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Building Nunavut Together
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Bâtir le Nunavut ensemble

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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Guidelines for Completing Well Child Record

Introduction

The *Well-Child Record* for infants and young children in Nunavut has been updated to better support primary care providers in assessing children's physical, cognitive and social development at regular visits.[1]

These visits are based on the immunization schedule for Nunavut and take place:

- Within the first week
- 2 weeks
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12-13 months
- 15 months
- 18 months
- 2-3 years
- 4-5 years (preschool)

This guide contains information from the 2014 Rourke Resources (General and Child Development) as well as specific information for health care providers in Nunavut. Other guidance documents to support the care of infants and children include:

- *Clinical Practice Guidelines for Nurses in Primary Care – Pediatric and Adolescent Care* from the First Nations and Inuit Health Branch.
- *Community Health Nursing Standards and Protocols* of the Department of Health.
- *Community Health Nursing Administration Manual* of the Department of Health
- The *Nunavut Immunization Schedule* and the *Nunavut Immunization Certification Information Package*.
- Bates DVDs: Head-to-Toe Assessment of the Infant and Child are available in each regional centre.

Throughout the *Guidelines* are references to background information for health care providers as well as to handouts for parents/caregivers. Some of these documents were developed by the Department of Health and are available on the Department's website.

Elders and other community members are a strong source of support for parents/caregivers of infants and young children across Nunavut. It is important for primary care providers to be respectful of the fact that parents/caregivers of infants and young children obtain information on caring for them from a number of trusted sources.

[1] The Well Child Record for Nunavut is based on the *Rourke Baby Record* which was copyrighted in 2014 by Drs. L Rourke, D Leduc and J Rourke. It has been adapted with permission of the authors. Since items unique to Nunavut have been added without levels of evidence, all fonts reflecting strength of recommendation have been omitted. Strength of recommendation of items based on existing levels of evidence in the national Rourke Baby Record can be found at www.rourkebabyrecord.ca.

PREGNANCY/BIRTH REMARKS/APGAR

Guide I: 0-1 month.

To complete this section, review the *Prenatal Record* to identify significant events in pregnancy which may impact on the health of the infant. This could be alcohol use, chronic medical conditions (e.g. diabetes, hypertension), anemia, bleeding, infection, fever, STIs (e.g. Chlamydia, Herpes) in pregnancy as well as complications at birth such as meconium which may impact on the health of the newborn.

Transcribe Apgar scores from *Newborn Record*. Gestational age, birth length/weight/head circumference and discharge weight should also be transcribed from this Record.

CURRENT FAMILY

Starts at Guide II: 2-6 months

Indicate who is responsible for the child (parent/guardian) and any changes in the family since the last visit. This will assist in understanding who is the child's primary caregiver.

RISK FACTORS/FAMILY HISTORY

- Risk factors could include having an infant or child with previous failure to thrive, anemia, developmental delay, rickets, obesity as well as experiences with raising other children.
- Family history includes previous significant medical history among first degree family relatives such as cardiac anomalies, neural tube defects, diabetes, hearing deficits, SIDS etc.

GROWTH

- While some initial weight loss (up to 10%) after birth is normal, infants should return to their birth weight by 10 days of age.
- Corrected age should be used until 24 to 36 months of age to assess premature infants born <37+0 weeks of gestation.
- The growth of all infants and young children should be evaluated using Growth Charts Adapted for Canada with measurement of recumbent length (birth to 2 years) or standing height (> 2 years), weight, and head circumference (birth to 2 years): CPS Position Statement .
- The Health Professionals Guide provides more detailed information for using these charts and is available on the *Dietitians of Canada* website.
- Chart length, height and head circumference in cm and weights in kg; plot on the growth charts as part of the infant/child's chart. The centile should be included on the Record next to the length, height, head circumference and weight measurements.
- Include the BMI at 4-5 years; and at subsequent visits.
- In most children, serial weight-for-length, length/height, head circumference and weight measurements follow consistently along a percentile curve. Unexpected downward moves on the curve could be a sign of failure to thrive and require a referral to a physician. Similarly unexpected movement upwards on the curve could indicate overweight and a consult to a dietician, or other provider, could be considered.

PARENT/CAREGIVER CONCERNS

Any significant concerns that parent/caregiver has in relation to the child's health or development should be charted; if insufficient space is available on the *Well Child Record* a *Progress Note* can be used.

NUTRITION

Information on nutrition for healthy term infants is available from a number of sources: Health Canada has recommendations for infants at 0–6 months, and 6–24 months, the CPS publishes Guidelines for 0–6 months and the Dietitians of Canada site has a broad range of information on nutrition for infants and young children. Handouts for parents in Nunavut are available on the Department of Health's Healthy Living website.

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 introduced at 6 months of age) may continue for up to two years and beyond.
- Breastfeeding reduces gastrointestinal and respiratory infections and helps to protect against SIDS, among other benefits. Support of the mother (both antepartum and postpartum) increases breastfeeding initiation rates and prolongs duration.
- Early and frequent mother-infant contact, rooming in, and banning handouts of free infant formula increase breastfeeding rates.
- Alcohol and drug use should be avoided while breastfeeding as these substances do go through to breast milk. If a woman is going to drink one evening she can breastfeed before she goes out and pump a bottle for the baby while she is away.
- Copies of Breastfeeding Basics and Breastfeeding your Baby booklets on the Department of Health website can be printed and shared with parents.
- Breastfeeding mothers should continue to take Vitamin D supplements for the duration of breastfeeding. Statement on Vitamin D from the CPS.

Iron-fortified infant formula

- Iron-fortified infant formula is recommended to prevent iron deficiency anemia among infants who are not breastfed.
- For information on formula preparation and handling for parents/caregivers: see the Department of Health website under *Health Professionals*: *Fact Sheets*.
- The milk consumption ranges in the *Well Child Record* are provided as an approximate guide for what infants usually consume at each age – they do not represent a guideline or target. The upper end of each amount indicated is the **maximum** recommended.
- 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; for more information see the CPS Position Statement on soy-based formula .
- Cow's milk has low iron content and the iron is poorly absorbed. To lower the risk of iron deficiency anemia, cow's milk is not recommended before 12 months of age although dairy products such as yoghurt and cheese can be introduced after 9 months.
- Infants do not need formula after 12 months of age; follow-up formulas are of **no benefit** to the infant.

Milk Recommendations

- Between 12 and 24 months homogenized milk (also called 'whole' milk or 3.25%) is recommended. After 24 months, 1%, 2% or skim milk may be used.
- The amounts given under each age provide a range of what most infants and young children will take each day.

- The upper end of the range, at every age, is the **maximum** amount of milk which should be given to the infant.
- For more information see CPS Position Statement on nutrition for healthy term infants six to 24 months.

Vitamin D

- Routine Vitamin D supplementation of 800 IU/day in the form of Baby Ddrops is recommended for all infants in Nunavut until the diet provides a sufficient source of Vitamin D (at approximately 2 years).
- For children older than 2 years of age, a daily multivitamin providing 400 IU/day is recommended.
- Vitamin D supplementation is an important part of preventing rickets among children living in northern latitudes. For more information see the Department of Health's Vitamin D Protocol.
- A handout on Vitamin D Drops from the Department of Health can be shared with parents.
- After solid foods are introduced, and throughout childhood, encourage Vit D rich foods including maqtaaq, bird eggs, fish eggs and fish.

Stool Pattern and Urine Output for the Breastfed Infant

- Urine and stool output is an indication of the adequacy of the breastfed infants' intake in the first week of life. The Nurses Desk Reference provides information on output for health care providers and the Breastfeeding Advice handout provides similar guidance for parents. Both are available on the Department of Health website.
- Over the first few days of life the breastfed infant's stools should transition from black tarry meconium, to brown/green and then yellow stools. By five days of age the breastfed infant should be having at least three large yellow soft stools a day and six heavy wet diapers with pale or clear urine.
- By six weeks of age the breastfed infant will have fewer stools – one or more every 1 to 7 days – and this is normal.

Introduction of Solids

- Introduction of solids should be led by the infant's signs of readiness – a few weeks before to just after **6 months**. Signs of readiness include: can sit with support; shows interest in food; holds food in mouth; opens mouth when food comes his way.
- First foods should be iron rich and of soft consistency. Some mothers may chew foods to soften them before offering to infant; this is a strategy to introduce infant to foods eaten by other family members. Food can also be mashed with a fork or ground with a food mill.
- Avoid offering solid foods that are hard, small and round, or smooth and sticky (e.g. raw carrot pieces, nuts, peanut butter) as these may cause aspiration and choking.
- The first foods introduced to the infant should contain iron to avoid iron deficiency; these include: infant cereals, meat (country foods and store bought), poultry, fish or whole eggs. See the Department of Health's handout on the introduction of solid foods.
- Vegetables, fruit and grain products (cereal and bread) are introduced after iron-rich foods. Milk products (yoghurt, cheese) can be introduced **after** 9 months.
- Foods for infants and young children should be prepared without salt and sugar.
- Encourage self-feeding with finger foods and offer foods with lumpy textures no later than nine months.
- No juices until 2 years of age – no pop/drink crystals. Limit 100% fruit juice to one 125ml or ½ cup serving per day. Use water as main beverage after 2 years of age.
- No candy or chips or other junk food should be offered to infants and young children.

- Delaying the introduction of priority food allergens is not currently recommended to prevent food allergies, including for infants at risk of atopy. For more information see the CPS Position Statement .
- Avoid honey until 1 year of age to prevent botulism.
- Advise no bottle in bed unless it contains water. By one year of age infant should start to be encouraged to use an open cup rather than a sippy cup or a bottle. Infant should be off the bottle completely by 18 months of age.
- Encourage a healthy diet for children as per Nunavut's Food Guide on the Dept of Health's website.

DEVELOPMENT

Milestones are based on the Nipissing District Development Screen™ 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. This means that, absence of any one or more items indicates consideration for further developmental assessment, as does parental/caregiver concern about development at any stage. For more information on developmental milestones please see Evidence-based milestone ages as a framework for developmental surveillance.

Correct for age if infant born at < 37+0 weeks gestation.

If a concern around child development is identified, referrals can be made to occupational/physical therapy, audiology, eye team, speech and language, physician or pediatrics for further assessment depending on the resources available in the Region. A telephone consultation may provide advice for the health care provider while the family waits for the referral.

For each milestone indicate a 'checkmark' if no concern and an 'x' if there is a concern – address any issues under 'Problems and Plans' on the *Record*, or in the *Progress Notes* if more space is required.

Parents can be encouraged to sing, talk and read to their baby from birth as well as to respond consistently to their infant's cues. Other strategies for parents to promote healthy development can be found in the *Additional Resources on Promoting Healthy Development* section below.

Exposure to Trauma

- To identify if infants and young children, or their parents, have been exposed to difficult situations the following question is suggested: "Since the last time I saw you has anything really scary or upsetting happened to you or your family?"
- The response to this question provides an opportunity to offer support and refer to resources in the community.

2 weeks to 15 months

- At each age, the health care provider should observe the infant/child and ask the parent about behaviour which indicates that developmental milestones have been achieved. This gets easier with practice and the health care provider is encouraged to assess milestones for as many infants/children as possible to build their skills in this area.

18 months

- This is a very important age to assess developmental milestones and identify developmental delays, including autism so that appropriate referrals can be made.
- The provider may consider making a longer appointment at 18 months to allow assessment of social/emotional developmental as well as communication, motor and adaptive skills. Absence of any developmental milestones or skills at this age would suggest a phone consultation and referral to occupational/physical therapy, audiology, eye team, speech and language, physician or pediatrics depending on resources available in Region.
- Specific screening for autism spectrum disorder (ASD) at 18–24 months 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, CHN or physician. The screening checklist M-Chat can be used.

2 to 5 years
- At these ages, the parent can be asked questions about the child's behaviour and questions can also be directed to the child. The parent can be asked to assist in the assessment of the child, for example, in relation to following 2-step directions.

Additional Resources on Promoting Healthy Development (Available on-line)
- Improving the Odds is a toolkit for primary healthcare providers on promoting healthy development from the Ontario College of Family Physicians.
- The On Track Guide has been developed by Best Start in Ontario to provide professionals with a tool to support healthy child development and early identification of indicators of risk.
- The Best Start in Ontario website contains resources for maternal, newborn, and early child development
- Pauktutiit has a range of resources for Inuit parents of young children.

PHYSICAL EXAMINATION

See Pediatric Health Assessment from the FNIHB *Pediatric and Adolescent Care Clinical Practice Guidelines* for more detailed information on conducting a physical exam on an infant or young child.

Bates DVDs: Head-to-Toe Assessment of the Infant and Child are also available in each regional centre

Components of the physical assessment change with the age of the infant/young child. The *Well Child Record* identifies areas for consideration at each age. For each area assessed indicate a 'checkmark' if no concerns and an 'x' if concerns. The plan for an area of concern should be documented in Problems and Plans on the *Record* or in the *Progress Notes* if more space is required.

Skin
- Check for jaundice, dryness or rash. Ask parent/caregiver about bath-time routines.

Birthmarks
- Monitor location, size, shape and colour to track changes.
- If the infant has a Mongolian spot or spots reassure parents that these are normal and will usually fade in the first year of life.

Fontanelles

- The posterior fontanelle is usually closed by 2 months and the anterior by 18 months. For more information on fontanelles see this article on the abnormal fontanelle from the American Family Physician.

Mobility of Tongue
- Inspect tongue mobility for ankyloglossia as it may have an impact on breastfeeding; for more information on ankyloglossia and breastfeeding please see this CPS Position Statement.

Heart/Lung Sounds
- Auscultate heart sounds in all regions for normal S1 and S2; murmurs or extra sounds. Auscultate all lung fields for air entry and adventitious sounds.

Umbilicus
- Examine for healing/drying, excoriation, discharge/bleeding and odour.
- If you note an umbilical hernia check notes from the place of birth. Umbilical hernias are fairly common in the neonate and most cases do not require surgical intervention until after one year of age.

Hips
- Examination of the hips should be included in physical assessment until at least one year, or until the child can walk. At 2-4 weeks conduct the Barlow and Ortolani manoeuvres. When the child is older than 4 weeks look for asymmetric thigh folds, poor hip abduction and Galeazzi sign (with both feet placed on table the knees are not symmetric).

Muscle tone
- Physical assessment for spasticity, rigidity, and hypotonia should be performed.

Testicles
- Check to ensure that the testicles are present bilaterally and descended. If one or both are not descended consult a physician.

Male urinary stream/foreskin care
- If possible, observe stream for direction and flow. Do not pull foreskin back. Teach parents to wash uncircumcised penis for infant and young boy without pulling back foreskin.
- **The foreskin will come back on its own when the child is older and should never be forced back.**

Vision inquiry/screening:
There is additional information on vision screening in *Community Health Nursing Standards and Protocols* from the Department of Health.

Refer to optometry services if a vision issue is identified.

- Check **Red Reflex** for serious ocular diseases such as retinoblastoma and cataracts: reflection of orange-red light from the retina through the pupil, seen at 0.5 m distance through the ophthalmoscope set on '2' diopters. The light should be equal in brightness and colour bilaterally, and should fill the pupil completely.
- **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.

- **Check visual acuity** at age 3–5 years using Snellen chart or Lea symbols at 20' (6 meters). Record L and R eye results. Refer when visual acuity is less than 20/40 and when there is a difference of more than two lines between each eye.

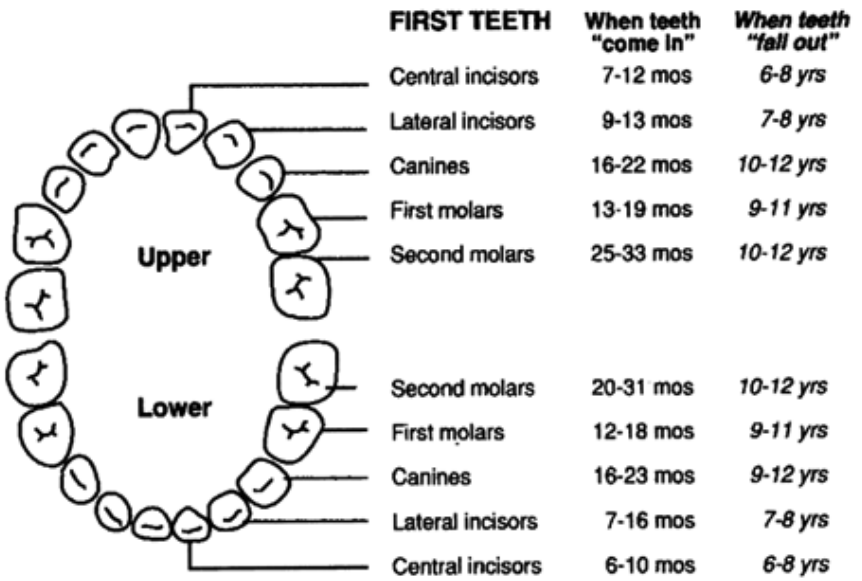
Hearing inquiry/screening

- Any parental concerns about hearing acuity or language delay should prompt a rapid referral for hearing assessment.
- Determine if infant turns to sound – this could be a clap or the ring of a bell – where the source of the sound cannot be seen.
- Formal audiology testing should be performed for all high-risk infants, including those who are born preterm and/or have had frequent experiences with otitis media. An early diagnosis of hearing loss in infants means more treatment options can be offered.
- Older children should be screened if clinically indicated. A hearing screen is also part of the pre-school health assessment.

Oral Health

- Early Childhood Tooth Decay (also known as Early Childhood Caries {ECC} or Baby Bottle Mouth) is a type of tooth decay that can affect the primary teeth, especially the upper front teeth. Signs of decay include chalky white crescent-shaped areas along the gum line of the front top teeth. This may progress to brown areas of decay and lead to infection (abscess) and broken teeth.
- If signs of tooth decay are present refer to a dental professional.
- Additional information on assessing oral health is provided in the *Community Health Nursing Standards and Protocols* of the Department of Health.
- See the *Education and Advice* section below for more information on dental care.

Tooth Eruption Chart



Blood pressure at 4 to 5 years

- Ensure cuff is proper size for child's arm.

- Refer to physician if outside of normal range:

Height Percentile	Systolic BP: 95th – 99th Percentile	Diastolic BP: 95th – 99th Percentile
15th	119	70
59th	115	72
99th	120	75

EDUCATION AND ADVICE

Review each of the topics with parent/caregiver; if there are areas of concern which need to be followed up identify them in the *Problems and Plans* section of the *Record* or in the *Progress Notes* if more space is required.

INJURY PREVENTION

In Nunavut, as in the rest of Canada, unintentional injuries are the leading cause of death in children and youth.

Safe sleeping environment

A safe sleeping environment reduces the risk of Sudden Infant Death Syndrome (SIDS). The rate of SIDS is higher in Nunavut than in other parts of Canada. Parents/caregiver should be encouraged to:

- Place infants on their back to sleep. Their heads should be placed in different positions on alternate days to reduce the risk of flattening on one side.
- Share a room but not a bed with their infant – bed sharing is associated with an increased risk of SIDS. Infants should sleep in a crib, cradle, laundry hamper, cardboard box or bassinette in parents' room for the first 6 months of life as room sharing is protective against SIDS.
- Families in Nunavut may not have planned to purchase a crib and the health care provider can propose other alternatives – if a laundry hamper, cardboard box or drawer is used it should be placed on the floor with only a thin blanket at the bottom.
- Breastfeeding has many advantages to mothers and infants; one of them is reducing the risk of SIDS.
- Give infants a smoke-free environment – anyone who smokes in the household should smoke outside.
- Avoid loose bedding or toys on infant's safe sleep surface. Nothing should be stored on the safe sleep surface.

Childproofing

Includes electric plugs/cords and poisons.

- Make sure children cannot put their fingers in plugs by putting covers on them and roll up cords out of reach of children. Keep medicines and cleaners locked up and out of child's reach.
- Childproofing the home before the infant can move helps to prevent injuries.

Firearm safety:

- Advise on removal of firearms from home or their safe storage to decrease risk of unintentional firearm injury, suicide, or homicide; for more information see the CPS Position Statement.

Plagiocephaly

- Plagiocephaly or flattening of the head occurs when the relatively soft head of the newborn or infant is placed in the same position for extend periods of time.
- To prevent plagiocephaly have newborns and infants face in different positions in their safe sleep surface on alternate days. When they are awake during the day, infants can also be placed on their tummy to reduce the risk. Infants should be supervised during tummy time.
- If plagiocephaly does not improve after the infant is sitting, at around 6 months, refer to physician.

Car Seats

This issue will only need to be discussed if the parent/caregiver will be taking the infant/child in a car. The discussion could be initiated by asking if they have any questions about car seats. Using a car seat is safer than having an infant/young child in an Amauti while in the car.

- 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/child seat that is manufacturer approved for use until age 2 years.
- Use forward-facing child seat after 2 years for as long as manufacturer specifications will allow.
- After this, use booster seat up to 145 cm (4'9").
- Use lap and shoulder belt in the rear middle seat for children over 8 years who are at least 36 kg (80 lb) and 145 cm (4' 9") and fit vehicle restraint system.

Choking/Safe Toys

- 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.

Hot water/bath safety

- Keep hot water at a temperature < 49^{o}C.
- 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, lifejackets, and boating safety to decrease the risk of drowning.

Fall Prevention

- Encourage parent/caregiver to 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.
- Ensure stability of furniture and TV so that toddler cannot pull them over.

Carbon Monoxide/smoke detectors

- Install smoke detectors in the home on each level.
- Carbon monoxide detectors installed on each storey of home and outside main sleeping areas is recommended.

Pacifier use

- Using a pacifier may decrease risk of SIDS and should not be discouraged in the 1st year of life after breastfeeding is well established. On the other hand, the use of pacifiers should be restricted in children with chronic/recurrent otitis media.
- By 18 months toddler should be weaned from pacifier as may lead to malocclusion.

Matches/Lighters

- Matches and lighters should be kept out of the reach of children.

BEHAVIOUR AND FAMILY ISSUES

While behavioural and family issues should be reviewed with the parent/caregiver at each visit, only chart on problems which need follow-up in the *Problems and Plans* section of the *Record* or in the *Progress Notes* if more space is required.

If a parent/caregiver is having significant difficulty with infant crying, family conflict/stress, alcohol/drug use in the home or any other issue which impacts the safety of the infant/young child – the health care provider must raise this as a concern and discuss possible approaches with the parent or caregiver which may include a referral to Child and Family Services. In addition, a Mental Health consult may be considered.

Risk factors for physical abuse include:

- Low socioeconomic status; young maternal age (<19 years); single parent family; parental experiences of own physical abuse in childhood; intimate partner violence; lack of social support; unplanned pregnancy or negative parental attitude towards pregnancy.

Risk factors for sexual abuse include:

- 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.

Consult with Child and Family Services if concerned about neglect or maltreatment of an infant or child.

Review the Department of Health's policy and guideline on child welfare in the *Community Health Nursing Administration Binder*, Communications Section, entitled: *Child Welfare*: Policy 06-016-00 and *Guidelines for Reporting Child Welfare Concerns:* Guidelines 06-016-01. For additional information see the FNIHB Guidelines on Pediatric and Adolescent Care - Chapter 5 - Child Maltreatment.

Crying

Excessive crying may be caused by behavioral or physical factors or simply be the upper limit of the normal spectrum. Evaluation of the causes of crying and of the burden for parents is essential and raises awareness of the potential for *Abusive Head Trauma (*formerly called Shaken Baby Syndrome). The CPS has prepared *Multidisciplinary Guidelines on the Identification, Investigation and Management of Suspected Abusive Head Trauma* .

- Many new parents and caregivers become frustrated and feel that a crying baby means they are doing something wrong. Understanding that crying is a normal and healthy part of infancy can greatly reduce the stress of anyone who cares for a child.

- If the baby's crying gets to be too much, advise a parent to put the baby down in a safe place and take a moment to deal with their own stress. Call a friend or family member who could help.
- Ways to quiet a baby include bringing baby's face close to yours, offering them a clean finger, soother or breast to suck, gently rocking the baby, talking or singing quietly.

Healthy Sleep Habits

- Normal sleep (quality and quantity for age) is associated with healthy development and leads to better health outcomes.
- Starting a consistent bedtime routine early in the infant's life will help to ensure healthy sleep habits.
- Proper swaddling of the infant for the first 2 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.

Night Waking

- Night waking occurs in 20% of older infants and toddlers who do not require night feeding.
- Counselling around positive and consistent bedtime routines and keeping bedtime and morning awakening time consistent have been shown to reduce the prevalence of night waking.

Soothability/Responsiveness

- Ask how easy or difficult it is to calm their crying baby and assess how responsive parent/caregiver is to infant cues.
- Some infants are harder to soothe than others. These parents need additional help to care for their baby –understanding that this is not a failure on their part can be reassuring to parents/caregivers.
- You can ask the parent/caregiver what they have tried, what seems to work and encourage them to try different strategies including consistently responding to infant cues.

Alcohol/Drug Use in Home

- Ask if parent/caregiver is concerned about alcohol or drug use in the home and explore how these concerns may be addressed within the resources available in the community.

Parenting/Bonding

- Ask about the parent/caregiver's experiences with the infant. Look for generally positive descriptions of the infant and positive comparisons with other children the parent/caregiver has known.
- If the parent/caregiver describes the infant as less attractive or well-behaved than other infants this may be a sign of difficulty bonding with baby. Additional support for the parent/caregiver may assist them in developing a stronger positive relationship with their baby.
- Explore how this issue may be addressed within the resources available in the community – this could include parenting groups which distribute the pamphlets *Childrearing Advice from Elders*.

Parental Fatigue/Postpartum Depression

- Ask the parent/caregiver if fatigue gets in the way of caring for their family and if they feel tense or worried.
- Ask about what kind of support they have from family or friends to help care for the baby. Discuss some of their worries or concerns.
- Be aware of the potential for maternal depression, which is a risk factor for the socio-emotional and cognitive development of children.

- The *Edinburgh Prenatal/Postnatal Depression Scale* is available on the *Prenatal Record* and is an example of a tool which can be used to assess a parent's depression/fatigue.
- Refer parent/caregiver to mental health services if there is a concern around depression.

Family conflict/stress
- Ask if there are any particular family conflicts/stresses at this time and explore with caregiver how these may be addressed within the resources available in the community.

Siblings
- Inquire about relationship to siblings and explore how issues could be addressed within the resources available in the community

Child Care/Return to Work
- Parents/caregivers who are planning to return to work will need to be aware of options for safe and stimulating child care in their community.

Readiness for school

Although children don't need to have specific knowledge or skills to start school it is helpful if they can:
- share and know how to take turns,
- cooperate and play well with others,
- listen and pay attention for short periods of time,
- speak and ask for what they need,
- help out and put away classroom materials and toys after activity time,
- dress and undress themselves,
- use the toilet independently and clean themselves,
- play by themselves with toys for a period of time without needing adult attention.
- be away from their caregivers and parents and understand that parents will come back.

Family health: active living/sedentary behaviour
- Parents should act as role models, using interactive floor-based play starting as early as 3-4 months to help promote the child's motor skills development.
- A variety of physical activities should be offered for young children, while at the same time limiting sedentary pastimes such as screen time. Recommend **no screen time** for children less than 2 years of age.

Discipline/Parenting
- Ask how parenting is going and if they are finding anything really difficult. Warm, responsive, flexible & consistent discipline techniques are associated with positive child outcomes.
- Explore how parenting and discipline issues could be addressed within the resources available in the community

Socializing/Peer Play Opportunities
- Ask caregiver about the child's opportunity to socialize and play with other children.
- Play is essential to help children develop social and emotional skills as well as healthy bodies.
- Referrals can be made to the Aboriginal Head Start program and other community resources if parent/caregiver is looking for additional peer play opportunities.

ENVIRONMENTAL HEALTH

Second-hand smoke

- Ask parent/caregiver about their infant/young child's exposure to second hand smoke. To support a smoke-free environment everyone who smokes in the household should smoke outside.
- Even when smoking outside it is best not to smoke when an infant/young child is in the Amauti.
- Exposure to second hand smoke contributes to childhood illnesses such as URTI, middle ear effusion, persistent cough, pneumonia, bronchiolitis, asthma, and SIDS.
- Consider offering support for smoking cessation, for example by referring to smoking cessation resources from the Department of Health – *Tobacco Has no Place Here*.

Sun exposure/sunscreens

- The Arctic sun can be very bright, particularly in the spring when it reflects off the snow. For infants and young children it is important to minimize sun exposure by having them wear protective clothing, hats and properly applied sunscreen with SPF ≥ 30 for those older than 6 months of age.

Extreme cold

- Inuit families have been successfully protecting their infants and young children from extreme cold for millennia. As the climate changes established patterns of extreme cold may change – ask parents what they do on extremely cold days.

OTHER

Over-the-counter medications

- Advise parents against using OTC cough/cold medications: the best treatment for a cold is still plenty of rest and fluids.

Home remedies

- Ask parents about what home remedies are being used for the infant and young child. Home remedies can be effective and should not be discouraged if they are not harmful.

Fever advice/thermometers

- **Fever ≥ 38°C in an infant < 3 months needs urgent evaluation.**
- While 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.
- For more information see the CPS fact sheet on Fever and temperature taking.

Footwear

- Shoes are for protection, not correction. Walking barefoot develops good toe gripping and muscular strength.

Food Security

- To determine if a household is struggling with food insecurity ask parent/caregivers: "Since our last visit, were there times when it was not possible to feed the child a healthy meal because there was not enough money?"
- Explore how food security for the family could be addressed within the resources available in the community

Temperature control and overdressing

- Discuss the importance of dressing child appropriately to avoid overheating which increases the risk of SIDS.
- Proper swaddling of the infant for the first 2 months of life may promote longer sleep periods but could be associated with adverse events (hyperthermia, SIDS, or development of hip dysplasia) if misapplied
- Swaddled infants must always be placed supine with free movement of hips and legs, and the head uncovered.

Tooth brushing/Fluoride

- To prevent early childhood caries: avoid sweetened juices/pop and constant sipping of milk or natural juices in both bottle and cup.
- Starting from birth, wipe the baby's gums twice per day with a clean, damp wash cloth (especially before bed).
- Once a first tooth is in, parents/caregiver can begin brushing with a soft infant's tooth brush and a rice grain sized smear of fluoridated toothpaste twice a day.
- Children under 3 years of age should have their teeth and gums brushed twice daily by an adult using a rice grain sized portion of fluoridated toothpaste.
- 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.
- Caregivers who brush with their child set a good example for lifelong dental hygiene.

Tummy Time

- Parent/caregiver can be encouraged to place infant on their tummy on the floor (on a small blanket) when awake to reduce the risk of plagiocephaly and give an opportunity to raise head and explore environment.

Encourage Parents to Read, Sing and Speak to Promote Child Development and Literacy

- Encourage parents to read, sing and speak to their children starting within the first few months of life and to limit TV, video and computer games throughout infancy and early childhood. This will help parents to promote healthy development and literacy.
- For more information see the CPS Position Statement. *Read, speak, sing: Promoting literacy in the physician's office* .

Toilet Learning

- The process of toilet learning has changed significantly over the years and within different cultures.
- At present, a child-centred approach is recommended, where the timing and methodology of toilet learning is individualized as much as possible; for more suggestions see the CPS position statement on toilet learning.

ROUTINE IMMUNIZATIONS/INVESTIGATIONS

Immunizations

- See the Nunavut Immunization Schedule for recommended immunization schedules for infants, children and youth and the Nunavut Immunization Certification Information Package *f*or more detailed information. Both are available on the Department of Health, Government of Nunavut website.

- The immunization schedule does not need to be adjusted for prematurity.
- 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.

Anemia screening

- All infants in Nunavut require screening for iron deficiency anemia between 6 months and 2 - 3 years of age. Please see *Iron Deficiency Anemia* protocol available on the Government of Nunavut website.