Appendices

Early Childhood Assessment Form

Name: (First, Middle, Last) HCN: Date of Birth: (YYYY/MM/DD)

Encounter Date (yyyy/mm/dd)						
Age						
Immunization Only (✓)						
Standard Assessment						
General Health	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Parental Concern	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Targeted Questions	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Growth	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Feeding Relationship	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Breastfeeding	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF	EXB NEB NBF
Formula Feeding/Milk (type)	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Nutrients of Concern	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Elimination	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Complementary Feeding	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Oral Health	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP	NA NAP
Additional Assessment						
Physical Sleep/Cry	NAP	NAP	NAP	NAP	NAP	NAP
Head to Toe	NAP	NAP	NAP	NAP	NAP	NAP
Hearing	NAP	NAP	NAP	NAP	NAP	NAP
Vision	NAP	NAP	NAP	NAP	NAP	NAP
Developmental Screen	NAP	NAP	NAP	NAP	NAP	NAP
Speech/Language	NAP	NAP	NAP	NAP	NAP	NAP
Sexual Health	NAP	NAP	NAP	NAP	NAP	NAP
Health Ed/Injury Prevention	NAP	NAP	NAP	NAP	NAP	NAP
Family Dynamics	NAP	NAP	NAP	NAP	NAP	NAP
Violence/Abuse	NAP	NAP	NAP	NAP	NAP	NAP
Seasonal	NAP	NAP	NAP	NAP	NAP	NAP
Second Hand Smoke						
Handouts (Initials)						
PHN Signature						

06/2015 PHNF 402

Code for charting screening/counselling: **NA:** Not assessed (only applies to Standard Assessments)
NAP: No Apparent Problem **REF:** Referred **CLS:** Closed – referral completed, concern no longer exists
OBS: Observe for future referral **UCC:** Under Continued Care by another health professional
Breastfeeding: **EXB:** exclusive **NEB:** non exclusive **NBF:** no breastfeeding **X:** see narrative for comments **XM:** see mother's record

Guidelines for CHC documentation

The following guidelines will assist the PHN to chart information collected through the new CHC process. The charting tool (Early Childhood Assessment Form) has been created for multiple visits and should be accompanied with Nurses' Notes, or equivalent as required. The Early Childhood Assessment Form should be stapled into the existing Child Health Record used by the RHA. Immunization documentation in electronic immunization registry and WHO growth charts will continue to be completed as they have always been. Maternal Mental Health documentation is to occur on the mother's chart. If the RHA is currently not using a mother's chart, documentation is to occur as per current regional protocol.

Client ID: Fill in the information under the appropriate headings. Other demographic information is not needed at this time. Please PRINT clearly;

Name: client's first, middle and last name should be put here. **Please note that recording the first name of the client first is a shift from current practice and is necessary for future practice.**

Health Card No (HCN): clearly print the client's 9 digit health card number here

Date of Birth: please put in the yyyy/mm/dd.

Encounter Date: Write in the date that the encounter (visit) is occurring. Use the yyyy/mm/dd format.

Age: Calculated child's chronological age should be written here. (Ex. 2 months 10 days written as 0·2·10). If using adjusted age for children born <37 weeks gestation and under 2 years of age, indicate the adjusted age – A.A. 1 month 14 days written as 0·1·14 (A.A.).

Immunization Only

- If this is an immunization only appointment and the record **is not** required, no documentation is needed on the record. Record immunization in the electronic immunization registry. (RHA specific)
- If this is an immunization only appointment or drop in clinic for immunization and the child record **is** required, place a checkmark in the **immunization only** box to indicate this. Record immunization in the electronic immunization registry.
- Record any other assessments done (i.e. Growth) and draw a diagonal line in the other assessment boxes (from the bottom LEFT corner to the top RIGHT corner) to indicate these assessments were not part of the encounter.

- If this is a drop in clinic offering full CHC services, the amount of service provided will indicate the documentation requirements. Record immunization in the electronic immunization registry.
- If this is **not** an immunization only appointment, draw a diagonal line in the other assessment boxes (from the bottom LEFT corner to the top RIGHT corner).

In each of the assessment categories, there is a selection of options to describe if the assessment has been done and what has to occur for follow up. Chart these options under the correct encounter date and assessment area. Procedures for providing the assessments can be found in the ***Saskatchewan Child Health Clinic Guidelines for Standard Practice***. Indicate in the assessment box the result of the assessment by either circling NAP or NA or putting in the appropriate abbreviation.
- If a Standard Assessment is not completed, not assessed (NA) is circled in the box and indicate in the Nurses' Notes why the assessment was not completed. If using an assessment result abbreviation, other than NAP, in the Standard Assessment area, documentation in the nurses' notes is required.
- If an Additional Assessment is not completed, a diagonal line is to be drawn in the box (from the bottom LEFT corner to the top RIGHT corner).
- If documentation needs to occur in the mother's record mark XM. Statements should be clear, concise and contain the reason/ information for referral and parent/guardian response of acceptance or refusal of the referral.

Abbreviation "key" definitions are found at the bottom of the page on the chart and apply to all assessment areas:

NAP – no apparent problem (no concerns or problems, passes assessment, meets expectations). No further charting is required.

Nurses' Notes will accompany the following codes to provide rationale:
NA – not assessed (only needs to be used for the Standard Assessments).
OBS – observe for future referral or parent refused referral
REF – referred (referral to appropriate healthcare or service provider)
UCC – under continued care by another healthcare professional
CLS – closed (no longer a concern/ referral completed)

Breastfeeding Codes:
EXB – exclusive breastfeeding **NEB** – non-exclusive breastfeeding
NBF– no breastfeeding

X – See narrative/ Nurses' notes
XM – see mother's record

Standard Assessments

General Health Status

The parent/caregiver is asked if the child is well today, if there are any allergies or recent medical conditions that have occurred.

- If these questions are not asked, circle NA (not assessed).
- If there is no change in the child's health status circle no apparent problem (NAP).
- If a change in health status has occurred (new allergy, disease process, hospitalization), indicate in the assessment box if the change is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS).

Parent Concern

- If these questions are not asked, circle NA (not assessed).
- If there is no concern expressed, circle NAP (no apparent problem).
- If a concern is expressed by a parent, mark an X in the box and write a concise statement about the concern in the Nurses' Notes and if appropriate chart in the appropriate assessment box.

Targeted Questions

These questions are age specific and found under the Parental Concern section of the Saskatchewan Child Health Clinic Guidelines for Standard Practice.

- If these questions are not asked, circle NA (not assessed).
- If there is no concern expressed, circle NAP (no apparent problem) and chart in the additional assessment area as appropriate.
- If a concern is expressed by a parent, mark an X in the box and write a concise statement about the concern in the Nurses' Notes and if appropriate chart in the appropriate assessment box.

Growth

Measurements of the client are to be recorded on the WHO growth chart that is age and gender appropriate.

- If measurements are not taken, circle NA (not assessed).
- If there is no concern, circle NAP (no apparent problem).
- If a concern is noted, indicate in the assessment box if the concern is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS).

Nutrition Assessment

This section begins with Feeding Relationship and ends with Oral Health. 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.

Nutrition Assessment for the two year old and older child:

- Feeding Relationship, Nutrients of Concern, Complementary Feeding and Oral Health assessments are to be documented.
- Breastfeeding and formula feeding/ milk should be assessed at age two and beyond. If no longer breastfeeding a diagonal line is to be drawn in the box (from the bottom LEFT corner to the top RIGHT corner).
- Formula feeding/ milk – type of milk to be recorded in the box
- Use the Complementary Feeding space to indicate a comprehensive nutrition assessment.

Feeding Relationship:

- If these questions are not asked, circle NA (not assessed)
- 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).

Breastfeeding:

- If these questions are not asked, mark NA (not assessed). If the child is exclusively formula fed, no comment is required and a diagonal line is to be drawn in the box (from the bottom LEFT corner to the top RIGHT corner).
- Based on the definitions in the CHC guidelines indicate by circling the appropriate abbreviation; exclusive (EXB), non-exclusive (NEB), or no breastfeeding (NBF). One of these definers needs to be circle the box to facilitate future data collection.
    - If there is no concern, mark 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).

Formula Feeding:

- If these questions are not asked, circle NA (not assessed). If the child is exclusively breastfed, no comment is required and a diagonal line is to be drawn in the box (from the bottom LEFT corner to the top RIGHT corner).
- If formula is being used, write in the brand of formula. If other milk is being used, write the type in here as well.
- If there is no concern, circle NAP (no apparent problem).
- If a concern exists indicate if the concern is to be observed (OBS), referred (REF), under continued care (UCC), or closed (CLS). .

Nutrients of Concern:

- If not assessed, circle NA (not assessed).
- 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).

Elimination:

- If not assessed, circle NA (not assessed).
- 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).

Complementary feeding:

- If these questions are not asked, circle NA (not assessed).
- 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), If not assessed, circle NA (not assessed).
- 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).

Oral Health:

- If these questions are not asked, circle NA (not assessed).
- 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), If not assessed, circle NA (not assessed).
- 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).

*There is a thicker black line between the Oral Health and Physical. This line indicates that the assessments above the line are the Standard Assessments and the assessments below the line are the Additional Assessments.

Additional Assessments

If the Additional Assessment is not completed, a diagonal line is to be drawn in the box (from the bottom LEFT corner to the top RIGHT corner).
Reminder - If any code other than NAP is used, there is an expectation that a comment is written in the Nurses' Notes.

Physical – Sleep/Cry

- 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), If not assessed, circle NA (not assessed).
- 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).

Head to Toe

- 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), If not assessed, circle NA (not assessed).
- 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).

Hearing

- 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), If not assessed, circle NA (not assessed).
- 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).

Vision

- 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), If not assessed, circle NA (not assessed).
- 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).

Developmental Screen

- If the assessment is completed and there are no concerns, circle NAP (no apparent problem) and chart the tool used in the Nurse's Notes if other than Nipissing District Developmental Screening tool.

- If a concern exists, indicate in the assessment box if the concern is to be observed (OBS), referred (REF), If not assessed, circle NA (not assessed).
- 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).
- Include in the Nurses' Notes the tool used if other than Nipissing District Developmental Screening tool.

Maternal Mental Health

- At two and six months, screening of the mother with the Edinburgh Postnatal Depression Scale (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.

Speech / Language

This is a required assessment at 18 months appointment.

- At 18 months if this is not done, mark NA (not assessed) and indicate the reason why in the Nurse's Notes.
- 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), If not assessed, circle NA (not assessed).
- 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).

Sexual Health

- If a parent asks questions regarding normal sexual health development and no further concerns are noted, 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).

Health Education / Injury Prevention

- 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) or under continued care (UCC).

Family Dynamics, Violence / Abuse, Seasonal, and Second Hand Smoke

- If the assessment is completed and there are no concerns, circle NAP (no apparent problem).
- If a concern exists or a referral is needed, indicate if the follow up is to be observed (OBS), referred (REF) or under continued care (UCC).
- For Second Hand Smoke, indicate in the Nurses' Notes if a member of the household uses tobacco and the smoker's plan for reduction, cessation or smoking away from the child.

**If child abuse is suspected, there is a duty to report. Follow the current guidelines and policies of the regional health authority for documenting and reporting.

Handouts (Initials): This box indicates that the standard handouts were given or offered to the client. These handouts are listed in the procedure part of the ***Saskatchewan Child Health Clinic Guidelines for Standard Practice***. These include the appropriate immunization fact sheets (this can include other information sheets related to consent and privacy), Caring for Your Child's Fever and age appropriate Growing Up Healthy. The PHN initials in the box indicating Handouts given. If other handouts are provided, mark X (along with the PHN initials) in the box and list the pamphlets in the Nurses' Notes.

PHN Signature: PHN to sign the chart to indicate who provided service. All comments made in the Nurses' Notes should be signed as per regional policy.

***** If an assessment box is inappropriately filled out, draw one line through the error and initial. Chart information in the appropriate area.**

CHC Summary Sheet for PHNs

Age	Target area	Developmental Milestones
2 months	**Maternal Mental Health – EPDS** Questions 3, 4, 5 = score > 4 - Probable anxiety <10 – unlikely to be depressed >12 – probable depression – make referral + q 10 – potential harm– assess harm intentions and take action	• 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
4 months	**Introduction of Solids** 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?	• 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.
6 months	**Maternal Mental Health – EPDS** Questions 3, 4, 5 = score > 4 - Probable anxiety <10 – unlikely to be depressed >12 – probable depression – make referral + q 10 – potential harm– assess harm intentions and take action	• 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.

12 months	**Growth, Development, Safety** 1. Does your child: • Respond to own name. • Understand simple requests (give me the ball?) • Make at least one consonant/vowel combination. • Say three or more words (do not have to be clear). • Crawl or "bum" shuffle. • Pull to a stand/walk holding on. • Show distress when separated from parent/caregiver. • Follow your gaze to jointly reference an object.	2. What type of car seat is your child using? • Respond to own name. • Understand simple requests (give me the ball?) • Make at least one consonant/vowel combination. • Say three or more words (do not have to be clear). • Crawl or "bum" shuffle. • Pull to a stand/walk holding on. • Show distress when separated from parent/caregiver. • Follow your gaze to jointly reference an object. 3 requirements to place in forward facing car seat Is the child walking? Is the child older than 12 months? Is the child over 10kg (22 lbs)?
18 months	**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	**<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.

4 years	**Social Behaviour** 1. Does your child play well with other children? 2. Does your child make a fuss when you leave them? 3. Do you have any concerns about your child's speech or communication skills?	• 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.

Developmental Milestones – If child is unable to do 2 or more – complete the Nipissing screen.

- If necessary -make a copy – keep one for the chart and send one home with parent
- If any "NO's" on Nipissing screen then refer to family physician or early childhood psychologist –use appropriate forms

EPDS SCREENING & CARE GUIDE

EPDS SCORE <10= UNLIKELY TO BE DEPRESSED
Confirm absence of depression/anxiety, or harm thoughts

Promote Positive Mental Health:
- Nurture emotional, mental, physical, and spiritual health
- Promote confidence

Encourage her to:
- **Find joy** and relaxation in life
- **Exercise** 20-30 min. each day
- **Sleep** 6 hrs in 24
- **Eat** healthy and regularly, drink plenty of fluids
- **Avoid** alcohol, tobacco, drugs
- **Reach out** for support and join mothers' groups

QUESTIONS 3, 4, 5 SCORE >4= PROBABLE ANXIETY
Confirm score and ask about harm thoughts

Promote Positive Mental Health:
- Encourage relaxation
- Discuss any concerns
- Offer referral and share concerns with health care team
  - Mental Health
  - Community supports
  - Family Dr/Nurse Practitioner
- Increase contact with visits or phone calls
- Repeat EPDS in 2 weeks
- Encourage family involvement

EPDS SCORE 10-11= POSSIBLE DEPRESSION
Confirm score and ask about harm thoughts

Promote Positive Mental Health:
- Discuss any concerns
- Offer referral and share concerns with health care team
  - Mental Health
  - Community supports
  - Family Dr/ Nurse Practitioner
- Increase contact with visits or phone calls
- Repeat EPDS in 2 weeks
- Encourage family involvement

EPDS SCORE ≥12= PROBABLE DEPRESSION
Confirm score and ask about harm thoughts

Take Action:
Offer Referral to a Family Doctor or Nurse Practitioner to initiate **Medical Management** *(see below) also*
- Share concerns with health care team
- Encourage family involvement
- Promote Positive Mental Health
- Increase contact – visits

Offer EPDS to partner to screen for depression

POSITIVE QUESTION 10 = POTENTIAL HARM
Assess harm intentions and for psychosis

Assess Harm Intention:
- Has she had previous harm attempts or harmful behaviours?
- Does she have a plan to harm self or others (baby, children)?

Assess for Psychosis
1. *Is she seeing or hearing things that aren't there?*
2. *Is she having strange experiences/ sensations?*
3. *Are her speech or thoughts disorganized?*
4. *Are things that she describes realistic or not?*

If concerned about harm or psychosis:
- Do not leave alone
- Notify next of kin and if woman agrees, family/friends

Contact or take to:
- Family Doctor, Crisis services, and/or Emergency room

Arrange for emergency medical assessment:
- Share situation with health care team and child services if necessary

Endorsed for use by:

EPDS OVER→

LOCAL COMMUNITY SUPPORTS

Mental Health Phone_____

Public Health Phone _____

Maternal-Home Visiting Programs:
(KidsFirst, Canada Prenatal Nutrition Program (CPNP), Parent Mentoring, Maternal Child Health)

Name_____

Phone _____

Name _____

Phone _____

Healthline (anytime): Phone 811
Available for everyone 24hrs/day

For information about medications during pregnancy or beastfeeding call medSask 1-800-665-DRUG (3784) (Saskatchewan only) or **306-966-6378** (Saskatoon)

Other supports_____

Supports and groups also listed on: **www.skmaternalmentalhealth.ca**

MEDICAL MANAGEMENT
- **Assess mental health:** *e.g. depression, anxiety, anger, psychosis, racing, intrusive or harm thoughts, substance use, stressors, and support.*
- **Assess perinatal health:** *e.g. hypertension, fetal wellbeing, breastfeeding.*
- **Assess physical health:** *e.g. sleep, appetite, nausea & vomiting, activity levels. Ensure thyroid and hemoglobin levels are within normal range.*
- **Maintain existing effective psychotropic medications:** *plan any medication changes 3 months before pregnancy to ensure mood stability.*
- **Consider medication:** *especially if EPDS score remains high and there is a history of psychiatric problems*. For questions about medications call **medSask health care professional line at 1-800-665-DIAL (3425) (Saskatchewan only)** or **306-966-6340 (Saskatoon) or text 306-260-3554.**
- **Use adequate dose of medication to manage symptoms:** *may need to increase dose as pregnancy progresses.*
- **Assess for bipolar disorder** *before ordering an antidepressant*
- **If mood-stabilizing medication is used:** *increase Folic Acid to 5 mg.*
- **Do not taper off dose before delivery:** increases risk for PPD.
- **If a prenatal antidepressant is used, monitor for Neonatal Adaptation Syndrome:** *this is transient in first few days; notify pediatrician if available.*
- **Refer to local community supports.**

IF NO IMPROVEMENT, CONSIDER PSYCHIATRIC REFERRAL

EPDS SCREENING & CARE GUIDE

OFFER all pregnant women the Maternal Mental Health print materials.

Download or order screening and print materials from the **Saskatchewan Prevention Institute** at www.skprevention.ca

Maternal Depression - which includes Antenatal Depression (AD) and Postpartum Depression (PPD) and **Maternal Anxiety** affect 1 in 5 women. There are potential effects to the whole family, as 10% of partners experience depression and anxiety, more if the mother is depressed. Parental mental health issues can affect child health and development. Treating anxiety may help to prevent depression.

Signs of anxiety and depression include:

- Irritability or anger
- Sleep problems
- Lack of bonding with baby
- Indecisiveness
- Excessive worry and guilt
- Sadness
- Crying
- Thoughts of harm to self or others
- Inability to relax
- Panic attacks
- Fearfulness
- Hypervigilence
- Repetitive thoughts
- Obsessive intrusive thoughts

UNIVERSAL SCREENING is a quick and easy way to **determine women at risk** as well as helping to **reduce stigma** of mental health problems. **The Edinburgh Postnatal Depression Scale – EPDS** – can be done in-person or over the phone. The EPDS is also valid for use with partners.

MINIMAL TIMES TO SCREEN

Pregnancy
- 1st prenatal visit and at 28-34 weeks gestation

Postpartum
- 2-3 weeks postpartum and at 2-month (or 4 if not done at 2) and 6-month well child visits

Or as deemed necessary by the practitioner

EPDS Screen

1. **I have been able to laugh and see the funny side of things:**
   - As much as I always could 0
   - Not quite so much now 1
   - Definitely not so much now 2
   - Not at all 3

2. **I have looked forward with enjoyment to things:**
   - As much as I ever did 0
   - Rather less than I used to 1
   - Definitely less than I used to 2
   - Hardly at all 3

Anxiety Subscale

3. **I have blamed myself unnecessarily when things went wrong:**
   - Yes, most of the time 3
   - Yes, some of the time 2
   - Not very often 1
   - No, never 0

4. **I have been anxious or worried for no good reason:**
   - No, not at all 0
   - Hardly ever 1
   - Yes, sometimes 2
   - Yes, very often 3

5. **I have felt scared or panicky for no very good reason:**
   - Yes, quite a lot 3
   - Yes, sometimes 2
   - No, not much 1
   - No, not at all 0

6. **Things have been getting on top of me:**
   - Yes, most of the time I haven't been able to cope at all 3
   - Yes, sometimes I haven't been coping as well as usual 2
   - No, most of the time I have coped quite well 1
   - No, I have been coping as well as ever 0

7. **I have been so unhappy that I have had difficulty sleeping:**
   - Yes, most of the time 3
   - Yes, sometimes 2
   - Not very often 1
   - No, not at all 0

8. **I have felt sad or miserable:**
   - Yes, most of the time 3
   - Yes, quite often 2
   - Not very often 1
   - No, not at all 0

9. **I have been so unhappy that I have been crying:**
   - Yes, most of the time 3
   - Yes, quite often 2
   - Only occasionally 1
   - No, never 0

10. **The thought of harming myself has occurred to me:**
    - Yes, quite often 3
    - Sometimes 2
    - Hardly ever 1
    - Never 0

TOTAL SCORE: _____

See Score Interpretation and Care OVER

Cox, JL, Holden, JM, & Sagovsky, R, Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal Psychiatry* 1987;150:782-786.

Appendix 5

Nipissing District Development Screen (NDDS) Sheets to be inserted here.

Check with your RHA for hard copies of the NDDS parent sheets or go to www.ndds.ca.

Appendix 6

Oral Health Screening Guidelines for Child Health Clinics can be found at https://publications.saskatchewan.ca/#/categories/2287.

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA / LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Pregnancy/Birth remarks/Apgar:	Risk factors/Family history:

Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance — GUIDE I: 0-1 mo

NAME: _____ Birth Day (d/m/yr): _____ M [ ] F [ ]

Gestational Age: _____ Birth Length: _____ cm Birth Wt: _____ g Head Circ: _____ cm Discharge Wt: _____ g

DATE OF VISIT	within 1 week			2 weeks (optional)			1 month		
GROWTH[1] use WHO growth charts. Correct percentiles until 24-36 months if < 37 weeks gestation	Height	Weight	HC (avg 35 cm)	Height	Weight (regains BW 1-3 wks)	Head Circ.	Height	Weight	Head Circ.
PARENT/CAREGIVER CONCERNS									
NUTRITION[1]	❍ **Breastfeeding (exclusive)[1]** **Vitamin D 400 IU/day[1]** ❍ *Formula Feeding (iron-fortified)[1]* [150 mL(5 oz)/kg/day[1]] ❍ Stool pattern and urine output			❍ **Breastfeeding (exclusive)[1]** **Vitamin D 400 IU/day[1]** ❍ *Formula Feeding (iron-fortified)[1]* [150 mL(5 oz) /kg/day[1]] ❍ Stool pattern and urine output			❍ **Breastfeeding (exclusive)[1]** **Vitamin D 400 IU/day[1]** ❍ *Formula Feeding (iron-fortified)[1]* [450-750 mL(15-25 oz) /day[1]] ❍ Stool pattern and urine output		

EDUCATION AND ADVICE

✓ discussed and no concerns
X if concerns

Injury Prevention
❍ **Car seat (infant)[1]** ❍ **Sleep position/room sharing/avoid bed sharing[1]** ❍ **Crib safety[1]** ❍ **Firearm safety/removal[1]**
❍ Carbon monoxide/*Smoke detectors[1]* ❍ *Hot water <49°C[1]* ❍ Choking/safe toys[1]

Behaviour and family issues
❍ Sleeping/crying[2] ❍ Soothability/responsiveness ❍ **High risk infants/assess home visit need[2]**
❍ Parenting/bonding ❍ Parental fatigue/postpartum depression[2] ❍ Family conflict/stress ❍ Siblings

Other Issues
❍ **Second hand smoke[1]** ❍ **No OTC cough/cold medn[1]** ❍ *Inquiry on complementary/alternative medicine[1]*
❍ *Counsel on pacifier use[1]* ❍ *Temperature control and overdressing* ❍ Sun exposure/sunscreens/insect repellent[1]
❍ Fever advice/thermometers[1]

DEVELOPMENT[2] (Inquiry and observation of milestones) Tasks are set after the time of normal milestone acquisition. Absence of any item suggests consideration for further assessment of development. NB-Correct for age if < 37 weeks gestation ✓ if attained X if not attained		❍ Sucks well on nipple ❍ *No parent/caregiver concerns*	❍ *Focuses gaze* ❍ *Startles to loud noise* ❍ *Calms when comforted* ❍ Sucks well on nipple ❍ *No parent/caregiver concerns*
PHYSICAL EXAMINATION Evidence-based screening for specific conditions is highlighted, but an appropriate age-specific focused physical examination is recommended at each visit. ✓ if normal X if abnormal	❍ *Skin (jaundice, dry)* ❍ Fontanelles[1] ❍ **Eyes (red reflex)[1]** ❍ *Ears (TMs) Hearing inquiry/screening[1]* ❍ Heart/Lungs ❍ Umbilicus ❍ Femoral pulses ❍ Hips[1] ❍ Muscle tone[1] ❍ Testicles ❍ Male urinary stream/foreskin care	❍ *Skin (jaundice, dry)* ❍ Fontanelles[1] ❍ **Eyes (red reflex)[1]** ❍ *Ears (TMs) Hearing inquiry/screening[1]* ❍ Heart/Lungs ❍ Umbilicus ❍ Femoral pulses ❍ Hips[1] ❍ Muscle tone[1] ❍ Testicles ❍ Male urinary stream/foreskin care	❍ *Skin (jaundice)* ❍ Fontanelles[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex[1]** ❍ *Hearing inquiry/screening[1]* ❍ Heart ❍ Hips[1] ❍ Muscle tone[1]
PROBLEMS AND PLANS			
INVESTIGATIONS/IMMUNIZATION **Discuss immunization pain reduction strategies[3]**	❍ **PKU, Thyroid** ❍ **Hemoglobinopathy screen (if at risk)[1]** ❍ **Universal newborn hearing screening (UNHS)[1]** ❍ **If HBsAg-positive parent/sibling Hep B vaccine #1[3]** ❍ **Record Vaccines on Guide V**	❍ **Record Vaccines on Guide V**	❍ **If HBsAg positive parent/sibling Hep B vaccine #2[3]** ❍ **Record Vaccines on Guide V**
Signature			

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care: **Good (bold type)**; *Fair (italic type)*; Consensus (plain type).
[1]see Rourke Baby Record Resources 1: General [2]see Rourke Baby Record Resources 2: Healthy Child Development [3]see Rourke Baby Record Resources 3: Immunization/Infectious Diseases

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Past problems/Risk factors:	Family history:	**Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance** **GUIDE II: 2-6 mos**

NAME: _____ Birth Day (d/m/yr): _____ M [ ] F [ ]

Gestational Age: _____ Birth Length: _____ cm Birth Wt: _____ g Birth Head Circ.: _____ cm

DATE OF VISIT	2 months			4 months			6 months		
GROWTH[1] use WHO growth charts. Correct percentiles until 24-36 months if < 37 weeks gestation	Height	Weight	Head circ.	Height	Weight	Head Circ.	Height	Weight (x2 BW)	Head Circ.
PARENT/CAREGIVER CONCERNS									
NUTRITION[1]	❍ **Breastfeeding (exclusive)[1]** **Vitamin D 400 IU/day[1]** ❍ *Formula Feeding (iron-fortified)[1]* [600-900 mL(20-30 oz) /day[1]]			❍ **Breastfeeding (exclusive)[1]** **Vitamin D 400 IU/day[1]** ❍ *Formula Feeding (iron-fortified)[1]* [750-1080 mL(25-36 oz) /day[1]]			❍ **Breastfeeding[1] – initial introduction of solids** **Vitamin D 400 IU/day[1]** ❍ *Formula Feeding – iron-fortified[1]* [750-1080 mL(25-36 oz) /day[1]] ❍ No bottles in bed ❍ Avoid sweetened juices/liquids ❍ Iron containing foods (cereals, meat, egg yolk, tofu) ❍ Fruits and vegetables to follow ❍ No egg white, nut products, or honey ❍ Choking/safe food[1]		
EDUCATION AND ADVICE ✓ discussed and no concerns X if concerns	Injury Prevention ❍ **Car seat (infant)[1]** ❍ **Sleep position/room sharing/avoid bed sharing/crib safety[1]** ❍ **Poisons[1]; PCC#[1]** ❍ **Firearm safety/removal[1]** ❍ *Electric plugs/cords* ❍ Carbon monoxide/*Smoke detectors[1]* ❍ *Hot water < 49°C/bath safety[1]* ❍ *Falls (stairs, change table, no walkers)[1]* ❍ Choking/safe toys[1] Behaviour and family issues ❍ Sleeping/crying/**Night waking[2]** ❍ Soothability/responsiveness ❍ **High risk infants/assess home visit need[2]** ❍ Siblings ❍ Parenting/bonding ❍ Parental fatigue/postpartum depression[2] ❍ Family conflict/stress ❍ *Child care[2]*/return to work Other Issues ❍ **Second hand smoke[1]** ❍ Teething/**Dental cleaning/Fluoride[1]** ❍ **No OTC cough/cold meds[1]** ❍ Fever advice/thermometers[1] ❍ *Temperature control and overdressing* ❍ *OTC/complementary/alternative medicine[1]* ❍ *Encourage reading[2]* ❍ Sun exposure/sunscreens/insect repellent[1] ❍ *Pesticide exposure[1]* ❍ *Pacifier use[1]*								
DEVELOPMENT[2] (inquiry and observation of milestones) Tasks are set after the time of normal milestone acquisition. Absence of any item suggests consideration for further assessment of development. NB-Correct for age if < 37 weeks gestation ✓ if attained X if not attained	❍ *Follows movement with eyes* ❍ *Coos - throaty, gurgling sounds* ❍ *Lifts head up while lying on tummy* ❍ *Can be comforted & calmed by touching/rocking* ❍ *Sequences 2 or more sucks before swallowing/breathing* ❍ Smiles responsively ❍ *No parent/caregiver concerns*			❍ *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* ❍ *Holds an object briefly when placed in hand* ❍ *Laughs/smiles responsively* ❍ *No parent/caregiver concerns*			❍ *Turns head toward 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* ❍ *No parent/caregiver concerns*		
PHYSICAL EXAMINATION Evidence-based screening for specific conditions is highlighted, but an appropriate age-specific focused physical examination is recommended at each visit. ✓ if normal X if abnormal	❍ Fontanelles[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex[1]** ❍ *Hearing inquiry/screening[1]* ❍ Heart ❍ Hips[1] ❍ Muscle tone[1]			❍ Anterior fontanelle[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex[1]** ❍ *Hearing inquiry/screening[1]* ❍ Hips[1] ❍ Muscle tone[1]			❍ Anterior fontanelle[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex/Cover-uncover test & inquiry[1]** ❍ *Hearing inquiry/screening[1]* ❍ Hips[1] ❍ Muscle tone[1]		
PROBLEMS AND PLANS									
INVESTIGATIONS/IMMUNIZATION **Discuss immunization pain reduction strategies[3]**	❍ **Record Vaccines on Guide V**			❍ **Record Vaccines on Guide V**			❍ Inquire about risk factors for TB ❍ **If HBsAg-positive parent/sibling Hep B vaccine #3[3]** ❍ **Record Vaccines on Guide V**		
Signature									

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care: **Good (bold type)**; *Fair (italic type)*; Consensus (plain type).
[1]see Rourke Baby Record Resources 1: General [2]see Rourke Baby Record Resources 2: Healthy Child Development [3]see Rourke Baby Record Resources 3: Immunization/Infectious Diseases

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Past problems/Risk factors:	Family history:	**Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance** **GUIDE III: 9-15 mos** NAME: _____ Birth Day (d/m/yr): _____ M [ ] F [ ] Gestational Age: _____ Birth Length: _____ cm Birth Wt: _____ g Birth Head Circ: _____ cm

DATE OF VISIT	9 months (optional)			12-13 months			15 months (optional)		
GROWTH[1] use WHO growth charts. Correct percentiles until 24-36 months if < 37 weeks gestation	Height	Weight	Head circ.	Height	Weight (x3 BW)	HC (avg 47cm)	Height	Weight	Head Circ.
PARENT/CAREGIVER CONCERNS									
NUTRITION[1]	❍ **Breastfeeding[1]/Vitamin D 400 IU/day[1]** ❍ *Formula Feeding - iron-fortified[1]* [720-960 mLs(24-32 oz) /day[1]] ❍ Avoid sweetened juices/liquids ❍ Encourage change from bottle to cup ❍ No bottles in bed ❍ Cereal, meat/alternatives, fruits, vegetables ❍ Cow's milk products (e.g., yogurt, cheese, homogenized milk) ❍ No egg white, nut products, or honey ❍ Choking/safe foods[1]			❍ **Breastfeeding[1]** ❍ Homogenized milk [500-750 mLs(16-24 oz) /day[1]] ❍ Avoid sweetened juices/liquids ❍ Promote standard cup instead of bottle ❍ Appetite reduced ❍ Choking/safe foods[1] ❍ Inquire re: vegetarian diets[1]			❍ **Breastfeeding[1]** ❍ Homogenized milk [500-750 mLs(16-24 oz) /day[1]] ❍ Avoid sweetened juices/liquids ❍ Promote standard cup instead of bottle ❍ Choking/safe foods[1] ❍ Inquire re: vegetarian diets[1]		
EDUCATION AND ADVICE ✓ discussed and no concerns X if concerns	Injury Prevention ❍ **Car seat (infant)[1]** ❍ **Poisons[1]; PCC#[1]** ❍ **Firearm safety/removal[1]** ❍ Carbon monoxide/*Smoke detectors*[1] ❍ *Hot water <49°C/bath safety*[1] Childproofing, including: ❍ *Electric plugs/cords* ❍ *Falls/stairs/no walkers*[1] ❍ Choking/safe toys[1] Behaviour and family issues ❍ Sleeping/crying/**Night waking**[2] ❍ Soothability/responsiveness ❍ **High risk children/assess home visit need**[2] ❍ Siblings ❍ *Parenting*[2] ❍ Parental fatigue/depression[2] ❍ Family conflict/stress ❍ *Child care*[2]/return to work Other Issues ❍ **Second hand smoke**[1] ❍ Teething/**Dental cleaning/Fluoride/Dentist**[1] ❍ *Complementary/alternative medicine*[1] ❍ **No OTC cough/cold medn**[1] ❍ Fever advice/thermometers[1] ❍ Active healthy living/screen time[1] ❍ *Encourage reading*[2] ❍ *Pacifier use*[1] ❍ Footwear[1] Environmental health including: ❍ Sun exposure/sunscreens/insect repellent[1] ❍ *Serum lead if at risk*[1] ❍ *Pesticide exposure*[1]								
DEVELOPMENT[2] (Inquiry and observation of milestones) Tasks are set after the time of normal milestone acquisition. Absence of any item suggests consideration for further assessment of development. NB-Correct for age if < 37 weeks gestation ✓ if attained X if not attained	❍ *Looks for an object seen hidden* ❍ *Babbles a series of different sounds (eg, baba, duhduh)* ❍ *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 objects* ❍ *Plays social games with you (eg, nose touching, peek-a-boo)* ❍ *Cries or shouts for attention* ❍ *No parent/caregiver concerns*			❍ *Responds to own name* ❍ *Understands simple requests, eg, Where is the ball?* ❍ *Makes at least 1 comonant/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* ❍ *No parent/caregiver concerns*			❍ *Says 5 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 ❍ *No parent/caregiver concerns*		
PHYSICAL EXAMINATION Evidence-based screening for specific conditions is highlighted, but an appropriate age-specific focused physical examination is recommended at each visit. ✓ if normal X if abnormal	❍ Anterior fontanelle[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex/Cover-uncover test & inquiry[1]** ❍ *Hearing inquiry/screening*[1] ❍ Hips[1]			❍ Anterior fontanelle[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex/Cover-uncover test & inquiry[1]** ❍ *Hearing inquiry/screening*[1] ❍ Snoring/tonsil size[1] ❍ Teeth[1] ❍ Hips[1]			❍ Anterior fontanelle[1] ❍ **Eyes (red reflex)[1]** ❍ **Corneal light reflex/Cover-uncover test & inquiry[1]** ❍ *Hearing inquiry/screening*[1] ❍ Snoring/tonsil size[1] ❍ Teeth[1] ❍ Hips[1]		
PROBLEMS AND PLANS									
INVESTIGATIONS/IMMUNIZATION Discuss immunization pain reduction strategies[3]	❍ **If HBsAg positive mother check HBV antibodies and HBsAg[3] (at 9 or 12 months)** ❍ *Hemoglobin (if at risk)*[1] ❍ **Record Vaccines on Guide V**						❍ **Record Vaccines on Guide V**		
Signature									

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care: **Good (bold type)**; *Fair (italic type)*. Consensus (plain type).
[1]see Rourke Baby Record Resources 1: General [2]see Rourke Baby Record Resources 2: Healthy Child Development [3]see Rourke Baby Record Resources 3: Immunization/Infectious Diseases

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Past problems/Risk factors:	Family history:	**Rourke Baby Record:** Evidence-Based Infant/Child Health Maintenance **GUIDE IV: 18 mo - 5 yr (National)** NAME: _____ Birth Day (d/m/yr): _____ M [ ] F [ ] Gestational Age: _____ Birth Length: _____ cm Birth Wt: _____ g Birth Head Circ: _____ cm

DATE OF VISIT	18 months			2-3 years			4-5 years	
GROWTH[1] use WHO growth charts. Correct percentiles until 24-36 mos if < 37 weeks gestation	Height	Weight	Head circ.	Height	Weight	HC if prior abN	Height	Weight
PARENT/CAREGIVER CONCERNS								
NUTRITION[1]	❍ **Breastfeeding**[1] ❍ Homogenized milk [500-750 mL's(16-24 oz) /day[1]] ❍ Avoid sweetened juices/liquids ❍ No bottles			❍ 1% to 2% milk [~ 500 mL's(16 oz) /day[1]] ❍ *Gradual transition to lower fat diet*[1] ❍ Inquire re: vegetarian diets[1] ❍ Canada's Food Guide[1]			❍ 1% to 2% milk [~ 500 mL's(16 oz) /day[1]] ❍ Inquire re: vegetarian diets[1] ❍ Canada's Food Guide[1]	
EDUCATION AND ADVICE Injury Prevention Behaviour Family Other ✓ discussed and no concerns X if concerns	❍ **Car seat (child)**[1] ❍ *Bath safety*[1] ❍ Choking/safe toys[1] ❍ Parent/child interaction ❍ *Discipline/Parenting skills programs*[2] ❍ Parental fatigue/stress/depression[2] ❍ **High-risk children**[2] ❍ Socializing/peer play opportunities ❍ *Wean from pacifier*[1] ❍ **Dental care/Dentist**[1] ❍ Toilet learning[2] ❍ *Encourage reading*[2]			❍ **Car seat** (child/booster)[1] ❍ **Bike helmets**[1] ❍ Firearm safety/removal[1] ❍ Carbon monoxide/*smoke detectors*[1] ❍ Matches ❍ *Water safety*[1] ❍ Parent/child interaction ❍ *Discipline/parenting skills programs*[2] ❍ **High-risk children**[2] ❍ Parental fatigue/depression[1] ❍ Family conflict/stress ❍ Siblings ❍ **Assess child care** /preschool needs/school readiness[2] ❍ **Second-hand smoke**[1] ❍ **Dental cleaning/Fluoride/Dentist**[1] ❍ *No pacifiers*[1] ❍ *Complementary/alternative medicine*[1] ❍ Toilet learning[2] ❍ **No OTC cough/cold medn**[1] ❍ Active healthy living/screen time[1] ❍ Socializing opportunities ❍ *Encourage reading*[2] Environmental health including: ❍ Sun exposure/sunscreens/insect repellent[1] ❍ *Pesticide exposure*[1] ❍ *Serum lead if at risk*[1]			
DEVELOPMENT[2] (Inquiry and observation of milestones) Tasks are set after the time of normal milestone acquisition. Absence of any item suggests consideration for further assessment of development. NB-Correct for age if < 37 weeks gestation ✓ if attained X if not attained	Social/Emotional ❍ *Child's behaviour 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 20 or more words (words do not have to be clear)* ❍ *Produces 4 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* ❍ *No parent/caregiver concerns*			**2 years** ❍ *Combines 2 or more words* ❍ *Understands 1 and 2 step directions* ❍ *Walks backward 2 steps without support* ❍ *Tries to run* ❍ *Puts objects into small container* ❍ *Uses toys for pretend play (eg. give doll a drink)* ❍ Continues to develop new skills ❍ *No parent/caregiver concerns* **3 years** ❍ *Understands 2 and 3 step directions (eg. "Pick up your hat and shoes and put them in the closet.")* ❍ *Uses sentences with 5 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 (eg. pretending to cook a meal, fix a car)* ❍ Turns pages one at a time ❍ Listens to music or stories for 5 - 10 minutes ❍ *No parent/caregiver concerns*			**4 years** ❍ *Understands 3-part directions* ❍ *Asks and answers lots of questions (eg. "What are you doing?")* ❍ *Walks up/down stairs alternating feet* ❍ *Undoes buttons and zippers* ❍ *Tries to comfort someone who is upset* ❍ *No parent/caregiver concerns* **5 years** ❍ *Counts out loud or on fingers to answer "How many are there?* ❍ *Speaks clearly in adult-like sentences most of the time* ❍ *Throws and catches a ball* ❍ *Hops on 1 foot several times* ❍ *Dresses and undresses with little help* ❍ *Cooperates with adult requests most of the time* ❍ *Retells the sequence of a story* ❍ *Separates easily from parent/caregiver* ❍ *No parent/caregiver concerns*	
PHYSICAL EXAMINATION Evidence-based screening for specific conditions is highlighted, but an appropriate age-specific focused physical examination is recommended at each visit. ✓ if normal X if abnormal	❍ Anterior fontanelle closed[1] ❍ **Eyes (red reflex)**[1] ❍ **Corneal light reflex/Cover-uncover test & inquiry**[1] ❍ Hearing inquiry ❍ Snoring/tonsil size[1] ❍ Teeth[1]			❍ *Blood pressure* ❍ **Eyes (red reflex)/Visual acuity**[1] ❍ **Corneal light reflex/Cover-uncover test & inquiry**[1] ❍ Hearing inquiry ❍ Snoring/tonsil size[1] ❍ Teeth[1]			❍ *Blood pressure* ❍ **Eyes (red reflex)/Visual acuity**[1] ❍ **Corneal light reflex/Cover-uncover test & inquiry**[1] ❍ Hearing inquiry ❍ Snoring/tonsil size[1] ❍ Teeth[1]	
PROBLEMS AND PLANS								
INVESTIGATIONS/IMMUNIZATION **Discuss immunization pain reduction strategies**[3]	❍ **Record Vaccines on Guide V**			❍ **Record Vaccines on Guide V**			❍ **Record Vaccines on Guide V**	
Signature								

Strength of recommendation based on literature review using the classification of the Canadian Task Force on Preventive Health Care: **Good (bold type)**; *Fair (italic type)*; Consensus (plain type)
[1]see Rourke Baby Record Resources 1: General [2]see Rourke Baby Record Resources 2: Healthy Child Development [3]see Rourke Baby Record Resources 3: Immunization/Infectious Diseases

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Childhood Immunization Record as per NACI Recommendations (as of July 29, 2011)
For additional information, refer to the National Advisory Committee on Immunization website: www.phac-aspc.gc.ca/naci-ccni/

Provincial guidelines vary and are available online: www.phac-aspc.gc.ca/im/ptimprog-progimpt/table-1_e.html

Rourke Baby Record: Evidence-Based Infant/Child Health Maintenance GUIDE V: Immunization

NAME: _____ Birth Day (d/m/yr): _____ M [ ] F [ ]

Date given	NACI recommendations	Injection site	Lot number	Expiry date	Initials	Comments
Rotavirus[3]	2 or 3 doses dose #1 (6 wks - 14 wks/6 days)					
# doses varies with manufacturer	dose #2					
	± dose #3 (by 8 mos/0 days)					
DTaP/IPV/[3]	4 doses (2, 4, 6, 18 months)					
Hib[3]	dose #1 (2 months)					
	dose #2 (4 months)					
	dose #3 (6 months)					
	dose #4 (18 months)					
Pneu-Conj[3]	4 doses (2, 4, 6, 12-15 months) dose #1 (2 months)					
	dose #2 (4 months)					
	dose #3 (6 months)					
	dose #4 (12-15 months)					
Men-Conjugate[3]	Men-C-C 2-3 doses under 12 mos (2-11 mos) AND booster dose between 12-24 months OR Men-C-C: 1 dose at 12 months					
	Men-C-C or Men-C-ACWY:1 dose at 12 years or during adolescence					
Hepatitis B[3]	3 doses in infancy OR 2-3 doses preteen/teen dose #1					
	dose #2					
	± dose #3					
MMR or MMRV[3]	2 doses (12 mths, 18 mths OR 4 yrs) dose #1 (12 months)					
	dose #2 (18 months OR 4 years)					
Varicella[3]	2 doses (12 mo-12 yrs - MMRV or univalent) OR 2 doses (>13 years- univalent) dose #1					
	dose #2					
DTaP/IPV[3]	1 dose (4-6 years)					
HPV[3]	In females 9 - 26 years, 3 doses at 0, 2, and 6 months dose #1					
	dose #2					
	dose #3					
dTap[3]	1 dose (14-16 years)					
Influenza[3]	1 dose annually (6-23 months and high risk > 2 years) First year only for < 9 years - give 2 doses one month apart					
Other						

Disclaimer: Given the constantly evolving nature of evidence and changing recommendations, the Rourke Baby Record is meant to be used as a guide only.
[3]see Rourke Baby Record Resources 3: Immunization/Infectious Diseases
Financial support has been provided by the Government of Ontario, with funds administered by the Ontario College of Family Physicians.

www.rourkebabyrecord.ca RBR **Rourke Baby Record: RESOURCES 1: General (July, 2011)**

GROWTH

- **Important:** Corrected age should be used at least until 24 to 36 months of age for premature infants born at <37 wks gestation.
- *Measuring growth* - The growth of all term infants, both breastfed and non breastfed, and preschoolers should be evaluated using Canadian growth charts from the 2006 World Health Organization Child Growth Standards (birth to 5 years) with measurement of recumbent length (birth to 2-3 years) or standing height (≥ 2 years), weight, and head circumference (birth to 2 years). www.cps.ca/english/publications/CPS10-01.htm www.dietitians.ca/growthcharts

NUTRITION - www.hc-sc.gc.ca/fn-an/pubs/infant-nourrisson/nut_infant_nourrisson_term_e.html - www.osnpph.on.ca/resources/index.php

- Colic - www.cps.ca/english/statements/N/InfantileColic.htm
- **Breastfeeding: Exclusive breastfeeding** is recommended for the first six months of life for healthy term infants. Breast milk is the optimal food for infants, and breastfeeding (with complementary foods) may continue for up to two years and beyond unless contraindicated. Breastfeeding reduces gastrointestinal and respiratory infections. Maternal support (both antepartum and postpartum) increases breastfeeding and prolongs its duration. Early and frequent mother-infant contact, rooming in, and banning handouts of free infant formula increase breastfeeding rates.
  - Breastfeeding - www.cps.ca/english/statements/N/BreastfeedingMar05.htm
  - Ankyloglossia and breastfeeding - www.cps.ca/english/statements/CP/cp11-01.htm
  - Maternal medications when breastfeeding - toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT
  - Motherisk - www.motherisk.org
  - Weaning - www.cps.ca/english/statements/CP/cp04-01.htm
- Routine **Vitamin D supplementation** of 400 IU/day (800 IU/day in northern communities) is recommended for all breastfed infants until the diet provides a sufficient source of Vitamin D (~ 1 year of age). Formula may only supply a portion of the recommended daily vitamin D intake if less than 1000 mL (33 oz) is consumed daily. Breastfeeding mothers should continue to take Vitamin D supplements for the duration of breastfeeding. www.cps.ca/english/statements/ii/fnim07-01.htm
- *Infant formula* - formula composition and algorithm re use www.albertahealthservices.ca/3505.asp
- Milk consumption range is consensus only & is provided as an approximate guide.
- Soy-based formula is not recommended for routine use in term infants as an equivalent alternative to cow's milk formula, or for cow milk protein allergy, and is contraindicated for preterm infants. www.cps.ca/english/statements/N/InfantSoyConcern.htm
- *Transition to lower fat diet:* A gradual transition from the high-fat infant diet to a lower-fat diet begins after age 2 years as per Canada's Food Guide.
- Encourage a healthy diet as per Canada's Food Guide
  - www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html
- Vegetarian diets - www.cps.ca/english/statements/CP/cp10-02.htm
- Mercury in fish - www.hc-sc.gc.ca/fn-an/securit/chem-chim/environ/mercur/index-eng.php

INJURY PREVENTION: In Canada, unintentional injuries are the leading cause of death in children and youth. Most of these preventable injuries are caused by motor vehicle collisions, drowning, choking, burns, poisoning, and falls. For more safety information: www.safekidscanada.ca www.cps.ca/english/publications/InjuryPrevention.htm

- **Transportation in motor vehicles:** www.cps.ca/english/statements/IP/IP08-01.htm
  Children < 13 years should sit in the rear seat. Keep children away from all airbags.
  Install and follow size recommendations as per specific car seat model and keep child in each stage as long as possible.
  Use rear-facing infant seat until at least 1 year of age AND 10 kg (22 lb)
  Use forward-facing child seat after 1 year of age AND 10 - 22 kg (22 - 48 lb) and up to 122 cm (48"). Maximum ht/wt may vary with car seat model.
  Use booster seat from at least 18 - 36 kg (40 - 80 lb) and up to 145 cm (4'9").
  Use lap and shoulder belt in the rear seat for children over 8 yrs who are at least 36 kg (80 lb) and 145 cm (4'9") and fit vehicle restraint system.
- **Bicycle:** wear **bike helmets**. Replace if heavy impact or sign of damage.
- Drowning: www.cps.ca/english/statements/IP/IP03-01.htm
  - *Bath safety:* Never leave a young child alone in the bath. Do not use infant bath rings or bath seats.
  - *Water safety:* Recommend adult supervision, training for adults, 4-sided pool fencing, lifejackets, swimming lessons, and boating safety to decrease the risk of drowning.
- Choking: Avoid hard, small and round, smooth and sticky solid foods until age 3 years. Use safe toys, follow minimum age recommendations, and remove loose parts and broken toys.
- *Burns:* Install smoke detectors in the home on every level.
  Keep hot water at a temperature < 49°C.
- Poisons: Keep medicines and cleaners locked up and out of child's reach. Have Poison Control Centre number handy. *Use of ipecac is contraindicated in children.*
- Falls: Assess home for hazards- never leave baby alone on change table or other high surface; use window guards and stair gates. Baby walkers are banned in Canada and should never be used. Advise against trampoline use at home. www.cps.ca/english/statements/IP/IP07-01.htm
- **Safe sleeping environment:** www.cps.ca/english/statements/CP/cp04-02.htm
  - **Sleep position and SIDS/Positional plagiocephaly:** Healthy infants should be positioned on their backs for sleep. Their heads should be placed in different positions on alternate days. Sleep positioners should not be used. While awake, infants should have supervised tummy time. Counsel parents on the dangers of other contributory causes of SIDS such as overheating, maternal smoking or second-hand smoke.
  - **Bed sharing:** Advise against bed sharing which is associated with an increased risk for SIDS.
  - **Crib safety/Room sharing:** Encourage putting infant in a crib, cradle or bassinette, that meets current Canadian regulations (www.hc-sc.gc.ca/ahc-asc/media/nr-cp/_2010/2010_212-eng.php) in parents' room for the first 6 months of life. Room sharing is protective against SIDS.
- **Firearm safety/removal:** There is evidence-based association between a firearm in the home and increased risk of unintentional firearm injury, suicide, or homicide. www.cps.ca/english/statements/AM/AH05-02.htm

INVESTIGATIONS/SCREENING

Anemia screening: All infants from high-risk groups for iron deficiency anemia require screening between 6 and 12 months of age, e.g. Lower SES; Asian; First Nations children; low-birth-weight and premature infants, and infants fed whole cow's milk during their first year of life.
Hemoglobinopathy screening: Screen all neonates from high-risk groups: Asian, African & Mediterranean.
Universal newborn hearing screening (UNHS) effectively identifies infants with congenital hearing loss & allows for early intervention & improved outcomes. www.cps.ca/english/statements/CP/cp11-02.htm

OTHER

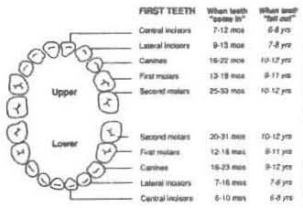
- **Second-hand smoke exposure**: contributes to childhood illnesses such as URTI, middle ear effusion, persistent cough, pneumonia, asthma, and SIDS.
- Advise parents against using **OTC cough/cold medications.**
  - http://www.hc-sc.gc.ca/ahc-asc/media/advisories-avis/_2008/2008_184-eng.php
- *Complementary and alternative medicine (CAM):* Questions should be routinely asked on the use of homeopathy and other complementary and alternative medicine therapy or products, especially for children with chronic conditions.
  - www.cps.ca/english/statements/DT/DT05-01.htm
  - Homeopathy - www.cps.ca/english/statements/CP/cp05-01.htm
- *Pacifier use* may decrease risk of SIDS and should not be discouraged in the 1st year of life after breastfeeding is well established, but should be restricted in children with chronic/recurrent otitis media. - www.cps.ca/english/statements/CP/cp03-01.htm
- Fever advice/thermometers: Fever ≥ 38°C in an infant < 3 months needs urgent evaluation. Ibuprofen and acetaminophen are both effective antipyretics. Acetaminophen remains the first choice for antipyresis under 6 months of age; thereafter ibuprofen or acetaminophen may be used. Alternating acetaminophen with ibuprofen for fever control is not recommended in primary care settings as this may encourage fever phobia, and the potential risks of medication error outweigh measurable clinical benefit. - www.cps.ca/english/statements/CP/cp00-01.htm
- Footwear: Shoes are for protection, not correction. Walking barefoot develops good toe gripping and muscular strength - http://www.cps.ca/english/statements/CP/FootwearChildren.htm
- Healthy Active Living: Encourage increased physical activity and decreased sedentary pastimes with parents as role models.
  - www.cps.ca/english/statements/HAL/HAL02-01.htm
  - Media use - www.cps.ca/english/statements/CP/pp03-01.htm
- Sun exposure/sunscreens/insect repellents: Minimize sun exposure. Wear protective clothing, hats, properly applied sunscreen with SPF ≥ 30 for those > 6 months of age. No DEET in < 6 months; 6-24 months 10% DEET apply max once daily; 2 - 12 yrs 10% DEET apply max TID.
- *Pesticides:* Avoid pesticide exposure. Encourage pesticide-free foods.
  - www.ocfp.on.ca/docs/public-policy-documents/pesticides-literature-review.pdf
- *Lead Screening* (www.cfp.ca/cgi/reprint/56/6/531) is recommended for children who:
  - in the last 6 months lived in a house or apartment built before 1978;
  - live in a home with recent or ongoing renovations or peeling or chipped paint;
  - have a sibling, housemate, or playmate with a prior history of lead poisoning;
  - live near point sources of lead contamination;
  - have household members with lead-related occupations or hobbies;
  - are refugees aged 6 mo - 6 yrs, within 3 months of arrival and again in 3-6 months.

Even for blood levels less than 10ug/dL, evidence suggests an association, and perhaps partial causal relationship with lower cognitive function in children. www.pulsus.com/journals/abstract.jsp?sCurrPg=abstract&jnlKy=5&atlKy=3087&isuKy=444&isArt=t&fromfold=

- Websites about environmental issues:
  - CPCHE - www.healthyenvironmentforkids.ca/
  - AAP - www.aap.org/healthtopics/environmentalhealth.cfm

Dental Care:

- **Dental Cleaning:** As excessive swallowing of toothpaste by young children may result in dental fluorosis, children 3-6 years of age should be supervised during brushing and only use a small amount (e.g. pea-sized portion) of fluoridated toothpaste twice daily. Children under 3 years of age should have their teeth and gums brushed twice daily by an adult using either water (if low risk for tooth decay) or a rice grain sized portion of fluoridated toothpaste (if at carries risk).



- Fluoride supplements are not recommended before eruption of the first permanent tooth (~6 - 8 years) unless the child is at high risk for dental caries. www.cda-adc.ca/_files/position_statements/Fluorides-English-2010-06-08.pdf
- *To prevent early childhood caries:* avoid sweetened juices/liquids and constant sipping of milk or natural juices in both bottle and cup.

PHYSICAL EXAMINATION

- Vision inquiry/screening: www.cps.ca/english/statements/cp/cp09-02.htm
  - Check **Red Reflex** for serious ocular diseases such as retinoblastoma and cataracts.
  - **Corneal light reflex/cover-uncover test & inquiry for strabismus**: With the child focusing on a light source, the light reflex on the cornea should be symmetrical. Each eye is then covered in turn, for 2 – 3 seconds, and then quickly uncovered. The test is abnormal if the uncovered eye "wanders" OR if the covered eye moves when uncovered.
- *Hearing inquiry/screening* – Any parental concerns about hearing acuity or language delay should prompt a rapid referral for hearing assessment. Formal audiology testing should be performed in all high-risk infants, including those with normal UNHS. Older children should be screened if clinically indicated.
- Fontanelles – The posterior fontanelle is usually closed by 2 months and the anterior by 18 months.
- Muscle tone – Physical assessment for spasticity, rigidity, and hypotonia should be performed.
- Hips – There is insufficient evidence to recommend routine screening for developmental dysplasia of the hips, but examination of the hips should be included until at least one year, or until the child can walk. http://pediatrics.aappublications.org/cgi/reprint/117/3/898
- Snoring in the presence of sleep-disordered breathing warrants assessment re obstructive sleep apnea. http://aappolicy.aappublications.org/cgi/reprint/pediatrics;109/4/704.pdf

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www.rourkebabyrecord.ca RBR **Rourke Baby Record: RESOURCES 2: Healthy Child Development (July, 2011)** **National**

DEVELOPMENT

Maneuvers are based on the Nipissing District Developmental Screen™ (www.ndds.ca) and other developmental literature. They are not a developmental screen, but rather an aid to developmental surveillance. They are set after the time of normal milestone acquisition. Thus, absence of any one or more items is considered a high-risk marker and indicates consideration for further developmental assessment; as does parental or caregiver concern about development at any stage.

- "Best Start" website contains resources for maternal, newborn, and early child development - www.beststart.org/
- OCFP Healthy Child Development- Improving the Odds publication is a toolkit for primary healthcare providers - www.ocfp.on.ca/docs/research-projects/improving-the-odds-healthy-child-development-manual-2010-6th-edition.pdf
  www.cdc.gov/ncbddd/child/screen_provider.htm
- Centre of Excellence for Early Childhood Development: www.child-encyclopedia.com

BEHAVIOUR

Crying: Excessive crying may be caused by behavioral or physical factors or be the upper limit of the normal spectrum. Evaluation of these etiological factors and of the burden for parents is essential and raises awareness of the potential for the shaken baby syndrome.
Shaken baby syndrome: www.cps.ca/english/statements/PP/cps01-01.htm www.dontshake.org
Night waking: occurs in 20% of infants and toddlers who do not require night feeding. Counselling around positive bedtime routines (including training the child to fall asleep alone), removing nighttime positive reinforcers, keeping morning awakening time consistent, and rewarding good sleep behaviour has been shown to reduce the prevalence of night waking; especially when this counselling begins in the first 3 weeks of life.

- www.mja.com.au/public/issues/182_05_070305/sym10800_fm.html

Swaddling: Proper swaddling of the infant for the first 6 months of life may promote longer sleep periods but could be associated with adverse events (hyperthermia, SIDS, or development of hip dysplasia) if misapplied. A swaddled infant must always be placed supine with free movement of hips and legs, and the head uncovered.

- http://pediatrics.aappublications.org/cgi/reprint/120/4/e1097

PARENTING/DISCIPLINE

Inform parents that warm, responsive, flexible & consistent discipline techniques are assoc with positive child outcomes. Over reactive, inconsistent, cold & coercive techniques are assoc with negative child outcomes.

- www.cps.ca/english/statements/CP/pp04-01.htm
- www.ocfp.on.ca/docs/research-projects/improving-the-odds-healthy-child-development-manual-2010-6th-edition.pdf (section 3)

Refer parents of children at risk of, or showing signs of, behavioral or conduct problems to structured parenting programs which have been shown to increase positive parenting, improve child compliance, and reduce general behavior problems. Access community resources to determine the most appropriate and available research-structured programs.
(eg. The Incredible Years, Right from the Start; COPE program).
http://www.child-encyclopedia.com/en-ca/parenting-skills/how-important-is-it.html

LITERACY

Encourage parents to read to their children within the first few months of life and to limit TV, video and computer games to provide more opportunities for reading.

- www.cps.ca/english/statements/CP/pp06-01.htm
- www.ncbi.nlm.nih.gov/pubmed/10742349?itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum&ordinalpos=28
- Arch Dis Child; 2008;93:554-7 http://adc.bmj.com/content/93/7/554.long

PARENTAL/FAMILY ISSUES - HIGH RISK INFANTS/CHILDREN

- Maternal depression - Physicians should have a high awareness of maternal depression, which is a risk factor for the socio-emotional and cognitive development of children. Although less studied, paternal factors may compound the maternal-infant issues.
  - www.cps.ca/english/statements/PP/pp04-03.htm
- Fetal alcohol spectrum disorder (FASD) - www.cps.ca/english/statements/II/ii02-01.htm
- Foster care - Children entering foster care are a high risk population requiring special needs for health supervision. www.cps.ca/english/statements/cp/cp08-01.htm
- **Assess home visit need:** There is good evidence for **home visiting by nurses** during the perinatal period through infancy for first-time mothers of low socioeconomic status, single parents or teenaged parents to prevent physical abuse and/or neglect.
  - www.cmaj.ca/cgi/content/full/163/11/1451
- *Risk factors for physical abuse*: low SES; young maternal age (< 19 years); single parent family; parental experiences of own physical abuse in childhood; spousal violence; lack of social support; unplanned pregnancy or negative parental attitude towards pregnancy.
- *Risk factors for sexual abuse*: living in a family without a natural parent; growing up in a family with poor marital relations between parents; presence of a stepfather; poor child-parent relationships; unhappy family life.

NONPARENTAL CHILD CARE

Inquire about current child care arrangements. High quality child care is associated with improved paediatric outcomes in all children.
Factors enhancing quality child care include: practitioner general education and specific training; group size and child/staff ratio; licensing and registration/accreditation; infection control and injury prevention; and emergency procedures.

- www.cps.ca/english/statements/CP/cp08-02.htm
- www.cps.ca/english/statements/CP/cp2009-01.htm
- Well Beings: www.caringforkids.cps.ca/wellbeings/index.htm

AUTISM SPECTRUM DISORDER

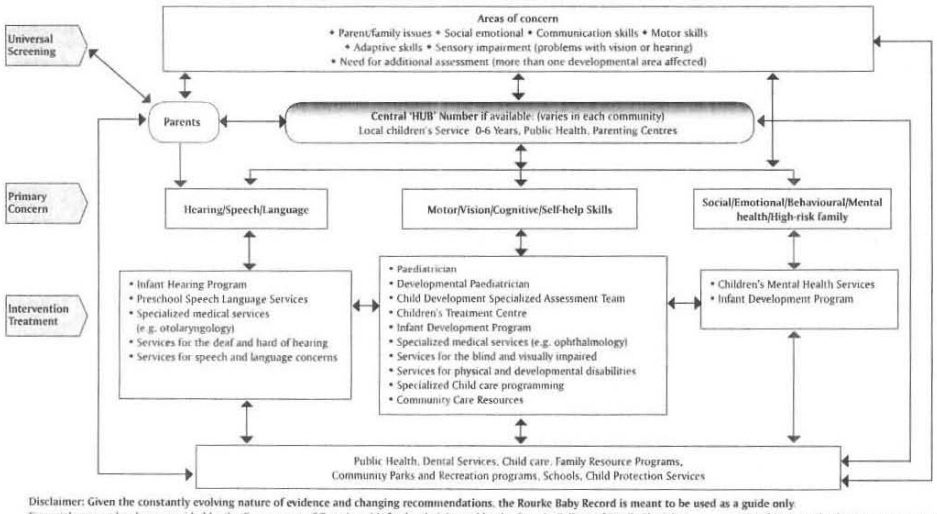
Specific screening for ASD at 18 - 24 months using the M-CHAT should be performed on all children with any of the following: failed items on the social/emotional/communication skills inquiry, sibling with autism, or developmental concern by parent, caregiver, or physician.
If the M-CHAT is abnormal, use the M-CHAT Follow-up Interview to reduce the false positive rate and avoid unnecessary referrals and parental concern. The M-CHAT tool and follow-up interview are found at: www.mchatscreen.com

TOILET LEARNING

The process of toilet learning has changed significantly over the years and within different cultures. In Western culture, a child-centred approach, where the timing and methodology of toilet learning is individualized as much as possible, is recommended.

- www.cps.ca/english/statements/CP/cp00-02.htm
- www.pulsus.com/journals/abstract.jsp?jnlKy=5&atlKy=7859&isuKy=769&isArt=t&HCtype=Consumer

Early Child Development and Parenting Resource System - National



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www.rourkebabyrecord.ca Rourke Baby Record: **RESOURCES 3: Immunization/Infectious Diseases** (July, 2011)

ROUTINE IMMUNIZATION

- **National Advisory Committee on Immunization (NACI) recommended immunization schedules for infants, children and youth can be found at the following website:** www.phac-aspc.gc.ca/naci-ccni/
- **Provincial/territorial immunization schedules** may differ based on funding differences. For provincial/territorial immunization schedules, see Canadian Nursing Coalition on Immunization chart on the website of the Public Health Agency of Canada: www.phac-aspc.gc.ca/im/ptimprog-progimpt/table-1_e.html
- Additional information for parents on vaccinations can be accessed through:
  CPS Parent website - www.caringforkids.cps.ca/immunization/index.htm
  Responding to Parental Refusals of Immunization of Children - pediatrics.aappublications.org/cgi/reprint/115/5/1428
  Dispelling myths held by parents about the influenza vaccine - www.cps.ca/english/statements/ID/DispellingMyths.pdf
- Information for physicians on vaccine safety can be accessed through:
  Presentation on vaccinations - www.cps.ca/english/HealthCentres/FirstShotsBestShot.htm?utm_source=Email-Marketing&utm_medium=email&utm_campaign=First-Shots-Best-Shot
  Autism spectrum disorder: No causal relationship with vaccines - www.cps.ca/english/statements/id/pidnote_jun07.htm
  Vaccine literacy - www.cps.ca/english/statements/ID/VaccineLiteracy.pdf
- AAP recommendation - http://aapredbook.aappublications.org/resources/2009_0-6yrs_Schedule_FINAL.pdf
- **Immunization pain reduction strategies:** During vaccination, pain reduction strategies with good evidence include breastfeeding or use of sweet-tasting solutions, use of the least painful vaccine brand, and consideration of topical anaesthetics.
  www.cmaj.ca/cgi/reprint/182/18/E843?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=Immunization&searchid=1&FIRSTINDEX=0&volume=182&issue=18&resourcetype=HWCIT

VACCINE NOTES (Adapted from NACI website: July 29, 2011)

- **Diphtheria, Tetanus, acellular Pertussis and inactivated Polio virus vaccine (DTaP-IPV):** DTaP-IPV vaccine is the preferred vaccine for all doses in the vaccination series, including completion of the series in children < 7 years who have received ≥ 1 dose of DPT (whole cell) vaccine (e.g., recent immigrants).
- **Haemophilus influenzae type b conjugate vaccine (Hib):** Hib schedule shown is for the Haemophilus b capsular polysaccharide – PRP conjugated to tetanus toxoid (Act-HIBTM) or the Haemophilus b oligosaccharide conjugate - HbOC (HibTITERTM) vaccines. This vaccine may be combined with DTaP in a single injection.
- **Measles, Mumps and Rubella vaccine (MMR):** A second dose of MMR is recommended, at least 1 month after the first dose for the purpose of better measles protection. For convenience, options include giving it with the next scheduled vaccination at 18 months of age or at school entry (4-6 years) (depending on the provincial/territorial policy), or at any intervening age that is practical. The need for a second dose of mumps and rubella vaccine is not established but may benefit (given for convenience as MMR). The second dose of MMR should be given at the same visit as DTaP-IPV (± Hib) to ensure high uptake rates. MMR and varicella vaccines should be administered concurrently (at different sites if the MMRV [combined MMR/varicella] is not available) or separated by at least 4 weeks.
- **Varicella vaccine:** Children aged 12 months to 12 years who have not had varicella should receive 2 doses of varicella vaccine (univalent varicella or MMRV). Unvaccinated individuals ≥ 13 years who have not had varicella should receive two doses at least 28 days apart (univalent varicella only). Consult NACI guidelines for recommended options for catch-up varicella vaccination. Varicella and MMR vaccines should be administered concurrently (at different sites if the MMRV [combined MMR/varicella] vaccine is not available) or separated by at least 4 weeks.
- **Hepatitis B vaccine (Hep B):** Hepatitis B vaccine can be routinely given to infants or preadolescents, depending on the provincial/territorial policy. The first dose can be given at 2 months of age to fit more conveniently with other routine infant immunization visits. The second dose should be administered at least 1 month after the first dose, and the third at least 2 months after the second dose, but again may fit more conveniently into the 4- and 6-month immunization visits. A two-dose schedule for adolescents is an option. For infants born to chronic carrier mothers, the first dose should be given at birth (with Hepatitis B immune globulin). (See also SELECTED INFECTIOUS DISEASES RECOMMENDATIONS below.)
- **Pneumococcal conjugate vaccine 13-valent (Pneu-Conj):** Recommended schedule, number of doses and subsequent use of 23 valent polysaccharide pneumococcal vaccine depend on the age of the child, previous administration of -7 or-10 valent vaccine, if at high risk for pneumococcal disease, and when vaccination is begun. Consult NACI guidelines for maximizing coverage up to 59 months of age.
- **Meningococcal conjugate vaccine (Men-C):** www.cps.ca/english/statements/ID/ID09-02.htm - Monovalent vaccine to Type C (Men-C-C) is indicated for all ages, and quadravalent to Types A/C/W/Y (Men-C-ACWY) for age 2 yrs and over. Recommended vaccine, schedule and number of doses of meningococcal vaccine depend on the age of the child and vary between provinces/territories. Possible schedules include:
  - Men-C-C: 2 - 3 doses under 12 mos of age AND booster dose between 12 - 24 mos age.
    OR
  - Men-C-C: 1 dose at 12 mos of age.

  Men-C-C or Men-C-ACWY booster dose should also be given at 12 yrs of age or during adolescence.
- **Diphtheria, Tetanus, acellular Pertussis vaccine - adult/adolescent formulation (dTap):** a combined adsorbed "adult type" preparation for use in people ≥ 7 years of age, contains less diphtheria toxoid and pertussis antigens than preparations given to younger children and is less likely to cause reactions in older people. This vaccine should be used in individuals > 7 years receiving their primary series of vaccines.
- **Influenza vaccine:** Recommended for all children between 6 and 23 months of age, and for older high-risk children. Previously unvaccinated children up to 9 years of age require 2 doses with an interval of at least 4 weeks. The second dose is not required if the child has received one or more doses of influenza vaccine during the previous immunization season.
- **Rotavirus vaccine:** Universal rotavirus vaccine is recommended by NACI and CPS. Two oral vaccines are currently authorized for use in Canada: Rotarix (2 doses) and RotaTeq (3 doses). Dose #1 is given between 6 wks and 14 wks/6 days with a minimum interval of 4 weeks between doses. Maximum age for the last dose is 8 mos/0 days. www.cps.ca/english/statements/ID/ID10-01.htm - www.phac-aspc.gc.ca/publicat/ccdr-rmtc/10vol36/acs-4/index-eng.php - www.cps.ca/English/statements/ID/ID10-01.htm

SELECTED INFECTIOUS DISEASES RECOMMENDATIONS

See CPS position statements of the Infectious Diseases and Immunization Committee: www.cps.ca/english/publications/InfectiousDiseases.htm

- **Hepatitis B immune globulin and immunization:**
  Infants with HBsAg-positive parents or siblings require Hepatitis B vaccine at birth, at 1 month, and 6 months of age.
  Infants of HBsAg-positive mothers also require Hepatitis B immune globulin at birth and follow-up immune status at 9 – 12 months for HBV antibodies and HBsAg.
  Hepatitis B vaccine should also be given to all infants from high-risk groups, such as:
  - infants where at least one parent has emigrated from a country where Hepatitis B is endemic;
  - infants of mothers positive for Hepatitis C virus;
  - infants of substance-abusing mothers.
- **Human Immunodeficiency Virus type 1 (HIV-1) maternal infections:**
  Breastfeeding is contraindicated for an HIV-1 infected mother even if she is receiving antiretroviral therapy.
- **Hepatitis A or A/B combined (when Hepatitis B vaccine has not been previously given):**
  These vaccines should be considered when traveling to countries where Hepatitis A or B are endemic.
- **Tuberculosis - TB skin testing:**
  TB skin testing should be done if the infant is living with anyone being investigated or treated for TB. TB skin testing should also be considered in high-risk groups, including Aboriginal people, immigrants and long-term travellers from areas with a high prevalence of TB.

Center for Hearing and Communication
Connect to Life®

Ototoxic Medications

Drugs that Can Cause Hearing Loss and Tinnitus

Certain medications can cause damage to your hearing or aggravate an existing hearing issue.

Hearing problems (such as a hearing loss or ringing in the ear) resulting from ototoxic medications typically occur when the recommended dosage is exceeded. Often these problems are reversible upon discontinuation of the drug. Occasionally there are times when this change in hearing can be permanent.

If you are experiencing a hearing problem, or if there is a hearing disorder in your family, it is imperative that your treating physician and pharmacist be aware of this fact.

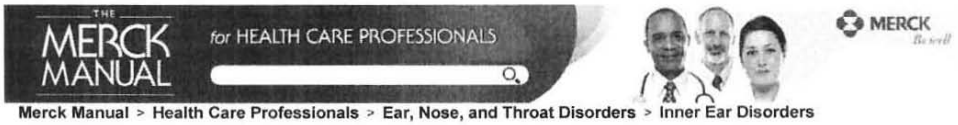
The Center for Hearing and Communication encourages you to take responsibility in knowing which drugs you should try to avoid.

Ototoxic medications include certain antibiotics, chemotherapeutic drugs, diuretics, and salicylates in high doses. To learn more about ototoxic medications, visit the Merck or Purdue website:

http://www.merckmanuals.com/professional/ear_nose_and_throat_disorders/inner_ear_disorders/drug-induced_ototoxicity.html#v944787

http://www.purdue.edu/hhs/slhs/documents/ototoxicguide.pdf

Center for Hearing and Communication ● 50 Broadway ● New York, NY 10004
(917) 305-7700 (Phone) ● (917) 305-7888 (Fax) ● info@CHChearing.org



Drug-Induced Ototoxicity

A wide variety of drugs can be ototoxic (see see Some Drugs that Cause Ototoxicity).

Factors affecting ototoxicity include dose, duration of therapy, concurrent renal failure, infusion rate, lifetime dose, coadministration with other drugs having ototoxic potential, and genetic susceptibility. Ototoxic drugs should not be used for otic topical application when the tympanic membrane is perforated because the drugs might diffuse into the inner ear.

Streptomycin tends to cause more damage to the vestibular portion than to the auditory portion of the inner ear. Although vertigo and difficulty maintaining balance tend to be temporary, severe loss of vestibular sensitivity may persist, sometimes permanently. Loss of vestibular sensitivity causes difficulty walking, especially in the dark, and oscillopsia (a sensation of bouncing of the environment with each step). About 4 to 15% of patients who receive 1 g/day for > 1 wk develop measurable hearing loss, which usually occurs after a short latent period (7 to 10 days) and slowly worsens if treatment is continued. Complete, permanent deafness may follow.

Neomycin has the greatest cochleotoxic effect of all antibiotics. When large doses are given orally or by colonic irrigation for intestinal sterilization, enough may be absorbed to affect hearing, particularly if mucosal lesions are present. Neomycin should not be used for wound irrigation or for intrapleural or intraperitoneal irrigation, because massive amounts of the drug may be retained and absorbed, causing deafness. Kanamycin and amikacin are close to neomycin in cochleotoxic potential and are both capable of causing profound, permanent hearing loss while sparing balance. Viomycin has both cochlear and vestibular toxicity. Gentamicin and tobramycin have vestibular and cochlear toxicity, causing impairment in balance and hearing.

Vancomycin can cause hearing loss, especially in the presence of renal insufficiency.

Chemotherapeutic (antineoplastic) drugs, particularly those containing platinum (cisplatin and carboplatin), can cause tinnitus and hearing loss. Hearing loss can be profound and permanent, occurring immediately after the first dose, or can be delayed until several months after completion of treatment. Sensorineural hearing loss strikes bilaterally, progresses decrementally, and is permanent.

Ethacrynic acid and furosemide given IV have caused profound, permanent hearing loss in patients with renal failure who had been receiving aminoglycoside antibiotics.

Salicylates in high doses (> 12 325-mg tablets of aspirin per day) cause temporary hearing loss and tinnitus. Quinine and its synthetic substitutes can also cause temporary hearing loss.

Table 1
Some Drugs that Cause Ototoxicity

Type	Examples
Antibiotics	Aminoglycosides
	Vancomycin
Chemotherapeutic drugs	Platinum-containing drugs (eg, cisplatin)

Diuretics	Ethacrynic acid
	Furosemide
Other	Quinine
	Salicylates

Prevention

Ototoxic antibiotics should be avoided during pregnancy. The elderly and people with preexisting hearing loss should not be treated with ototoxic drugs if other effective drugs are available. The lowest effective dosage of ototoxic drugs should be used and levels should be closely monitored. If possible before treatment with an ototoxic drug, hearing should be measured and then monitored during treatment; symptoms are not reliable warning signs.

Key Points

- Drugs may cause hearing loss, dysequilibrium, and/or tinnitus.
- Common drugs include aminoglycosides, platinum-containing chemotherapy drugs, and salicylates.
- Symptoms may be transient or permanent.
- Drugs are stopped if possible, but there is no specific treatment.

Last full review/revision October 2012 by Lawrence R. Lustig, MD
Content last modified September 2013

Standard Appointment

The PHN Managers have previously discussed and agreed to make child health clinic appointments a standard 30 minutes effective with the implementation of the new Child Health Clinic Guidelines for Standard practice. Pilot testing prior to the implementation of Panorama, has demonstrated that the new Saskatchewan Child Health Clinic Guidelines for Standard Practice can be delivered to most clients in 30 minutes.

Parental concern and immunization against vaccine preventable diseases is the primary focus of the CHC appointment. If the parental concern expressed relates to immunization, nutrition or growth, the PHN can address that concern during the time the assessment is being done. If the parental concern is of another nature, the PHN can determine when to best address the concern, before or after immunization or at another opportunity such as offering a home visit.

The concept of Standard Work for CHCs is being further discussed and explored at the Managers of Public Health Nursing in Saskatchewan Committee as of May 2015. More details about this concept and recommended practice will be placed in this appendix at a future date.

Recommended Standard Flow for CHC

1. Prepare for immunization appointment by:
   - Reviewing the client profile report, warnings, risk factors, Imms Interpretation.
   - Bring up Record and Update Imms to determine what vaccines the clients is eligible for and verify against the Forecaster.
2. Bring client into room and inquire as to parental concerns. Indicate will address concerns after immunization.
3. Initiate informed consent process, including confirming identify, reviewing pre-screen questions, identifying new risk factors or contraindications and document.
4. Review Vaccine Fact sheets with a focus on contraindications, side effects and answer any questions.
5. Obtain or verify consent for all vaccines and document.
6. Complete weight and height.
7. Prepare vaccine including reviewing name of vaccine and expiry date with client.
8. Administer vaccine and document.
9. Print Client Profile.
10. Address parental concerns, including nutrition/oral health and other identified assessments and documents.
11. Review client profile report pointing out next vaccine/CHC due date.

Government of Saskatchewan
Ministry of Social Services

Child Protection Services

about

For further information please call your local service area office (*see page 4*).

Educational handouts in the ***about*** series are available from:

Communications Division
Saskatchewan Ministry of Social Services
1920 Broad Street
Regina SK S4P 3V6

Visit us on our web site and follow the links:

www.socialservices.gov.sk.ca

Recycled Paper

FAM-4 01/13

We all share the responsibility for making sure every child is safe and cared for. When parents cannot or will not care for, supervise, and protect their children, someone else may have to step in to make sure the child's needs are being met.

The Ministry of Social Services provides child protection services. The Ministry is given the authority to do this by *The Child and Family Services Act.* First Nations Child and Family Services Agencies provide similar services to children and families living on-reserve.

According to *The Child and Family Services Act,* unless it is otherwise stated, a child means an unmarried person under the age of 16 years.

What is child abuse or neglect?

There are many forms of child abuse. Generally, abuse means anything that may be harmful to a child's physical, emotional or psychological health, or that takes advantage of a child.

- **Physical abuse** — any action, including discipline, which causes injury to the child's body.
- **Sexual abuse** — any action to involve a child in a sexual activity including sexual touching, exposure, using a child in the making of/or viewing pornography, and/or involving a child in prostitution.
- **Emotional mistreatment** — expecting a child to be able to do things he or she cannot do, embarrassing or insulting a child, making hurtful comments about a child's appearance, intelligence, size, ability, etc.
- **Neglect** — failing to provide a child with enough good food, proper clothing, shelter, health care, or supervision.

Why do people abuse or neglect their children?

Parenting can be a tough job. Some people have trouble handling all of the responsibility and pressure that comes with being a parent. Some parents do not understand that their children are not always able to do the things they expect them to do. Sometimes this leads to abuse or neglect.

Being abused or neglected may lead to lifelong problems. There are many things that can lead a parent to abuse a child, including:

- marriage, personal or financial problems;
- alcohol, drug or other substance abuse;
- lack of family or friends;
- poor or over-crowded housing;
- lack of knowledge about how children develop;
- inappropriate discipline;
- little or no experience caring for children;

- demands of a child with a special need; and
- being abused or neglected as a child.

Can abuse and neglect be prevented?

Yes. Child abuse and neglect can be prevented by helping parents to:

- learn about what is normal in terms of their child's development and what they can expect at certain ages;
- improve their parenting skills, including how to use proper discipline;
- learn how to settle family conflicts;
- learn to deal with stress; and
- recognize and seek help for drug, alcohol, gambling or other addictions.

How can I help stop child abuse and neglect?

If you have reason to believe a child is being abused or neglected, it is important to remember that **it is NEVER the child's fault.**

As a parent — If you think you may be abusing your child or you are afraid you may abuse your child, or if you would just like information or someone to talk to, call the nearest office of the Ministry of Social Services. *(See page 4.)*

Asking for help does not mean you are a poor parent. Just the opposite — it means that you care about your child and want to do the best job you can.

As a member of the community — If you have reason to believe a child may be neglected or abused, you have a legal responsibility under *The Child and Family Services Act* to report your concerns. You may report them to the Ministry of Social Services, the police, or a First Nations Child and Family Services agency.

You are asked to report your suspicions. You are not expected to figure out who may have caused the abuse or neglect.

If you are not sure whether or not you should report a particular situation, you may wish to discuss it with a child protection worker or the police.

If I make a report — what happens then?

All reports of abuse or neglect are investigated by trained, professional staff. They will usually discuss the situation with the family and decide what would be the best plan for the child and the family.

As noted above, everyone has a responsibility to report a situation where they believe a child may be in need of protection. Most people who report possible abuse or neglect do so because they have a real concern about the child's safety and well-being.

Sometimes, though, a person may make a false report out of spite, anger, revenge or a desire to cause problems for a parent. Any person who does this may have legal action taken against them by the person against whom the false report is made.

What are the signs that a child may be abused or neglected?

There are usually signs that a child is being abused or neglected. The signs may be physical which means it is possible to see them. In other cases, the child's behaviour may lead to concerns about abuse. Often, one sign is not enough to suggest abuse or neglect, but several signs or a pattern of signs make it more likely that abuse or neglect may exist. The following chart lists a number of physical signs and types of behaviour which might suggest abuse or neglect.

	Physical Indicators	Behavioural Indicators
Physical Abuse	• injuries (bruises, cuts, burns, bite marks, fractures, etc.) that are not consistent with explanation offered (e.g., extensive bruising to one area) • the presence of several injuries over a period of time • any bruising on an infant • facial injuries in preschool children (e.g., cuts, bruises, sores, etc.) • injuries inconsistent with the child's age and development	• cannot recall how injuries occurred, or offers an inconsistent explanation • wary of adults or reluctant to go home, absences from school • may cringe or flinch if touched unexpectedly • may display a vacant stare or frozen watchfulness • extremely aggressive or extremely withdrawn • wears long sleeves to hid injury • extremely compliant and/or eager to please • sad, cries frequently
Emotional Abuse	• bedwetting and/or diarrhea which is non-medical in origin • frequent psychosomatic complaints: headaches, nausea, abdominal pain • child fails to thrive Rarely is any one indicator conclusive proof that a child has been harmed. In most instances, children present a cluster of behavioural and physical indicators.	• extreme withdrawal or aggressiveness, mood swings • overly compliant; too well-mannered; too neat and clean • extreme attention-seeking behaviours • displays extreme inhibition in play • poor peer relationships • severe depression, often suicidal • running away from home • constantly apologizes
Sexual Abuse	• unusual or excessive itching in the genital or anal area • torn, stained or bloody underwear (observed if the child requires bathroom assistance) • pregnancy or venereal disease • injuries to the vaginal or anal areas (e.g., bruising, swelling or infection) While the above are not conclusive indicators of sexual abuse, one or more could be a sign that a child needs help.	• age-inappropriate sexual play with toys, self, others (e.g., replication of explicit sexual acts) • age-inappropriate, sexually explicit drawings and/or descriptions • bizarre, sophisticated or unusual sexual knowledge • promiscuity • prostitution • seductive behaviours • fear of home, excessive fear of men or women • depression
Neglect	• abandonment • unattended medical or dental needs • consistent lack of supervision • consistent hunger, inappropriate dress, poor hygiene • persistent conditions (e.g., scabies, head lice, diaper rash or other skin disorder) • developmental delays (e.g., language, weight)	• regularly displays fatigue or listlessness, falls asleep in class • steals food, begs from classmates • reports that no caretaker is at home • frequently absent or late • self-destructive • school drop-outs (adolescents)

Social Services Child Protection Offices

Buffalo Narrows 1-800-667-7685
Waite Street 306-235-1700
S0M 0J0

Creighton 1-800-532-9580
1st Street East 306-688-8808
S0P 0A0

Estevan 306-637-4550
1219 - 5th Street
S4A 0Z1

Fort Qu'Appelle 1-800-667-3260
177 Segwun Avenue 306-332-3260
S0G 1S0

Kindersley 306-463-5470
125 1st Avenue East
S0L 1S0

La Loche 1-877-371-1131
La Loche Avenue 306-822-1711
S0M 1G0

La Ronge 1-800-567-4066
1320 La Ronge Avenue 306-425-4544
S0J 1L0

Lloydminster 1-877-367-7707
4910 - 50th Street 306-820-4250
S9V 1Z5

Meadow Lake 1-877-368-8898
Unit 5, 101 Railway Place 306-236-7500
S9X 1X6

Melfort 1-800-487-8640
107 Crawford St. E. 306-752-6100
S0E 1A0

Moose Jaw 306-694-3647
36 Athabasca Street E.
S6H 6V2

Nipawin 1-800-487-8594
210 - 1st Street E. 306-862-1700
S0E 1E0

North Battleford 1-877-993-9911
#300, 1146 - 102 St. 306-446-7705
S9A 1G1

Prince Albert 1-866-719-6164
800 Central Avenue 306-953-2422
S6V 6G1

Regina 306-787-3760
2045 Broad Street
S4P 3V6

Rosetown 306-882-5400
122 - 2nd Avenue North
S0L 2V0

Saskatoon 1-877-884-1687
122 - 3rd Avenue North 306-933-5961
S7K 2H6

Swift Current 306-778-8219
350 Cheadle Street West
S9H 4G3

Weyburn 306-848-2404
110 Souris Avenue N.E.
S4H 2Z9

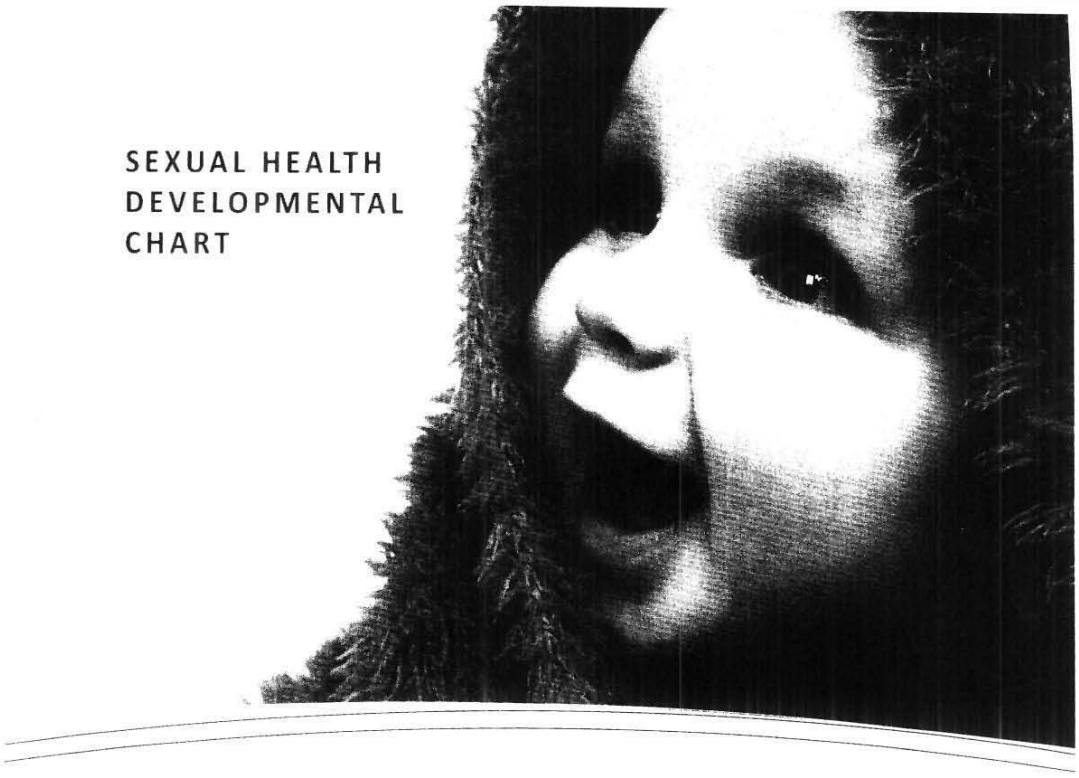
Yorkton 306-786-1300
72 Smith Street East
S3N 2Y4

After Hours Crisis Services

Prince Albert 306-764-1011
Saskatoon 306-933-6200
Regina 306-569-2724

Other Communities ..... Local Police

SEXUAL HEALTH DEVELOPMENTAL CHART



References

13-16 Years

9-12 Years

5-8 Years

2-5 Years

Birth-2 Years

HOW YOUR CHILD DEVELOPS

- Normal Sexual Development
- Healthy Sexual Development
- Sexual Health Promotion and Prevention of Abuse

saskatchewan
preventioninstitute
our goal is healthy children

Can be accessed through Sask Prevention Institute.

Vocabulary Checklist

Date:	Age:	Vocabulary Size:

Child's Name:_____

Actions:
bath
bring
catch
clap
climb
close
come
cough
cuddle
cut
cry
dance
eat
fall
feed
finish
fix
fly
get
give
go
have
help
hit
hug
jump
kick
kiss
knock
laugh
look
love
make
nap
need
open
peek
pee
pooh
pop
pull
push
read
ride
run
see
show
shut
sing
sit
skip
sleep
smile
splash
stop
swim
swing
take
throw
tickle
walk
want
wash
wear
wiggle
wipe

Food:
apple
banana
beans
bread
broccoli
butter
cake
candy
carrots
cereal
cheese
coffee
cookie
corn
cracker
drink
egg
food
grapes
gum
hamburger
hotdog
icecream
juice
meat
milk
orange
peas
pizza
pop
pretzel
raisins
soup
spaghetti
tea
toast
water
yogurt
other foods:
_____
_____

Toys:
ball
balloon
barn
blocks
book
bubbles
crayons
doll
game
markets
present
puzzle
slide
swing
teddy bear
other toys:
_____
_____

People:
aunt
baby
boy
daddy
doctor
girl
grandma
grandpa
lady
man
mommy
own name
uncle
other names:
_____
_____

Pronouns:
me
my
myself
you
your
she
he
his/her
him/her
I
They
we

Body Parts:
arm
belly
button
bum
chin
ear
elbow
eye
eyebrow
eyelash
face
finger
foot
hair
hand
knee
leg
mouth
neck
nose
teeth
thumb
toe
tongue
tummy

Vehicles:
bike
boat
bus
car
motorcycle
plane
scooter
stroller
train
truck

Places:
cabin
church
daycare
home
hospital
library
outside
park
pool
school
store
zoo

Animals:
animal sounds
bear
bee
bird
bug
bunny
butterfly
cat
chicken
cow
dog
dinosaur
duck
elephant
fish
frog
horse
lion
monkey
mouse
moose
pet's name:
_____
pig
puppy
snake
spider
tiger
turkey
turtle

Household:
bathtub
bed
blanket
bottle
bowl
chair
clock
cloth
crib
cup
door
floor
fork
garbage
glass
knife
light
mirror
movie
pillow
plate
potty
radio
room
sink
soap
spoon
stairs
table
telephone
towel
TV
Window

Personal:
bag
brush
cell phone
comb
glasses
key
money
paper
pen
pencil
purse
tissue
toothbrush
toothpaste
umbrella
watch

Clothes:
belt
boots
coat
diaper
dress
gloves
hat
jacket
mittens
pyjamas
pants
running shoes
scarf
shirt
shoes
shorts
slippers
socks
sweater
swimsuit

Outdoor:
Cloud
dirt
flower
garden
grass
house
lake
leaf
moon
mud
pond
puddle
rain
sidewalk
sky
snow
star
street
sun
tree

Location words:
down
here
in
off
on
out
over
there
under
up

Descriptive words:
bad
big
colour words:
_____
_____
_____
broken
bumpy
clean
cold
cute
dark
dirty
dry
fast
fuzzy
good
happy
hard
heavy
hot
hungry
little
mad
nice
pretty
rough
sad
shiny
slow
smooth
soft
sticky
stinky
thirsty
tired
warm
wet
yucky
yummy

Other:
ABC's
all done
all gone
alright
away
bye
excuse me
good morning
good night
hi/hello
this
that
more
no
ouch
please
thank you
welcome
what
where
why
yes

Other Words: _____
_____
_____
_____
_____

Saskatoon Health Region

Appendix C
Procedure for 5A's of Tobacco Intervention

References:

Preventing Children's Exposure to Secondhand smoke and Tobacco Cessation Intervention
(PHS Libraries)

Protecting Your Children from Secondhand smoke
(PHS Pamphlet)

Are You Thinking about Quitting Smoking or Other Tobacco Products
(SHR Pamphlet)

Part 1: Brief Tobacco Intervention - Child(ren)'s Exposure to Secondhand Smoke

☐ **1. ASK** about secondhand smoke exposure (SHS) with all clients during all PHS direct client contacts. Best practice literature indicates that clients expect their health care professionals to ask about smoking and cessation.

Place a check mark in the **1. Ask** box

"Does your child(ren ever breathe in secondhand smoke?"

→

When response is "NO":

Congratulate and reinforce benefits of smoke-free air and reduced risk of SIDS, asthma, lung cancer, heart disease and tooth decay.

→

Continue to ask "So, do you or anyone in your household use tobacco?"

If response is "yes" and it is the presenting parent, proceed to side 2.

If it is other family member – offer cessation information.

↓

If the client responds "Yes, their child(ren) is exposed".

☐ **2. ADVISE** about protecting children from SHS exposure by giving a strong personalized message such as *"The most important advice I can give you is to keep your child(ren) from breathing second hand smoke and I can help."*

Place a checkmark in the **2. ADVISE** box

Proceed to **3. ASSESS**

↓

☐ **3. ASSESS**

☐ where the smoking around the child(ren) is occurring (home, vehicle, family/friends, daycare, other)

☐ who is smoking around the child(ren) (parents, grandparents/relatives, childcare providers, other)

Proceed to **4. ASSIST**

↓

4. ASSIST by providing Motivational Intervention

Provide client with "Protecting Your Children From Secondhand Smoke" booklet. Review relevant sections of the booklet in relation to the Motivational Interventions listed below.

Note: The motivational interventions under ASSIST follow the booklet order, but they do not need to be used in this order. After assessing, the chosen motivational intervention will be based on client's situation. You may choose one area to provide information, or deal with as many as possible. Base this on the client's need, willingness and time constraints.

☐☐☐**With each intervention addressed, put a check mark in the box.**

Risks:
You are probably aware of the health problems caused by children breathing secondhand smoke. Tell me about the ones that really worry you.
Relevant section: Effects of Secondhand Smoke on Children.

The dialogue printed in blue on master copy of flow chart is a suggestion – you will find your own style and may have already altered this information. Most clients know there are dangers to SHS, but research is always adding new risks (i.e. more likely to develop learning, memory and language problems, ADD and increased dental caries). One of these risks may be the motivation parents need to protect children all of the time

Relevance:
You do many things to protect your children (i.e. bringing them for immunization). Do you think that reducing secondhand smoke is an important thing to do to help your children be healthy?
Relevant section: Protect Your Children From Secondhand Smoke

Acknowledging the ways parents care for their children is positive and confirming, (i.e. bringing your child for immunization or holding their hands when outside - you can always find something positive); showing that protecting their children from SHS is another thing they can do.

Giving parents suggestions on how to keep their home and car smoke-free may be what is needed to make changes in their children's environment. The best choice is keeping a child's world completely smoke-free; however reducing the amount of secondhand smoke exposure is a beginning. Start with small steps and build on them, including having parents look at their smoking habits.

Rewards:
It may be hard to protect your children from secondhand smoke. What are the benefits for you and your children when you are able to provide a smoke-free environment all of the time?
Relevant section: Benefits of a Smoke-Free Environment

It's important to acknowledge the daily challenges parents have in protecting children from SHS; however, reinforcing the rewards for parents and baby may be influential. Especially with low income, single parents who smoke by emphasizing their own health rather than just health benefits for baby, appears to foster motivation to quit.

70% of women stop smoking for pregnancy and 6 months after birth. They look forward to smoking as a reward for temporarily quitting and describe their relapse as a way to manage the stress of caring for a new baby. Smoking was a coping strategy that worked in the past and they see no alternative but to return.

Roadblocks:
You may feel a smoke-free environment is not possible all of the time. What is making it difficult for you to create a smoke-free environment?
Relevant section: Challenges, supplementary tear sheets

Moving families forward to protecting their children from secondhand smoke all of the time may require people to look deeper into their own situation and what is making this goal difficult to achieve.

Research shows that an approach that includes decision making and motivation (not just advice about quitting smoking or general information) is necessary for success with the committed smoker, especially low income, single parents.

Referring parents to supplementary tearsheets assists those parents who are smoking to think about their smoking. Tearsheets include: *Why Do I Smoke?, Identify Your Triggers, Coping with Cravings* and *Ideas to Keep your Hands Busy.*

4. ASSIST (Continued)

Repetition:
Repeat any of the above interventions until smoke-free environments are established all of the time.

When time permits or when this is identified as a major area of concern by the client, you would focus your time exploring the motivational interventions.

The check boxes will indicate where time was spent and with consistent nurse CHC, follow-up and tailored individual counselling will be supported.

↓

5. ARRANGE for further assistance, if required.

Refer to contact list on the back of "Protecting Your Children from Secondhand Smoke".

Providing this booklet is the minimum expectation in all client contacts.

☐ **If presenting parent is a smoker, proceed to Part 2**

Part 2: Brief Tobacco Intervention – Quitting Tobacco

When the presenting parent is a smoker the PHN will implement **The 5A's of Brief Tobacco Intervention – Quitting Tobacco**

The PHN would have already talked about protecting the children from exposure to secondhand smoke.

☐ **1. ASK**:
What type of tobacco do you use?
- ☐ cigarettes
- ☐ cigars
- ☐ pipe
- ☐ snuff
- ☐ chewing tobacco

We ask this question to raise awareness to all forms of tobacco. Some people think cigars, pipes and spit tobacco are not as harmful.

When client is not asked about all forms of tobacco, this information may not be voluntarily offered.

→

☐ **2. ADVISE:**
The most important advice I can give you is to quit and I can help.

A strong personal message – a key part of this statement is "I can help". This has been shown to significantly increase success with cessation

→

☐ **3. ASSESS:**
Are you thinking about quitting?

- ☐ Yes
  - ☐ In next 6 months (contemplation)
  - ☐ In next 30 days and set quit date (preparation)
  - ☐ Want to quit now (action)
- ☐ No
  - ☐ Not ready (pre-contemplation)

If client says "yes" – check corresponding box. A client may be at a stage for a while as they move from contemplation to preparation to action.

☐ **4. ASSIST** (for those in contemplation, preparation, or action stages)

YES
(Thinking about Quitting)

Home Visit/Phone ⟷ **Clinic**

4. ASSIST
Intensive Intervention:
☐ Provide:
"Are You Thinking About Quitting Smoking or Other Tobacco Products? Booklet.
Relevant section: Five Steps for Quitting

- Assist client to set quit date
- Review potential challenges and triggers
- Discuss Pharmacotherapy options
- Use of NRT related to breastfeeding
- Determine client needs for further support

4. ASSIST
Brief Intervention:
☐ Provide:
"Are You Thinking About Quitting Smoking or Other Tobacco Products" booklet.

For home visits and phone calls, provide the "*Are you Thinking About Quitting Smoking or other Tobacco Products?*" More intensive intervention is possible. Use booklet to review 5 Steps for Quitting, review potential challenges, triggers (use tearsheets), discuss pharmacotherapy options, use of NRT related to breastfeeding/pregnancy and other needed supports.

In CHC, the expectation for intervention is brief. Offer *"Are You Thinking About Quitting Smoking or Other Tobacco Products?"* booklet.

Note: Products used intermittently (gum, inhaler) are preferred to continued smoking to minimize exposure of the fetus or breastfed baby to nicotine – avoid NRT for approximately 2-3 hours before breastfeeding.

↓

☐ **5. ARRANGE**

Refer to cessation/community resources

- Community Addiction Services (655-4100)
- Smokers Helpline (1-877-513-5333)
- Community Pharmacist
- Physician
- Nurse Practitioner
- www.gosmokefree.ca

Follow up at next encounter as needed.

Most smokers attempt to quit 4 – 11 times. Since only 20 – 40% succeed with the first attempt, client may be interested in more than one resource.

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☐ **4. ASSIST** (for those in contemplation, preparation, or action stages)

NO
(Thinking about Quitting)

Home Visit/Phone ⟵ ⟶ **Clinic**

4. **ASSIST/5 R's**
Intensive Intervention:
☐ Provide:
- *"Are You Thinking About Quitting Smoking or Other Tobacco Products?* Booklet in relation to Motivational Intervention listed below.

4. **ASSIST**
Brief Intervention:
☐ Offer:
- *"Smokers Who Don't Want to Quit"* tearsheet.

When the client indicates they are not ready to think about quitting:

For **Home Visits/Phone:**

- PHN provides the *"Are You Thinking About Quitting Smoking and Other Tobacco Products?"* booklet (review relevant sections) in relation to the Motivational Interventions.
- PHN selects a Motivational Intervention based on client needs.
- PHN places a checkmark in the box to indicate progress in order to follow-up at next contact.

In **CHC,** again the expectation for intervention is brief.
- Offer the tearsheet *"For Smokers Who Don't Want To Quit";* PHN will have access to free copies of this booklet for clients who have limited resources. PHS has to purchase copies so there are limited supplies. If client orders their own, they are free.
- There is space for notes on the cessation side of the flowchart.

Relevance: ***Do you feel quitting smoking is an important thing to do for yourself and others around you?***
Relevant section: Good Reasons for Quitting

As with decreased SHS, motivation to quit smoking must be based on client's need and therefore, tailoring information is important. Relevant section – Good Reasons for Quitting, lists benefits of quitting (strength based and positive).

Risks: ***What effect do you think your continued smoking will have on you and others around you?***
Relevant section: Secondhand Smoke

Exploring the issue of SHS and how smoking affects others – children and client themselves may be the motivational strategy for your client contact

Rewards:
Can you identify the benefits of quitting for yourself and not smoking around others?
Relevant section: Good Reasons for Quitting, Secondhand Smoke

Providing information on the benefits of cessation for client and children would be helpful. Supplementary tearsheets will introduce new skills. For example, instead of smoking– what could you do instead? *(Identify Your Triggers, Ideas to Keep Your Hands Busy* tearsheets*)*

Roadblocks:
What is stopping you from quitting?
Relevant section: Questions to Think About

Thinking about the smoking habit may be the motivation necessary in "Questions to Think About" or tearsheet *"Why Do I Smoke?."* This tearsheet may be especially helpful to women smokers where the function of smoking may be to suppress their appetite, give them a sense of control, a break, a reward or deal with difficult emotions – they call tobacco their best friend. Many women have not looked at the WHY's of smoking; therefore, this discussion may create some insight and motivation to quit.

Repetition:
Repeat interventions until smoker expresses interest in quitting.

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☐ **5. ARRANGE (for either Home Visit/Phone or Clinic)**

☐ Reassess at next clinic visit

OR

☐ Refer to cessation/community resources

DOCUMENTATION

For HGD-15 charts printed prior to 2010:

- record directly onto flowsheet using documentation key as indicated on the algorithm.

For HGD-15 charts printed in 2010:

Situation 1: No exposure to secondhand smoke and no household use of tobacco products:

- check NO under exposure to secondhand smoke on the front of the HGD-15.

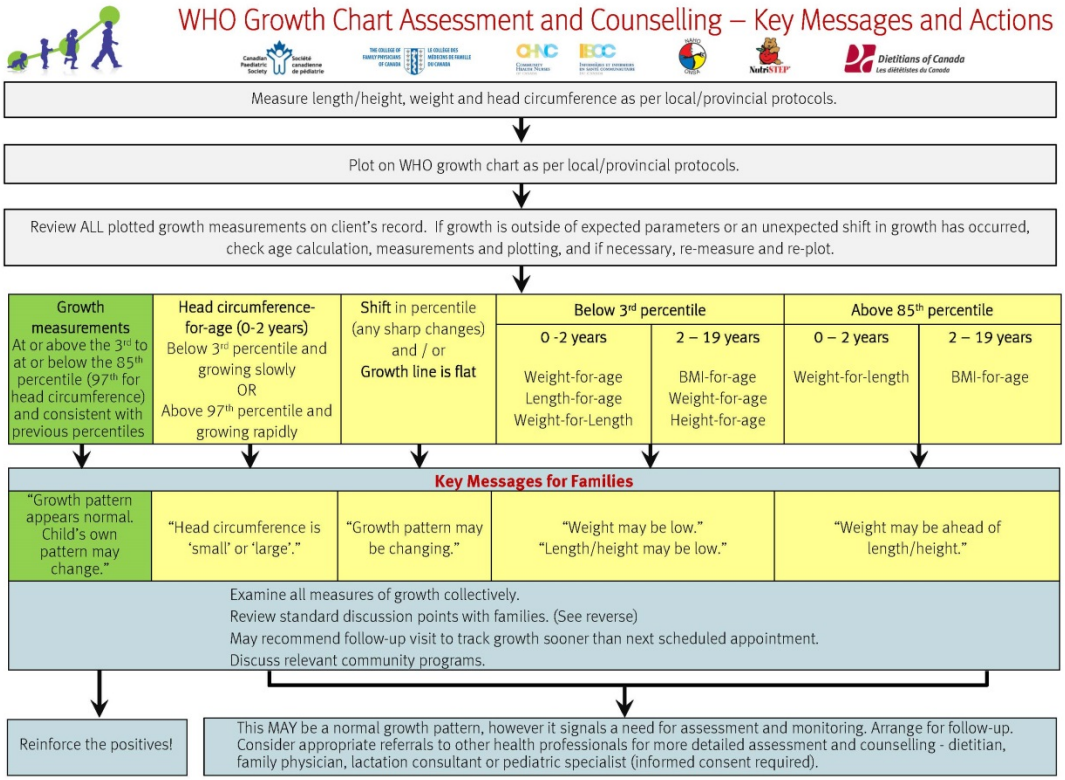
Situation 2: Exposure to secondhand smoke

- Check YES on the front of the HGD-15
- Check (✓) under smoking cessation on HGD-15
- Attach a copy of "The 5A's of Brief Tobacco Intervention" to the HGD-15
- Record directly onto flowsheet using documentation key as indicated on the algorithm

Situation 3: No Exposure to secondhand smoke and tobacco is used by someone in the household (occasional or regular basis).

- Check NO under SHS exposure on the front of the HGD-15
- Check (✓) under smoking cessation on the HGD-15
- Attach a copy of the tobacco flowsheet to the HGD-15
- Record directly onto flowsheet using documentation key as indicated on algorithm.

- NOTE: once a tobacco flowsheet is attached to the HGD-15, complete all future documentation on the flowsheet. There is no need to record directly onto the HGD-15 (duplicate charting).



WHO GROWTH CHART ASSESSMENT AND COUNSELLING – KEY MESSAGES AND ACTIONS

CORE GROWTH MESSAGES

- Measurements are health SCREENING tools.
- Growth is one of the signs of GENERAL HEALTH.
- Growth patterns are assessed for the INDIVIDUAL.
- Growth may reflect FAMILY growth patterns.
- Growth pattern OVER TIME is more important than one single measurement.

COUNSELLING: STANDARD DISCUSSION POINTS

0-2 years	*2-19 years*
• BREASTFEEDING pattern and technique • Formula feeding – pattern; technique; preparation; etc. • Age-appropriate milk, beverages and introduction to solid foods	• Intake of foods high in fat, sugar or salt • Body image issues • Disordered eating pattern • Eating well with Canada's Food Guide
• Child's overall health • Presence or recent history of acute illness • Presence of chronic illness or special health care needs • Stress or change in child's life • Family growth patterns • Family meal patterns • Sleep pattern	• Feeding relationship • Family physical activity routines • Food and activity routines in child care or school • Screen time • Amount of juices and/or sweetened beverages • Food security concerns: availability and access to healthy foods

Recommended Cut-Off Criteria Using the WHO Growth Charts

Cut-off points are intended to provide guidance for further assessment, referral or intervention. They should not be used as diagnostic criteria.

Growth Indicator	*0 – 2 years*	*2 – 5 years*	*5 - 19 years*	*Growth Concern*
Weight-for-age	< 3rd	< 3rd	< 3rd	Underweight
Height / Length-for-age	< 3rd	< 3rd	< 3rd	Stunted
Weight-for-length	< 3rd			Wasted
Weight-for-length	> 85th			Risk of overweight
Weight-for-length	> 97th			Overweight
Weight-for-length	> 99.9th			Obese
Head Circumference	< 3rd or > 97th			Head circumference
BMI-for-age		< 3rd	< 3rd	Wasted
BMI-for-age		> 85th		Risk of overweight
BMI-for-age		> 97th	> 85th	Overweight
BMI-for-age		> 99.9th	> 97th	Obese
BMI-for-age			> 99.9th	Severely obese

Resources available at *www.whogrowthcharts.ca*

- A Health Professional's Guide to the WHO Growth Charts
- 2014 WHO Growth Charts Adapted for Canada
- BMI Tables and Calculator
- Self-Instructional Training Program on the WHO Growth Charts Adapted for Canada
- Is My Child Growing Well? Questions and Answers for Parents
- Tips to Help Your Child and Teen Grow Well

Other resources

- Nutrition for Healthy Term Infants: Recommendations from Birth to 24 months available at *http://www.hc-sc.gc.ca/fn-an/nutrition/infant-nourisson/index-eng.php*
- Find a Dietitian *www.dietitians.ca/find*
- Healthy eating/active living resources available at *www.dietitians.ca*, from Health Canada and provincial government web sites and local public health centres.

PEN ✓ PEN APPROVED Until April 2017

Adapted from: *Growth Assessment and Counselling Summary Sheet*, 2011. Alberta Health Services.
www.whogrowthcharts.ca

Dietitians of Canada / Les diététistes du Canada

Smoking in Vehicles Resource List

The following are trusted website supporting current law in Saskatchewan that it is illegal to smoke in a vehicle with a child under sixteen inside.

http://www.skprevention.ca/wp-content/uploads/2013/07/3-306_Tobacco_Smoke_Booklet.pdf

http://www.health.gov.sk.ca/tobacco-legislation

http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/t14-1.pdf

The Tobacco Control Act: Part III section 10.1 Smoking in vehicles. The fine for breaking this law is $280.00.

Regional Referral Forms

Referral forms that are required by regional health authorities to complete for access to resources within the region may be kept here. When a referral report is received, a summary of the report should be recorded in the General Comments section of a new early childhood assessment record and encounter date.

Regional Specific Policy, Strategies, Guidelines and Programs

Regional Health Authority's to insert documents here.

2014 WHO Growth Charts

A copy of the WHO Growth Charts can be found at http://www.saskatchewan.ca/live/health-and-healthy-living/health-care-provider-resources/treatment-procedures-and-guidelines/world-health-organization-growth-charts.