2021 NWT Well Child Record Handbook

Government of
Northwest Territories

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INTRODUCTION:

The introduction of standardized tools for early childhood assessment in the Northwest Territories (NWT) is one of the commitments under the *NWT Early Childhood Development (ECD) Framework Action Plan – Right from the Start.*

The NWT Well Child Record (WCR) is based on the 2014 Rourke Baby Record (RBR), which is endorsed by the Canadian Paediatric Society (CPS), the College of Family Physicians of Canada (CFPC), and Dieticians of Canada (DC). With permission, the RBR has been adapted for NWT use by expanding priority areas such as oral health, nutrition, environmental health, referrals, and NWT specific investigations and immunizations.

The NWT WCR helps to support the 19th Legislative Assembly Mandate Commitment: **Improving early childhood development indicators for all children,** by providing a standardized assessment and documentation tool for health care providers (HCPs) to complete regular assessments of infants and children during a well child visit.

In addition to being part of the child's personal health record, the data from the NWT WCR will be used to help identify population health and developmental trends, and to monitor early childhood indicators that provide direction for the delivery of programs and services for infants, children and their families.

Overview

The well child visit is part of core services identified in the *NWT Community Health Core Service Standards and Protocols.* The well child visit is offered to all infants and children, nine times before the age of 5, in all NWT primary care settings. The purpose of the NWT WCR tool is to provide HCPs with a standardized assessment and documentation tool at well child visits. It provides a record of health, social, and developmental surveillance of the infant/child, and parameters for physical examination, development, growth, nutrition, and oral health, and anticipatory guidance for nutrition, safety, behaviour, family, and environmental health promotion teaching. Information on immunizations is also given so that vaccines may be provided.

The well child visit is an opportunity for health care providers (HCPs) to engage one-on-one with families, and with the help of the NWT WCR, recognize infants/children, and families who might be at risk. This involves asking caregivers for any concerns about the infant/child's health and development, observing the infant/child, identifying risk and protective factors (including determinants of health), and using the NWT WCR to monitor progress, document attainment of milestones, and the plan of care. Early identification of any risk factors or challenges in these areas should be followed up with additional assessments, screening, referrals, and interventions to improve an infant/child's and their family's outcomes.

The protocol for the well child visit is described in the NWT Community Health Core Service Standards and Protocols

Questions about the NWT Well Child Record form, and 2021 WCR Handbook and Desk Reference should be directed to: *Nursing@gov.nt.ca*

Questions on WCR EMR data fields, EMR utility, or data integrity comments, contact *yhssa_helpdesk@gov.nt.ca*

EMR Helpline at 867-767-9108, option 4#

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Well Child Program

Developmental Surveillance

An individual's health, social and developmental history can help identify deviations (e.g., achievement of skills out of typical sequence, regression of skills) that warrant investigation. Ongoing surveillance of an individual's health, and development helps to identify areas of concern early, so interventions may be implemented when they are most impactful.

The well child visit can help build relationship-based care by providing nine visits with the family to monitor, engage, and provide family-centered, safe, respectful, high quality care. These visits are connected to core programming across the lifespan, which starts with prenatal care. By involving the family in identifying an area of health, social or developmental concern, and the plan of care can be grounded in trust, and shared outcomes.

NWT WCR Forms:

There are 9 forms in the NWT WCR series, and most correspond to the NWT immunization schedule. Do not let the need for, or refusal of an immunization, limit the WCR assessment:

- Within 1 week
- 1 month
- 2 months
- 4 months
- 6 months
- 12 months
- 18 months
- 3 years
- 4 to 5 years

The infant/child's chronological age will determine which NWT WCR form to use during the well child visit. For example, the 6 month well child visit would ideally be done within a few weeks of the infant turning 6 months because the developmental milestones and skills on the developmental assessment portion should be mastered by most children at that chronological age. **If the child's age falls between two NWT WCR forms at the well child visit, use the earlier of the NWT WCR forms,** because the later assessment option is too advanced to be mastered by most children and may result in a false developmental area of concern (e.g., for an 8 month old child, use the 6 month old NWT WCR form). **For premature infants born at less than 37 weeks use corrected age for growth and development until 24 to 36 months.**

NWT Well Child Record Handbook:

The NWT WCR Handbook is a comprehensive resource and should be used as a compendium to the WCR tool to help ensure the NWT WCR tool is being completed as intended in the EMR and during the well child visit.

- The Item column lists all fields collected on the NWT WCR. An item may need to be asked at more than one visit depending on risk or need. **Repeated discussion of items is based on perceived risk or need.**
- The **Description** column provides clinical information on the NWT WCR content items and NWT approved resources. *Referral recommendations* are also given for when a ***Red Flag*** concern is identified.
- The **Appendix** contains well child discussion questions: key actions, messages, and resources.

NOTE- Clinical judgment based on assessment is always required for all *Descriptions* or concerns, with or without *referral recommendations,* and may still warrant a referral.

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NWT Well Child Record Desk Reference:

The NWT WCR Desk Reference is a quick resource to help HCPs facilitate the completion of the NWT WCR in the EMR system and during the well child visit. **Clinical judgement is still required**.

Well Child Record Recommended Resources:

The following clinical resources should be provided by each NWT Regional Health and Social Services Authority (HSSA) to each Primary Health Care Setting for the effective use of the NWT WCR during well child visits:

- **Resource Box:** A plastic bin containing a variety of preschool picture books and plain language literacy resources from the NWT Literacy Council.
- **Family Oral Health Kit:** A supply of family dental kits containing toothbrushes, toothpaste, floss/flossers, brushing chart and timer and dental education materials.
- **Oral Health Teaching Aids:**
    - A large-scale mouth model with toothbrush for demonstrations
    - A colour flip chart *A Pediatric Guide to Children's Oral Health* by the American Academy of Pediatrics
- **Developmental Assessment Kit:** Kit(s) containing the following toys and items to assist with the developmental assessment portion of the well child visit:
    - Rattle (plastic)
    - Balls (2 sizes approximately 1.5" and 3" diameters)
    - Stacking blocks (plastic)
    - Truck with wheels that roll. Ideally one that you could put an item in the truck bed. (plastic)
    - Coloured pencils pack
    - Crayons pack (thick crayons to avoid breakage)
    - Bowl & spoon (plastic, child sized)
    - Doll (plastic)
    - Toy telephone, plane or other item for pretend play
    - 2 board books

Items are all plastic for easy cleaning. Clean items as per the NWT Infection Prevention and Control Manual

Important Reminders:

- There may be more than one HCP involved in the well child visit. The NWT WCR must be signed by a licenced practitioner who takes overall responsibility for the accurate completion of the form.

- It is important to note the items marked on the NWT WCR indicate items that have been discussed. If an item has been left blank, the item has not been discussed.

- **There should be no blanks in the DEVELOPMENT section. All items should be assessed.**

- Developmental tasks are set after the time of normal milestone acquisition. The absence of any one or more developmental items is considered a high-risk marker and indicates consideration for further developmental assessment and referral. **Caregiver concern about development at any stage is also considered a high-risk marker, and therefore requires further assessment and referral**.

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- Individuals can self-refer for occupational therapy and physiotherapy programs in Yellowknife, Inuvik, Hay River and Fort Smith. This program includes occupational therapy, physiotherapy, speech-language pathology, and audiology. **HCPs must refer if there is a concern found during the assessment or if the caregiver requests a referral.**

- An optimal time to tell families about the **Healthy Family Program** (HFP) and provide a universal active offer invitation to the HFP is during well child visits.

- NWT Elders and other community members are a strong source of support for caregivers of infants and young children. It is important for primary HCPs to be respectful that caregivers of infants and young children obtain information on caring and support from a number of sources that the caregiver trusts.

- The NWT WCR is a tool and it will not always detect concerns. **Clinical judgment is still required**.

- If a health, social and/or developmental area of concern is detected in the infant or child during the well child visit, a referral to the appropriate HCP(s) should be completed by following the HSSA operational referral pathway.

- If suspicious about a finding, discuss it with an NP/MD or Paediatrician on call.

- All HCPs are responsible for using approved HSS resources, and Wolf EMR when using the NWT WCR and EMR.

- The **EMR Learning Portal** on Wolf contains approved training material, archived EMR Notification communications, and the contact for your regional help desk and EMR support team for users requiring NWT EMR support.

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Abbreviations Used in the NWT WCR Handbook:

CDA	Canadian Dental Association
CHN	Community Health Nurse
CPI	Clinical Practice Information
CPS	Canadian Paediatric Society
CSEP	Canadian Society for Exercise Physiology
ECD	Early Childhood Development
EMR	Electronic Medical Record
ENT	Ear Nose & Throat
HCP	Health Care Provider
HFP	Healthy Family Program
HSS	Health and Social Services
HSSA	Health and Social Services Authority
MD	Medical Doctor
NP	Nurse Practitioner
NTHSSA	Northwest Territories Health and Social Services Authority
NWT	Northwest Territories
OH	Oral Health
OT	Occupational Therapist
OTC	Over the Counter
PHN	Public Health Nurse
PT	Physical Therapist
RBR	Rourke Baby Record
SIDS	Sudden Infant Death Syndrome
SLP	Speech Language Pathologist
STH	Stanton Territorial Hospital
TCSA	Tłı̨chǫ Community Services Authority
UNHS	Universal Newborn Hearing Screening
URTI	Upper Respiratory Tract Infection
URTI	Upper Respiratory Tract Infection
WCR	Well Child Record

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Birth Information

Item	Description
Pregnancy/Birth Remarks/Apgar **Referral**	**Document concerns during pregnancy or birth that may impact the care of the infant and Apgar scores. Review Newborn Delivery Record and NWT Prenatal Record.** For example, polysubstance use, chronic medical conditions (e.g. diabetes, hypertension), anemia, bleeding, infection, fever, STI (e.g. Chlamydia, Herpes) in pregnancy, etc. **Ensure Apgar scores from Newborn Delivery Record are populated.** Fetal alcohol spectrum disorder (FASD) Acting early is important to reduce the chances that children with FASD will have secondary impacts when they get older. Resources identifying children with FASD, so supports can be offered, change as the child ages. If a caregiver has concerns that their child is impacted by FASD, they can talk to their HCP about what can be done to help them and their child. **HCPs should ask the following to provide a referral for further assessment**: • if the mother drank prior to pregnancy and during pregnancy and how much, • about the child's behaviour, • how the child is doing in school (if school age), and • if the child has trouble learning. **Provide referral to the Child Development Team at Stanton Territorial Hospital for further support and assessment of FASD.**
Past Problems / Risk Factors/Family History	**Document any major problems/risk factors identified to date. Review Newborn Delivery Record and NWT Prenatal Record.** For example, failure to thrive, anemia, developmental delays, rickets, obesity, mother with hepatitis or HIV, etc. Any significant diagnosis of birth defect or developmental condition in biological family, including biological siblings, aunts, uncles, grandparents and cousins. For example, cardiac anomalies, neural tube defects, diabetes, hearing deficits, SIDS, etc.
Gestational Age	**Document the gestational age at date of birth found in the Newborn Delivery Record.**
Birth Length (cm)	**Document the length of baby at birth in centimetres found in the Newborn Delivery Record.**
Birth Weight (g)	**Document the weight of baby at birth in grams found in the Newborn Delivery Record.**
Birth Head Circ (cm)	**Document the head circumference of baby at birth in centimetres found in the Newborn Delivery Record.** See *Physical Examination section* item fontanelles for more information.
Discharge Weight	**Document the weight of baby when discharged from hospital/birthing centre found in the Newborn Delivery Record.**
Resources	HSS Resources • Fetal Alcohol Spectrum Disorder Health Canada Resources: • Support for fetal alcohol spectrum disorder

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Biometrics

Important: Corrected age for plotting on WHO Growth Chart should be used until at least 24 to 36 months of age for premature infants born at less than 37 weeks gestation.

Item	Description
Length / Height (cm)	**Document the length or height in cm (to nearest 0.1 cm) taken during the examination.**
Weight (g)	**Document weight in grams or kilograms (to nearest 0.1 kg) taken during the examination.**
Head Circumference	**Document the head circumference in cm (to nearest 0.1cm) taken during the examination.**
BMI	**Document the Body Mass Index calculated with the length/height and weight taken during the examination.**
Referral	**Refer to next level of HCP (NP/MD or paediatrician):** • **if infant does not regain birth weight 2 weeks after birth;** • **if the growth parameters crosses percentile lines on the WHO growth chart or growth indices less than 3rd percentile or greater than 97th percentile for infants 2 months to children 4-5 years;** • **if absent/small anterior fontanelle with falling head circumference growth rate for infants at 6 months;** • **if a falling head circumference size in children of all ages**
Resources	NWT HSS Resources • NWT Child Growth Chart Standard

Parent/Caregiver Concerns

Item	Description
Parent / Guardian concerns	**Document any caregiver health, social, and developmental concerns about the infant/child.** Explore if the caregiver has any health, social, and/or developmental caregiver concerns for the infant/child at any stage because these are considered a high-risk marker, and therefore requires further assessment.
Referral	**Refer to next level of HCP (NP/MD or Paediatrician) if any significant health, social, or developmental caregiver concerns for any infant/child at any stage.**

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Nutrition

Supporting families in infant feeding and nutrition.

Explore with the caregiver *"if they have difficulty in making ends meet? Do they have trouble feeding their family?"*
See Appendix: *Well Child Food Security Questions* for more information

Item	Description
Breastfeeding (exclusively)	**Indicate if infant is breastfed and exclusively breastfeeding.** Exclusive breastfeeding: Includes the infant receiving human milk (including expressed milk, donor milk) and receiving oral rehydration solutions (ORS), or syrups (vitamins, minerals, medicines) if required, but does not include the infant receiving anything else (WHO). **Discuss client's knowledge and experience with breastfeeding**. See Appendix: *Well Child Infant Feeding Discussion Questions* for more information. **Discuss Oral Health Care** See NWT WCR Handbook item *Oral Health* for information on breastfeeding and oral health for all well child visits.
Breast milk and other feeds	**Indicate if the infant is breastfed non- exclusively.** Non-exclusive breastfeeding: The infant/child has received human milk (includes expressed milk, donor milk) and water, water-based drinks, fruit juice, ritual fluids or any other liquid including non-human milk or solids. **Discuss client's knowledge and experience with breastmilk and other feeds**. See Appendix: *Well Child Infant Feeding Discussion Questions* for more information. **Advise caregiver to clean infant's mouth and gums with a clean, damp cloth after every feed.** See *NWT WCR Handbook* item *Oral Health* for information on oral health for all well child visits. **Advise that infants should always be held when feeding from a bottle.** See *NWT WCR Handbook* item *No Bottles in Bed.*
Iron–fortified formula	**Indicate if infant is fed a commercial infant formula in any form.** **Discuss the caregiver's knowledge and experience with formula**. See Appendix: *Well Child Infant Feeding Discussion Questions* for more information. **Advise caregiver to use only iron-fortified formula.** Formula includes powdered concentrate, liquid concentrate or ready-to-feed.
Vitamin D	**Indicate infant Vitamin D Supplementation.** All infants and children under 3 years should receive a total of 800 IU Vitamin D per day. **Discuss Vitamin D Supplementation** • Routine Vitamin D supplementation of 800 IU/day is recommended for all exclusively breastfed infants until 3 years. • Standard fortified formula contains 400 IU Vitamin D per liter. • Infants should be supplemented with Vitamin D to ensure they are receiving a total of 800 IU/day.
Discontinue Breastfeeding	**Document how old child was when breastfeeding was discontinued.**
Stool pattern and	**Indicate stool pattern and urine output discussed**.

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Item	Description
Urine output	Note: volume and consistency of output helps to assess hydration and digestive function.
Referral	**Refer to Lactation consultant if previous difficulties with infant feeding were experienced.** **Offer a referral to Public Health Nurse, Lactation Consultant or other maternity care provider, and breastfeeding education/peer support in the community (i.e. Mom's, Boobs and Babies support group).**
Resources	NWT HSS Resources: • NWT Vitamin D Supplementation Recommendations • Breastfeeding and Infant Nutrition

Solids, Milk and other Nutrition issues

Explore with the caregiver *"if they have difficulty in making ends meet? Do they have trouble feeding their family?"*
See Appendix: *Well Child Food Security Questions* for more information

Item	Description
Introduction of solids	**Indicate future introduction of solids.** Discuss the introduction of iron-containing foods to avoid iron deficiency, at a few weeks prior, or just after six months. A variety of soft-textured foods, ranging from purees to finger foods can be introduced.
Iron containing foods	**Indicate discussion on ensuring the infant/child is getting adequate iron.** Infants with lower iron stores are at a higher risk of iron deficiency. Infants include those with a birth weight less than 3000 grams, born to mothers with iron deficiency or diabetes, mothers who consumed excess alcohol during pregnancy, infants fed whole cow's milk before 9 months or at quantities greater than 750 mLs/day, or if iron containing foods are not provided to the infant/child.
Age solids introduced	**Indicate the age (months) at which solid food was introduced.**
No honey	**Indicate discussion on advising no honey until 1 year of age.** Infants under 1 year of age should not have honey to prevent botulism.
Choking/safe food	**Indicate discussion on safe feeding practices.**

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Item	Description
No bottles in bed	**Indicate discussion on how infants should always be held when feeding from a bottle.** Infants/children should never be put to bed with a bottle, and infants should be held while feeding from a bottle (no bottle-propping). This helps prevent ear infections, aspiration, and tooth decay. **Advise caregiver that if bottles are used for feeding:** Only breastmilk, formula or water should be given in a bottle. This is important to prevent infant dental caries.
Avoid Sweetened Juices	**Indicate discussion on avoiding sweetened juices.** No fruit juice should be given before 1 year of age and should be limited after this time.
Frequency of sweetened beverage	**Indicate how often infant/child is drinking sweetened beverages.**
Homogenized milk	**Indicate if homogenized (3.5% MF) milk is being given.** After 12 months of age, to prevent iron deficiency, cow's milk should be limited to 500-750mL (16-24oz)/day. Feeding excessive fluids limits intake of nutritious table foods. Pasteurized fresh whole cow's milk (3.5%MF), ultra-high temperature processed, or diluted 1:1 canned evaporated milk may be introduced at 12 months of age and continued to the second year of life. **Inquire about whether the child is drinking cow's milk alternatives.** Cow's milk alternatives often contain less protein and fewer calories in comparison to cow's milk. Most alternatives are fortified with vitamin D and calcium. Check the labels because protein and vitamin content may differ among brands.
Skim, 1% or 2% milk	**Indicate if a transition to lower fat milk has occurred.**
Canada/ Northern food guide	**Indicate whether information on healthy eating has been provided.** From one year of age, young children begin to have a regular schedule of meals and snacks. Encourage healthy food choices by using information from Canada's Food Guide and Canada's Food Guide: First Nations, Inuit and Métis.
Promote open cup	**Indicate promoting the use of an open cup instead of a bottle or sippy cup.** Use of bottles or sippy cups may delay the development of a mature swallow pattern that is effective for more advanced textures and effective and efficient eating, more advanced language skills, and facial development. A sippy cup may also promote the pooling of sugar containing liquids. These can remain on teeth for hours, providing food for decay-causing bacteria.
Vegetarian diets	**Indicate inquiry about whether the child is on a vegetarian diet.** Discuss ensuring the consumption of key nutrients such as B vitamins, protein, and iron.

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Item	Description
No bottles	**Indicate that caregiver has been advised that child should be off the bottle by 18 months.** The child should no longer use a bottle for all fluids by 18 months if possible, to reduce the risk of dental caries.
Lower fat diet	**Indicate discussion on gradual transition to a lower fat diet.** There is no evidence that restrictions of dietary fat provide any benefits during childhood and may compromise the intake of energy and essential fatty acids required for growth and development. Care should be made in choosing nutritious higher-fat foods and limiting high fat methods of food preparation (deep frying, frying food in oil).
Resources	NWT HSS Resources: • Drop the Pop NWT • NWT Vitamin D Supplementation Recommendations • Breastfeeding and Infant Nutrition • Food and Nutrition Health Canada Resources: • Infant Feeding • Canada's Food Guide • Eating Well With Canada's Food Guide-First Nations, Inuit and Metis

Education & Advice

Injury Prevention

Category	Description
Car seat	**Indicate discussion on the appropriate use of car seats for the child's weight and age.** The NWT Motor Vehicles Act requires all passengers in a motor vehicle to be secured by a properly adjusted seat belt or prescribed child restraint. Provide information on vehicle safety for motor vehicles such as cars, ATVs, and snowmobiles.
Carbon monoxide/ smoke detectors	**Indicate discussion on having carbon monoxide and smoke detectors in the home.**
Safe Sleep	**Indicate discussion on safe sleep position, room sharing, avoid bedsharing, crib safety.** Explore how the family sleeps and discuss harm reduction strategies for safer sleeping.
Hot water/ bath safety	**Indicate discussion on safe bathing.** The maximum bathwater temperature should be 39°C (100°F). Hot water at 60° C can produce third-degree burns in one to five seconds. Advise to set the maximum temperature of the water tank to 49 °C (120 °F).
Firearm safety	**Indicate discussion on firearm safety.** The safe storage of firearms in the home is important to decrease risk of unintentional firearm injury, suicide, or homicide.

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Category	Description
Choking / Safe Toys	**Indicate discussion on choking prevention.**
Pacifier use	**Indicate discussion on pacifier use.** Successful breastfeeding and pacifier use can occur together. It is important to assess breastfeeding effectiveness and ensure adequate support is provided in the early postpartum period. Pacifier use should be restricted in children with chronic/recurring otitis media. Pacifiers should never be dipped in honey, syrup or any other liquid or food to promote their use.
Shaken baby syndrome	**Indicate discussion on shaken baby syndrome.** Discuss what shaken baby syndrome is and ways to prevent it. See *NWT WCR Handbook* item *Crying* for more information.
Electric plugs/ cords	**Indicate discussion on electric plugs and cords.** Discuss safety precautions for electric plugs and cords.
Falls	**Indicate discussion on falls (stairs, change table, unstable furniture/TV, not walkers)** Discuss fall prevention in the home and advise against trampoline use.
Poisons	**Indicate discussion on poisons and poison control centres.** Discuss poisoning prevention and what to do in case of poisoning. Provide information on PADIS.
Wean from pacifier	**Indicate discussion on a plan for weaning child from pacifiers.** Limiting pacifier use should begin around age 2 to 3 and weaning should be achieved by age 5. See *WCR Handbook* item *Pacifier Use* for more information.
Bike helmets	**Indicate discussion on the use of bike helmets.** Children should wear a bike helmet**.** A helmet should be replaced immediately if there is obvious damage, if it has sustained a heavy impact, or if the child has outgrown it.
Matches	**Indicate discussion on matches.** Matches and lighters should be kept out of reach of children.
Water safety	**Indicate discussion on water safety.** Recommend adult supervision, training for adults, lifejackets, swimming lessons, boating safety, and 4-sided pool fencing to decrease the risk of drowning.
Referral	**Unexplained injuries (e.g. fractures, bruising, burns) or injuries that do not fit the rationale provided or developmental stage that raise concerns for child maltreatment.** See *NWT WCR Handbook* items *Physical Examination: Skin* and *High Risk Infants/Children/Caregivers/Families* for more information

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Category	Description
Resources	NWT HSS Resources: • Child Passenger Safety Government of Canada Resources: • Child car seat safety • Is Your Child Safe? Series. Other Education and Advice Resources: • Pacifiers and Thumb Sucking • Perinatal Services BC- Safer Infant Sleep A Practice support tool intended to support safer sleep and open discussion about bedsharing. • First Nations Health Authority- New Safe Infant Sleep Toolkit-Honouring Our Babies Safe Sleep Cards and Guide An interactive, evidence-informed toolkit that incorporates cultural beliefs, practices, and issues specific to First Nations and Indigenous communities to promote safer infant sleep. • Poison & Drug Information Service (PADIS)

Behaviour and Family Issues

Explore the caregiver's need for family supports.
See Appendix: *Well Child Making Community Connections Questions* for more information

Item	Description
Crying	**Indicate discussion on crying.** Explore the caregiver's response to the infant/child's crying. When caring for a crying baby begins to become frustrating or makes a caregiver angry, it is time to take a break. The best thing a caregiver can do for the infant is to get away from the crying for a while and calm down. This does not mean the caregiver is bad. It only means they are normal. Encourage the caregiver to ask their partner, a relative, or friend if they could help with the infant for a while. If none of these options are available, encourage them to set the infant down in a safe place and walk away while emotions are high. It is important to take some time to allow emotions to calm down before returning to care for the infant.
Night waking	**Indicate discussion on night waking.** Explore if infant/child has periods of wakefulness at nighttime, common sleep problems like sleep deprivation, separation issues, and nightmares.
Healthy sleep habits	**Indicate discussion on healthy sleep habits.** Explore infant/child's current sleep strategies and discuss healthy sleep strategies for the infant and child. Discuss how much sleep a child requires.
Parental fatigue/ depression **Referral**	**Indicate discussion on parental fatigue/depression.** **Explore the caregiver's mood and risk for fatigue/depression.** See Appendix: *Well Child Caregiver Mood Discussion Questions* for more information. **HCPs should refer to next level NP/MD and/or mental health specialist if there is possible Postpartum Depression and connect the caregiver with available community supports.**

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Item	Description
Parenting/ Bonding	**Indicate discussion on parenting/bonding.** **Explore how the caregiver is bonding with the infant and if they feel like they are connected and attached with the infant. Ask how they feel about being a new parent.** Encourage the caregiver to hold and play with the infant and to breastfeed. Connecting with others, including informal supports like extended family or other parents, friends and peer support who share in similar experiences may help them in developing a stronger, positive relationship with their infant.
Soothability/ responsiveness	**Indicate discussion on soothability/responsiveness.** Explore how easy/difficult it is to soothe the child. See *NWT WCR Handbook* item *Crying* for more information on parental coping.
Family conflict/stress	**Indicate exploration of whether there are any family conflicts/stresses at this time.** Explore with the caregiver how these family conflicts and stresses may be addressed within the resources available in the community. To identify if infants and young children, or their parents have been exposed to difficult situations or trauma, the following question is suggested: "*Since your last visit has anything really scary or upsetting happened to you or your family?*" See *NWT WCR Handbook* items *High Risk Infants/Children/Caregivers/Families* and *Potential Resources* for more information.
Parent/child interaction	**Assess quality of caregiver/child interaction.** Explore with caregiver possible concerns when interacting with their infant/child and provide support/ options and how concerns may be addressed within the resources available in the community.
Discipline/ parenting skills	**Ask if there are issues with being a caregiver and/or discipline.** Explore how being a caregiver is going. Are the caregivers finding anything difficult? How is setting limits with the child? Discipline? Handling tantrums?
Referral	**The response to questions when exploring the infant/child's behaviour and any family issues is an opportunity to link caregivers to available community resources, including peer-to-peer caregiver groups. Provide the *Universal Active Offer invitation* to the Healthy Family Program.** See also Appendix: *Well Child Making Community Connections Questions* for more information.

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High risk infants/ Children/ Caregivers/ Families	**If there are suspected child protection concerns, there is a legal responsibility for all individuals to immediately contact a Child Protection Worker, or if unavailable, the RCMP** *(Child and Family Services Act, 2016 (Section 7); Criminal Code of Canada.)* **Indicate that have assessed for a possible high-risk infant/child, which may include child protection concerns, and the need for a possible home visit.** The first point of contact for child protection concerns is Child and Family Services. If Child and Family Service is not available, contact the RCMP. Health care staff should take care to provide a safe environment and **not "probe" further or pursue an informal "investigation"** as multiple re-telling's can be re-traumatizing. To help maintain trust with the caregiver(s), be transparent and explain to the caregiver(s): "*you are obligated to report when*: '*Things*' or '*concerns like this come up*' (i.e., signs of abuse, disclosure of abuse, etc.) *and that Social Services will follow up with them to talk more and see the family to make sure everyone is safe and has the support they need."*
Referral	**If there are child protection concerns, immediately contact a Child Protection Worker, or if unavailable, the RCMP (Child and Family Services Act, 2016 (Section 7); Criminal Code of Canada).**
Referral	**The response to questions when exploring the infant/child's behaviour and any family issues provides an opportunity to link caregivers to available community resources, including peer-to-peer caregiver groups. Provide the *Universal Active Offer invitation* to the Healthy Family Program.** See also Appendix: *Well Child Making Community Connections Questions* for more information
Resources	HSS Resources: • Child and Family Services • Northwest Territories Healthy Family Program • NWT Family Violence Shelters • Community Counselling Program (CCP) • NWT Help Line

Family

Siblings	**Indicate discussion about relationship to siblings**. Explore with the caregiver the relationship between the infant/child and any siblings, and/or other close members of the family unit.
Childcare/ return-to-work	**Indicate discussion about current childcare arrangements.** Explore the childcare options that are available and encourage ones that are safe and stimulating for child.
Active living/ sedentary behaviour	**Indicate discussion on the family's healthy active living/sedentary behaviours.** Explore the family's physical activity level and encourage them to be physically active, rather than sedentary together, to promote life-long healthy choices.

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Encourage reading	**Indicate discussion on encouraging reading.** Explore how often caregivers should read to their infant/child/children. Exposing infants and children to books promotes early literacy, and language skills. Discuss limiting TV, video, and computer games to provide more opportunities for reading and interactive/imaginative play. **Ask if caregivers have access to books**. If not, suggest where books can be borrowed in the community or provide a picture book appropriate to child's age from the WCR Resource Box.
Socializing/peer play	**Indicate discussion on the child's socialization/peer play opportunities.** Explore with the caregiver about the child's opportunities to socialize and play with other children. Discuss with caregivers of preschoolers teaching names of genitalia, appropriate and inappropriate touch, and normal sexual behaviour for their age.
Referral	**The response to questions when exploring the infant/child's family may be an opportunity to link caregivers to available community resources, including caregiver groups. Provide the *Universal Active Offer invitation* to the Healthy Family Program.**
Assess childcare, preschool needs/ school readiness **Referral**	**Indicate assessment of childcare/ preschool needs/ school readiness.** Although children do not 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 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, and • be away from their caregivers and parents and understand that parents will come back. **Refer to OT/PT/SLP as appropriate if area of concern identified or caregiver has concerns.**
Screen time	**Indicate discussion on screen time.** Explore with the caregiver what is the amount of time the infant/child spends in front of a screen. Screen time includes TV, computers, tablets and smart phones.
Resources	HSS Resources • Drop the Pop NWT Health Canada Resources: • Mind: Screen Time Other Resources: • NWT Licensed day homes and day cares • Early Childhood Development • Yellowknife Dene First Nation- Aboriginal Head Start • NWT Literacy Council- Resources • Government of Alberta- Teaching Sexual Health

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Environmental Health

Item	Description
Second-hand smoke exposure	**Indicate discussion on second-hand smoke.** There is no safe level of smoke exposure. Advise caregivers to protect infants/ children from second-hand smoke by making their homes and vehicles smoke-free. Avoiding the use of tobacco, vaping, e-cigarettes and cannabis around infants and children is strongly recommended. Cannabis and Safe Storage Encourage those who use cannabis to ensure they are storing their products in a safe place where children cannot reach them. Teach caregivers that if a child does consume cannabis to immediately call PADIS due to its toxicity in children.
Sun exposure/ sunscreens/insect repellent	**Indicate discussion on sun exposure/sunscreens/insect repellent.** Discuss with caregivers the use of sunscreens, sun protection clothing, and to minimize sun exposure in spring and summer. Advise caution when using insect repellents in infants and children and discuss instead using loose fitting, all-covering clothing to help protect children from possible mosquito vector borne illnesses.
Pesticide Exposure	**Indicate discussion on pesticide exposure.** Advise caregivers to avoid pesticide exposure including home, garden and agricultural use.
Blood Lead If at Risk	**Indicate discussion on blood lead if at risk.** There is no safe level of lead exposure in infants/children. Evidence suggests that low blood lead levels can have adverse health effects on an infant/child's cognitive function.
Resources	HSS Resources: • NWT Quitline • Health Effects of Cannabis • Lead Environmental Health-Contaminants Fact Sheets • Environmental Health Resources Health Canada Resources • Lead Information Sheet

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Other Issues

Item	Description
Teething/Dental Cleaning/ Fluoride	**Indicate discussions on teething/dental cleaning/fluoride.** Advise the caregivers what strategies are recommended when baby teeth come in if the child is getting their teeth and seems to be in pain. Provide oral health resources from the **Family Oral Health Kit.** See *NWT WCR Handbook* item *Oral Health* for information on oral health that applies to every well child visit.
OTC cough/ cold medication	**Indicate discussion on OTC cough/cold medicine use.** Advise caregivers against using OTC cough/cold medications in all infants/children under age 6. Productive coughs should not be suppressed. No products with acetylsalicylic acid should be given to youths because it can cause Reyes syndrome**.**
Temp control and overdressing	**Indicate discussion on temperature control and overdressing the child.** Discuss the importance of dressing an infant/child appropriately for conditions to avoid overheating or cold exposure.
OTC/ Complementary Alternative/ medicine	**Indicate discussion on the use of OTC/complementary/alternative medicines.** Explore about the use of traditional, and homeopathy/complementary and alternative medicine therapy or products, especially for children with chronic conditions.
Fever advice /thermometers	**Indicate discussion and advice for fevers/thermometers.** Discuss treatment of fever in children and temperature taking.
Footwear	**Indicate discussion on appropriate footwear.** Discuss the use of footwear in infants and children.
Toilet learning	**Indicate discussion on toilet learning.** Discuss with the caregiver how toilet learning is progressing for the child.
No pacifiers	**Indicate discussion on no pacifier use.** Explore the use of pacifiers and advise the caregiver that pacifier use should be limited beginning around age 2-3 and weaning should be achieved by age 5.
Resources	Other Resources: • CPS Position Statement- Children and natural health products: What a clinician should know • CPS Position Statement- Homeopathy in the paediatric population • CPS Position Statement- Chiropractic care for children: Controversies and issues • CPS-Fever and temperature taking • CPS Practice Point- Footwear for children • CPS Position Statement-Toilet learning: Anticipatory guidance with a child-oriented approach • CPS-Toilet Learning

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Environment

Item	Description
Smokers in the house	**Indicate if smoking occurs in the house.** See *NWT WCR Handbook* item *Secondhand Smoke Exposure* for more information**.**
Location of smoking	**Indicate location of smoking and if smoking occurs inside or outside the house.** See *NWT WCR Handbook* item *Secondhand Smoke Exposure* for more information**.**
Child safety concerns	**Indicate if asked caregiver if they have any concerns regarding the infant/child's safety.** This would include any concerns about physical, emotional or sexual abuse. *See also NWT WCR Handbook* item *High Risk Infants/Children/Families/Caregivers* for more information.
Electronic devices	**Indicate if infant/ child watches entertainment on electronic devices and document amount of time spent.** See also *NWT WCR Handbook* item *Screen Time* for more information.
Video games	**Indicate if child plays video games and document amount of time spent.** See also *NWT WCR Handbook* item *Screen Time* for more information.
Reading	**Indicate if caregiver or others read with infant/child.** See also *NWT WCR Handbook* item *Encourage reading* for more information.
Day care/child development program	**Indicate if child attends a day care/child development program.** See also *NWT WCR Handbook* items *Assess child care, preschool needs/ school readiness* and *Socializing/Peer Play* for more information.

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Development

All items of the Development Section should be addressed at every visit. Indicate ✓ for no concerns and X if a concern(s) is identified.

Where possible, try to observe the child doing the item using items from the Developmental Assessment Kit rather than relying on the parent's report of developmental skill acquisition. Correct for age for premature infants born at less than 37 weeks gestation until 24 to 36 months.

Item	Description
1 Month	
Focusses gaze	Observe infant. Can they focus on an object or face?
Startles to loud noise	Clap hands and observe infant's response.
Calms when comforted	Observe or ask parent this item.
Sucks well on nipple	Observe.
No parent/caregiver concerns	Ask caregiver if they have any concerns about how the infant is developing.
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or** **any significant caregiver concerns for infant's development.**
2 Months	
Follows movement with eyes	Observe infant.
Coos – throaty, gurgling sounds	Observe infant.
Lift head up while lying on tummy	Observe infant in prone position.
Can be comforted & calmed by touching/rocking	Observe infant.
Sequences 2 or more sucks before swallowing/breathing	Observe infant feeding if possible.
Smiles responsively	Observe infant.
No parent/caregiver concerns	Ask caregiver if they have any concerns about how the infant is developing.

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Item	Description
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or** **any significant caregiver concerns for infant's development.**
4 Months	
Follows a moving toy or person with eyes	Move a toy in front of the infant (approximately 1 foot away from the head).
Responds to people with excitement (leg movement/ panting/vocalizing)	Observe how infant responds to people.
Holds head steady when supported at the chest or waist in a sitting position	Observe infant when sitting in parent's lap.
Holds an object briefly when placed in hand	Place the toy in the infant's hand.
Laughs/smiles responsively	Observe infant.
No parent/ caregiver concerns	Ask caregiver if they have any concerns about how the infant is developing.
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting 2 or more developmental milestones, and/or** **if missing one milestone, then recheck in 1 month. If continues to not meet milestone, then refer to next level of HCP (NP/MD or paediatrician), and/or** **any significant caregiver concerns for infant's development.**
6 Months	
Turns head toward sounds	Shake a rattle or make a sound to one side of the infant and see if they turn towards you.
Makes sounds while you talk to them	Talk to the infant and see if they make sounds back to you? Wait and listen for the infant to respond.
Vocalizes pleasure and displeasure	Does the infant make sounds that show pleasure and displeasure? Try eliciting these by showing them a colourful toy.

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Item	Description
Rolls from back to side	Place the infant on a flat surface and observe its movements. Ask parents if you do not observe the item.
Sits with support	Sit the infant on a flat surface (not in a parent's lap). The infant can use their arms for support or a pillow or rolled up blanket. Can the infant maintain this position?
Reaches/grasps objects	Bring a toy close to infant's hand and see if they reach for it.
No parent/ caregiver concerns	Ask caregiver if they have any concerns about how the infant is developing.
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting 2 or more developmental milestones, and/or** **any significant caregiver concerns for infant's development.** **If missing one milestone, then recheck in 1 month. If continues to not meet milestone, then refer to next level of HCP (NP/MD) or paediatrician.**
12 Months	
Responds to own name	Say the child's name. Do they look toward you?
Understands simple requests	Ask "give the ball to mom", or "give me the ball".
Makes at least 1 consonant/ vowel combination	For example: any combination of p, b, m, n, a and uh – e.g. puh, buh, ma, na, ba
Says 3 or more words (don't have to be clear)	Elicit words by labelling familiar pictures in a book, or a familiar toy and waiting for the child to take a turn. Or, invite the parent to do this as shy children may be more willing to speak when interacting with a parent or caregiver. The child is engaged in conversation: • beginning to use jargon (or a nonsense like language) • seeks out socialization • maintains eye contact with communication partner
Crawls or "bum" shuffles	Observe child.
Pulls to stand/Walks holding on	Observe child. Have child size furniture that they can pull themselves up on.
Picks up small items using tips of thumb and fingers	Place small toys/ cheerios in front of child and see if they can pick them up using pincer grasp (between thumb and index finger.)

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Item	Description
Takes things out of containers	Place the container of blocks in front of the child and see if they take blocks out of the container.
Shows distress when separated from parent/caregiver	Does child have stranger anxiety?
Follows your gaze to jointly reference an object	Observe if the child does this or ask caregiver "do they look at things you are looking at or paying attention to?"
No parent/ caregiver concerns	Ask caregiver if they have any concerns about how the child is developing.
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or** **any significant caregiver concerns for child's development.** **Referral not necessary if they do not yet have their first word or are not cruising.**
18 Months	
Child's behaviour is usually manageable	Ask caregiver this item. Can the child sit and listen to stories?
Interested in other children	Ask caregiver this item.
Usually easy to soothe	Observe how child responds to caregiver's attempts to soothe. For example, after immunization.
Comes for comfort when distressed	Does the child turn to the caregiver for comfort when distressed?
Points to several different body parts	Ask child "Where is your nose, foot, etc." If the child is shy, get the caregiver to ask child to show the body parts.
Tries to get your attention to show you something	Observe or ask parent if the child does this.
Turns/responds when name is called	Call child's name when they are facing away from you.
Points to what they want	Keep the toys slightly out of reach and ask child which toy they want from a selection of toys so child has to point.
Looks for toy when asked or pointed in direction	Ask for a toy that the child is familiar with but that is out of the child's direct sight. If child does not respond or can't find it, the HCP can point in the direction of the item and say something like, "I see the (x)". Does the child look where the HCP is pointing?

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Item	Description
Imitates speech sounds and gestures	Ask the caregiver what animal sounds the child knows, and then ask the child to make the noise the animal makes. Make the animal noise and see if the child imitates you. At the end of the appointment, say "bye" and wave to the child and see if they imitate you.
Says 20 or more words (words do not have to be clear) **Referral** **Referral** **Referral**	Observe child's speech. Ask caregiver if required. The child can continue to use jargon between actual words. Many children do not say 20 words by age 18 months and subsequently develop speech rapidly after. The 18 to 24 month age group is extremely variable for speech development, and early intervention is important. **Refer to audiology and SLP for children who say less than 15 words at 18 months, as the wait time may take several months. Families can cancel if the child's speech improves.** **Paediatric referrals for an isolated speech delay should happen on or after 2 years old in conjunction with audiology and SLP.** There is no need for a paediatric referral if there are no other medical or developmental concerns. **If other developmental concerns are identified (i.e. motor or social) a paediatric referral should also be made with the audiology and SLP referral.**
Produces 4 consonants (e.g. BDGHNW)	Observe if any 4 consonants can be produced.
Walks alone	Observe child.
Feeds self with spoon with little spilling	Ask child to show you how they eat using the bowl and spoon from the kit. Or, ask caregiver to report on skill.
Stacks three or more blocks	Observe child playing with blocks. Prompting may be required.
Removes hat/socks without help	Ask "Can you take your socks off for me?" Can the child follow 1-2 step directions?
No parent/ caregiver concerns	Ask caregiver if they have any concerns about how the child is developing.

The Developmental Assessment at 18 months is a key time for early initial screening for possible autism. At 18 months, does the child:

1. Look at you and point when they want to show you something?
2. Look when you point to something
3. Use imagination to pretend play?

Based on CHAT (Checklist for Autism in Toddlers)

Referral- If areas of concerns are identified during the early initial screening for possible autism at 18 months, and/or if there are caregiver concerns, refer the child to next level of HCP (NP/MD or paediatrician.)

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Item	Description
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or** **any significant caregiver concerns for child's development.** **If isolated speech concerns, initiate audiology/SLP referral at 18 months, and/or** **if speech, motor, and social concerns, initiate audiology/SLP and paediatric referral 16-30 months.**
3 Years	
Understands 2 and 3 step directions	Give a direction such as "pick up the block and truck and put them on the table."
Uses sentences with 5 or more words	Observe child's speech using prompts as required.
Walks up stairs using handrail	Ask if child was able to do this coming into the health centre.
Twists lids off jars or turns knobs	Ask child to take off the lid. (Having something interesting in the jar will help motivate child).
Shares some of the time	Interact in play with the child and observe if they share
Plays make believe games with actions and words	Observe the child playing with the doll or truck or ask parent if the child plays make believe.
Turns pages one at a time	Provide child with a book and observe.
Listens to music or stories for 5 to 10 minutes	Ask caregiver this item.
Speaks clearly enough to be understood all of the time by family	Observe or ask caregiver this item. Does the child take part in conversation and maintain topics of conversation? Does the child seek out socialization with family and friends?
Jumps off the floor with both feet	Ask child "can you do this?" (HCP jumps.)
Imitates drawing horizontal and vertical lines	Draw horizontal and vertical lines on paper and ask child to copy.
No parent/ caregiver concerns	Ask caregiver if they have any concerns about how the child is developing.
Referral	**Refer to next level HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or** **any significant caregiver concerns for child's development.**

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Item	Description
4 Years	
Understands 3-part directions	Ask the child to "take the truck from the bag, put a block in it and drive it under the table."
Asks and answers lots of questions	Observe or ask caregiver this item.
Walks up/down stairs alternating feet	Ask caregiver this item unless there are stairs available for observation.
Undoes buttons and zippers	Ask the caregiver "does your child have clothes with buttons and zippers? Can they do them up and undo them or do they need help?"
Tries to comfort someone who is upset	Ask caregiver this item.
Holds a pencil or crayon correctly	Modified tripod or tripod grasp is acceptable.
Draws a person with three or more body parts	Give child paper and a pencil and ask them to draw a person.
No parent/ caregiver concerns	Ask caregiver if they have any concerns about how the child is developing.
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or any significant caregiver concerns for child's development.**
5 Years	
Counts out loud or on fingers to answer the question "How many are there?"	Put 4 blocks on the table and ask the child "how many are there?" Or ask "how many fingers do you have? Let's count them."
Speaks clearly in adult-like sentences most of the time	Observe.
Throws and catches a ball	Get child's attention and throw the ball to them. Ask the child to throw it back to you.
Hops on one foot several times	Ask child to hop on one foot.
Dresses and undresses with little help	If possible, ask child to put on own coat when leaving. Otherwise, ask caregiver this item.
Cooperate with adult requests	Assess during time with child. Ask caregiver for their observations.

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Item	Description
most of the time	
Retells the sequence of a story	Using a book with pictures, tell the child a short story. Then ask them to tell it back to you in their own words.
Separates easily from parent/caregiver	Observe or ask caregiver this item.
Holds a crayon or pencil correctly	Tripod grasp is acceptable.
Draws lines simple shapes and a few letters	Draw an X and two letters and ask the child to draw them for you.
No parent/caregiver concerns	Ask caregiver if they have any concerns about how the child is developing.
Referral	**Refer to next level of HCP (NP/MD or paediatrician) if not meeting developmental milestones, and/or** **any significant caregiver concerns for child's development.**

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Physical Examination

Indicate ✓ on appropriate box in the physical examination section where N is normal, and A is abnormal.

A physical examination is required for all infants and children using references approved by HSS and employing NWT HSSA which include NWT clinical practice guidelines, standards and protocols, as well as national resources that are adopted by HSS and employing NWT HSSAs.

NOTE- Clinical judgment is still required for all *Descriptions* with or without *referral* recommendations

Item	Description
Is child cooperative?	**Indicate if child is cooperating during the developmental and/or physical exam.** May give context to developmental indicators or physical exam parameters if unusual behaviour for child.
Skin **Referral**	**Check skin for signs of jaundice, dryness, bruising, or rash.** **Unexplained bruising warrants evaluation regarding child maltreatment or medical illness.** Bruising is rare (less than 1%) in infants prior to 9 months of age, in contrast to being common (40 to 90%) in those 9 months of age and older. *See WCR Handbook section High Risk Infants/Children/Caregivers/Families* for more information **Bilirubin testing (total and conjugated)** if jaundice persists beyond 2 weeks of age. Continue to monitor the presence or absence of jaundice at the 2 month well child visit. **Refer to next level HCP (NP/MD or Paediatrician) for persistent jaundice in infants older than 1 month old, especially if bottle fed.**
Fontanelles **Referral**	**Check to ensure that fontanelles are closing at appropriate times.** The posterior fontanelle is usually closed by 2months and the anterior by 18 months. **Refer to next level HCP (NP/MD or Paediatrician) for absent/small anterior fontanelle with falling head circumference growth rate at 6 months.**
Tongue mobility	**Inspect tongue mobility for ankyloglossia (tongue-tie).**
Heart/lungs/Abd **Referral** **Referral** **Referral**	**Auscultate heart in all regions.** Assess for normal S1 and S2; murmurs; extra sounds. **Auscultate all lung fields for air entry and adventitious sounds.** A lung assessment should include any symptoms of upper airway pathology, for example stridor, which may indicate laryngomalacia, and is a common newborn issue. **Assess the Abdomen.** Assess for the detection of a congenital or acquired renal lesion presenting as an abdominal mass. **Refer to next level HCP (NP/MD or Paediatrician) if heart murmur noted in all infants.** **Refer to next level HCP (NP/MD or Paediatrician) if abdominal mass assessed.** **Immediate referral to paediatrician for signs of heart disease including central cyanosis, breathing issues such as indrawing, tachypnea, or a palpable liver on exam.**
Umbilicus	**Examine umbilicus.** Assess for healing, drying, excoriation, redness, discharge/bleeding, odour.

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Item	Description
Referral	**Refer to Emergency if a possible umbilicus infection.**
Femoral pulses	**Palpate femoral pulses.** Assess for strength, equality; auscultate for bruit**.**
Hips **Referral** **Referral**	**Examine for developmental dysplasia of the hips until at least one year of age or until the child can walk.** 2 to 4 weeks - Barlow and Ortolani manoeuvres Greater 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). **Refer to next level HCP (NP/MD or Paediatrician) for hip click or clunk until 4 weeks.** **Refer to next level HCP (NP/MD or Paediatrician) if asymmetry of the legs at 12 months or older.**
Muscle tone/reflexes **Referral** **Referral**	**Physical assessment for spasticity, rigidity, and hypotonia should be performed up to one year.** **Ensure the infant sucks well on the nipple within 1 week of age**. Concerns with this reflex and development may indicate a concern for development and hydration**. Refer to next level HCP (NP/MD or Paediatrician).** **Refer to next level HCP (NP/MD or Paediatrician) if a child has good intellect and attentiveness AND hypotonia for possible spinal muscle atrophy.**
Testes/vagina **Referral** **Referral**	**Check to ensure these anatomical components are developing normally.** Check to ensure that the testicles are present bilaterally and descended. In female, check for clitoromegaly or other signs of hyperandrogenism, such as body hair or acne. **Refer to next level HCP (NP/MD or Paediatrician) for undescended testicle(s).** **Refer to paediatrics by phone for an immediate referral for signs of hyperandrogenism.**
Male urinary stream/foreskin care	**If possible, observe stream for direction and flow.** Check for foreskin adherence and that the penis tip is pink and patent. Discuss foreskin care and post circumcision care if appropriate.
Patency of anus	**Ensure regular bowel movements. Observe anus for bleeding, fissures, and intactness/patency.** Ask/check chart to see if infant passed meconium within the first 48 hours.
Positional Plagiocephaly **Referral**	**Check to ensure the infant is not developing positional plagiocephaly between 1 to 6 months.** Check neck for torticollis. **Refer to next level HCP (NP/MD or Paediatrician) and OT for torticollis and positional plagiocephaly for infants 2 to 4 months.**

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Item	Description
Vision inquiry/ Screening	**Check Red Reflex for serious ocular diseases such as retinoblastomas and cataracts.** **Do Corneal light reflex/cover-uncover test & inquiry for strabismus.** The test is abnormal if the uncovered eye 'wanders' OR if the covered eye moves when uncovered. <u>Clinically useful normal visual development landmarks:</u> Face follow: Birth to four weeks of age. Visual following: Three months of age. **Do visual acuity check at 4-5 years and record L and R eye results.** Use a Snellen chart or Lea symbols at 20 feet (6 meters).
Referral	**Refer when visual acuity is less than 20/40.**
Referral	**Refer when there is visual acuity difference of more than two lines between each eye.**
Referral	**Immediate referral to next level HCP (NP/MD or Paediatrician) for absent red reflex 1 week to 4 months.**
Referral	**Refer to next level HCP (NP/MD or Paediatrician) for abnormal corneal light reflex 2 months to 12 months.**
Referral	**Refer to next level HCP (NP/MD or Paediatrician) for abnormal cover/uncover test over 6 months.**
Hearing inquiry	**Check in chart if Universal Newborn Hearing Screening (UNHS) was completed at the hospital or by midwife, and/or if any anomalies noted by the caregiver.** UNHS effectively identifies infants with congenital hearing loss and allows for early intervention. This is done at birth and should be documented in birth records.
Referral	**Refer to Audiology if UNHS has not been completed.**
Hearing /Audiometry **Referral**	**Test hearing in both ears using age appropriate approved HSSA hearing screening resources, and a calibrated Audiometer at the Preschool (4 to 5) visit.** **Refer to Audiology as per age appropriate HSSA Hearing Screen recommendation**
Evidence of ear infection	**Ask caregiver if child has had any signs of ear infection.** **Check the child's ears for signs of ear infection including redness, swelling, fluid in ear, fever.** Recurring infections can cause hearing loss and have an impact on speech and language development. Ensure proper treatment and follow up of all ear infections.
Referral	**Refer to next level HCP (NP/MD or Paediatrician) if have had 3 or more ear infections in the last year.**
Referral	**Refer to next level HCP (NP/MD or Paediatrician) for frequent ear infections (3 or more in 6 months, or greater than 4 in the past year.)**

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<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>Tonsil size

Referral</td><td>Examine tonsils and ask about snoring or frequent tonsil infections.

Snoring can be a sign of Childhood Obstructive Sleep Apnoea Syndrome (COSAS) which can lead to neurocognitive impairment, behavioural problems, failure to thrive and/or cor pulmonale. Therefore, snoring should be evaluated for associated sleep disruption, snorts or gasps during sleep and daytime neuro-behavioural problems.

Sleep apnoea and snoring can be present even when the tonsils are not obviously enlarged.

Refer to next level HCP (NP/MD or Paediatrician) or ENT for possible obstructive sleep apnoea.</td></tr>
<tr><td>Blood pressure

Referral</td><td>Take and document blood pressure at 4 to 5 years visit.

If the blood pressure for the height percentile is higher than the numbers listed, it should be repeated in about 2 to 4 weeks. If it still falls outside of the range, then an NP/MD or paediatrician should be notified.

<table>
<tr><td>Height Percentile</td><td>Systolic BP: 95th to 99th Percentile</td><td>Diastolic BP: 95th to 99th Percentile</td></tr>
<tr><td>15th</td><td>115</td><td>70</td></tr>
<tr><td>50th</td><td>119</td><td>72</td></tr>
<tr><td>99th</td><td>120</td><td>75</td></tr>
</table>
Refer to paediatrician with hypertension (with at least 2 different readings.)</td></tr>
</table>

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Oral Health

Use Recommended Resources from the **Family Oral Health Kit** and the **Oral Health Teaching Kit**

Item	Description
Drinking from cup	**Indicate if the infant drinks from a cup and ✓ appropriate box** Begin to transition to an open cup by 12 months of age. Sippy cups are not recommended and are best avoided as they encourage constant sipping and allow fluid to pool behind teeth where bacteria can promote dental decay. See *NWT WCR Handbook* Item *Promote Open Cup* for more information.
Drinking from bottle	**Indicate if the infant drinks from a bottle and ✓ appropriate box** Infants/children should be off the bottle and using an open cup for fluids by 12 – 18 months.
Bottle in bed	**Indicate how often a bottle is taken to bed (excluding water) and ✓ appropriate box** Infants should not be put to bed with a bottle. **Advise against bottle propping.** See *NWT WCR Handbook o*n item *No Bottles in Bed* for more information

Cleaning/brushing frequency	**Indicate how often mouth and teeth are cleaned or brushed and ✓ appropriate box**
	Advise caregivers on oral health for all infants and children:
	Before teeth erupt, caregivers should wipe the gums after each feeding with a clean, damp cloth.
	• Once teeth erupt, caregivers should brush children's teeth twice a day for two minutes.
	  ○ Children 0 to 3 years of age – With a smear/grain of rice-size amount of fluoridated toothpaste.*
	  ○ Children 3 to 6 years of age – With a pea-size amount of fluoridated toothpaste
	• Ensure children spit out and don't swallow the toothpaste.
	• Caregivers should floss children's teeth once daily.
	*If the child scores a 0 (zero) on the *Canadian Caries Risk Assessment Tool,* they should have their teeth brushed with water or non-fluoridated toothpaste.
	Children should receive fluoride varnish four times a year beginning as soon as teeth erupt. See *WCR Handbook* Oral Assessment item.

Tooth extractions	**Indicate if child has had a tooth extracted for any reason and ✓ appropriate box** Ask caregiver and review chart if uncertain. Teeth are commonly extracted for extensive decay or breakage.
Tooth decay **Referral**	**Indicate if signs of tooth decay are present and ✓ appropriate box** 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. **If signs of tooth decay, refer to dentist or oral health professional (dental therapist or registered dental hygienist) as available and provide oral health anticipatory guidance**.

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Item	Description

Oral assessment

Assess the infant/child's mouth and indicate if healthy or unhealthy.

Examine the teeth, gums, tongue and mucosal lining of the mouth:

- Look at the teeth for visible plaque (white or pale-yellow build-up) and/or food debris.
- Look at the teeth for signs of dental decay: obvious chalky white spots (early decay), brown spots (frank decay), or holes/erosion of tooth structure (advanced decay).
- Look at the gums for areas of redness or inflammation.
- Look at the mucosal lining of the mouth and tongue for lesions or other irregularities.

Indicate "Unhealthy" if there are one or more unhealthy mouth factors listed below:

Healthy Mouth	Unhealthy Mouth
No Early Childhood Tooth Decay (see above)	Signs of tooth decay present (see above)
No sign of infection or swelling	Infection and swelling
Pain free	Pain
Pink gingiva that does not bleed	Red or inflamed gingiva with or without bleeding
Pleasant odour	Foul odour

Oral Health Providers and Fluoridation

The CDA recommends the assessment of infants, by a dentist, within 6 months of the eruption of the first tooth or by 12 months of age. The goal is to have all children visit the dentist before there is a problem with their teeth. In most cases, a dental exam every six months will let the child's dentist catch small problems early.

Following the first dental visit, all children should have follow-up checkups with a dentist, dental therapist or dental hygienist twice yearly. Well child visits are an excellent opportunity for HCPs to check in with families and see if follow ups are occurring.

Fluoride varnish should be applied as soon as the first teeth erupt. A good time to apply fluoride varnish is at the well child visit and at minimum, every three months. Check in the chart or with families when the last fluoride varnish was applied and provide varnish during the well child visit or a referral to appropriate oral health care provider for service.

Referral — **Refer all children for their first dental visit by 12 months of age.**

Referral — **Send medical referral if swelling or infection is present with the oral assessment.**

Referral — **Refer to dentist or oral health professional (dental therapist or dental hygienist) if any sign of oral disease (unhealthy mouth assessed.)**

Resources

HSS Resources:

- Oral Health Care in NWT
- NTHSSA Oral Health Program Screening Assessment for Children-Lift the Lip Referral Guide for Health Professionals
- NTHSSA-Clinical Resources: Oral Health Key Messages

Canadian Dental Association Resources:

- Pacifiers and Thumb Sucking
- Cleaning Teeth
- Canadian Caries Risk Assessment Tool

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Current Services and Referrals

Item	Description
Current services	**Indicate if child is currently being seen by a specialist for a particular issue.** Use Problems and Plans section to provide additional info if required.
Referrals made	**Indicate any referrals being made on the basis of this visit.** Use Problems and Plans section to provide additional info if required. **Please note that when multiple areas of concern are noted with growth, development, and/or physical assessment, a paediatrician referral may also be appropriate.** • If suspicious about a finding, discuss it with an NP/MD or Paediatrician on call. • Follow your Territorial HSSA Operation process for referrals.
Healthy Family Program	**Indicate on 'Other Referrals' and Document "Healthy Family Program"** if a referral to the Healthy Family Program (HFP) is provided. The HFP has been renewed so that services are more inclusive, preventative, and centered around culture. Many communities in each NWT region have a HFP, and it is open universally to anyone who has young children (prenatal to age six) that is interested in learning and sharing about children and caregiving. The HFP supports early childhood development by providing information and activities that are fun and free for families, as well as targeted one-on-one support based on what families want and need. Healthy Family Program Referral The HFP is a universal program open to all families with children 0-6 years and participation is voluntary. Families can be encouraged to 'try it out'. It is important that **all families are informed about the HFP, invited to participate, and that they may also self-refer at any time** before their child is 6 years of age. An optimal time to tell families about the HFP is during well child visits: • Offer HFP information to all families with children under 6 years of age. • Provide the *HFP Universal Active Offer* by providing an invitation to the program by asking all families "if they would like to be referred to the program." Families may also wish to call the community's HFP on their own to self-refer. Assist them by providing the community's HFP contact information. • If the family wishes to be referred to the HFP, complete the referral form by following the community health centre's current HFP referral process • Forward all completed referrals to the HFP in your community • An appointment will be arranged by HFP staff to discuss the HFP with the family in further detail. • If there is no HFP in the community, contact the community Social Services Office to discuss potential supports.
Resources	HSS Resources: NTHSSA- Paediatric Referral Guide NTHSSA- Healthy Family Program

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Investigations and Immunization

Item	Description
Newborn screening **Referral**	**Indicate if newborn genetic screening has been completed and review the results for abnormalities** **Refer to next level HCP (NP/MD or Paediatrician) if results of genetic screening show abnormality**
Universal Newborn Hearing screening	**Indicate if the UNHS has been completed.** Refer to Audiology if UNHS has not been completed.
Risk for TB	**Ask about risk factors for TB.** Ensure that all eligible babies have received their Bacillus Calmette-Guérin (BCG) immunization at birth following NWT protocol. **Indicate in Problems & Plans if BCG has been declined.**
Fit to immunize	**Indicate if child is fit to immunize.** • Follow the NWT Immunization Schedule program guidelines and Canadian Immunization Guide. • Ask the caregiver about the child's health status. Based on the caregiver's responses, further nursing assessment of the child's health status may be required prior to immunization.
NWT Immunization	**Indicate if an immunization has been given.** **Record immunization as per NWT Immunization schedule in the vaccine module.** **Indicate if the vaccination is refused in Vaccination Schedule and document rationale for refusal in *Problems and Plans* section of NWT WCR if caregiver declined immunizations.**
Haemoglobin	**Indicate if haemoglobin has been tested.** All high-risk children should be screened for haemoglobin at 6 and 12 months. An additional F/U screening at 18 months should be considered for high risk children. *See NWT WCR Handbook Iron Containing Foods* and *Homogenized Milk for* risk factor considerations.
Congenital Anomalies	**Indicate if the child has ever been diagnosed with a congenital anomaly.** Please complete the form if uncertain previously filled out and submitted.
Resources	HSS Resources • NWT Immunization Portal • NWT Bacille Calmette-Guerin (BCG) Standard • NWT Tuberculosis Manual • NWT Disease Registry Congenital Anomalies Reporting Form Health Canada Resources: • Canadian Immunization Guide • Canadian Immunization Guide Bacille Calmette- Guerin Vaccine

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Appendix: Well Child Discussion Questions, Key Actions, Messages and Resources

QUESTION 1: INFANT FEEDING

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE A REFERRAL WHEN:
•Ask permission to discuss infant feeding • Acknowledge that caregiver should be supported with whatever decision they make on infant feeding • Assess what is the plan for feeding their newborn? • Assess what the caregiver knows about infant feeding? • Assess what the caregiver has heard about breastfeeding? • Assess how the caregiver feels about breastfeeding? • Assess how the caregiver feels about other infant feeding options?	• Assist with identifying and developing infant feeding goals and an action plan/plan of care. • Assist by offering and providing information on local breastfeeding education/peer support groups in the community. • Assist by offering and providing a referral to a public health nurse, lactation consultant, or other maternity care provider if previous breastfeeding difficulties were experienced. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Infant weight gain is inadequate BMI category on WHO Growth Chart • The caregiver expresses concern about having difficulty breastfeeding.

Key Messages and Counselling Tips:

- Focus on facilitating and encouraging an open discussion, so caregivers can make an informed decision on how to feed their baby.
- Provide unbiased evidence-based information and support to make the best decision on how they will feed the baby within the family's unique context.
- Breastfeeding is the unequalled method of feeding infants. Health Canada recommends breastfeeding exclusively for the first six months and sustained for up to two years or longer, with appropriate complementary feeding for the nutrition, immunologic protection, growth, and development of infants and toddlers.
- Breastfeeding provides warmth and close physical contact, which can help physical and emotional development.
- Explore opportunities that reduce barriers to participation, such as love and support from grandmothers, fathers, family members, community members and HCPs.
- Breastfeeding is a traditional practise and traditional knowledge is kept alive through intergenerational relationships and supported by community and the family.

Additional Resources:

NWT HSS Resources:

- Breastfeeding Program
- NWT Infant Formula: Resources and Practice Support Tools
- Infant Formula: What you need to know. A practice support tool for healthcare professionals
- Health Effects of Cannabis: Pregnant and Breastfeeding Mothers

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Health Canada Resources:

- Infant Feeding
- Recommendation on the use of breastmilk substitutes
- Recommendations for the Preparation and Handling of Powdered Infant Formula (PIF)

Other Resources:

- Moms Boobs and Babies

QUESTION 2: CAREGIVER MOOD

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE A REFERRAL WHEN:
•Ask permission to discuss the caregiver's mood. • Acknowledge a new infant in the family can be challenging at the best of times, both physically and emotionally • Assess if the caregiver has been feeling sad in the last the last two weeks? • Assess if their fatigue gets in the way of caring for their family? • Assess if they feeling tense or nervous or worrying a lot? • Assess if they ever feel overwhelmed? • Assess if the caregiver is experiencing any of the following which may be postpartum depression: • not enjoying the infant • having frequent thoughts that they're a bad parent • having thoughts around harming themselves • having thoughts around harming their infant.	• Assist with exploring what kind of support they have from family or friends to help care for the infant. Discuss some of their worries or concerns. • Assist by offering and providing information on education/peer support groups in the community. • Assist by offering and providing a referral to an NP/MD and/or mental health specialist if the caregiver reports previous general and/or post-partum mood difficulties were experienced. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Although it's rare for a caregiver to make plans to act on postpartum depression thoughts, the situation is serious and requires urgent medical care.

Key Messages and Counselling Tips:

- Focus on what can be improved within the current situation and keeping the caregiver and baby safe.
- All mothers are to be screened for antenatal depression at their prenatal visit. Postnatal depression screening should also be completed at 6 weeks postpartum.
- It is natural for new caregivers to experience mood swings, feeling joyful one minute and depressed the next. These feelings are sometimes known as the "baby blues," and often go away soon after birth.
- However, some caregivers may experience a deep and ongoing depression that lasts much longer. This is called postpartum depression, which may start during pregnancy or at any time up to a year after the birth of an infant.
- Although it's more commonly reported by mothers, it can affect any new caregiver and can affect caregivers who adopt.
- Postpartum depression is likely caused by many different factors that work together, including family history, prior experience of depression, biology; personality, life experiences, and the environment (especially sleep

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deprivation).

- Be aware of the potential for maternal depression, which is a risk factor for the socio-emotional and cognitive development of infants and children**.** Although less studied, paternal factors may compound the maternal-infant issues.

Additional Resources:

- The Edinburgh Depression Scale is an example of a useful tool to assess a caregiver's depression/fatigue Edinburgh Postnatal Depression Scale.
- CPS Position Statement- Maternal depression and child development

QUESTION 3: Making Community Connections

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE A REFERRAL WHEN:
•Ask permission to discuss the family and how they may be supported. • Acknowledge that family can be supported in many ways. • Assess ways in which the caregivers would like supports.	• Assist with identifying and developing family goals and an action plan/plan of care. • Assist by offering and providing information on local education/ peer support groups in the community. • Assist by providing the family with information on the Healthy Family Program, and a *Universal Active Offer* to the HFP • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is provided in the community.	• Provide a Universal Active Offer to all families and support them with a referral to the Healthy Family Program if they desire

Key Messages and Counselling Tips:

•Focus on facilitating and encouraging an open discussion, so families feel supported and can make an informed decision on available healthcare services and community supports.
•Provide unbiased evidence-based information and support to help the caregiver make the best decision on services and supports they may connect with that fit within the family's unique context.

Indigenous children

• It is well documented Indigenous People experience disproportionate health and social outcomes in comparison to non-Indigenous people in Canada. The well child visit is an opportunity to provide equitable access to a continuum of inclusive, culturally relevant ECD programs, services and resources for children, caregivers, families, and communities.

Children newly adopted or entering foster care

• Children newly adopted or entering foster care are a high-risk, special needs population with many barriers to optimum health care, which may include a lack of or inadequate medical records, lack of consistent care or follow-up due to temporary placements, and difficulty accessing services. The coordination of the infant/child's well visit plan of care with the child and family services system helps to ensure infants, children and families that access services under the *Child and Family Services Act* do not experience disruptions to supports and services that help provide optimum healthy childhood development.

Children new to Canada

• Children new to Canada may not have the same health status as their Canadian born peers. Explore the health status of the child and identify culturally safe and respectful strategies to support the child and family if there are

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health disparities, and the family would like help and/or information on available supports.

Additional Resources:

NWT HSS Resources:

- Northwest Territories Healthy Family Program

Health Canada Resources:

- Indigenous Children: the healing power of cultural identify

Other Resources:

- Yellowknife Dene First Nation- Aboriginal Head Start
- CPS- Indigenous Child & Youth Health
- CPS- Special considerations for the health supervision of children and youth in foster care
- CPS- Caring for Kids New to Canada

QUESTION 4: FOOD SECURITY

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE A REFERRAL WHEN:
• Ask permission to discuss food access issues. • Acknowledge that food insecure families without access to local or store foods can be difficult and assess challenges. • Assess barriers to food security (low incomes or less access to local food). • Assess root causes. Discuss reasons for going hungry, missing meals, not eating for days, worrying about food.	• Assist with identifying and developing goals and an action plan/plan of care. • Assist by providing information on local collective kitchens or cooking programs, soup kitchens, food banks, social services or income support. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Infant/child weight is inadequate BMI category on WHO Growth Chart. • Client expresses concern about access to healthy food, inadequate intake, or inability to afford healthy food. • Food intake is very limited.

Key Messages and Counselling Tips:

•Focus on facilitating and encouraging an open discussion, so families feel supported and can make an informed decision on available supports. •Provide unbiased evidence-based information and support to help the caregiver make the best decision on services and supports to connect to within the family's unique context. •Be aware that healthy eating may not be a priority if there are other immediate issues. • Focus on what can be improved within the current situation; accept small changes, such as eating one healthier choice daily. • Explore opportunities that reduce barriers to participation, such as transportation subsidies, onsite childcare, discounts for low income families.

Additional Resources:

NWT HSS Resources

NWT Child Growth Chart Standard

Health Canada Resources:

- Social determinants of health and health inequalities
- Food Security

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