Sharing Public Health News & Views

Nexus

with the Health Care Community

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Active Healthy Kids Report Card

Canada's Active Healthy Kids report Card has been released[1]. The theme this year is "how Canada stacks up against 14 other countries". Canada performed well in the areas of well-developed infrastructure, including organized sports and the built environment, yet Canada trails at the back of the pack for overall physical activity levels of children. We have "Built it" but they are not coming.

Even though 84% of Canadian kids aged 3-4 are active enough to meet guidelines, this falls to only 7% of kids meeting the guidelines at ages 5-11, and only 4% meeting the guidelines at ages 12-17.

According to the report, it appears that a large part of the problem is that we live in a culture of convenience.

- Canadian parents look to structured activities and schools to get their kids moving. Instead parents could consider a mix of physical activities, as well as to take a step back, do less, and simply allow kids to play. Both actions would help their children meet recommended guidelines of 60 minutes of moderate to intense physical activity every day.
- The social norm in Canada is to drive kids to school and other places, rather than let them bike or walk.
- When kids do have free time, busy lives and safety concerns mean much of it is spent sedentary. Canada receives an F for Sedentary Behaviours (our lowest grade), tied at the bottom with Nigeria, Scotland and South Africa. 61% of Canadian parents agree their kids spend too much time in front of the TV or computer. Establishing household rules for television and other screen use and setting reasonable limits to break up sedentary time would improve this.

All family members benefit from regular physical activity, especially if it is outside in nature, and adults are important role models for children. Physical activity supports both physical and mental health, builds social connections with friends and family, and enhances awareness of and connection to the environment.

Some helpful resources to promote regular play and physical activity, both structured and unstructured, are available on the Health Unit website at www.healthunit.org

- An individual physical activity plan
- A family physical activity plan and a winter physical activity pact
- Winter outdoor games ideas and tips for winter safety

Health Canada's Tips to get Active sheets:
http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/pa-ap/04paap-eng.php

Reference

1. http://dvqdas9jty7g6.cloudfront.net/reportcard2014/AHKC_2014_ReportCard_Short_ENG.pdf

INSIDE:

nexus ('nek-sus) noun, Latin: bond, tie; from nectere - to bind : a connection or link between things, persons, or events esp. that is or is part of a chain of causation

Source: Merriam-Webster's Dictionary of Law, © 1996 Merriam-Webster, Inc.

Leeds, Grenville & Lanark District HEALTH UNIT

Promoting Safe Sleep for Infants

The Registered Nurses Association of Ontario, with the support of a multi-disciplinary advisory panel, released, in February 2014, a best-practice document entitled "*Working with families to promote safe sleep from birth to 12 months*". The document recommends that health care providers discuss safe sleeping arrangements at every encounter with pregnant women, parents and other caregivers.

The Canadian Paediatric Society states that infants have a lower risk of SIDS[1] with the following:

- Breastfed baby
- Non-smoking parents and smoke-free home
- Sleeping in parent's bedroom for first 6 months
- No swaddling – baby's hands and arms are free
- Comfortable room temperature
- Baby sleeping on their backs
- Infants in fitted one-piece sleepwear.

The safest place for an infant to sleep is in a crib, cradle or bassinette that meets current Canadian regulations. The sleeping area should be empty of all toys, bumper pads and bedding except for fitted sheets. Babies need a firm surface that they can't roll off of or get trapped in.

Some parents may want to co-sleep with their baby in order to help with frequent night feedings or provide comfort to their baby. The following will decrease the risk of problems:

- Ensure that others who are sharing the bed are aware of the infant's presence.
- Ensure that the mattress is firm and flat.
- Ensure that there are no spaces between the mattress and headboard, walls and other surfaces, which may entrap the infant and lead to suffocation.
- Ensure that the infant does not get too warm. Never overdress, swaddle or wrap the infant tightly with sheets or blankets.
- Ensure that the infant cannot fall out of bed.
- Always place the infant on his or her back to sleep.
- Avoid smoking or using substances, such as alcohol or drugs, which may impair arousal/ ability to respond to the infant.
- Discontinue bed sharing when ill or taking medications that may affect ability to respond to the infant.
- Do not bed share if either partner is obese.
- Use sheets and light blankets rather than duvets and comforters in the infant's sleep environment.
- Never put an infant to sleep on a pillow or adjacent to a pillow.
- Never leave an infant alone on an adult bed.
- Do not allow siblings or other children to co-sleep with an infant.
- Do not allow pets to share the bed.
- Preterm infants are at greater risk when bed sharing. Parents should delay bed sharing until infant reaches their estimated due date of delivery and is free from any medical conditions.

Reference

1. www.rnao.ca/sites/rnao-ca/files/PromoteSafeSleepForInfant.pdf

Skin to Skin Contact for *all* Mothers and Babies

Immediately after birth uninterrupted **skin to skin contact** with the mother is highly recommended. The benefits of skin to skin in the first hour include:

- Baby is able to hear the mom's heart beat and breathing, and smell and feel her skin, which is very comforting.
- It stabilizes baby's vital signs – heart rate, breathing, blood sugar, body temperature.
- Promotes interaction and bonding with the baby.
- Decreases the level of stress hormones in mom and baby, which results in a calmer baby who cries less.
- Increases mom's confidence and relaxation, which helps stimulate milk production and let down.
- Promotes earlier establishment of a proper latch and feeding, which means that mom is less likely to have sore nipples and baby will get more milk.
- Babies are more likely to breastfeed exclusively.

Hospitals providing maternal/newborn services are encouraged to adopt policies and procedures that ensure equitable opportunities for women who deliver either by vaginal or caesarean birth the experience of immediate (at birth) or early (within an hour) of unhurried skin to skin time (till the end of the first feed). Father's or partner's can provide skin to skin care to the baby if the mother is unable to begin skin to skin for medical or personal reasons. Babies who require Special Care or NICU support can begin skin to skin once intensive medical care needs have stabilized.

Reference:

1. Stevens, Jeni, Virginia Schmied, Elaine Burns, and Hannah Dahlen. "Immediate or early skin-to-skin contact after a Caesarean section": a review of the literature." Maternal & child nutrition (2014).

Animal Bite Rabies Prophylaxis

Rabies is a rare viral central nervous system infection most often transmitted to humans through the bite of an infected mammal. Human rabies occurs very rarely in Canada, but if not prevented, is almost always fatal once symptoms develop. Post-exposure prophylaxis is highly effective in preventing rabies.

Between January and October 2014, 15 bats tested positive for rabies in Ontario. In Lanark, Leeds and Grenville, we have not had a positive test for rabies among wild, agricultural or domestic animals for several years because of the success of the raccoon and fox vaccine bait program.

While the risk is low, animal bites, particularly wild animals, must be reported to the public health unit for a risk assessment. Evaluation of an individual's need for post-exposure prophylaxis (PEP) includes risk assessment related to the bite or scratch of the animal.

Post-exposure management of the bite/scratch includes thorough cleaning and flushing the wound with soap and water - the most important post-exposure measure – whether or not there is a risk of rabies.

In cases where rabies transmission cannot be ruled out, rabies prophylaxis will be recommended to the health care provider. If needed, the Health Unit provides both the immune globulin and the vaccine to the care provider for administration to the individual at risk.

- If indicated, initiate post-exposure prophylaxis as soon as possible but administer regardless of the time interval since the bite/scratch.
- An immunocompetent person who has not been previously immunized with rabies vaccine will receive:
  - rabies immune globulin (20 IU/kg body weight) given on day 0 with as much as possible infiltrated into and around the wound; and
  - four 1.0 mL IM doses of rabies vaccine given on days 0, 3, 7 and 14.
- Individuals who have not previously been immunized and are immunocompromised or are taking antimalarials, a fifth dose of vaccine should be given on day 28.
- Adverse reactions for rabies vaccines include local site reactions, such as pain, erythema, swelling and itching.

Reference

Canadian Immunization Guide: Part 4 – Active Vaccines – Rabies
http://www.phac-aspc.gc.ca/publicat/cig-gci/p04-rabi-rage-eng.php

New Vaccine Eligibility Criteria

Effective immediately, the following changes will be made to the eligibility criteria for Ontario's publicly funded immunization programs.

- All adults are eligible for a single life-time dose of Tdap (Adacel) vaccine including those 65 years of age and older, regardless of whether they received a pertussis-containing vaccine in adolescence.
- Two new high risk groups are now eligible for Meningococcal Conjugate ACYW-135 (Menactra) - individuals with HIV, and persons with acquired complement deficiency. All high risk individuals should have an age appropriate primary series followed by booster doses.
- A new high risk meningococcal serogroup B immunization program is available for individuals two months of age through 17 years who meet one or more of the following criteria
    - close contacts with a case of invasive meningococcal disease (IMD) caused by serogroup B, or at risk of an IMD outbreak caused by serogroup B; and
    - individuals with specific underlying medical conditions.
- Pneumococcal conjugate vaccine and pneumococcal polysaccharide vaccine can be administered to high risk adults aged 50 years and older with hematopoietic stem cell transplants, HIV, and/or with immunosuppressive conditions.

An updated Schedule will be made available in early 2015.

For more info: **www.health.gov.on.ca/en/pro/programs/immunization/resources.aspx**

Materials:**www.health.gov.on.ca/en/pro/programs/immunization/schedule.aspx**

Adverse Events Following Immunizations
Adverse events following immunization should now be reported to the Health Unit using the Public Health Ontario form and not the previous PHAC form. The form is available on the PHO website: **http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/Pages/Immunization-Resources.aspx**

Travel Clinics

Residents of Lanark, Leeds and Grenville who are travelling overseas may visit, by appointment, the Travel Clinic of the Leeds, Grenville and Lanark District Health Unit. A public health nurse will review the travel itinerary and discuss general advice to prevent food, water and insect borne illness. If needed, the following travel vaccines can be provided at cost - *Hepatitis A, Hepatitis B, Typhoid, and Dukoral*. Yellow Fever vaccine is not provided at the clinic and staff are not able to administer vaccines that are not dispensed by the Health Unit. Recommended malaria prophylaxis is discussed and the individual can take this information to their primary care provider to obtain a prescription.

For our immunization clinic locations and times, refer to:
www.healthunit.org/clinics/immunization_clinics.html

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Local Schools will be Implementing New Concussion Protocols

The Ministry of Education has mandated all school boards in Ontario to develop a policy on concussion. The expected date for full implementation of these policies is **January 30, 2015**.

Based on the concussion protocol outlined in the Ontario Physical Safety Guidelines (http://safety.ophea.net), our local school boards have developed policies and protocols that include strategies to develop awareness of the seriousness of concussions; prevent and identify concussions; manage procedures for diagnosed concussions; and train board and school staff.

For an overview of these concussion protocols, the attached chart summarizes the steps and responsibilities that school staff and parents are expected to take in suspected and diagnosed concussions.

The following information is particularly relevant to medical doctors and nurse practitioners:

- If a concussion is suspected at school, parents/guardians will be expected to have their child medically examined, and must inform the school principal of the results by completing a documentation of medical examination form (**no signature required** by the medical doctor or nurse practitioner at this time)
- A student with a diagnosed concussion will be expected to follow a medically supervised, 6 step"Return to Learn/Return to Physical Activity Plan". In order for the student to proceed to Step 5 (participation in full physical activity), the parent/guardian must provide the principal with **written documentation from a medical doctor or nurse practitioner** that indicates the student is symptom free and able to return to full participation in physical activity. To view a sample "Return to Learn/Return to Physical Activity Plan", please visit: http://safety.ophea.net/sites/safety.ophea.net/files/docs/appendices/E_C/E_C_AppendixC4_14.pdf

Resources:

The Ontario Neurotrauma Foundation's "Guidelines for Diagnosing and Managing Pediatric Concussion". www.onf.org

Ontario Ministry of Health and Long Term Care's concussion web portal: www.ontario.ca/concussions

CHART 1: Steps and Responsibilities in Suspected and Diagnosed Concussions