Practice Guideline for Public Health Nurses working in Healthy Parenting & Early Childhood Development based on the Professional Practice Model

EVIDENCE INFORMED PRACTICE TOOLS

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Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

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PURPOSE AND INTENT

Protect, promote and preserve the health of the population and promote health equity among families, women, and children (0-5 years) in the Winnipeg Health Region.

PRACTICE OUTCOMES

- Public Health Nurses (PHNs) will work with a population level focus, through collaborations and partnerships, to address public health issues and improve health outcomes among the healthy parenting and early childhood population. PHNs may work at the community, group, family, and/or individual level as appropriate.

- PHNs will identify and engage with various community stakeholders (based on assessment findings) to address the population health needs of the Healthy Parenting & Early Childhood Development (HPECD). Early childhood development (ECD) should be prioritized, as this has been shown to have the greatest population impacts [1-5].

- PHNs and community areas will prioritize and evaluate interventions and outcomes on a regular basis. PHNs use assessment data and evaluation tools as required and recommended. Findings can then be shared within community areas and throughout the region.

- PHNs recognize that the prenatal and perinatal periods are important opportunities to access and engage families, with priority given to structurally disadvantaged populations [6-11]. PHNs will endeavour to engage these clients early and at multiple opportunities to establish health promoting relationships.

- PHNs will prioritize efforts based on the provincial public health nursing standards for prenatal, postpartum, and early childhood[12], the nursing process, as well as the guiding principles identified in the Professional Practice Model (PPM)[13]. These principles are: accessibility, cultural proficiency, determinants of health, engagement, harm reduction, health equity, practice excellence, and quality. The PPM identifies ten Strategic Approaches which apply at a population level and therefore to prenatal and early childhood populations. These are discussed in the Guidelines Section below.

BACKGROUND

The Commission on Social Determinants of Health advocates for "equity from the start," recognizing the potent effect that early childhood development has on future lifelong success. Children are more susceptible to environmental toxins and experiences than adults, particularly prenatally [14]. By age five there are significant differences in physical, social/emotional, and language/cognitive development based on level of income, education, and parenting [15]. Readiness for kindergarten is one method of assessing the adequacy of early childhood experiences [16, 17]. The Early Development Instrument assesses key indicators of development that include physical, social cognitive, emotional and language skills [18]. Research using the Early Development Instrument in Manitoba and British Columbia found that close to 30% of the kindergarten population was delayed in at least one area [19]. While approximately 5% of infants had detectable developmental limitations at birth, Early Development Instrument scores ranged from 5-70% based on neighbourhood diversity. Failure to adequately support early childhood development in Canada has increased inequities and resulted in considerable numbers of children with substantive but preventable learning disabilities, mental health issues, emotional, and social disabilities [20]. Deficiencies in education programs that promote early childhood learning perpetuate inequities for children living in poverty [21].

Outcomes are particularly troubling for Canadian Indigenous people; countless numbers experience poor health for their entire life, contributing to a reduced life expectancy rate that is comparable to third world countries [22]. Core areas of Canadian cities are disproportionately populated by homeless and marginalized Indigenous people with crowded housing, low literacy, and unemployment [23]. Funding to Indigenous people has not kept up with population growth, further increasing the gap between Indigenous and non-Indigenous people [24]. The population is young and growing, with 50% of Indigenous people being less than 25 years old [22].

Rates of Indigenous children living in poverty are particularly high [25-28]. Manitoba has a higher proportion of Indigenous people than other provinces [29] and has been named the "child poverty capital of Canada" with estimates of 43,000 affected children [30]. Poverty has been strongly correlated with low birth weight, and disproportionate infant morbidity and mortality [25, 31-33].Although Indigenous infant mortality has declined, rates remain significantly higher than for non-Indigenous people [25, 34]. There are also more Indigenous children in government care today than during peak times of the residential school system [28].

In the WRHA, vastly different population health outcomes exist in the lowest income areas of Downtown, Point Douglas, and Inkster [31]. The most disadvantaged neighbourhoods had rates of breastfeeding and immunization below average, but rates of dental surgery up to 11 times higher. Newborns are significantly more likely to be readmitted to hospital for respiratory illness, jaundice, and infectious/parasitic diseases. Rates of children taken into care by Child & Family Services, as well as those receiving protective or supportive services, are also highest.

The greatest concentrations of teens giving birth are in the most disadvantaged neighborhoods. Teen pregnancy is an equity issue, universal interventions have widened the gap between higher and lower socioeconomic neighborhoods. For instance teen pregnancy rates dropped 17.6% in the neighborhoods of lowest socio-economic status, compared to a decline of 48.4% in the highest income neighborhoods, accounting for a nine-fold difference. The numbers of teen mothers in Downtown, Point Douglas and Inkster with Grade 12 education was also far below the Winnipeg average [35]. Teens were up to 3 times more likely to be on antipsychotic medications. Rates of suicide and hospitalization for injury in children under age 19 were also far above WRHA averages [31].

More can be done to support the health of women and children in the early childhood period in this province. Many women do not access prenatal care, and one out of every seven reports drinking during pregnancy; the highest rates of alcohol and tobacco use are among Indigenous women [29]. Manitoba has the highest provincial rates of fetal and neonatal deaths [36], as well as infant deaths in the 1st year of life [37]. Rates of infant mortality are almost double national rates at 6 per 1000, compared to the national average of 3.7 [38]. Each year there are about 100 deaths in infants under 1 year of age, and 100 deaths in children ages 1 to 5 years, largely from preventable causes [29]. In children less than 5 years of age, 24% of deaths are in the lowest income quintile [39]. Universal injury promotion programs and policies have reduced hospitalizations in higher SES groups, but rates have increased for children most at risk [40].

The final report of the World Health Organization's Commission on Social Determinants of Health described growing and avoidable health inequities and posed the challenge to improve the conditions that perpetuate inequities within one generation [41]. Specific actions highlighted as solutions within the report present an opportunity for PHNs to contribute to this important global movement. In Manitoba, PHNs work with all new families and have access to others who may be experiencing inequities through mandated communicable disease work and community relationships. Health inequities are growing in areas of teen pregnancy, dental caries, childhood mortality, premature mortality and potential years of life lost, mental health and suicide [39]. These issues represent the growing gap between individuals, families, and communities living in poverty and others, which has resulted in disproportionate population health outcomes. Multiple access points, combined with PHN knowledge and expertise, make PHNs ideally situated to reduce inequities and to contribute to population-level health improvements.

GUIDELINES

Public health HPECD Clinical Practice:

PHN clinical practice consists of health promotion, disease and injury prevention, health protection, health assessment, as well as emergency response and preparedness. PHN practice is family centred and culturally safe. A case management approach is used to coordinate care and promote equitable access to services and resources for long-term clients with identified risk factors for poor health outcomes.

Examples:

- ✓ A PHN considers population based practice at every client contact and redirects clients with medical issues to primary care.
- ✓ A PHN considers injury prevention and safety in all client contacts.
- ✓ A PHN develops a strength based relationship with clients, CFS, and Manitoba Housing to develop a smoke free policy in a housing unit.
- ✓ A PHN organizes a preschool immunization clinic at a school celebration and uses this as an opportunity to identify clients requiring additional follow-up and referrals.
- ✓ A PHN initiates a survey of breastfeeding clients/community to determine their perspective on what services could be helpful.

Outreach:

PHNs use outreach/ targeted home visiting to actively seek out and engage those clients at risk for negative outcomes. PHNs use case finding and establish relationships to become known in the community. PHNs endeavour to increase access to services and resources for prenatal, postpartum, and early childhood clients not currently accessing healthcare.

Examples:

- ✓ A PHN works with target populations attending community based groups such as Healthy Baby/Healthy Start.
- ✓ A PHN partners with existing agencies and organizations, such as Primary Care Providers, Child Development Clinic, EIA, CFS, McDonald Youth Services, Ekota Lodge, HB sites, Welcome Place etc., to encourage prenatal referrals to Public Health.
- ✓ A PHN attends the St. Anne's Resource Center (MB Housing Unit) once a month. The PHN attends the "Breakfast Program", provides information and links families to resources based on their needs (healthy eating, diabetes info, child development for 0-5 year olds, school readiness).
- ✓ A PHN increases visibility in community by partnering with groups such as Parent Child Coalitions and attends meetings and public events.

Healthy Public Policy:

PHNs are aware of policies and programs that promote healthy pregnancies and HPECD. PHNs identify gaps, and work collaboratively to implement programs that address policy program gaps. PHNs advocate for policies at multiple levels affecting the HPECD population.

Examples

- ✓ PHNs collaborate with midwives, hospital staff and primary care to develop regional guidelines in regards to safe sleep and swaddling.
- ✓ PHNs participate on a committee to gain more assisted housing options for structurally disadvantaged families that lack adequate housing.
- ✓ A PHN is involved in development of policies with the aim of improving relationships and increasing communication with partners such as CFS and EIA.
- ✓ A PHN assumes a leadership role in achieving Baby Friendly Initiative (BFI) accreditation in the community.
- ✓ A PHN aadvocates for bike helmet legislation for all.

Healthy Built and Social Environment:

PHNs work collaboratively with community partners, building coalitions and networks (including those that already exist) to promote healthy built and social environments that impact HPECD. PHNs advocate on behalf of, and with communities and community based organizations to address the social determinants that impact health.

Examples:

- ✓ A PHN works with the City of Winnipeg to ensure sidewalks are cleared in winter so that families are able to walk with strollers to access healthy parenting groups and health care.
- ✓ A PHN collaborates with a community based organization whose members wish to start a community garden.
- ✓ A PHN works with a local area food bank to establish services for socially isolated, disadvantaged families.
- ✓ A PHN collaborates with the community facilitator and public health dietician to identify healthy food options and to increase awareness within the community.
- ✓ A housing complex is closed and a PHN works in collaboration with Manitoba Housing, the community facilitator and others to advocate for healthy housing options within the same neighborhood.
- ✓ A high rise apartment building houses a number of families with young children. The PHN works with the property management company to establish a green space where families can engage in recreational and social activities.

Health Communication:

PHNs provide and facilitate access to counselling and education for individuals/ families/ communities. PHNs understand and communicate their role in promoting population health and refer clients to the most appropriate provider. PHNs work with long-term clients to promote health and facilitate change. PHNs use the most appropriate communication methods to connect with individuals/ families/ communities.

Examples:

- ✓ PHNs make referrals to community resources and groups that include the Breastfeeding Hotline, Parenting Groups, Health Links/info Santé, and Dial-a-Dietician
- ✓ A PHN is presenting to a group of newcomer families and adapts the communication to be relevant for that target population.
- ✓ A PHN is working with a well resourced new mom who has many questions and is requesting information. The PHN empowers the client and builds capacity by referring her to evidence based websites and community resources.
- ✓ A PHN is working with a disadvantaged prenatal client. The client is isolated and doesn't have phone access. The PHN plans to communicate using home or office visits.
- ✓ PHNs advocate and facilitate access and support to parents experiencing anxiety and mental health issues by making referrals to appropriate disciplines such as Family Dynamics, psychologists, and physicians.
- ✓ PHNs regularly attend and support parent-child coalitions.
- ✓ PHNs advocate for more up-to-date modes of communication/ technology in their workplace, to better communicate with families.
- ✓ PHNs refer families to reputable on-line sources of information such as the Canadian Pediatric Society.

Health Assessment

PHNs use the Families First screen and parent survey to assess the health of prenatal and postpartum families. PHNs integrate knowledge of public health sciences and nursing theory, such as equity, growth and development, breastfeeding, and postpartum recovery. In reference to the BC clinical practice guidelines. PHNs complete an assessment to determine the need and timing of PHN follow up with priority being given to disadvantaged clients. PHNs make referrals to the most appropriate Health Care Provider and use strategies of targeted home visiting and outreach to build relationships with those who are disadvantaged.

Examples:

- ✓ PHNs use the nursing process components of assessment, diagnosis, planning, intervention, and evaluation while working with clients, families and communities.
- ✓ PHNs use the Families First screen and parent survey to assess prenatal and postpartum families. PHNs offer Families First services to families in the WRHA scoring ≥ 25.

When services are not available or the family declines, PHNs will endeavour to maintain a relationship to provide public health services and connections to community resources.

- ✓ PHNs use a holistic and culturally sensitive focus and approach while working with individuals, families, and communities. An example of this may be to help organize a smudging ceremony with an elder in the community.
- ✓ PHNs make referrals to breastfeeding clinics, Healthy Baby groups, and local Mental Health resources. An example may be a young mother who is struggling with breastfeeding is invited to a breastfeeding clinic to meet other mothers in the community to provide support.
- ✓ PHNs make referrals to different agencies based on the health assessment for example: speech and language pathologists, mental health providers, addictions counsellors, housing and food banks. For example while completing your health assessment you discover that your client is living in an unsafe environment and refer the client to housing to find accommodations that are affordable and safe.
- ✓ PHNs complete developmental screening to identify developmental issues in other children at home visits. For example: while doing a routine home visit you learn that the older sibling has trouble speaking clearly. You complete a screen and provide a referral to the speech pathologist along with provide information for the family.
- ✓ PHNs advocate for clients and their families. For example helping to navigate through the EIA system for transportation to and from medical appointments.

Community Development

PHNs identify HPECD populations at risk based on multiple sources of data. PHNs work to build community capacity, using strategies such as partnering; empowering; building coalitions and networks and working with a variety of stakeholders to promote HPECD.

Examples:

- ✓ EDI can motivate community planning and programming, supporting school readiness. A PHN works with Parent Child Coalitions to share this information and take action. (eg encourage more programs like "Abecedarian Program" in Lord Selkirk Park that helps to promote school readiness or a PHN works with a parent child coalition to develop drop-in programs to meet the needs of parents with children age 1-5).
- ✓ A PHN enhances working relationship by organizing regular meetings with the community facilitator and works together to promote community action.
- ✓ PHNs use the community assessment findings to encourage addressing specific community issues (eg program to deal with smoking cessation in areas where smoking rates are high or where there is no smoke free policy like in MB housing units/apartments).
- ✓ A PHN works with City of Winnipeg to ensure equity affected families get access to free programs, swimming, skating.
- ✓ A PHN supports community leaders and partners with community centres to establish family drop in centers or get involved with existing programs.(eg Partner with community centers and second hand sports stores to obtain free equipment for low income families).

- ✓ PHNs partner with healthy baby groups/healthy start.
- ✓ A PHN works with students and community members to develop a peer led parenting group in an inner city neighborhood.

Collaboration and Partnership:

PHNs act as collaborator/partner building on client strengths, rather than acting as the expert to foster mutual goals. PHNs facilitate opportunities for collaboration and partnership to promote HPECD, such as Families First, Healthy Child Manitoba. PHNs advocate and coordinate services /care for those unable to do so. PHNs collaborate with other providers, this includes but is not limited to midwives, primary care, Dietitians, Child & Family Services, Employment & Income Assistance, and Parent Child Coalitions.

Examples:

- ✓ The Knox group; NOWAN; healthy baby sites.
- ✓ A PHN advocates for a client requiring lice treatment and works in collaboration with an EIA worker to navigate system barriers.
- ✓ A PHN works with daycares and community drop-ins to identify children who are disadvantaged and would benefit from intervention (case coordination).
- ✓ A PHN works with the midwife to coordinate client care.
- ✓ A PHN attends/facilitates community events such as health fairs to promote the role of the PHN.
- ✓ A PHN provides health presentation to community agencies (EIA, CFS, Housing) around the role of the PHN.
- ✓ A PHN works with the community facilitator to initiate a parenting program for children ages 1-5.
- ✓ A PHN works with community organizations such as Boys and Girls Club and Family Resource Centres to assist with programming that promotes health for young families.
- ✓ A PHN is asked to be a collaborator on the "Bike Together Winnipeg" initiative.

Applied Public Health Research:

PHNs apply public health and nursing theory to promote HPECD. PHNs appraise and synthesize literature to promote evidence based care and prioritize PHN activities. PHNs promote evidence based practice by incorporating research and evaluation in all activities.

Examples:

- ✓ A PHN uses current safe sleep evidence and anticipatory guidance while working with a vulnerable young mother.
- ✓ A PHN develops partnerships with researchers, ex: University of Manitoba, Centre for Health Policy, CNSs, to identify research needs that further PHN practice.
- ✓ A PHN promotes public health opportunities to participate in population health research.

- ✓ A PHN provide suggestions for future research projects and participates accordingly.
- ✓ A PHN uses research / available data Youth Health Survey, Public Health Agency of Canada, Manitoba Health, Maternal and Child Healthcare Services (prenatal connections) to encourage and support change.
- ✓ A PHN uses research to identify potential next steps for a project aiming to create community change, in collaboration with leaders.

Surveillance:

PHNs collect and interpret HPECD surveillance data, and apply surveillance information to guide their practice. PHNs monitor community based trends and health assessment data to promote HPECD.

Examples

- ✓ Data elements collected by PHNs are used in a variety of population level reports and research studies that include the Families First program evaluation, Towards Flourishing, Early Development Instrument.
- ✓ PHNs to collect and use data from Manitoba Centre for Health Policy and HPECD to increase breastfeeding rates where rates and duration are low in comparison to the norm.
- ✓ PHNs access and utilize data in HPECD, WRHA Epidemiology Unit, Immunization rate data and FFHV program uptake to help determine trends and potential issues in individual communities and in the Winnipeg region overall.
- ✓ PHNS are aware of public health issues in MB, Canada and internationally. Examples include: pertussis outbreak in SK, meningitis in northern MB, Tuberculosis trends, sexually transmitted and blood borne infections.

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