Spring 2012

ONTARIO FAMILY PRACTICE NURSES

To promote and support the role of the RN in Family Practice

SPRING 2012

SPECIAL POINTS OF INTEREST:

- **Baby-led weaning: increasing in popularity is this a new approach to recommend to families?**
- **A look at a developing RN Clinical Practice Co-ordinator Role**

INSIDE THIS ISSUE:

PRESIDENT'S MESSAGE

These are exciting times for nurses working in Family Practice/ Primary Care. I would like to share some of the activities going on.

On March 1, 2012 I participated in RNAO's Queen's Park Day. For any of you who are RNAO members, I strongly encourage you to participate in this annual event. We started off with a dinner meeting the night before for a review of logistics, an update of RNAO's platform and briefing notes on some of the issues. We met up with our small groups and planned our meetings with MPPs. We met with Hon. Deb Matthews, Minister of Health and Long-Term Care who spoke to us for a few minutes, and answered questions. We then proceeded to the public galleries to observe Question Period. After Question Period we proceeded in groups of 3 and 4 to our arranged meetings with MPPs. There were 70 MPPs and approximately 150 nurses taking part in these meetings. We asked our questions and presented our data on a range of political issues. Later, we heard speeches from Tim Hudak, Leader of the Progressive Conservative Party, Elizabeth Witmer, PC Critic for Health, and Andrea Horwath, Leader of the New Democratic Party. All of the MPPs seemed to be very interested in hearing what we had to say. In a minority government no one really wants another election, and so all parties, despite their posturing for the

(Continued on page 2)

OFPN BIENNIAL CONFERENCE

FROM WOMB TO TOMB

May 4&5, 2012

Hilton Toronto Airport, Mississauga

For conference agenda details, and registration:

www.ofpnconference.com

Early bird registration fees are now closed

FEES:

$375 (OFPN members), $425 (non-members)

(Continued from page 1)

media, are anxious to make things work.

One of the issues brought forward by RNAO and re-iterated over and over throughout the day and the Assembly meeting the next day, was the importance of all nurses working to full scope of practice, especially nurses in Primary Care. RNAO has pulled together a Task Force, which Doris Grinspun (Executive Director of RNAO) and I are co-chairing. Judith Manson and Kelly Pensom also sit on the Task Force, as well as representatives from RPNAO, NPAO, ONA, OMA, CCFP and a representative from the Nursing Secretariat. We have had 3 meetings, with another scheduled for mid April. We are collecting job descriptions from across the sector, and from them will identify areas of competency where RNs are working to full scope of practice. From this we will make recommendations to government and to the stakeholders about increasing scope of practice for all nurses in primary care. Since this is a scary thought for nurses who have been working in the field for years at considerably less than full scope, RNAO will offer a one week educational opportunity for RNs and RPNs to upgrade skills and learn ***how*** to maximize their scope.

For RNs, there is also the George Brown College post grad course in Family Practice Nursing. The first class of this course will be completing their clinical placements in April. There will be another intake in September.

At the RNAO Annual Meeting (April 27-28) we will have a table in the display area to show other nurses what Family Practice nursing is all about, as well as the work of the Task Force. If anyone is planning to attend, and would like to help staff the booth, let me know.

And finally, the conference is coming May 4-5. As I write this in mid March we have 107 people registered so far. Among other things, we are planning a networking session. This will be an opportunity for participants to connect with other nurses in their region. We hope that for regions which do not have local Chapters, we can assist the groups to establish a communication method and perhaps some local continuing education activities. At the conference, we will also be holding biennial meeting and elections for OFPN. Please consider getting involved.

Judie Surridge, RN
OFPN President

TO RECEIVE REGULAR OFPN UPDATES

please ensure our membership coordinator has your most current email address.

ATTENTION OTTAWA MEMBERS:

OTTAWA CHAPTER UPDATE

We currently have 50 active members and a hard working executive of 8.

We have decreased the number of our meetings to every 2 months from the monthly which we had maintained for the past few years. There have been 20-25 attendees per meeting. This winter's speaker's have been a Sports Therapist on Concussion, A Neurology Nurse speaking about Botox Treatment for Headaches, and yet to come a CPR refresher and an Immunisation Update.

Our 22nd Annual Professional Development Day will take place October 13th 2012.

For more information on meetings and other ways to be involved contact:

Margaret Budd,RN
OFPN–Ottawa Chapter President
margaretbudd@rogers.com

FOCUS ON PEDIATRIC CARE

BABY-LED WEANING: AN EMERGING WEANING RECOMMENDATION?

KELLY PENSOM, RN, BSCN,

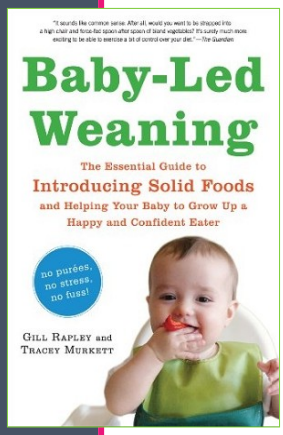
Currently on parental leave I am building my knowledge about well baby care from a different perspective; in addition to my background as an FP RN and support from our family RN (EC), I am spending time learning amongst a community of mothers with infants and toddlers. On my own mind, is how to best wean my son, by the safest and most pleasant means possible. As family practice nurses, we hear some horror stories about difficulties weaning and fussy eaters in the toddler years; issues that cause stress and anxiety for parents. We also have concerns about nutrient and energy deficiencies and potential allergic reactions to foods during this important developmental time. Recently a fellow new mum asked me, as her 5.5 month babe was happily gumming on a green bean she was holding in her hand, "Is this ok?" My family practice nurse brain ran through *The Rourke* and our Health Canada recommendations on beginning solids, and an image of pureed food introduced in an orderly fashion entered my mind. This, however, was a beautiful and whole green bean; not a mushy bland cereal. And he was loving it! Importantly: intuitively it felt safe. I wasn't sure how to answer. Other mums I have met had called this baby-led weaning, a concept I knew little about.

Interestingly, later that week I read an article published this February in the BMJ discussing the concept of baby-led weaning, and it's potential impact food choices and BMI in early childhood.[1] Townsend and Pitchford investigated different approaches to weaning and compared the exposure to and preference for foods between conventionally spoon fed infants and infants encouraged to self feed with developmentally appropriate pieces and textures of whole foods. This self feeding is termed Baby Led Weaning (BLW). The authors found that, from the retrospective opinions of parents, infants self fed during weaning were more likely to choose carbohydrate rich whole foods in early childhood, important for providing the main sources of energy for the body; in contrast to the more sweet foods preferred by children weaned by spoon feeding. They also determined that BLW is more highly correlated with healthier whole food choices and lower BMI in early childhood, with an increase incidence of early childhood obesity in the spoon fed weaning group. Given these potentially health promoting findings, I was intrigued and wanted to know more about this approach!

Currently, the primary proponent of baby-led weaning is Gill Rapley, a former UK health visitor and midwife, who has had many years of studying infant feeding during the weaning process. Her parental advice can be found at www.baby-led.com and www.rapleyweaning.com. Rapley outlines BLW as a gradual process of weaning whereby the infant is allowed to direct and control feeding from the very beginning of weaning.[2] While parents choose what to offer, the baby decides what to eat, how much and how quickly. The features of BLW are that babies are seated with families at mealtimes; a variety of whole family foods are offered in developmentally appropriate shapes and sizes; the baby self-feeds from the beginning (though parents may hold food the child is interested in eating, the parent is not to put the food in the babes mouth); and breastfeeding continues on demand.[2] In the media, BLW is presented as a 'skip the puree' mode of weaning. Some research indicates these philosophies may lead to positive health outcomes: variety that is less restrictive from parental control in infancy may promote healthy food choices in childhood and beyond[1-3,6]; earlier chewing with whole foods may enhance speech development[3]; and an earlier introduction to lumpier and whole foods may decrease food rejection and fussiness throughout the weaning process.[2-4]

BLW is a gradual process of weaning whereby the infant is allowed to direct and control feeding from the very beginning of weaning

Rapley believes that the conventional western approach to weaning with pureed foods is falsely rooted in perceived infant hunger, placing an emphasis on quantity consumed rather than on exploring food, developing skills and gradually expanding the diet. Rapley's research suggests that hunger is not the primary driving force toward weaning for an infant; interest, curiosity and exploration of foods are the more likely motivators until the skills of biting, chewing and swallowing are developed.[2] Rapley argues this skill development requires practice with whole versus pureed foods. In a review of BLW, Reeves suggests that the use of purees at 6 months potentially delays and interferes with practicing chewing.[3] Further, Rapley states that there is no evidence based rationale and little research to support the use of purees and spoon feeding for normal, healthy infants who begin weaning at the WHO recommended age of 6



Rapley's co-authored book reveals BLW: the philosophy, how to start, and what to expect.

months. Instead BLW literature suggests that the use of pureed foods emerged as a common practice when weaning was recommended for 4-6 months of age.[2,3] Six months has been deemed a developmentally appropriate age to initiate BLW.[2-4] A recent study highlights that the majority of healthy 6 month old babes hold their head steady while sitting upright, are reaching out, grabbing and mouthing, all fundamental skills for self-feeding.[4] Rapley provides a number of recommendations for families interested in safely implementing BLW (click here for a parental guide, or more detailed BLW Guidelines). The approaches appear similar to those described by the WHO as 'Responsive Feeding' whereby feeding occurs together with family, the infant feeds slowly while observing satiety cues and allowing the child to experiment with texture, tastes and variety; yet the WHO still recommends infants fed by care provider rather than self feeding.[5] Socioculturally, BLW infants learn that food is associated with family and family meals, a concept with arguably positive influences on a healthy diet throughout the lifespan.[6]

Admittedly, from a nursing perspective I was initially skeptical about some aspects of baby-led weaning. From health promotion and injury prevention perspectives, I was concerned about both adequate nutrition and safety.

Are infants who are self-feeding getting enough of what they need?

In a western conventional approach of spoon feeding, parents can assure the quantities of food a baby takes. Rapley argues that our current, commercially influenced, assumptions of adequate intake lead to a balance in favour of solids over breast milk too early in infancy.[2] Indeed, in her recommendations to parents, Rapley advocates for continued breastfeeding on demand, offering complementary foods only when an infant is not in need of nursing. The WHO suggest that breast milk ought to comprise a greater proportion of feeding in the first year of life; indeed it should provide the major source of energy until 12 months, with no decrease in daily milk intake seen until around 9 months of age.[2,5,6] Developmentally, BLW suggests a sustained reliance on breast feeding, until the improved skills of self feeding and safely ingesting solid whole foods allow for increased solid intake between 9-12 months.[4,6] Weaning literature suggests parents should not be overly prescriptive about the amount of complementary foods taken; instead use early weaning as a time of learning for the infant, as well as the care provider, to respond to satiety cues.[5,6] BLW advocates suggest that parent controlled spoon feeding may actually lead to *overfeeding* because parents may feel the need to have the infant complete what is in the jar or on the plate, in addition to feeling general anxiety about adequate food intake during weaning. Such an approach could be considered coercive and controlling, potentially leading to compromises in a healthy diet in childhood.[1,2,7] In BLW, while parents are not prescribing how much is eaten, they are deciding what is eaten, with an emphasis on the quality of food versus quantity consumed.

Weaning is a time to consider adequate increases in important nutrients. At this developmental stage the role of iron in brain development is of particular significance.[8,9] The highest risk for iron deficiency in the lifespan is between 6-24 months[8-10], corresponding with the fact that this development stage has the highest iron requirements per unit of body weight.[10] Inadequate iron intake during this time has been correlated with adverse affects on brain development and function: poorer cognitive, social, emotional functioning and motor development have all been observed in toddlers, children and adolescents with chronic or severe iron deficiency (with or without anemia) in infancy and early childhood.[8,9] Infants enter the world with iron stores acquired during gestation, which gradually deplete, with lactation providing little iron. It is for this reason that weaning should involve the introduction of foods high in bioavailable iron early on.[10] From a conventional approach to weaning, advising the use of iron fortified cereal to introduce solids is intended to address this increased iron demand. However, there is increasing evidence that commercial iron fortified infant foods are actually low in bioavailable iron, that the cereals themselves may actually inhibit iron absorption, and that further processing is required to add synthetic ascorbic acid (Vitamin C).[10] Growing evidence shows that introducing meat early in weaning is an important step in preventing declining iron stores, which is arguably more effective than introducing solids with iron fortified cereals.[7,10-12] Dietetics literature argues that from 6 months, the importance of foods (meat) should be encouraged over processed (fortified cereal) products that aim to provide certain nutrients, as nutrient absorption will be enhanced.[12] Further, that offering a variety of foods, versus processed commercial foods offered alone, is crucial to optimizing nutrient absorption.[6,12] BLW certainly encourages the introduction of iron rich foods in their whole food form, starting with developmentally appropriate choices, such as egg yolk or grated

liver. BLW also encourages variety. Currently, studies comparing the iron levels and incidence of iron deficiency of baby-led versus conventionally weaned infants are lacking, as are comparisons of other important nutrients.

Is baby-led weaning safe?

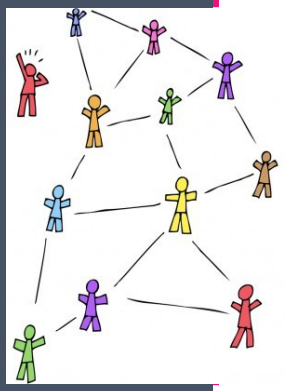
From an injury prevention perspective, allowing infants to feed themselves whole foods poses a potentially serious health risk: choking, a concern for parents with regard to weaning in general. The risk for an infant to bite off more than can be chewed and safely swallowed is real and BLW advocates are very aware of this concern. Rapley asserts that choking is no more common in BLW than spoon feeding. In fact, Rapley suggests that choking may be more likely when spoon feeding pureed foods, as infants will use their well practiced suction reflex to take food from the spoon, increasing the likelihood of it being propelled to the back of the throat and aspirated.[2] Evidence to support or refute these claims are difficult to find. Rapley proposes that during weaning parents misinterpret the natural gag reflex for choking.[2] Rapley indicates that the position of the gag reflex changes during infancy, moving from closer to the tip towards the throat in the first year.[2] Upon the introduction of solid foods, gagging is a common occurrence; no more so in BLW than a spoon-fed approach. BLW advocates stress the importance of waiting until the developmentally appropriate age of 6 months when mouthing changes from simply putting objects into the mouth to exploring the texture of objects with the lips and tongue.[2,4] From a BLW perspective, using pureed foods at this developmental stage encourages infants to learn to swallow without chewing, rather than using the gag reflex to help develop chewing skills before swallowing.[2,4] Truly, gagging is widely recognized as a natural response to prevent choking that all humans experience to varying degrees, and that the introduction to solid foods represents a time of frequent gagging as the infant becomes accustomed to new textures. Parents need to be reassured about gagging and informed about its difference to choking, as well as what to do and not do if choking does occur, despite weaning approach. To reduce choking risk, BLW makes suggestions about food textures and shapes that are developmentally appropriate.

Another potential safety risk of BLW from a health care professional's perspective is the possibility of ingesting harmful foods too soon. BLW promotes the use of a less restrictive approach to eating whereby the infant is encouraged to eat family foods,[2,3,7] a concept open to interpretation by all families. BLW certainly discourages the use of fast, processed or salted foods during weaning; it actually promotes the use of a variety of whole healthy foods. To minimize contact with potentially allergenic or poorly tolerated foods, conventional weaning uses a prescriptive approach to introducing solids, such as that recommended by Health Canada, whereby foods are introduced individually. Dietetics research shows that such a prescriptive approach is less necessary when weaning commences at 6 months, as the gut is more mature and able to cope with variety.[5,6,13] A review reveals such recommendations are based on assumed allergy risk, not evidence, and that they potentially delay the evidence-based promotion of variety that is necessary for nutritional adequacy.[6,12,13] In terms of allergenic exposure, there are world-wide differences in recommendations.[6] A review of weaning recommendations reveals that while Europe suggests first foods be low in allergenicity, the WHO denies that there is sufficient evidence to delay allergenic foods.[6] While most research in this field suggests delayed introduction of potentially allergenic foods for children considered high risk for allergies, some new research may show that there is a critical window for food tolerance early in weaning and delaying introduction of certain potentially allergenic foods may increase the risk of allergic reaction or food intolerance rather the decrease it.[6] With regard to BLW and family foods, families with high risk for allergic reaction and food intolerance should avoid foods with high allergenicity, and recommendations to avoid allergenic foods could still be practiced in a BLW approach.

It is clear that while this approach to weaning may have a number of health and development promoting benefits, further (unbiased) research is required to determine such claims, as well as investigate any potential harm from baby-led weaning. Baby-led weaning may emerge positively as a highly evidence based recommendation for well baby care. The internet has a number of sites dedicated to demystifying the fear around a baby-led approach to controlling food intake. Some public health initiatives throughout Europe are advocating the education of families about the approach, such as that provided by some health visitors in the UK. Nurses in primary care are ideally situated within interprofessional teams to educate families about the potential pros and cons of this weaning style, as well as research potential harms, benefits and family perspectives. Doing so would increase our ability to provide parents with the knowledge available on *all* safe approaches to weaning, better helping to prepare parents to make decisions that are right for their families.

My girlfriend and son have embraced BLW. She speaks excitedly about how much her son love the foods she is sharing with him at mealtimes. At 7 months he's enjoying a safe variety of foods. She feels BLW feels intuitive and importantly, that it feels safe and positive. It certainly inspires my mother-self to attempt this approach with my own son, and my nursing-self to learn more about it for the benefit of knowledge I can share with families while providing well baby care.

(Refs on *page 7*).



Practice Corner

The number of primary care nurses is expanding throughout the province. As the RNAO task force on the role of primary care nurses continues to evaluate work being done by nurses in this field, it becomes clear that we can learn from each other in our diverse roles.

Truly, amongst our OFPN members there are volumes of experience. There is also a growing roster of nurses new to this field of nursing; some of these bring experience from other settings, but some new nurses are showing a keen interest in primary care as well. Data collected at our last conference demonstrates that the average number of years of service as a nurse is 26 years; while the average number of years of service in FP/Primary Care is 12 years (ranging from 0-40+ years). That being said the greatest proportion of survey respondents (40.7%) indicated they had only 0-5 years of experience in FP/ primary care, a finding likely consistent with the rolling out of FHT models of care.

OFPN would like to help create a forum for family practice nurses to learn from one another about their roles: what they entail, the developmental process, how collaboration is working, and future visions. Perhaps even sharing some hurdles and how they have been collaboratively overcome. Some nurses may even care to share their observations on how things have changed over time.

This is the first installment of a nurse sharing her role description from the City of Kawartha Lakes FHT, which has only been operational since January 2011.

If you are interested in sharing your role to help build this community of practice and learning please contact OFPN.

Kelly Pensom, RN BScN
Communications
kellypensom@gmail.com

MY NURSING ROLE FHTS!

CONNECTING CLINICAL WORK AND HEALTH POLICY AS A SENIOR RN

Family care nurses are key to comprehensive primary care. My role as a registered nurse with the City of Kawartha Lakes Family Health Team incorporates all areas of my nursing practice from injections and well-baby check ups to health promotion, education and procedures. Working collaboratively with the four physicians and nurse practitioner in my FHT practice group, I am proud to be providing key health services to a variety of patients, as part of each patients' care team. Beyond working to my scope of practice – which seems to be expanding daily with training as our FHT grows – I am pleased that my role in the team helps make the office more efficient; ensuring patients do not have to wait as long and my physician colleagues can take on more patients. The City of Kawartha Lakes continues to have a significant number of people in need of a primary health care provider.

As a new Family Health Team, our health human resources focused on front-line, primary care. Early on, our Executive Director recognized the need for our Team to have expertise on staff to serve as a resource and lead development of FHT health policies from a health care practice perspective. These policies enhance patient care and our FHT nurses' scopes of practice while ensuring compliance with the Ministry of Health's requirements and our FHT's obligations to the Ministry.

(Continued on page 7)

(Continued from page 6)

Coming from the hospital setting, both as a critical care registered nurse and health educator, I was attracted by the opportunity not only to return to primary care in the family practice setting – and the diversity it offers – but also by the work to contribute to enhancing the professional services and organizational capacity of the new Family Health Team in town. The role also includes inputting into the development of our FHT's Chronic Disease Management Programs, which continue to evolve with our patients' needs.

Moving forward, I am excited about the potential of this position and it enabling me to make a collaborative contribution to family health care in my community. My role continues to develop – as does our new FHT – and I am able to play an active role in the evolution of both. From my perspective – a clinical nurse with a policy work habit - my current job is the best of both worlds. I enjoy being able to provide our FHT's nurses with up to date information, practice support and regular learning plans to enhance and support their full scope of practice, which benefits the patients and the nurses.

Linda Ready, BNSc., R.N., CNCC(C)
Clinical Practice Coordinator
City of Kawartha Lakes Family Health Team

BABY-LED WEANING: AN EMERGING WEANING RECOMMENDATION? REFERENCES

- Townsend, E., & Pitchford, N.J. (2012). Baby knows best? The impact of weaning style on food practices and BMI in early childhood in a case-controlled sample. *BMJ Open 2012, 2: e000297*
- Rapley, G. (2011). Baby-led weaning: transitioning to solid foods at the baby's own pace. *Community Practitioner, 84*(6), 20-23.
- Reeves, S. (2008). Baby-led weaning. *Nutrition Bulletin, 33*(2), 108-110.
- Wright, C.M, Cameron K., Tsiaka, M., & Parkinson, K.N. (2011). Is baby-led weaning feasible? When do babies first reach out for and eat finger foods? *Maternal and Child Nutrition, 7*(1), 27-33.
- World Health Organization. (2003). Guiding principles for complementary feeding of the breastfed child. http://whqlibdoc.who.int/paho/2003/a85622.pdf
- Anderson, J., Malley, K., & Snell, R. (2009). Is 6 months still the best for exclusive breastfeeding and the introduction of solids? A literature review with consideration to the risk of the development of allergies. *Breastfeeding Review, 17*(2), 23-31.
- Brown, A., & Lee, M. (2011). Maternal control of child feeding during the weaning period: differences between mothers following a baby-led or standard weaning approach. *Maternal and Child Health, 15*(8), 1265-1271.
- Lozoff, B., & Georgieff, M.K. (2006). Iron deficiency and brain development. *Seminars in Pediatric Neurology, 13*(3), 158-165.
- McCann, J.C., & Ames, B.N. (2007). An overview of evidence for a causal relation between iron deficiency during development and deficits in cognitive or behavioural function. *American Journal of Clinical Nutrition, 85*(4), 931-45.
- Hallberg, L., Hoppe, M., Andersson, M., & Hultham, L. (2003). The role of meat to improve the critical iron balance during weaning. *Pediatrics, 111*, 864-870
- Fox, M.K., Reidy, K., Novak, T, & Ziegler, P. (2006). Sources of energy and nutrients in the diets of infants and toddlers. *Journal of the American Dietetics Association, 106*(Suppl 1), S28-42.
- Butte, N., Cobb, K., Dwyer, J., Graney, L., Heird, W., & Rickard, K. (2004). The Start Health Feeding Guidelines for infants and toddlers. *Journal of the American Dietetic Association, 104*(3), 441-453.

EXECUTIVE COMMITTEE

Judie Surridge	OFPN President	Judie.surridge@wchospital.ca
Judith Manson	OFPN Vice President	Judith.manson@sunnybrook.ca
Mary Lou Craft	Secretary	craft@bmts.com
Barbara Thompson	Membership	Thompson.barb@sympatico.ca
Sue Finnie	Treasurer	sfinnie3@cogeco.ca
Kelly Pensom	Communications	kellypensom@gmail.com
Mary Knipfel	Member at Large	maryknipfel@rogers.com
Ann Alsafar	CFPNA Representative	annalsafar@hotmail.com
Margaret Budd	Ottawa Chapter President	margaretbudd@rogers.com
Claire Vickery	London and Area Chapter	cdvickery@rogers.com
Darilyn Racz	Kingston Chapter	daracz@hotmail.com
Dianne Blonde Pinkerton	Chatham/Kent Chapter	dianneblonde@hotmail.com

CHAPTER NEWS

THERE IS NO ADDITIONAL COST TO
JOIN A CHAPTER

CONTACT US IF YOU ARE INTERESTED IN STARTING A
CHAPTER IN YOUR REGION

THERE WILL BE A FACILITATED NETWORKING SESSION
AT THE CONFERENCE TO HELP BUILD CHAPTERS
AND COMMUNITIES OF PRACTICE.
FRIDAY, MAY 4

OFPN BIENNIAL GENERAL MEETING

SATURDAY MAY5, 2012 8:30-9:30 AM

HILTON TORONTO AIRPORT

IF YOU HAVE QUESTIONS OR CONCERNS TO BRING TO THE MEETING, PLEASE CONTACT OFPN PRESIDENT, JUDIE SURRIDGE