about six months. • Breastfeeding is defined as: ➢ Exclusive breastfeeding –infant receives breast milk (including expressed milk, donor milk) and allows the infant to receive oral rehydration solution (ORS), syrups (vitamins, minerals, medicines) but does not allow the infant to receive anything else (from birth).	**Counseling** • Assist with any feeding concerns while sustaining breastfeeding beyond six months. See **NAMIC Standard:** Mother and child exhibit satisfaction with feeding relationship.	• Breastfed infant receives formula.

Expected Standards	Client-based Support	Red Flags
➢ Non-exclusive breastfeeding – infant has received breast milk (includes expressed milk, donor milk) and water, water-based drinks, fruit juice, ritual fluids (water infused with herbs or water mixed with different grains/cereals into a thin paste. They may be used as part of a religious ceremony, provided regularly (e.g., 1x per day) or only given during a disease state) or any other liquids including non-human milk or solids. ➢ No breastfeeding – the infant receives no breast milk. • Infant does not receive commercial infant formula unless medically indicated. • Mother has the skill to express breast milk. • Mother understands what to do about common breastfeeding problems and concerns.	• Ask mother if she is comfortable with hand expression of breast milk. For instructions on hand expression, see *Mother's Milk Baby's Choice: The Miracle Food Handout.*	• Mother does not have the skill to hand express breast milk. • Mother does not know what to do about breastfeeding problems or concerns.
Non-breastfed Infant • Parent indicates that infant is held or supervised when bottle fed. • Infant receives a commercial infant formula which meets their nutritional needs.	**Counseling** • Advise if necessary that infant should be held or supervised while bottle feeding as the use of a propped bottle increases the risk for aspiration, choking, ear infection and early childhood tooth decay.	• Infant is fed with propped bottle; bottle in crib. • Inappropriate quantity or concentration of formula offered.

Expected Standards	Client-based Support	Red Flags
• Infant receives the quantity of formula that best meets her need. • Infant receives formula in the proper concentration.	• Advise that a regular cow's milk-based commercial formula with sufficient iron meets the needs of healthy term infants. See Public Health Nutritionist for more information about commercial infant formulas. • Advise that starter formula is adequate for infants up to a year (follow-up or Step 2 formulas is not recommended). • Advise that cow's or goat's milk is not recommended until after a year. • If soy formula is used for cultural, religious or medical reasons (e.g.: galactosemia) infant should continue to use it for the first year.	• Inappropriate formula is given such as regular cow's milk, goat's milk or homemade formula.
• Sanitary and safe procedures are followed when preparing and storing formula and feeding the infant. • Water used in the preparation of infant feeds meets current safety standards.	• Advise parents that powdered infant formula (PIF) is not a sterile product and must be prepared according to Health Canada recommendations. See *Recommendations for the Preparation and Handling of PIF* www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/pif-ppn-recommandations-eng.php	• Inappropriate safety precautions. • Inappropriate formula preparation.
Complementary Feeding • Child exhibits age-appropriate development as it pertains to feeding. • Mother sustains breastfeeding while solid foods are gradually introduced. • Infant receives foods rich in iron among the first foods offered at about six months. • Foods are modified in texture to age and stage of development.	**Counseling** • Advise parents of the physical and social milestones as they pertain to feeding including signs of readiness for solids. See **NAMIC Standard:** Child exhibits age appropriate development as it pertains to feeding. • Advise parents about the need to introduce a variety of foods more often and with more texture as infant develops.	• Feeding is forced or restricted. • Infant cereal or other pureed foods given in a bottle. • Introduction of solids prior to 17 weeks (four months) or later than 26 weeks.

Expected Standards	Client-based Support	Red Flags
• Infant is given the opportunity to self-feed.	• Advise parents to encourage self-feeding as soon as possible, especially when infant shows an interest. Parents can offer foods and fluids by finger, spoon, or regular open cup.	• Infant is not given opportunity to self-feed.
• Foods are selected, prepared and stored using sanitary and safe procedures.	• Advise parents about reducing risks associated with adverse food reactions. For example: avoid introducing solid foods prior to 17 weeks (four months) and preferably not until six months; offer single foods before mixtures. • Advise parents about the need for iron-rich foods as some of the first foods offered at around six months (e.g. meat, beans, egg yolk, and iron fortified cereal). Note: a whole egg can be offered, but the iron is contained within the yolk. • Advise parents that whole cow milk is a poor source of iron and should not be used as the main source of milk prior to 12 months; to offer water and to make sure that if fruit juice is offered it is unsweetened 100% fruit juice and is offered in moderate amounts only (e.g. about 60 mL (2 oz) a day). • Assess awareness and advise parents what foods to offer and how to prepare and store them safely, avoiding choking hazards. Remind parents that gagging is a natural reflex that helps infants avoid choking. See **NAMIC Standard:** Safe and sanitary procedures are followed when preparing and storing foods and feeding the infant/ young child.	• By seven months infant is not consuming iron rich foods. • Infant is drinking cow's milk prior to 9 months. • Infant consumes juice frequently throughout the day or drinks >125 mL (4 oz) per day. • Infant consumes fruit drinks, pop, coffee, tea, hot chocolate, soy beverage or other vegetarian beverages or herbal teas. • Honey is given. • Inappropriate food is offered and/or not modified, increasing risk of choking.

Expected Standards	Client-based Support	Red Flags
	Handouts: • 10 Valuable Tips for Successful Breastfeeding • Breastfeeding Your Baby: Mother's Milk Baby's Choice(revised) • Infant Formula Feeding	
Nutrients of Concern • Infant receives adequate vitamin D. • Infants receive adequate iron from food source. • Mother takes only medically indicated supplements including over-the-counter medications and herbs.	**Counseling** • Supplement with vitamin D. • All infants who are breastfed or receiving breast milk should be provided with a daily vitamin D supplement of 400 IU. • Non-breastfed infants who are receiving a commercial infant formula do not require a vitamin D supplement. • See Public Health Nutritionist for **BACKGROUND PAPER**: *Vitamin D for Healthy Term Infants (0-12 months of age).* • Iron rich foods should be offered 2 or more times a day. See **NAMIC Standard**: Infant is offered foods rich in iron at 6 months amongst the first foods. • Ask mother if she is aware of the potential increase in health risks from taking over-the-counter drugs and herbs. See *Breastfeeding and Drugs – Prescribed, Over-the-counter, Herbs, Illegal* (www.ibreastfeeding.com/content/free-stuff-14).	• Breastfed or partially breastfed infant is not receiving a daily vitamin D supplement. • By seven months, infants is not consuming iron rich foods. • Mother is taking potentially harmful over-the-counter drugs or herbs and is breastfeeding.
Elimination • Infant has clear or pale yellow urine. • Infant has at least 5 wet diapers a day • Infant passes stools without difficulty.	• Advise parents that constipation is hard stools that often make stooling difficult. See **NAMIC Standard:** Infant exhibits normal elimination patters.	• Stools that are not yellow, soft and curdy.

Expected Standards	Client-based Support	Red Flags
	• Advise parents of non-breastfed infants that the colour of bowel movements varies with composition of the formula. • Infrequent stooling may be an indication of inadequate calorie and fluid intake.	• Non-breastfed infant has a change in consistency of the stool, this may be the infant's normal pattern however, it may signal a need for further assessment. • Infant has green watery stools.
	• Advise parents re: signs of dehydration and when to seek medical assistance: child has bloody or black stools, is still vomiting after four to six hours, has diarrhea and a fever with a temperature higher than 38.5°C (101.5°F), has dehydration, stomach pains getting worse. See **NAMIC Standard:** Infant exhibits normal elimination patterns. **Handouts** **Caring For Kids** Refer to www.caringforkids.cps.ca for handouts: • Healthy Bowel Habits for Children • Dehydration and Diarrhea in Children: Prevention and Treatment	• Infant does not have heavy wet diapers. Urine is dark yellow or orange rather than pale yellow.
Oral Health • Oral health assessment. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity. • Signs of teething.	**Counseling** **If no teeth are present:** Gums should be cleaned with a moist cloth after every feeding**.** **If teeth are present:** Gently clean your baby's teeth and gums twice a day using a small, soft toothbrush. Babies at risk for tooth decay should have their teeth brushed by an adult using fluoridated tooth paste the size of a grain of rice. • Tooth eruption (central incisors).	• Parental concerns about teeth. • Presence of plaque or early signs of tooth decay.

Expected Standards	Client-based Support	Red Flags
• Risk for developing tooth decay is assessed	**To ease teething:** Rub baby's gums with a soft toothbrush or allow them to chew on a clean, cold (not frozen) teether ring or wet face cloth. Teething ointments and gels are not recommended as they may numb baby's throat and cause choking. • Training cups are not recommended. • Encourage the use of a regular open cup. Children are able to begin to use a regular cup as early as 6 months of age. • Encourage the parent to regularly lift the lip and look for plaque and early signs of tooth decay. **References:** Oral Screening Guidelines for Child Health Clinics **Resources:** Toothpaste Use for children Under 3 Drinking From a Cup	• Use of teething ointments and gels. • Refer to an oral health professional if any concerns or risk factors identified.
Standard Handouts: Immunization Fact Sheets Caring for Your Child's Fever Growing Up Healthy 6-12 months		

Child Health Clinic – 6 month
Additional Assessments

Expected Standards	Client-based Support	Red Flags
Offer and discuss highlights of the 6-12 months Growing Up Healthy resource. **Physical** **Sleep/Cry** • These infants require about 14 hours of sleep per day which includes a day time nap of two to three hours.	• Bedtime routines foster health child development and parenting. • Baby's sleep patterns. • Reality vs. expectations. • Affirm family's sleep/room sharing choices. • Coping: what helps? Caring for Kids http://www.caringforkids.cps.ca healthy sleep for your baby and child	• No bedtime routine established. • Parent has unreasonable expectations of baby's sleep. • Co-sleeping with parents.
Head to Toe • Symmetry of body and movement.	**Counseling** • Referral to the primary care practitioner if appropriate. • Prevention of plagiocephaly (flattening of the head) - change the position of your baby's head each day when she is laying down. Because babies like to have something interesting to look at, they tend to turn their head to look out into their room rather than toward the wall.	• Presence of asymmetry in body or movement. • Presence of plagiocephaly. • Fontanel is bulging or depressed; early closure is not an indication of any problem in the absence of other signs of cranial abnormality; hydrocephalus will present with a bulging fontanel in the sitting

Expected Standards	Client-based Support	Red Flags
• Skin: colour, turgor, appearance.	Canadian Paediatric Society www.cps.ca Suggested Resource: Jarvis, C. (2009 or 2014) Physical Examination and Health Assessment; Mosby's.	position; asymmetry to the head including craniosynostosis. • Presence of rash, inconsistent skin colour, cradle cap.
• Muscle tone present and strong with coordinated movements.		• Lack of muscle tone or uncoordinated or spastic movement.
Podiatry 6 – 9 months • Starts to weight bear on feet. • Stands at seven to nine months. • Bow legs.	• Children will walk when ready. • No footwear is needed until toddlers walk. • Children should not be "encouraged" to walk (made to weight bear on legs and supported by arms to walk).	• Referral to podiatrist or primary care provider for ingrown toenails, signs of pressure on nails, metatarsus adductus.
9 – 12 months • At about 10 months pulls to standing. • May be an early walker. • If walking, walks with a widespread gait. • Bowlegs. • In-toeing.	• No footwear needed until infant walks on a hard surface – shoes are only for protection. Feet do not need "support". Barefoot is best!	• Refer to podiatrist or primary care practitioner for in-grown toenails or Metatarsus adductus.
Hearing • Do you have any concerns about your child's hearing? *ask hearing risk assessment if not previously done at two or four months.	**Counseling** • Review of family or child history for risk factors for deafness. • Parents are asked if they have any concerns about their child's hearing.	High-risk factor for deafness is identified. • Mechanical ventilation for > 5 days. • Bacterial meningitis. • Congenital perinatal infection. • Defects of head or neck. • Hyperbilirubinemia requiring transfusion. • Family history of childhood deafness. • Birth weight <1500 gms.
• When sleeping in a quiet room babe stirs or wakes to someone talking or loud noise.		

Expected Standards	Client-based Support	Red Flags
• Babe turns head to sound they cannot see. • Babe gurgles and coos.		• History of ototoxic medication use (i.e. Salicylates, Non Steroidal Anti-Inflammatory Drugs, Antibiotics, Diuretics, Chemotherapeutic Agents, Quinine, Mucosal Protectant, Narcotic Analgesics: see http://chchearing.org/nyc/otology/ototoxic-medications and www.merckmanual.com for detailed medications list) See Appendix 8 • History of ear infections. • Concerns expressed by parents/caregivers. • Infant does not startle to loud unusual noise. • Infant does not vocalize. • Infant does not turn head towards sounds. • Refer to Saskatchewan Hearing Aid Plan (audiologist) if concerns.
Vision • Follows objects in all directions. • Focuses and follows moving objects. • Prefers faces. • Encourage parents to take child to optometrist at recommended age.	**Counseling** • Advise parents that amblyopia is common in young infants. • The Optometric Association of Saskatchewan encourages parents to get their child's eyes assessed by an optometrist at six months and then again at three years of age, earlier if there are any concerns.	• Refer to Optometrist if amblyopia is still present at six months of age or older or if there are any other vision concerns.

Expected Standards	Client-based Support	Red Flags
Developmental Screening ** For children born <37 weeks gestation or earlier, please calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. • Turns head towards sounds. • Makes sounds while you talk to him/her. • Vocalizes pleasure and displeasure. • Rolls from back to side. • Sits with support (e.g. pillows). • Reaches/ grasps objects.	**Counseling** • Encourage talking, reading and singing with the child. • Encourage Tummy Time. • Children learn speech through interactions with human faces and voices. These are more interactive than TV, phone or video screens. Screen Smart www.screensmart.ca/early_years Canadian Society for Exercise Physiologists www.csep.ca/english/view.asp?x=949 Canada's Physical Activity Guidelines **Anticipatory guidance for 6 – 12 months:** 9 months • Look for an object that was hidden. • Babbles a series of different sounds (ex. Baba, dada).	• If there is a parental concern or if two or more of the milestones are not being met, use the age appropriate Nipissing District Developmental Screen (NDDS). If two or more "No" responses are marked, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "no" may be influenced by culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.**

Expected Standards	Client-based Support	Red Flags
	• Responds differently to different people. • Makes sounds/ gestures to get attention or help. • Sits without support. • Stands with support when helped into standing position. • Opposes thumb and fingers when grasps object. • Plays social games with you (e.g. nose touching, peek-a-boo). • Cries or shouts for attention. 12 months • Responds to own name. • Understands simple requests (where is the ball?). • Makes at least 1 consonant/vowel combination). • Says 3 or more words (do not have to be clear). • Crawls or "bum" shuffles. • Pulls to stand/walks holding on.	
Sexual health development • Infant has skin to skin contact with parent. • Parent uses correct name of body parts including genitals.	• It is normal for children to explore their own bodies including their genitals. • Children enjoy touch as well as skin to skin contact. • Children like to be naked. Saskatchewan Prevention Institute www.skprevention.ca • Shows distress when separated from parent/caregiver. • Follows your gaze to jointly reference an object.	• Concerns expressed by parent that they suspect their child has been abused. • Possible signs of sexual, physical abuse or neglect.

Expected Standards	Client-based Support	Red Flags
Maternal Mental Health • At the 6 month visit, use of the EPDS is part of the targeted questions. See the "Targeted Question" section for information. • Provide EPDS screen to any mom who is at risk for or indicates concerns about postpartum anxiety or depression. • Public Health Nurse assists in scoring the EPDS.	**Counseling**	
Health Education / Injury Prevention Anticipatory guidance for health education and prevention.	**Counseling**	• Information in this section supports the previous assessments. Refer back to assessments for red flag identification and appropriate referral.
General Safety	• Plastic plugs should be placed in electrical wall outlets.	
Child restraints	• Infants must use in a rear-facing car seat until they are one year old and 10 kg (22 lbs) and can walk.	
Shaken Baby Syndrome	• Many caregivers and parents become frustrated and angry when caring for a crying baby. Encourage parents to have a plan to recognize and deal with frustration. It is more important to stay calm than to stop the crying. Never Shake a Baby.	
Drowning and Suffocation	• Never leave a baby alone while he or she is being bathed.	

Expected Standards	Client-based Support	Red Flags
	• Remove the plastic wrapping on cribs, make sure the mattress fits snugly, and do not place pillows, stuffed toys, or bumper pads in the crib.	
Burns and Scalds	• Always test the temperature of bath water with your elbow and make sure the hot water temperature at the taps is set at no more than 49°C (120°F).	
SIDS	• Infants should be placed on their backs when sleeping. • Make sure that nobody smokes around your baby. • Avoid putting too many clothes and covers on your baby. • Breastfeed your baby, it may give some protection against SIDS.	
Falls	• Safety gates on stairs. • Children will start climbing at this stage be aware of potential dangers of falling.	
Screen time/Physical Activity	• Canadian Physical Activity Guidelines recommend physical activity several times daily – particularly through interactive floor-based play. • Being active as an infant means: ➢ tummy time; ➢ reaching for or grasping balls or other toys; ➢ playing or rolling on the floor.	

Expected Standards	Client-based Support	Red Flags
	• Canadian Sedentary Behaviour Guidelines recommend for healthy growth and development, caregivers should minimize the time infants spend being sedentary during waking hours. This includes prolonged sitting or being restrained for more than one hour at a time. (stroller, high chair, car seat) • Limit use of playpens and infant seats when baby is awake. • Explore and play with your child. • Stop during long car trips for playtime. Canadian Society for Exercise Physiologists www.csep.ca	
Family Dynamics	• Discuss sibling rivalry, grandparents, and changes in family dynamics related to parents as needed.	
Violence and Abuse	• Assess for concerns or presence of domestic violence or child abuse (see page 64 of the Registered Nurses Association of Ontario (RNAO) guidelines for possible action).	• Signs and symptoms of domestic violence or child abuse. See the Registered Nurses Association of Ontario (RNAO) best practice guidelines for a list of signs of abuse: http://rnao.ca/sites/rnao-ca/files/Guideline__Supplement_PDF.pdf. See the Ministry of Social Service brochure for child abuse indicators: www.socialservices.gov.sk.ca/child-protection.pdf

Expected Standards	Client-based Support	Red Flags
		• Parents experiencing domestic violence should consider a safety plan and also have a copy of important documents in a safe place outside the home (HSN, tax return, driver's license).
Seasonal Concerns Mosquitoes	• Protect your baby from mosquitoes by providing netting around strollers and other areas where immobile children are placed. • Protective light-coloured clothing with long cuffed sleeves, long pants, tucked into socks or shoes, and hats. • Do not apply insect repellent to children under six months of age. • Keep infants inside during dusk and dawn when mosquitoes are out. Caring for Kids www.caringforkids.cps.ca/handouts/insect_repellents	
Sun	• Keep young children in the shade. • Use long sleeves and long pants to protect your baby from the sun. • Do not apply sunscreen on babies less than six months old.	
Frostbite	• Use of proper clothing. • Dressing the child in layers.	

Expected Standards	Client-based Support	Red Flags
	• Cover head with a warm, close-fitting hat that protects the ear lobes. • Be aware of wind chill as it greatly speeds up the process of body heat loss. • Remove wet clothes as soon as possible to avoid additional chilling. Resources: Saskatchewan Prevention Institute www.skprevention.ca	
• Advise to book next appointment. • Discuss public health/community services. • Provincial HealthLine 811. • Parenting program (if available in your area).		

Child Health Clinic – 12 month
Standard Assessments

Expected Standards	Client-based Support	Red Flags
Demographics • Confirmation of Demographic information (e.g. name, address, date of birth, gender and HSN number). • This can be done by PHN or support staff. • Client identifiers (right child).	• Updated information allows for improved contact and follow-up. • Confirmation of client identifier contributes to zero immunization errors.	• Any errors or changes to be updated on the child record and reported to Ministry of Health by the parents.
Parent Support • Parents are able to ask questions about their child's health, growth, development, behaviour or other concerns. • Do you have any questions or concerns about your child's health, development, behaviour or growth? **Targeted Questions:** **Developmental Milestones** **<u>12 – 15 months</u>** 1. Is your child able to:? • Responds to own name. • Understands simple requests (where is the ball?) • Makes at least 1 consonant/vowel combination).	**Counseling** • Parents are asked if they have any questions or concerns about their child's physical growth, health, behaviour, or development. • If parent is concerned about the child, the PHN could offer a home visit or phone call for further follow-up. • Counseling should be safety focused around gross motor skill (stairs, falls) and car seats.	• If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.

Expected Standards	Client-based Support	Red Flags
• Says 3 or more words (do not have to be clear). • Crawls or "bum" shuffles. • Pulls to stand/walks holding on. • Shows distress when separated from parent/caregiver. • Follows your gaze to jointly reference an object. 2. What type of car seat is your child using? **Developmental Milestones:** **<u>16 – 18 months</u>** <u>Social/Emotional</u> • Child's behavior is usually manageable. • Interested in other children. • Usually easy to soothe. • Comes for comfort when distressed. <u>Communication skills</u> • Points to several different body parts. • Tries to get your attention to show you something. • Turns/responds when name is called. • Points to what he/she wants. • Looks for toy when asked or pointed in direction.		• If not walking or not yet 22 lbs (10 kg) and are in a forward facing car seat, refer to SGI website and car seat clinics. • If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.

Expected Standards	Client-based Support	Red Flags
• Imitates speech sounds and gestures. • Says 25 or more words (words do not have to be clear) • Produces four consonants (e.g. B D G H N W). <u>Motor skills</u> • Walks alone. • Feeds self with spoon with little spilling. <u>Adaptive skills</u> Removes hat/socks without help. Parental Strengths	• Acknowledge and give positive feedback.	
Growth ** For children born <37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. • Child's growth is progressing normally • Serial measurements of length, weight, and head circumference are recorded and plotted on the appropriate WHO growth chart (i.e. weight-for-age, length-	**Counseling** • Assess a child's growth pattern based on recorded and plotted measurements and using *A Health Professional's Guide for using the new WHO Growth Charts* (www.whogrowthcharts.ca).	**When growth pattern is outside of expected parameters: re-measure, verify age and re-plot.**

Expected Standards	Client-based Support	Red Flags
for-age, weight-for-length, head circumference-for-age). • Age of child is identified and plotted to the nearest completed half month. • Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and tracks parallel to the 50th percentile. • Record all measurements in metric.	• Advise parents that measurements help confirm that their child is growing and developing well and that it is important to look at patterns as opposed to any one single measurement. • Advise that after the first year, parents can expect their child's growth rate to slow down and their appetite to fluctuate. This is normal. When appetite picks up it usually means a child is going through a growth spurt. Advise that parental size has a big impact on the size to which their child may grow. • Assist parents in identifying any issues or concerns they may have about the feeding relationship, the child's nutrition intake, elimination patterns, and other health concerns related to development and behaviour, all of which have an impact on growth. • Assist parents with any information they may need for corrective action and connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support.	• Growth pattern remains **flat** ➢ Obtain consent for referral to primary care provider or paediatrician. Primary care provider notified**.** • **Sharp incline or decline** in growth pattern ➢ Further investigation and follow-up required. ➢ Based on assessment of all growth measures consider appropriate referral. See **NAMIC Standard**: Guide to Resource Referral Resources. • **Growth measures plotted at <3rd or >85th percentile** ➢ This growth pattern may be normal, but children in these extremes should be assessed for whether this pattern is appropriate for them or due to a pathological situation and requires referral. See **NAMIC Standard**: Guide to Resource Referral Resources. • **Head circumference** for age <3rd percentile and growing slowly or >97th percentile and growing rapidly. ➢ Rapidly increasing head circumference requires immediate referral.

Expected Standards	Client-based Support	Red Flags
Immunization • Assessment of the individual's health. • Determination of which vaccines to provide. • Discussion of follow-up care. • Obtain informed consent for immunization. • Administration of those vaccines. • Documentation within 24 hours into the provincial immunization registry.	**Counseling** • **See Saskatchewan Immunization Manual** for recommended vaccines, counseling, procedures, and parental resources. www.ehealthsask.ca/services/manuals/Pages/SIM.aspx Immunize Canada: http://immunize.ca Caring for Kids (resources to share with parents): www.caringforkids.cps.ca See Appendix 3.1 in the Saskatchewan Immunization Manual for other reliable websites.	• Unable to obtain consent as legal guardianship in question. • Contraindications to immunization.
Nutrition **Parental Support** • Parents are aware of resources they can access if family is food insecure. • Mother is aware of resources she can access to sustain breastfeeding while returning to work or school. •	**Counseling** • Assist food insecure families by connecting them to community resources they can access locally. • See **NAMIC Standard**: Mothers and family have access to enough healthy foods. • Advise parents of resources available to sustain breastfeeding while returning to work or school (refer to Pregnancy, Parenting and the Workplace handbook found at www.shrc.gov.sk.ca/pdfs/publications/PPW-v2.pdf).	• Family is unable to access enough healthy food to meet their needs. • Mother returning to work or school does not have information to support sustained breastfeeding.

Expected Standards	Client-based Support	Red Flags
Feeding Relationship • Mother and infant exhibit satisfaction with the feeding relationship. • A quality feeding relationship exists within the context of a supportive family environment where child joins the family at mealtimes. • Child shows cues of hunger and fullness and parents can identify these cues and respond appropriately. • Child is offered a variety of healthy foods but is given the responsibility for how much to eat.	**Counseling** • Assess satisfaction with sustained breastfeeding while child continues to explore and eat a variety of foods appropriate for age and stage of development. See **NAMIC Standard**: Infant exhibits age appropriate development as pertains to feeding. • Assess parenting style and discuss positive ways to respond to child feeding cues. See **NAMIC Standard**: A quality feeding relationship exists within the context of a supportive family environment (complementary feeding). For example**:** let child take the lead on how much to eat as growth slows down and then picks up leading to appetite fluctuations after the first year, encourage child to self feed, include child at family meals, and encourage parental responsibility for providing structure, planned meals and snacks and supervision during feedings. • Advise parent to provide opportunities for the child to self-feed.	• Sustained breastfeeding is diminished. • Child does not eat with rest of the family and/or is not offered at least some of the table foods other members eat (no positive role modeling). • Feeding is coaxed, forced or restricted. • Eating behaviour problems. • Child is not supervised during feedings. Child is encouraged to *empty their bottle or clean their plate* which can lead to excess energy intake.
Breastfed Infant • Child continues to be breastfed for up to two years and beyond with the addition of energy and nutrient rich complementary foods. • Mother understands what to do about common breastfeeding problems and concerns.	**Counseling** • Assist with any feeding concerns while sustaining breastfeeding beyond six months and up to two years of age or beyond. See **NAMIC Standard**: Mother and child exhibit satisfaction with the feeding relationship.	• Breastfed child receives formula. • Mother does not have the skill to hand express breast milk. • Mother does not know what to do about breastfeeding problems or concerns.

Expected Standards	Client-based Support	Red Flags
• Child is non-exclusively breastfed and is taking complementary foods.	• Advise that breastfeeding at night is the normal way to sustain breastfeeding through the second year. • Advise that for children who are breastfed or receiving breast milk, continued vitamin D supplementation is recommended.	• Parent expects child to sleep through the night and may use training to promote this behaviour. • Child is not receiving a source of vitamin D.
Non-breastfed Infant • Pasteurized cow's milk is offered to healthy non-breastfed infants at 12 months of age. • Infants who are receiving soy-based formula for medical, cultural or religious reasons should continue to stay on it until they reach two years of age. • Child using a bottle is offered only formula, pasteurized whole cow's or fortified goat's milk, is supervised, and is not roaming with bottle.	**Counseling** • Advise if necessary about appropriate milk feeds and the use of pasteurized milks only. • Advise that by 12 months of age a healthy term infant will receive the nutrition they need by drinking cow's milk along with nutritious family food. • Advise that children who receive soy formula should continue to be offered soy formula for up to two years. See **NAMIC Standard**: Infant is receiving commercial infant formula that meets their nutritional needs. • Advise if necessary that child needs to be supervised and not roaming with a bottle and that child should not be put to bed with a bottle.	• Child is receiving unpasteurized cow's or fortified goat's milk. • Child is receiving soy beverages, rice milk or other vegetarian beverages, whether or not they are fortified. • Child roams with bottle and/or is put to bed with a bottle.
Complementary Feeding • Child exhibits age-appropriate development as it pertains to feeding. • Child continues to be offered a variety of nutritious and energy dense foods from the four food groups daily.	**Counseling** • Advise parents of the physical and social milestones as they pertain to feeding including the progression to more texture according to developmental readiness. See N**AMIC Standard**: Child exhibits age appropriate development as it pertains to feeding.	• Child refuses lumpy or textured food. • Child drinks from a cup with a valve, spout or straw. • Child is not receiving a variety of foods from the four food groups including iron rich foods.

Expected Standards	Client-based Support	Red Flags
• Child is offered small, planned meals and snacks throughout the day. • Child is given the opportunity to self-feed. • Child is breast fed or offered pasteurized whole milk preferably in a regular open cup and limited to no more than 500 mL (16 oz) to 750 mL (24 oz) daily. • If offered. Provide juice in moderate amounts only (i.e., 4-6 oz per day). • Foods are selected, prepared, and stored using sanitary and safe procedures.	• Advise the use of a regular open cup for drinking water, whole milk, and juice if introduced as part of the diet at this stage. See **NAMIC Standard**: Infant can drink from an open cup (complementary feeding). • Advise about the need for energy and nutrient dense foods from the four food groups offered through planned meals and snacks (e.g. three small meals and two to three snacks a day. • Most children will have the manual skills to drink from a regular open cup using both hands and may be trying to eat from a spoon. This is part of self-feeding and should be encouraged. Reassure parents that continuing to enjoy using hands to eat is normal. • Advise that children who continue to breastfeed can rely on breast milk as a reliable milk source (along with continued vitamin D supplementation). It is not necessary to introduce cow's or other milks. • Advise parents to limit the amount of whole cows or fortified goat's milk to no more than 500 mL (16 oz) to 750 mL (24 oz). Milk is a poor source of iron. Excess amounts may limit intake of other important nutrients and may also contribute to constipation. See **NAMIC Standard:** Child is not offered cow or fortified goat milk until 9 to 12 months of age (complementary feeding).	• Infant is not self-feeding • Child's diet is restricted in fat and/or includes use of skim milk, low fat milk or soy beverage on a regular basis. • Child is drinking large amounts of fluid, including more than 750 mL (24 oz) of milk a day, and eating very little other food. • Child consumes juice frequently throughout the day or drinks >175 mL (6 oz) daily. • Child consumes fruit drinks, pop, coffee, tea, hot chocolate, soy beverage or other vegetarian beverages or herbal teas

Expected Standards	Client-based Support	Red Flags
	• Advise that fruit drinks should be avoided. Unsweetened 100% fruit juice can be offered in moderate amounts only (e.g. 125 mL (4 oz) to 175 mL (6 oz) daily) in a regular open cup. Juice offers little fibre, can replace important nutrients, and may contribute to toddler diarrhea. Emphasize vegetables and fruits instead of juice. • Advise that water should be offered for thirst between planned meals and snacks. • Advise regarding the importance of modifying certain foods to avoid inhaling and choking hazards. Remind parents that gagging is a natural reflex that helps infants avoid choking. See **NAMIC Standard:** Child is offered foods adapted to age and stage of development to reduce risk of choking.	• Food offered is not prepared or stored properly increasing risks of choking hazards or food safety issues.
Nutrients of Concern • Child receives adequate vitamin D. • Child does not take a vitamin/mineral supplement including an iron supplement unless medically indicated.	**Counseling** • Emphasize offering foods rich in vitamin D including cow's milk. Children may benefit from a daily vitamin D supplement of 400 IU (10mg) until their diet regularly includes vitamin D from food sources and/or they drink 500ml of fortified cow's milk daily. See **NAMIC Standard**: Child receives adequate vitamin D complementary feeding. • Assess whether child is offered a variety of table foods including foods rich in iron at each meal.	• Child is not receiving vitamin D from food and/or supplementation. • Child does not receive iron rich foods or suffers from iron deficiency/anemia.

Expected Standards	Client-based Support	Red Flags
• Mother takes only medically indicated supplements including over-the-counter medications and herbs.	• If child takes a supplement including iron, advise parent regarding safe storage of all supplements to avoid accidental overdose leading to death by poisoning. See **NAMIC Standard:** Child is not given vitamin/mineral or iron supplement unless medically indicated. • Ask mother if she is aware of the potential increase in health risks from taking over-the-counter drugs and herbs while breastfeeding. See *Breastfeeding and Drugs – Prescribed, Over-the-counter, Herbs, Illegal* (www.ibreastfeeding.com/content/free-stuff-14)	• Mother is taking potentially harmful over-the-counter drugs or herbs and is breastfeeding.
Elimination • Child has regular bowel movements with stools that are passed without difficulty (considering individual variation). • Child has straw-coloured odourless urine.	**Counseling** • Advise parents that constipation is hard stools often make bowel movements difficult and/or painful. See **NAMIC Standard:** Child exhibits normal elimination patterns. • Advise parents about signs of dehydration and when to seek medical assistance**:** child has bloody or black stools, is still vomiting after four to six hours, has diarrhea and a fever with a temperature higher than 38.5°C (101.5°F), has dehydration, stomach pains getting worse. See **NAMIC Standard:** Child has regular bowel movements which are passed without difficulty.	• Constipation or diarrhea. • Dehydration. • Child drinks excessive amounts of milk including more than 750 mL (24 oz) a day. • Child eats excessive amounts of one food to serve as a laxative (e.g. prunes) or drinks > 175 mL (6 oz) of prune juice or apple juice. • Child is offered laxatives and/or fibre supplements.

Expected Standards	Client-based Support	Red Flags
	• Advise parents to introduce fibre containing foods gradually and to offer a variety of whole grain breads and cereals, fruit like apples, banana, berries or prunes, vegetables and cooked legumes (split peas, chickpeas and lentils). Offer water more often. • Assess child's fluid intake if voiding is inadequate (frequency, volume, and colour). **Resources:** Caring for Kids: Refer to www.caringforkids for handouts: ➢ Healthy Bowel Habits for Children ➢ Dehydration and Diarrhea in Children: Prevention and Treatment	
Oral Health • Oral health assessment. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity. • Mother indicates breast or bottle nipple is removed from the mouth when infant falls asleep. • The spoon used during feeding is not shared with other family members.	**Counseling** • Advise parents that frequent sipping and prolonged contact of teeth with liquids other than water, increases the risk of Early Childhood Tooth Decay. • Advise parents that decay causing bacteria is transmitted through saliva so avoid sharing a spoon when tasting baby food. • Advise parents to keep own mouth clean and have regular dental checkups. • If juice is provided, offer only in a regular open cup at meal times.	• Infant continues to feed while sleeping. • Infant and family member(s) eat from the same spoon. • Child consumes juice from a bottle or cup with a spout or straw. • Infant's teeth are not brushed daily. • Parents have not had a dental check up in the last year • Refer to an oral health professional if any concerns or risk factors identified.

Expected Standards	Client-based Support	Red Flags
• If child is offered juice, it is provided in moderate amounts only (i.e., no more than 4 oz per day). • Infant's teeth are brushed twice a day by an adult. If the infant is at risk for developing tooth decay then the child's teeth should be brushed using fluoridated toothpaste the size of a grain of rice. • Ask parent/caregiver if the child has seen a dentist for an initial assessment. • Risk for developing tooth decay is assessed.	• Advise that the Canadian Dental Association recommends that the first dental visit be six months after the eruption of the first tooth or at age one. **References:** Oral Screening Guidelines for Child Health Clinics **Resources:** Toothpaste Use for children Under 3 Drinking From a Cup Fluoride Varnish Protects Teeth Early Childhood Tooth Decay	
Standard Handouts Immunization Fact Sheets Caring for Your Child's Fever Growing Up Healthy 12 – 18 months		

Child Health Clinic – 12 month
Additional Assessments

Expected Standards	Client-based Support	Red Flags
Offer and discuss highlights of the 12 - 18 months Growing Up Healthy resource. **Physical** **Sleep/Cry** Children at this age average 10 – 13 hours of sleep per day. Some of it may be a day time nap.	**Counseling** • Encourage routines for bedtime to foster health child development and parenting. • Toddler's sleep patterns. • Reality vs. expectations. • Affirm family's sleep/room sharing choices. • Coping: what helps? Caring for Kids: www.caringforkids.cps.ca/handouts/healthy_sleep_for_your_baby_and_child	• No bedtime routine established. • Parent has unreasonable expectations of toddler's sleep. • Co-sleeping with parents.
Head to Toe **12 – 15 months** • Anterior fontanel may remain open – closes between 9 and 18 months. • Mouth (see oral screening guidelines). • Signs of Teething – tooth eruption. ➢ Symmetry of body and movement. ➢ Skin, color. ➢ Muscle tone. ➢ Podiatry • Walks well at 15 months.	**Counseling** • Referral to the primary care practitioner if appropriate.	• Presence of rash, inconsistent skin color. • Lack of or limited muscle tone. • If parent has any concerns or questions, refer to primary care provider, paediatrician or podiatrist as appropriate.

Expected Standards	Client-based Support	Red Flags
• Apparent flat feet and internal rotation of lower limbs giving pronation of feet. • Bowlegs. • In-toeing. • May be an early runner. **<u>15 – 18 months</u>** • Anterior fontanel may remain open – closes between 9 and 18 months. • Mouth (see Oral Health Screening Guidelines) Symmetry of body and movement. Skin, color. Muscle tone. Podiatry • Walks well at 15 months. • Apparent flat feet and internal rotation of lower limbs giving pronation of feet. • Bowlegs • In-toeing • May be an early runner		• If fontanel not closed by 18 months, refer to primary care provider. • If not walking by 18 months, refer to primary care provider.
Hearing • Do you have any concerns about your child's hearing?	**Counseling** • Hearing and speech development are inter-related. • If you have concerns about how your child communicates or if they are not responding to you when you call to talk with them, seek further assessment from your primary care provider.	• History of ear infections. • Concerns expressed by parents/caregivers. • Refer to Saskatchewan Hearing Aid Plan (audiologist) or primary care provider if concerns.

Expected Standards	Client-based Support	Red Flags
Vision • Do you have any concerns about your child's vision?	**Counseling** • Advise parents that some amblyopia is common in young infants. • The Optometric Association of Saskatchewan encourages parents to have their child's eyes assessed by an optometrist now if not previously done and then again at three years of age, earlier if there are any concerns. • Parents to consult their optometrist for further direction on when the child is to be seen. • Ministry of Health covers yearly eye exams for children up to their 18th birthday.	• Refer to Optometrist if amblyopia or other eye concerns exist at this age.
Developmental Screening ** For children born at 37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. **<u>12 – 15 months</u>** 12 months • Responds to own name. • Understands simple requests (where is the ball?)	**Counseling** • At this age, there is a wide variance of normal behaviours, encourage parents to provide opportunities for the child to learn and use his new skills.	• If there is a parental concern or if the milestones are not being met, use the age appropriate Nipissing District Developmental Screen (NDDS).

Expected Standards	Client-based Support	Red Flags
• Makes at least 1 consonant/vowel combination). • Says 3 or more words (do not have to be clear). • Crawls or "bum" shuffles. • Pulls to stand/walks holding on. • Shows distress when separated from parent/caregiver. • Follows your gaze to jointly reference an object.	• Parents should be aware of the amount of "screen" time their children are getting with items such as phones, games, television, computers, etc. • Children learn speech through interactions with human faces and voices. These are more interactive than TV, phone or video screens. Screen Smart: www.screensmart.ca/early_years Canadian Society of Exercise Physiologists www.csep.ca/english/view.asp?x=949 Canada's Physical Activity Guidelines **Anticipatory guidance for 15-18 months** **15 months** • Says five or more words (words do not have to be clear). • Picks up and eats finger foods. • Walks sideways holding onto furniture. • Shows fear of strange people/places. • Crawls up a few stairs/steps. • Tries to squat to pick up toys from the floor. **18 months** Social/Emotional • Child's behavior is usually manageable. • Interested in other children. • Usually easy to soothe. • Comes for comfort when distressed.	• If two or more "No" responses are marked, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "no" may be influenced by culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.**

Expected Standards	Client-based Support	Red Flags
	Communication skills • Points to several different body parts. • Tries to get your attention to show you something. • Turns/responds when name is called. • Points to what he/she wants. • Looks for toy when asked or pointed in direction. • Imitates speech sounds and gestures. • Says 25 or more words (words do not have to be clear) • Produces four consonants (e.g. B D G H N W). Motor skills • Walks alone. • Feeds self with spoon with little spilling. Adaptive skills Removes hat/socks without help.	
Sexual Health Development • Exploring own body including genitals. • Enjoys touch as well as skin to skin contact. • Likes to be naked.	**Counseling** • Child will develop the capacity to trust caregivers. • Child will experience pleasure through touch. • Teach your child the correct names of body parts including genitals.	• If the PHN suspects possible abuse or if the parent suspects abuse, report to appropriate authorities. • Be aware of possible signs of sexual abuse (trauma to genitals, resistant or fearful touch from others).

Expected Standards	Client-based Support	Red Flags
Health Education / Injury Prevention Anticipatory guidance for health education and prevention.	**Counseling**	• Information in this section supports the previous assessments. Refer back to assessments for red flag identification and appropriate referral.
Child restraints	• Infants must use a rear-facing car seat until they are one year old and 10 kg (22 lbs) and can walk. • Once children are one year of age and 22 lbs. (10kg) and can walk, they can use a forward-facing seat that has a tether strap until they are a minimum of 40 lbs. (18kg). Contact SGI for more information. Saskatchewan Prevention Institute: www.skprevention.ca child injury prevention	
Shaken Baby Syndrome	• Many caregivers and parents become frustrated and angry when caring for a crying child. Encourage parents to have a plan to recognize and deal with frustration. It is more important to stay calm than to stop the crying.	
Drowning and Suffocation	• Never leave a child alone while he or she is being bathed. • Remove the plastic wrapping on cribs, make sure the mattress fits snugly, and do not place pillows, stuffed toys, or bumper pads in the crib.	
Burns and Scalds	• Always test the temperature of bath water with your elbow and make sure the hot water temperature at the taps is set at no more than 49°C (120°F).	

Expected Standards	Client-based Support	Red Flags
Poisons	• Poison control number - 1-866-454-1212. • Keep all medicine and cleaning products locked away in the kitchen and bathroom.	
Falls	• Safety gates on stairs. • Children will start climbing at this stage be aware of potential dangers of falling.	
Screen time/Physical Activity	• Canadian Physical Activity Guidelines recommend that toddlers (aged 1-2 years) should accumulate at least 180 minutes of physical activity at any intensity spread throughout the day including: ➢ A variety of activities in different environments. ➢ Activities that develop movement skills. ➢ Progression toward at least 60 minutes of energetic play by 5 years of age. • More daily physical activity provides greater benefits. • Being an active toddler means: ➢ Any activity that gets kids moving. ➢ Climbing stairs and moving around the home. ➢ Playing outside and exploring their environment. ➢ Crawling, brisk walking, running or dancing. • Canadian Sedentary Behaviour Guidelines recommend for toddlers that time sitting or being restrained should be minimized. • For those under 2 years, screen time (e.g. TV, computer, electronic games) is not recommended.	

Expected Standards	Client-based Support	Red Flags
	• Limit use of playpens and infant seats when baby is awake. • Explore and play with your child. • Stop during long car trips for playtime. Canadian Society for Exercise Physiologists: • www.csep.ca	
Family Dynamics	• Discuss sibling rivalry, grandparents, and changes in family dynamics related to parents as needed.	
Violence and Abuse	• Assess for concerns or presence of domestic violence or child abuse (see page 64 of the Registered Nursing Association of Ontario (RNAO) guidelines for possible action).	• Signs and symptoms of domestic violence or child abuse. See the Registered Nurses' Association of Ontario (RNAO) best practice guidelines for a list of signs of abuse: rnao.ca/sites/rnao-ca/files/Guideline__Supplement_PDF.pdf. See the Ministry of Social Service brochure for child abuse indicators: www.socialservices.gov.sk.ca/child-protection.pdf. • Parents experiencing domestic violence should consider a safety plan and also have a copy of important documents in a safe place outside the home (HSN, tax return, driver's license).
Seasonal Concerns Mosquitoes	• Protect your child from mosquitoes by providing netting around strollers and other areas where immobile children are placed.	

Expected Standards	Client-based Support	Red Flags
	• Protective light-coloured clothing with long cuffed sleeves, long pants, tucked into socks or shoes, and hats. • Insect repellent with < 30% Deet can be used on children. Avoid applying Deet to hands and face. • Keep children inside during dusk and dawn when mosquitoes are out. Caring for Kids www.caringforkids.cps.ca/handouts/insect_repellents	
Sun	• Keep young children in the shade. • Use long sleeves and long pants and a hat to protect your child from the sun. • Sunscreen can be applied to young children, avoid putting it on the child's hands.	
Frostbite	• Use of proper clothing for the weather including footwear. • Dressing the child in layers. • Cover head with a warm, close-fitting hat that protects the ear lobes. • Be aware of wind chill as it greatly speeds up the process of body heat loss. • Remove wet clothes as soon as possible to avoid additional chilling. For more information : Saskatchewan Prevention Institute: www.skprevention.ca child injury prevention	

Expected Standards	Client-based Support	Red Flags
Second-hand smoke	• Ask if the child is ever exposed to second-hand smoke. Reinforce benefits of smoke free air and reduced risk of SIDS, asthma, lung cancer, heart disease and tooth decay. • Assess where and who may be exposing the child to second-hand smoke. • Assist in offering information on protecting the child from second-hand smoke. • Arrange for more information or contacts to assist in eliminating second-hand smoke. If the presenting parent is a smoker: • Ask what type of tobacco they use. • Advise them that quitting is best. • Assess if they are thinking about quitting tobacco use. • Assist them by reviewing the risks, relevance, roadblocks, rewards and the need for repetition (resource information available on cessation). • Arrange: refer to cessation contacts or their primary care provider: Appendix 13: Procedure for the 5A's of Tobacco Intervention. i.e. Smoker's Help Line 1-877-513-5333 Prevention of Gestational and Neonatal Exposure to Tobacco Smoke: www.pregnets.ca	• Child is exposed to second-hand smoke.
Advise for next CHC appointment. Parent groups. Provincial HealthLine - 811		

Child Health Clinic – 18 month
Standard Assessments

Expected Standards	Client-based Support	Red Flags
Demographics • Confirmation of Demographic information (e.g. name, address, date of birth, gender and HSN number). • This can be done by PHN or admin staff. • Client identifiers (right child).	• Updated information allows for improved contact and follow-up.	• Any errors or changes to be updated on the child record and reported to Ministry of Health by the parents.
Parent Support • Parents are able to ask questions about their child's health, growth, development behaviour, or other concerns. • Do you have any questions or concerns about your child's health, development, behaviour or growth? **Targeted Questions:** **Speech and Language** 1. Is your child using at least 25 words that the parent recognizes? Yes/No 2. Is your child able to follow simple directions like "give me the ball" or "bring your shoes" or "find the doll" without you looking or pointing at it? Yes/No 3. Does your child come to you to play, show you things, and seek your help? Yes/No	**Counseling** • Parents are asked if they have any questions or concerns about their child's physical growth, health, behaviour, or development. • If parent has concerns about the child which can not be addressed in CHC, the PHN could offer a home visit or phone call for further follow-up. • Encourage parents to read to their children, sing songs, play rhyming games, use correct words to describe people, places and objects. **Parent Resources:** • Growing Up Healthy - 18 months to 4 years • Will I Grow Out of It?	• A "no" response to any one of the questions or a parent's expression of a speech/language concern will trigger a referral to a Speech Language Pathologist. (use regional referral form)

Expected Standards	Client-based Support	Red Flags
Developmental Milestones: <u>Social/Emotional</u> • Child's behavior is usually manageable. • Interested in other children. • Usually easy to soothe. • Comes for comfort when distressed. <u>Communication skills</u> • Points to several different body parts. • Tries to get your attention to show you something. • Turns/responds when name is called. • Points to what he/she wants. • Looks for toy when asked or pointed in direction. • Imitates speech sounds and gestures. • Says 25 or more words (words do not have to be clear. • Produces four consonants (e.g. B D G H N W). <u>Motor skills</u> • Walks alone. • Feeds self with spoon with little spilling. <u>Adaptive skills</u> • Removes hat/socks without help. Parental Strengths	• Acknowledge and give positive feedback.	• If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.

Expected Standards	Client-based Support	Red Flags
Growth ** For children born < 37 weeks gestation, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details. **18 months to two years** • Child's growth is progressing normally. • Serial measurements of length, weight, and head circumference are recorded and plotted on the appropriate WHO growth chart (i.e. weight-for-age, length-for-age, weight-for-length, head circumference-for-age). • Age of child is identified and plotted to the nearest completed quarter year. • Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and tracks parallel to the 50th percentile. • Record all measurements in metric.	**Counseling** • Assess a child's growth pattern based on recorded and plotted measurements and using *A Health Professional's Guide for using the new WHO Growth Charts* (www.dietitians.ca/growthcharts). • Advise parents that measurements help confirm that their child is growing and developing well and that it is important to look at patterns as opposed to any one single measurement. • Advise that after the first year, parents can expect their child's growth rate to slow down and their appetite to fluctuate. This is normal. When appetite picks up it usually means a child is going through a growth spurt. Advise that parental size has a big impact on the size to which their child may grow.	**When growth pattern is outside of expected parameters: re-measure, verify age and re-plot.** • Growth pattern remains **flat.** ➢ Obtain consent for referral to primary care provider or pediatrician. Primary care provider notified. • **Sharp incline or decline** in growth pattern. ➢ Further investigation and follow-up required. ➢ Based on assessment of all growth measures consider appropriate referral. See **NAMIC:** Guide to Referral Resources.

Expected Standards	Client-based Support	Red Flags
	• Assist parents in identifying any issues or concerns they may have about their feeding relationship, the child's nutrition intake, elimination patterns, and other health concerns related to development and behaviour, all of which have an impact on growth. • Gradually crossing of **both** weight and height up to two percentile curves may be normal for the first two to three years as children move toward their genetic potential but also depends on other key information. • Assist parents with any information they may need for corrective action and connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support.	• **Growth measures plotted at <3rd or >85th percentile .** ➢ This growth pattern may be normal, but children in these extremes should be assessed for whether this pattern is appropriate for them or due to a pathological situation and requires referral. See **NAMIC** Guide to Referral Resources. • **Head circumference** for age <3rd percentile and growing slowly or >97th percentile and growing rapidly. Rapidly increasing head circumference requires immediate referral.
2 to 4 years • Child's growth is progressing normally • Serial measurements of height and weight are recorded and plotted on the appropriate WHO growth chart (i.e.: weight-for-age, height- for-age). • BMI-for-age is calculated, recorded, and plotted on the appropriate growth chart (i.e.: 2-19 years old). See Growth Assessment for BMI calculation formula.	**NOTE:** 1. BMI-for-age is the best indicator for assessing body weight status in children older than two years. ; Weight-for-height should not be used as an indicator **for children over two years** as it is not age specific and does not measure adiposity (fatness). **2.** A single BMI-for-age measurement reflects a child's size and point in time and provides a baseline for following the child's growth pattern during school years.	• **Growth measures plotted at <3rd or >85th percentile.** ➢ Children in these extremes should be assessed for whether this BMI-for-age value is appropriate for them or due to a pathological situation and requires referral. See **NAMIC** Guide to Referral Resources.

Expected Standards	Client-based Support	Red Flags
• Age of child is identified and plotted to the nearest completed quarter year. • Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and is proportional. • Any growth concerns are identified using recommended cut-off criteria provided below and **used as a guide not a diagnostic tool.** • Record all measurements in metric.	However, a single BMI-for-age measurement **does not** provide adequate information to assess the preschool child's rate of growth upward or downward and therefore their growth pattern. 3. BMI-for-age serial measurements at two, three, four and five years that show an unexpected early upward trend (such as the early adiposity rebound) alert parents of the need to slow the trend upward helping to promote healthy weights and to prevent obesity later in life. **If the BMI-for-age is between the 3rd and 85th percentile**, advise parents that although this single indicator does not give enough information to assess their child's growth pattern, it does tell us that the child**'s body weight status is within** what we consider to be a normal range. • Advise parents of the positive things that they are doing that promote healthy body weight whether related to the feeding relationship, activity, food offered, sleep, or screen time. Remind parents that their own body size and genetic background also influence a child's body weight status. • **If the BMI-for-age is below the 3rd or above the 85th percentile,** create a non-judgmental atmosphere when discussing weight issues. Reinforce the positive as above, be factual, make no assumptions nor attribute motives.	

Expected Standards	Client-based Support	Red Flags
	• Assist parents by connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support. **Handouts** • Growing Up Healthy • Tips to Help Your Child and Teen Grow Well by Dietitians of Canada (www.whogrowthcharts.ca)	
Immunization • Assessment of the individual's health. • Determination of which vaccines to provide. • Discussion of follow-up care. • Obtain informed consent for immunization. • Administration of those vaccines. • Documentation within 24 hours into the provincial immunization registry.	**Counseling** • **See Saskatchewan Immunization Manual** for recommended vaccines, counseling, procedures, and parental resources. http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx Immunize Canada: http://immunize.ca Caring for Kids (resources to share with parents): www.caringforkids.cps.ca See Appendix 3.1 in the Saskatchewan Immunization Manual for other reliable websites.	• Unable to obtain consent as legal guardianship in question. • Contraindications to immunization.
Nutrition **Parental Support** • Parents are aware of the resources they can access if family is food insecure.	**Counseling** • Assist food insecure families by connecting them to community resources they can access locally. • See **NAMIC Standard**: Mother and family have access to enough healthy foods.	• Family is unable to access enough healthy food to meet their needs. • Mother returning to work or school does not have information to support sustained breastfeeding.

Expected Standards	Client-based Support	Red Flags
	• Advise parents of resources available to sustain breastfeeding while returning to work or school (refer to Pregnancy, Parenting and the Workplace handbook found at www.shrc.gov.sk.ca/pdfs/publications/PPW-v2.pdf).	
Feeding Relationship • A quality feeding relationship exists within the context of a supportive family environment where child joins the family at mealtimes. • Child is offered a variety of healthy foods but is given the responsibility for how much to eat.	**Counseling** • Assess parenting style. See **NAMIC Standard:** a quality feeding relationship exists within the context of a supportive family environment. Reassure parents that they have an important role to: ➢ create a structure and routine of where and when food will be offered; ➢ offer a variety of nutritious age-appropriate meals and snacks; and ➢ create an environment that is pleasant without distractions from television and other activities and where the family eats together. • Advise parents that they can take the pressure off eating (e.g. praises, rewards, bribery, punishment) by allowing their children to decide how much to eat or whether to eat at all. How much they eat will vary depending on appetite, activity level, whether they are having a growth spurt, are excited, or overtired.	• Child eats at any time and place with regular distractions and little structure appropriate for age and stage of development. • Child does not eat with the rest of the family and/or is not offered at least some of the table foods other members eat (no positive role modeling). • Child is not supervised during feedings. • Feeding is coaxed, forced or restricted not permitting the child to self-regulate the amount of food and energy consumed. • Eating behaviour problems (struggles, battles).

Expected Standards	Client-based Support	Red Flags
	• Advise parents that when introducing a new food they need to be patient. If an unfamiliar food is rejected, it may be offered in another form or the same form on another day (may require up to 15 times before a food is accepted). See **NAMIC Standard:** Child is offered a variety of healthy foods but is given the responsibility to decide how much to eat.	
Breastfed Infant • Child continues to be breastfed for up to two years and beyond with the addition of energy and nutrient rich complementary food being offered.	**Counseling** • Assist with any feeding concerns while sustaining breastfeeding up to two years of age or beyond. See **NAMIC Standard:** Mother and child exhibit satisfaction with the feeding relationship. • Advise that breastfeeding at night is the normal way to sustain breastfeeding through the second year. • Advise that for children who are breastfed or receive breast milk, continued vitamin D supplementation is recommended.	• Mother has feeding concerns related to diminished breastfeeding which she wants to sustain. • Parent expects child to sleep through the night and may use training to promote this behaviour. • Child is not receiving a source of vitamin D.
Non-breastfed Infant • Child is consistently being offered appropriate milk feeds such as pasteurized whole cow's or fortified goat's milk.	**Counseling** • Advise if necessary about appropriate milk feeds and the use of pasteurized milks only. • Advise if necessary that child needs to be supervised and not roaming with a bottle and that child should not be put to bed with a bottle. Advise parents to use an open or lidless cup for milk and other fluids.	• Child is receiving unpasteurized cow's or goat's milk. • Child is receiving soy beverages, rice milk or other vegetarian beverages, whether or not they are fortified. • Child uses, roams with bottle and/or is put to sleep with a bottle. • Child uses a sippy or training cup with a valve, spout or straw.

Expected Standards	Client-based Support	Red Flags
	• Advise that children who receive soy formula but not cow's milk should continue to be offered soy formula for up to two years. Parents may wish to consult with a registered dietitian. See **NAMIC Standard:** Child is receiving commercial infant formula that meets their nutritional needs.	
Complementary Feeding • Self-feeding is encouraged within a responsive feeding relationship. • Child continues to be offered fluids in regular open cup. • Child continues to be offered a variety of nutritious foods from the four food groups. • If child is offered juice, it is provided in moderate amounts only (i.e. 4-6 oz/day). • Child is offered pasteurized fortified whole milk in regular open cup and limited to no more than 500-750ml (16-24g) daily.	**Counseling** • Advise parents of the physical and social milestones as they pertain to feeding including the progression to more texture according to developmental readiness. See **NAMIC Standard:** Child exhibits age-appropriate development as it pertains to feeding. • When children can walk they are developmentally ready to eat coarsely chopped food with more texture, bite-sized pieces of food and a variety of finger foods. • Advise about the use of a regular open or lidless cup and trying to use a spoon. Use of an open or lidless cup, not a baby bottle or cup with spout or straw, when offering any fluids helps to prevent tooth decay and promotes appropriate muscle development for speech. • Advise about the need for energy and nutrient dense foods from the four food groups offered through planned meals and snacks (e.g. three small meals and two to three snacks a day).	• Child refuses lumpy or coarsely chopped textured food • Child is using a training cup with a spout or straw. • Child is not self-feeding • Child's diet is restricted in fat and/or includes use of skim milk, low fat milk or soy beverage on a regular basis. • Child is not receiving a variety of foods from the four food groups including iron rich foods.

Expected Standards	Client-based Support	Red Flags
	• Advise that children who continue to breastfeed can rely on breast milk as a reliable milk source instead of introducing other milks.	
	• Advise parents to limit the amount of whole cow's or fortified goat's milk to no more than 500 mL (16 oz) to 750 mL (24 oz) daily as milk is a poor source of iron. Excess amounts may limit intake of other important nutrients and may also contribute to constipation.	• Child is drinking large amounts of fluid, including more than 750 mL (24 oz) of milk a day, and/or eating very little other food.
	• Advise that fruit drinks, pop, sports drinks, coffee, teas, hot chocolate, soy beverage or other vegetarian beverages or herbal teas should be avoided. Unsweetened 100% fruit juice can be offered in only moderate amounts (e.g. about 125 mL (4 oz) to 175 mL (6 oz) daily) in a regular open cup. Juice offers little fibre, can replace important nutrients, and may contribute to toddler diarrhea. Emphasize vegetables and fruit instead of juice.	• Child consumes juice frequently throughout the day or drinks >175 mL (6 oz) daily. • Child consumes fruit drinks, pop, sports drinks, coffee, teas, hot chocolate, soy beverage or other vegetarian beverages or herbal teas.
	• Advise parents to offer food and beverages at mealtimes and snack times, but not in between. Offer water if the child is thirsty between meals or snacks.	• Food offered is not prepared or stored properly increasing risks of choking hazards or food safety issues.
	• Remind parents that gagging is a natural reflex that helps infants avoid choking.	
	• Advise regarding the importance of modifying certain foods to avoid inhaling and choking hazards See **NAMIC Standard:** Child is offered foods adapted to age and stage of development to reduce risk of choking.	

Expected Standards	Client-based Support	Red Flags
Nutrients of Concern • Child receives adequate vitamin D. • Child does not take a vitamin/mineral supplement including an iron supplement unless medically indicated. • Mother takes only medically indicated supplements including over-the-counter medications and herbs.	**Counseling** • Emphasize offering foods rich in vitamin D including fortified cow's milk. Children may benefit from a daily vitamin D supplement of 400 IU (10mg) until their diet regularly includes vitamin D from food sources and/or they drink 500 ml of fortified cow's milk. See **NAMIC Standard**: Child receives adequate vitamin D (complementary feeding). • Advise that vitamin D supplement of 400 IU per day is recommended for children who are breastfed or receiving breast milk. • Assess whether child is offered a variety of table foods including foods rich in iron at each meal. • If child takes a supplement including iron, advise parent regarding safe storage of all supplements to avoid accidental overdose leading to death by poisoning. • Ask mother if she is aware of the potential increase in health risks from taking over-the-counter drugs or herbs while breastfeeding. See *Breastfeeding and Drugs – Prescribed, Over-the-counter, Herbs, Illegal* (www.ibreastfeeding.com/content/free-stuff-14)	• Child is not receiving adequate vitamin D from food and/or a supplementation. • Child does not receive iron rich foods or suffers from iron deficiency /anemia • Mother is taking potentially harmful over-the-counter drugs or herbs and is breastfeeding.
Elimination • Child has regular bowel movements that are passed without difficulty (considering individual variation). • Child has straw-coloured odourless urine.	**Counseling** • Advise parents that constipation is hard stools that often make bowel movements difficult and/or painful. See **NAMIC Standard:** Child exhibits normal elimination patterns.	• Constipation or diarrhea.

Expected Standards	Client-based Support	Red Flags
	• Advise parents about signs of dehydration and when to seek medical assistance**:** child has bloody or black stools, is still vomiting after four to six hours, has diarrhea and a fever with a temperature higher than 38.5°C (101.5°F), has dehydration, stomach pains getting worse. See **NAMIC Standard:** Child has regular bowel movements that are passed without difficulty. • Advise parents to introduce fibre containing foods gradually and to offer a variety of whole grain breads and cereals, fruit like apples, banana, berries or prunes, vegetables and cooked legumes (split peas, chickpeas and lentils). Offer water more often. • Assess child's fluid intake if voiding is inadequate (frequency, volume, colour). **Resources:** Caring for Kids: www.caringforkids for handouts: • Healthy Bowel Habits for Children • Dehydration and Diarrhea in Children: Prevention and Treatment	• Dehydration. • Child drinks excessive amounts of milk including more than 750 mL (24 oz) a day. • Child eats excessive amounts of one food to serve as a laxative (eg: prunes) or drinks >175 mL(6 oz) of prune juice or apple juice. • Child is offered laxatives and/or fibre supplements.
Oral Health • Oral health assessment. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity.	**Counseling** • Advise parents that frequent sipping and prolonged contact of teeth with liquids other than water increases the risk of Early Childhood Tooth Decay.	• Child does not receive daily brushing by an adult. • Child consumes beverages from a bottle or cup with a spout or straw.

Expected Standards	Client-based Support	Red Flags
• Child receives liquids served in a regular open cup and drinks no more than 4 oz. of juice per day. • Child is limited to food and beverages containing sugar to planned meal and snack times. • Teeth/gums should be brushed with a small, soft-bristled tooth brush twice a day by an adult. Bedtime cleaning is most important. • Ask parent/caregiver if the child has seen a dentist for an initial assessment. • If child is at risk of tooth decay (see page 2 of Oral Health Screening Guidelines), their teeth should be brushed using a fluoridated toothpaste, the size of a grain of rice. • Risk for developing tooth decay is assessed.	• Advise parents to select healthy snack choices as per Canada's Food Guide. It is the frequency of snacking or grazing and sipping, not the amount of sugar, carbs/starch consumed that affects tooth decay. • Advise parents that the Canadian Dental Association recommends yearly dental visits after age one. • Fluoride varnish applications are available in your area. • Encourage parents to keep their own mouth clean and healthy, brush and floss daily, have regular dental check-ups, and receive treatment as needed. • Tooth Eruption: central and lateral incisors, first molars and canines. **References:** Oral Screening Guidelines for Child Health Clinics. **Resources:** • Fluoride Varnish Protects Teeth • Toothpaste Use for Children Under 3 • Early Childhood Tooth Decay • Drinking From a Cup	• Child eats and drinks foods containing sugar outside planned meal and snack times. Child is allowed to graze and sip all day. • If child has not had a first dental visit. • Refer to an oral health professional for any concern or risk factors identified.
Standard Handouts Immunization Fact Sheets Caring for Your Child's Fever Growing Up Healthy 18 months to 4 years		

Child Health Clinic – 18 month
Additional Assessments

Expected Standards	Client-based Support	Red Flags
Offer and discuss highlights of the 18 months - four years Growing Up Healthy resource as appropriate. **Physical** **Sleep/Cry** Children at this age average 10 – 13 hours of sleep per day. Some of it may be a day time nap.	**Counseling** • Encourage routines for bedtime, foster health child development and parenting. • Toddler's sleep patterns. • Reality vs. expectations. • Affirm family's sleep/room sharing choices • Coping: what helps? Caring for Kids www.caringforkids.cps.ca/handouts/healthy_sleep_for_your_baby_and_child	• No bedtime routine established. • Parent has unreasonable expectations of toddler's sleep.
Head to Toe • Observe child's stance bare foot. • Observe Posture and symmetry (especially from back). • Walking. • Inspect the wear on child's shoes (equal or abnormal wear).	**Counseling** • Runs without falling by two years. • Apparent flat feet – internal rotation of lower limbs giving pronation of feet. • Lateral stability by two years of age. • Bowleggedness maximizes at two years. • In-toeing.	• Referral to the primary care practitioner if appropriate. • Referral to a podiatrist for: ➢ Abnormal gait patterns; ➢ Persistent in-toe gait; ➢ Out-toeing; ➢ Problems in weight bearing; or ➢ Limping.

Expected Standards	Client-based Support	Red Flags
		• Referral to a primary care practitioner for: ➢ Unusual gait such as ataxic, spastic, waddling, steppage. • Walking delayed longer than 18 months of age. Refer to a primary care provider and early childhood psychologist as per RHA protocol.
Hearing Do you have any concerns about your child's hearing or speech?	**Counseling** • Hearing and speech development are inter-related. • If you have concerns about how your child communicates or if they are not responding to you when you call to talk with them, seek further assessment from your primary care provider.	• History of ear infections. • If concerns expressed by parents/caregivers. • Refer to Saskatchewan Hearing Aid Plan (audiologist) or primary care provider as needed.
Vision Do you have any concerns about your child's vision?	**Counseling** • The Optometric Association of Saskatchewan encourages parents to have their child's eyes assessed by an optometrist now if not previously assessed and then again at three years. • Ministry of Health covers yearly eye exams of children up to their 18th birthday.	• Refer to Optometrist if amblyopia or other eye concerns exist at this age.
Developmental Screening ** For children born < 37 weeks gestation or earlier, calculate adjusted age and assess development based on adjusted age. This calculation should be made until the child reaches two years of age. See Demographics Standard of CHC Guidelines for Standard practice for calculation details.	**Counseling**	

Expected Standards	Client-based Support	Red Flags
18 months Social/Emotional • Child's behavior is usually manageable. • Interested in other children. • Usually easy to soothe. • Comes for comfort when distressed. Communication skills • Points to several different body parts. • Tries to get your attention to show you something. • Turns/responds when name is called. • Points to what he/she wants. • Looks for toy when asked or pointed in direction. • Imitates speech sounds and gestures. • Says 25 or more words (words do not have to be clear • Produces four consonants (e.g. B D G H N W). Motor skills • Walks alone. • Feeds self with spoon with little spilling. Adaptive skills • Removes hat/socks without help.	• At this age, there is a wide variance of normal behaviours, encourage parents to provide opportunities for the child to learn and use his new skills. • Parents should be aware of the amount of "screen" time their children are getting with items such as phones, games, television, computers, etc. • Physical activity of being active and further developing gross motor skills should be encouraged. • Children learn speech through interactions with human faces and voices. These are more interactive than TV, phone or video screens. References/ Resources: Screen Smart www.screensmart.ca/early_years Canadian Society for Exercise Physiologists www.csep.ca/english/view.asp?x=949 Canada's Physical Activity Guidelines **Anticipatory guidance for 2 – 4 years** **2 years** • Combine two or more words. • Understand one and two step directions. • Walks backward two steps without support. • Tries to run. • Puts objects into small container.	• If there is a parental concern or if the milestones are not being met, use the age appropriate Nipissing District Developmental Screen (NDDS). If two or more "No" responses are marked, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "No" may be influenced by culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.**

Expected Standards	Client-based Support	Red Flags
	• Uses toys for pretend play (e.g. give doll a drink). • Continues to develop new skills. **3 years** • Understands two and three step directions (e.g. pick up your hat and shoes and put them in the closet). • Uses sentences with five or more words. • Walks up stairs using handrail. • Twists lids off jars or turns knobs. • Shares some of the time. • Plays make-believe games with actions and words (e.g. pretending to cook a meal, fix a car). • Turns pages one at a time. • Listens to music or stories for five to ten minutes. **4 years** • Understands three part directions. • Asks and answers lots of questions (e.g. what are you doing?). • Walks up/down stairs alternating feet. • Undoes buttons and zippers. • Tries to comfort someone who is upset.	
Sexual Health Development • Normal sexual development in children at 18 months to 2 years includes: ➢ Explores own body including genitals. ➢ Enjoys appropriate touch as well as skin to skin contact. ➢ Likes to be naked.	**Counseling** • Child will develop the capacity to trust caregivers. • Child will experience pleasure through touch. • Teach your child the correct names of body parts including genitals. • Be aware of possible signs of sexual abuse (trauma to genitals, resistant or fearful touch from others).	• If the PHN suspects possible abuse or if the parent suspects abuse, report to appropriate authorities.

Expected Standards	Client-based Support	Red Flags
• Normal sexual development in children 2 to 5 years: ➢ Identifies self as a boy or girl. ➢ Is curious about the genitalia of peers and adults of the same and opposite sex. ➢ Begins to understand the concept of privacy in relation to nudity and sexuality. ➢ Is able to understand the basic elements of human reproduction.	• Do not scold your child for demonstrating normal developmental behaviour such as talking about private parts or attempting to see other people when they are naked or undressing. • Explain to your child that touching his or her genitals is a private act. • Avoid instilling a sense of guilt or shame. • Understand that your reaction to the opposite sex or nudity will influence the child's perception of sexuality, gender and sexual behaviour.	
Health Education / Injury prevention Anticipatory guidance for health education and injury prevention. Child restraints	**Counseling** • Once children are one year of age and 22 lbs. (10kg) and can walk, they can use a forward-facing seat that has a tether strap until they are a minimum of 40 lbs. (18kg). Contact a SGI for more information. Best practice is: www.sgi.sk.ca/individuals/safety/carseats/index.html • Once children are 40 lbs (18 kg) and meet the minimum age requirements for the seat, a booster seat may used. See Prevention Institute website for more details: Saskatchewan Prevention Institute www.skprevention.ca/child-traffic-safety/#Booster%20Seats	• Information in this section supports the previous assessments. Refer back to assessments for red flag identification and appropriate referral.

Expected Standards	Client-based Support	Red Flags
Drowning and Suffocation	• "Never leave a child alone near or in water. This includes pools (including paddling pools), lakes, bathrooms, and other sources of water."	
Burns and Scalds	• Always test the temperature of bath water with your elbow and make sure the hot water temperature at the taps is set at no more than 49°C (120°F). • Turn pot handles inward on the stove.	
Poisons	• "Keep all medicine and cleaning products locked away in the kitchen and bathroom". • Poison control number 1-866-454-1212.	
Falls	• "Keep the child's furniture, including his or her bed, away from the windows." • Safety gates on stairs.	
Screen time/Physical Activity	• Canadian Physical Activity Guidelines recommend that toddlers (aged 1-2 years) should accumulate at least 180 minutes of physical activity at any intensity spread throughout the day including: ➢ A variety of activities in different environments. ➢ Activities that develop movement skills. ➢ Progression toward at least 60 minutes of energetic play by 5 years of age. • More daily physical activity provides greater benefits.	

Expected Standards	Client-based Support	Red Flags
	• Being an active toddler means; ➢ Any activity that gets kids moving. ➢ Climbing stairs and moving around the home ➢ Playing outside and exploring their environment. • Crawling, brisk walking, running or dancing. Canadian Sedentary Behaviour Guidelines recommend for toddlers that time sitting or being restrained should be minimized. • For children under 2 years, screen time (e.g. TV, computer, electronic games) is not recommended. • For children 2 to 4 years, screen time should be limited to less than one hour per day; less is better. • Explore and play with your child. • Limit use of playpens and infant seats when baby is awake. • Stop during long car trips for playtime. Canadian Society of Exercise Physiologists: www.csep.ca	
Family Dynamics	• Discuss sibling rivalry, grandparents, and changes in family dynamics related to parents as needed.	
Violence and Abuse	• Assess for concerns or presence of domestic violence or child abuse (see page 64 of the RNAO guidelines for possible action).	• Parents experiencing domestic violence should consider a safety plan and also have a copy of important documents in a safe place outside the home (HSN, tax return, driver's license).

Expected Standards	Client-based Support	Red Flags
Seasonal Concerns Mosquitoes	• Protect your child from mosquitoes by providing netting around strollers and other areas. • Protective light-coloured clothing with long cuffed sleeves, long pants, tucked into socks or shoes, and hats. • Insect repellent with < 30% Deet can be used on children. Avoid applying Deet to hands and face. • Keep children inside during dusk and dawn when mosquitoes are out. www.cps.ca	
Sun	• Use long sleeves and long pants and a hat to protect your child from the sun. • Sunscreen can be applied to young children, avoid putting it on the child's hands.	
Frostbite	• Use of proper clothing for the weather including footwear. • Dressing the child in layers. • Cover head with a warm, close-fitting hat that protects the ear lobes. • Be aware of wind chill as it greatly speeds up the process of body heat loss. • Remove wet clothes as soon as possible to avoid additional chilling. For more information : Saskatchewan Prevention Institute www.skprevention.ca	

Expected Standards	Client-based Support	Red Flags
Advise for next CHC appointment Parent groups Provincial HealthLine 811		

Child Health Clinic – 4 to 6 year old
Standard Assessments

Expected Standards	Client-based Support	Red Flags
Demographics • Confirmation of Demographic information (e.g. name, address, date of birth, gender and HSN number). • This can be done by PHN or support staff. • Client identifiers (right child).	• Updated information allows for improved contact and follow-up. • Confirmation of client identifier contributes to zero immunization errors.	• Any errors or changes to be updated on the child record and reported to Ministry of Health by the parents.
Parent Support • Parents are able to ask questions about their child's health, growth, development, behaviour, or other concerns. • Do you have any questions or concerns about your child's health, development, behaviour or growth? **Targeted Questions:** **Development** 1. Does your child play well with other children? 2. Does your child make a fuss when you leave them?	**Counseling** • Parents are asked if they have any questions or concerns about their child's physical growth, health, behaviour, or development. • If parent is concerned about the child, the PHN could offer a home visit or phone call for further follow-up. • Refer to additional assessments development for further direction.	

Expected Standards	Client-based Support	Red Flags
3. Do you have any concerns about your child's speech or communication skills? Developmental Milestones: • Understands three part directions. • Asks and answers lots of questions (e.g. what are you doing?) • Walks up/down stairs alternating feet. • Undoes buttons and zippers. • Tries to comfort someone who is upset. Parental Strengths	• Acknowledge and give positive feedback.	• If child is unable to do 2 or more of the milestones, full developmental screening should be done. See developmental screening assessment for use of NDDS and referral guidelines.
Growth • Child's growth is progressing normally • Serial measurements of height and weight are recorded and plotted on the appropriate WHO growth chart (i.e.: weight-for-age, height- for-age). • BMI-for-age is calculated, recorded, and plotted on the appropriate growth chart (i.e.: 2-19 years old). • Age of child is identified and plotted to the nearest completed quarter year. • Growth pattern follows the same growth curve over time that falls between the 3rd and 85th percentiles and is proportional.	**Counseling** **NOTE:** • BMI-for-age is the best indicator for assessing body weight status in children older than 2 years; Weight-for-height should not be used as an indicator **for children over 2 years** as it is not age specific and does not measure adiposity (fatness). • A single BMI-for-age measurement reflects a child's size and provides a baseline for following the child's growth pattern during school years. However, a single BMI-for-age measurement **does not** provide adequate information to assess the preschool child's rate of growth upward or downward and therefore their growth pattern.	**When growth pattern is outside of expected parameters: re-measure, verify age and re-plot.** • **Growth measures plotted at <3rd or >85th percentile.** ➢ Children in these extremes should be assessed for whether this BMI-for-age value is appropriate for them or due to a pathological situation and requires referral. See **NAMIC** Guide to Referral Resources.

Expected Standards	Client-based Support	Red Flags
• Record all measurements in metric.	• BMI-for-age serial measurements at two, three, four and five years that show an unexpected early upward trend (such as the early adiposity rebound) alert parents of the need to slow the trend upward helping to promote healthy weights and to prevent obesity later in life. **Counseling:** • **If the BMI-for-age is between the 3rd and 85th percentile**, advise parents that although this single indicator does not give enough information to assess their child's growth pattern, it does tell us that the child**'s body weight status is within** what we consider to be a normal range. • Advise parents of the positive things that they are doing that promote healthy body weight whether related to the feeding relationship, activity, food offered, sleep, or screen time. Remind parents that their own body size and genetic background also influence a child's body weight status. • **If the BMI-for-age is below the 3rd or above the 85th percentile,** create a non-judgmental atmosphere when discussing weight issues. Reinforce the positive as above, be factual, make no assumptions nor attribute motives. • Assist parents by connecting them to resources and community supports that are available as needed. • See Appendix 14 WHO Growth Chart Assessment and Counseling – Key Messages and Actions for further parent support.	

Expected Standards	Client-based Support	Red Flags
	Handout: Tips to Health Your Child and Teen Grow Well www.whogrowthcharts.ca	
Immunization • Assessment of the individual's health. • Determination of which vaccines to provide. • Discussion of follow-up care. • Obtain informed consent for immunization. • Administration of those vaccines.	**Counseling** • **See Saskatchewan Immunization Manual for** recommended **vaccines, counselling and procedure.** http://www.ehealthsask.ca/services/manuals/Pages/SIM.aspx Immunize Canada: http://immunize.ca Caring for Kids (resources to share with parents): www.caringforkids.cps.ca See Appendix 3.1 in the Saskatchewan Immunization Manual for other reliable websites.	• Unable to obtain consent as legal guardianship in question. • Contraindications to immunization.
Nutrition **Parental Support** • Parents are aware of resources they can access if family is food insecure.	**Counseling** • Assist food insecure families by connecting them to community resources they can access locally. See **NAMIC Standard**: Mother and family have access to enough healthy foods.	• Family is unable to access enough healthy food to meet their needs.
Feeding Relationship • A quality feeding relationship exists within a supportive family environment.	**Counseling** • Remind parents to be aware of their parenting style. A supportive nurturing environment is important for a child's development as it pertains to feeding. The parent's primary role is to provide structure, offer nutritious choices and to support their child as they learn to become a competent eater.	• Parent serves only those foods child requests.

Expected Standards	Client-based Support	Red Flags
• Child exhibits age-appropriate development as it pertains to feeding. **Nutrition** • Child continues to be offered a variety of nutritious and energy dense foods from the four food groups daily. • Child is offered 500 ml (16 oz) pasteurized milk.	• Advise parents of the physical and social milestones as they pertain to feeding. See **NAMIC Standard:** A quality feeding relationship exists within a supportive family environment. • Encourage parents to be patient when child is making food selections as they may choose a limited variety of foods. • Encourage parents to model positive food behaviours. Food acceptance improves when parents eat the same foods offered to child. • Children naturally distrust the new. Encourage parents to patiently offer new foods many times (15 times or more) perhaps in new forms and with foods they accept. See **NAMIC Standard:** Child is offered new foods in a manner that supports acceptance. • Encourage parents to provide opportunities for the child to participate in food preparation activities appropriate for age. • At this stage, children self-feed and drink from a regular open cup easily. By age 4 children are better at using a spoon and fork. By about age 5 children can use a fork and knife together. **Counseling** • Advise parents that children aged two and older can get all the nutrients and calories they need for healthy growth and development by planning meals and snacks that provide the recommended number of food guide servings a day.	• Nutritious foods are restricted because of their fat content. • Child is not receiving a variety of foods from the four food groups.

Expected Standards	Client-based Support	Red Flags
• If a child is offered juice, it is limited to 125 – 175 ml (4 -6 oz) per day. • Child is offered small, planned meals and snacks throughout the day. • Foods are selected, prepared, and stored using sanitary and safe procedures.	• The amount of food eaten will vary day to day depending on the child's appetite, activity level and whether they are experiencing a growth spurt, or if they are overly excited. • Advise parents to offer 500 ml (16 oz) of milk or fortified soy beverage daily to help meet vitamin D. Milk is a poor source of iron and excess amounts may limit intake of other important nutrients or contribute to constipation. • Advise that fruit drinks should be avoided and that unsweetened 100% fruit juice should be offered in only moderate amounts i.e., about 125 ml (4 oz) to 175 ml (6 oz) daily as juice offers little fibre and can replace important nutrients. • Advise parents to offer food and drinks at mealtimes and at snack times, but not in between. Offer water if the child is thirsty between meals or snacks. • Advise parents to strive for a balance between fluids & nutritious solid foods. • Advise parents that the following foods contain certain bacteria that can make a child sick – raw sprouts; unpasteurized milk and cheese; unpasteurized fruit juice; uncooked dough, batter or foods that contain raw eggs; undercooked meat, poultry or seafood. For more information on food safety see www.healthcanada.gc.ca.	• Child is drinking large amounts of fluid and/or eating very little food including: ➢ More than 750 ml (24 oz) of milk a day. ➢ More than 175 ml (6 oz) of juice a day. • Child is offered rice, almond or other vegetarian beverages. • Child consumes sweetened drinks including fruit drinks, pop, teas, coffee, and hot chocolate. • Child is grazing on food and beverages throughout the day. • Child is offered foods that are not cleaned, prepared, cooked or stored safely.

Expected Standards	Client-based Support	Red Flags
Nutrients of Concern • Child does not take a vitamin/mineral supplement including an iron supplement unless medically indicated. • Child receives adequate amounts of vitamin D.	**Counseling** • Advise parents that although their child's appetite may vary on a daily basis it does not necessarily indicate the need for a vitamin/mineral supplement • Assess whether child is offered a variety of table foods including foods rich in iron daily. • If child takes a supplement including iron, advise parent regarding safe storage of all supplements to avoid accidental overdose leading to death by poisoning. • Assess whether child is offered food sources, including 500ml/day of fortified cow's milk, that provide an adequate intake of vitamin D.	• Parent perceives that child requires a vitamin/mineral supplement. • Child does not receive iron rich foods or suffers from iron deficiency anemia. • Child's diet does not provide for adequate vitamin D intake.
Elimination • Child has regular bowel movements with stools that are passed without difficulty (considering individual variation). • Child has straw-coloured odourless urine.	**Counseling** • Advise parents that bowel movements can be very different from one child to another. What is normal for their child depends on what the child eats and drinks. • Advise that constipation is hard stools that often make bowel movements difficult and painful. See **NAMIC Standard:** Young children exhibit normal elimination patterns. • Advise parents to introduce fibre containing food gradually and to offer a variety of whole grain breads and cereals; fruit like apples, banana, berries or prunes; vegetables and cooked legumes (split peas, chickpeas and lentils).	• Constipation. • Child drinks excessive amounts of milk including more than 750 ml (24 oz) a day or excessive amounts of one food to serve as a laxative (e.g.: prunes, prune juice, apple juice).

Expected Standards	Client-based Support	Red Flags
	• Advise parent re: signs of dehydration and when to seek medical assistance. Parents should consult with a physician if child has bloody or black stools; is vomiting after four to six hours; has diarrhea and a fever with a temp higher than 38.5°C (101.5°F); has dehydration; stomach pains getting worse. See **NAMIC Standard**: Child has regular bowel movements which are passed without difficulty. • If voiding is inadequate (frequency, volume, colour) assess infant's fluid intake. Caring for Kids: www.caringforkids for handouts: ➢ Healthy Bowel Habits for Children ➢ Dehydration and Diarrhea in Children: Prevention and Treatment **Handouts:** • Growing Up Healthy 4 to 6 years • The following handouts as needed: ➢ Eating Well with Canada's Food Guide. ➢ Mealtime Mentoring – Canada's Food Guide a Focus on Children. ➢ Mealtime Mentoring – Encouraging a Competent Eater. ➢ Mealtime Mentoring – Children with Food Preferences.	• Dehydration.

Expected Standards	Client-based Support	Red Flags
Oral Health • Oral health assessment. Lift the child's lip and have the child open their mouth; assess the anterior and posterior of the oral cavity. • Child receives beverages served in a regular open cup and if juice is offered no more than 4 - 6oz per day is provided. • Child's teeth are brushed twice a day. • Child's teeth should be brushed by an adult using a pea sized amount of fluoridated toothpaste. • Child's teeth are flossed daily. • Ask parent/caregiver if child has seen a dentist within the last year. • Risk for developing tooth decay is assessed.	**Counseling** • Advise parents that frequent sipping and prolonged contact of teeth with liquids other than water, increases the risk of tooth decay. • Advise parents that young children do not have the ability to brush thoroughly, so parents need to brush their child's teeth until eight years of age. • Encourage children to brush independently (for example, the child should take a turn and then the adult taking a turn will help develop brushing skills and habits. • Advise parent to floss daily as at this age when the second year molar teeth are present. • Advise the parent that the Canadian Dental Association recommends yearly dental visits. • Fluoride varnish applications are available in your area. • Tooth Eruption: complete eruption of all 20 primary teeth. References: Oral Health Screening Guidelines for Child Health Clinics. Resources: • Fluoride Varnish Protects Teeth • Early Childhood Tooth Decay • Drinking From a Cup • Toothpaste Use for Children Under 3 (back page)	• Child does not receive daily brushing and flossing by an adult. • Child consumes beverages from a bottle or cup with a spout or straw. • Refer to an oral health professional if there are any concerns or risk factors identified.

Expected Standards	Client-based Support	Red Flags
Standard Handouts Immunization Fact Sheets Caring for Your Child's Fever Growing Up Healthy 4-6 years		

Child Health Clinic – 4 to 6 year
Additional Assessments

Expected Standards	Client-based Support	Red Flags
Offer and discuss highlights of the Growing Up Healthy 4 - 6 years resource. **Physical** **Sleep/Cry** • Preschoolers generally sleep 10 – 12 hours per day and give up their daytime naps as early as age three.	**Counseling** • Consider using naptime as a quiet time for your child to read and relax. • It's common for preschoolers to wake up during the night, and to have nighttime fears or nightmares. • Avoid stimulants, such as drinks with caffeine. • Avoid television before bedtime. Don't allow your child to have a television, computer or video games in his bedroom. • Some children will try to delay bedtime. Set limits, such as how many books you will read, and be sure your child knows what they are. • Tuck your child into bed snugly for a feeling of security. • Don't ignore bedtime fears. If your child has nightmares, reassure and comfort him. Caring for Kids www.caringforkids.cps.ca/handouts/healthy_sleep_for_your_baby_and_child	• If you have any concerns about your child's sleep, contact your primary care practitioner.

Expected Standards	Client-based Support	Red Flags
Head to Toe • Assess for frequent illness, injury or hospitalization. • Do parents have any concerns about child's physical health?	**Counseling** • Encourage parents to have their children assessed by their primary care provider on an annual basis. Include healthy weight and height monitoring.	• Assess for frequent illness, injury or hospitalization. • Do parents have any concerns about child's physical health?
Hearing • Do you have any concerns about your child's hearing?	**Counseling** • Hearing and speech development are inter-related. • If you have concerns about how your child communicates or if they are not responding to you when you call to talk with them, seek further assessment from your primary care provider.	• History of ear infections. • If concerns expressed by parents/ caregivers. Refer to Saskatchewan Hearing Aid Plan (audiologist) or primary care provider as needed.
Vision • Do you have any concerns about your child's vision?	**Counseling** • Ministry of Health covers yearly eye exams for children up to their 18th birthday.	• Refer to Optometrist for any concerns with eye or vision concerns.
Development **4 years** • Understands three part directions. • Asks and answers lots of questions (e.g. what are you doing?). • Walks up/down stairs alternating feet. • Undoes buttons and zippers. • Tries to comfort someone who is upset.	**Counseling** • At this age, there is a wide variance of normal behaviours, encourage parents to provide opportunities for the child to learn and use his new skills. • Parents should be aware of the amount of "screen" time their children are getting with items such as phones, games, television, computers, etc. • Physical activity of being active and further developing gross motor skills should be encouraged.	• If there is a parental concern or if the milestones are not being met, use the age appropriate Nipissing District Developmental Screen (NDDS). If two or more "No" responses are marked, a referral is recommended to the child's primary care provider, early childhood psychologist or speech and language pathologist. If the question that is answered "no" may be influenced by

Expected Standards	Client-based Support	Red Flags
	• Children learn speech through interactions with human faces and voices. These are more interactive than TV, phone or video screens. Screen Smart www.screensmart.ca/early_years Canadian Society of Exercise Physiologists www.csep.ca/english/view.asp?x=949 Canada's Physical Activity Guidelines	culture or lack of opportunity, discuss milestone with parent and determine if referral is **required or milestone may need to be monitored by the PHN.** • If child has not reached milestones, he may be eligible for early preschool entry. Encourage parents to contact the school in their area. • If child is receiving more that two hours of screen time per day. • If child is not active for 60 – 90 minutes most days.
Sexual Health Development Normal sexual development in children 4 to 6 years. • Identifies self as a boy or girl. • Is curious about the genitalia of peers and adults of the same and opposite sex. • Begins to understand the concept of privacy in relation to nudity and sexuality. • Is able to understand the basic elements of human reproduction.	**Counseling** • Do not scold your child for demonstrating normal developmental behaviour such as talking about private parts or attempting to see other people when they are naked or undressing. • Explain to your child that touching his or her genitals is a private act. • Avoid instilling a sense of guilt or shame. • Understand that your reaction to the opposite sex or nudity will influence the child's perception of sexuality, gender and sexual behaviour.	• If the PHN suspects possible abuse or if the parent suspects abuse, report to appropriate authorities.

Expected Standards	Client-based Support	Red Flags
Health Education / Injury Prevention Anticipatory guidance for health education and injury prevention.	**Counseling**	• Information in this section supports the previous assessments. Refer back to assessments for red flag identification and appropriate referral.
Child restraints	• Booster seats allow the seat belt to work much more effectively on small bodies. Once children are 40 lbs (18 kg) and meet the minimum weight requirements for the seat, a booster seat should be used. See Prevention Institute website for more details: Saskatchewan Prevention Institute: www.skprevention.ca/child-traffic-safety/#Booster%20Seats	• If not meeting booster seat requirements, provide information from SGI Car Seat pamphlet or SGI website. SGI: www.sgi.sk.ca/individuals/safety/carseats/index.html
Motor vehicle safety	• Children are not capable of safely crossing a street alone until they are about 9 years old. • All children must use bike helmets from the time a child begins to ride a bicycle.	
Drowning	• Never leave a child alone near or in water. This includes pools (including paddling pools), lakes, bathrooms, and other sources of water.	
Burns and Scalds	• Always test the temperature of bath water with your elbow and make sure the hot water temperature at the taps is set at no more than 49°C (120°F). • Children at this age like to assist in the kitchen with cooking, watch for pot handles extending beyond cook top range, hot ovens and pans.	

Expected Standards	Client-based Support	Red Flags
Poisons	• Keep all medicine and cleaning products locked away in the kitchen and bathroom. • Poison control number 1-866-454-1212.	
Falls	• Always supervise children at the playground; this is the age when they start to engage in more risky behaviour." • "Children must always wear a helmet when bicycling, scootering, rollerblading, and skateboarding."	
Screen time/Physical Activity	• The Canadian Physical Activity Guidelines for pre-schoolers should accumulate at least 180 minutes of physical activity at any intensity spread through the day, including; ➢ A variety of activities in different environments ➢ Activities that develop movement skills ➢ Progression toward at least 60 minutes of energetic play by 5 years of age • More daily physical activity provides greater benefits. • Being an active preschooler means; ➢ Any activity that gets kids moving ➢ Climbing stairs and moving around the home ➢ Playing outside and exploring their environment ➢ Crawling, brisk walking, running or dancing. • The older the child becomes the more energetic play he needs, such as hopping, jumping, skipping and bike riding.	

Expected Standards	Client-based Support	Red Flags
	• The Canadian Sedentary Behaviour Guidelines for health benefits of children 5-11 years should minimize the time they spend being sedentary each day. This may be achieved by; ➢ Limiting recreational screen time to no more than 2 hours per day; lower levels are associated with additional health benefits. ➢ Limiting sedentary (motorized) transport, extended sitting and time spent indoors throughout the day. Canadian Society for Exercise Physiologists: www.csep.ca	
Family Dynamics	• Discuss sibling rivalry, grandparents, and changes in family dynamics related to parents as needed.	
Violence and Abuse	• Assess for concerns or presence of domestic violence or child abuse (see page 64 of the RNAO guidelines for possible action).	• Parents experiencing domestic violence should consider a safety plan and also have a copy of important documents in a safe place outside the home (HSN, tax return, driver's license).
Seasonal Mosquitoes	• Protective light-coloured clothing with long cuffed sleeves, long pants, tucked into socks or shoes, and hats. • Insect repellent with < 30% Deet can be used on children. Avoid applying Deet to hands and face. • Keep children inside during dusk and dawn when mosquitoes are out. Canadian Pediatrics Society: www.cps.ca	

Expected Standards	Client-based Support	Red Flags
Sun Frostbite	• Use long sleeves and long pants and a hat to protect your child from the sun. • Sunscreen can be applied to young children, avoid putting it on the child's hands. • Use of proper clothing for the weather including footwear. • Dressing the child in layers. • Cover head with a warm, close-fitting hat that protects the ear lobes. • Be aware of wind chill as it greatly speeds up the process of body heat loss. • Remove wet clothes as soon as possible to avoid additional chilling. Resources: Saskatchewan Prevention Institute: www.skprevention.ca	