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Smells like team spirit

Welcome to the April issue of Community Practitioner.

Ask any member of the public on the street and invariably they would have something to say about the state of the NHS – whether it’s cuts to vital services, understaffing or underpayment of staff – let alone those who actually work for it.

At the time of writing, the announcement of a one per cent pay increase for public sector workers has represented yet another nail in the coffin for some, with Unite assistant general secretary for public services, Gail Cartmail, arguing “it is small wonder that NHS staff are leaving the health service for better pay and work/life balance”.

It’s at times like these that our dedicated frontline professionals, who work tirelessly to meet the health needs of a growing population on ever-dwindling budgets, are having to dig deep into their reserves of morale and motivation. But find it they do, sometimes with all the will in the world, and our communities are all the more fortunate for it.

For this reason it’s so important to take any small opportunity that arises to celebrate the outstanding – and let’s face it, often taken for granted – individuals who make our healthcare sector so special. This brings me to the CPHA Awards, which aim to do just that. I’m very excited to attend for the first time and witness what is sure to be a fantastic afternoon of solidarity and high spirits.

For those health visitors attending the Awards, you may well find team Community Practitioner, which now includes our new reporter Alice Harrold (alice.harrold@zincmedia.com/@Alice_Harrold), asking you to talk to us about what a health visitor is. Fear not – there is method to this madness! The question ties in with HVweek, which takes place on 26-30 September and for which plans are already well underway (see Dave Munday’s update on page 14). Do come and say hi – we’d like to speak to as many members as possible about what the profession means to you. You might even take inspiration from this month’s ‘Look back’ feature on Maggie Breen, which now includes our new reporter Alice Harrold, asking you to talk to us about what a health visitor is. Fear not – there is method to this madness! The question ties in with HVweek, which takes place on 26-30 September and for which plans are already well underway (see Dave Munday’s update on page 14). Do come and say hi – we’d like to speak to as many members as possible about what the profession means to you. You might even take inspiration from this month’s ‘Look back’ feature on

Finally, speaking of change, you may notice a difference in our email addresses at Community Practitioner, which is due to the recent rebranding of Ten Alps Media to become Zinc Media, so do note the new email addresses on the left hand side of this page if you wish to get in touch.

Helen Bird, Editor

April 2016 Community Practitioner 5
Government announces one per cent pay increase for public sector staff

THE GOVERNMENT HAS ACCEPTED A recommended one per cent pay rise for public sector workers, including nurses and other NHS staff, on the Agenda for Change pay bands.

The announcement was made on 8 March after the recommendation was made by the NHS Pay Review Body (PRB).

Gail Cartmail, Unite’s assistant general secretary for public services, said: “Once again, the hardworking and dedicated employees in the public sector are the whipping boys for the government’s misguided and discredited austerity agenda.”

“Since David Cameron became prime minister in 2010, NHS nurses, librarians, refuse collectors and those working in social care are just some of those who have seen their pay eroded by thousands of pounds in real terms, while government policy has heavily favoured the City and the well-off.”

She added: “As a consequence, billions of pounds are being spent on agency staff to plug the gaps. This is no way to run the NHS.”

Unite/CPHVA professional officer Dave Munday added: “It’s unsurprising that the government is continuing its ideological attack on our health service, and that they are picking a fight with health visitors, school nurses, nursery nurses and all community practitioners.”

Although the government would want to pretend that the cupboard is bare for public sector workers, they feel happy to reward their friends in the City with all of the benefits inaccessible to public healthcare workers,” he said.

The remainder of the PRB reports will be delivered over the course of the current pay round and the government will respond in due course.

Information sharing app aims to address families’ ‘biggest fears’ about home care

AN APP THAT ALLOWS FOR A PATIENTS’ UP-TO-DATE care records to be viewed in real-time, either in their homes or remotely, has been launched.

OpenPASS aims to reduce the need for paperwork and make sure that care notes are delivered and able to be analysed as quickly as possible.

It is hoped that the app will significantly reduce the risk of medicine mismanagement and be a step towards uniting health and social care between professionals and families.

The Good Care Guide’s latest evaluation of reviews found home care services to be in a “dire state”.

It cited short visits and “missed and late appointments” by many staff looking after vulnerable older people as the cause for falling levels of satisfaction.

It was revealed that disjointed care notes, lack of continuity and lack of information are the biggest concerns held by the families of those needing care.

OpenPASS will provide current information on care notes, medications, length of visits, and missed and late appointments. The content can be shared between the patient’s healthcare professionals, carers and loved ones.

The app will come with both free and paid subscription options.
More than 815,000 people have signed the petition to extend free Meningitis B vaccinations to children up to 11 years, making it the most supported appeal to the UK parliament to date.

Despite this, the plan has been preliminarily rejected by the government, which claimed the idea is not “cost-effective” enough.

“The NHS budget is a finite resource,” the government statement said. “Offering the vaccine outside of [the Joint Committee on Vaccination and Immunisation’s] advice would not be cost-effective, and would not therefore represent a good use of NHS resources.”

The petition was launched in September by Lee Booth after his six-month-old daughter was refused the NHS vaccination.

Support for his plea grew immensely when pictures of two-year-old Faye Burdett, who died from the disease on Valentine’s Day, were published.

A debate will still take place to discuss the petition although a date has yet to be announced. For more information about identifying the signs and symptoms of Meningitis B turn to page 22 of this issue.

**First Infant Mental Health Week set for June**

The first national Infant Mental Health Week (IMHW) will take place from 6 to 10 June 2016, it has been announced.

The event, organised by the Parent Infant Partnership (PIP), will unite professionals, policy-makers and parents in the conversation about infant mental health.

More than 100 partner organisations will also take part, including Unite/CPHVA.

IMHW will highlight preventative policy, practice, research and implementation beginning in the antenatal period.

The week was organised in conjunction with the Association of Infant Mental Health (AIHM) and sponsored by the 1001 Critical Days campaign.

Events held around the country during the week will include the PIP UK Inaugural National Conference and the Infant Mental Health Awards.

The conference will take place on 9 June at Central Hall Westminster in London and tickets can be purchased at infantmentalhealthweek.com

**Joint Unite publication to replace Birth to Five**

The print publication of the Birth to Five handbook for practitioners and families has been stopped throughout England and the material is now digital only.

The book was withdrawn from print circulation despite concerns raised by Unite/CPHVA on behalf of its members.

The Department of Health has made the content available online in England, but Unite/CPHVA said the lack of print copies “runs contrary to ensuring inclusivity and accessibility”.

In response a new publication – A Guide to Your Baby’s First Years – has been developed by Unite/CPHVA in partnership with Emma’s Diary.

The pilot edition of A Guide to Your Baby’s First Years was introduced in the North West of England in March and a revised edition is due to become available across the UK in Autumn 2016.

The handbook focuses on children from birth to two years and is compliant with UNICEF’s Baby Friendly Initiative.

The team from Emma’s Diary aims to provide a copy of the publication for every new family that practitioners work with and they can be contacted for additional copies through their website or on 01628 535482.

**App offers support to self-harming teens**

An app designed to support teenagers who self-harm or are at risk of self-harming has been launched.

School nurses are being encouraged to tell teenagers in distress about the new service.

STEM4 charity’s website gives advice to teenagers, parents, schools and health professionals regarding eating disorders, depression, addiction, and self-harm.

The new app provides tasks that help to distract and comfort the users, while allowing them to express their feelings and release their urges.

**Government rejects Men B vaccination plea**

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Dear Editor...

CUTTING the complexity of a topical treatment-reducing regimen for atopic eczema

We read with interest the article by Jean Robinson on the management of eczema in children (Community Practitioner, 2015) and agree with the points raised. We wish to contribute our experiences as dermatologists on a technique that we have found helpful in promoting compliance to steroid therapy.

In atopic eczema, topical corticosteroids have long been proven to be a safe and effective means of management when applied correctly. A commonly used treatment regimen starts at the highest required potency, before ‘stepping down’ to a lower potency agent (Friedmann et al, 2010). A typical regimen for a flare of atopic eczema could comprise betamethasone valerate 0.1 per cent (Class 2; potent) followed by clobetasone butyrate 0.05 per cent (Class 3; moderately potent) and finally hydrocortisone 0.1 per cent (Class 4; mild) over a period of four to six weeks.

We find that this method introduces multiple points of failure. Patients and their carers can and often will get confused by the names of the corticosteroids, many of which sound similar even to professionals, and this is before we include the emollients and a second tapering regimen for the face!

We therefore propose corticosteroid use tapering with time by increasing the non-treatment gap (CUTTING) as a protocol to simplify the treatment regimen. Instead of altering the potency of the topical steroid, we taper the effective dose of topical corticosteroid by altering the frequency of application. In the example above, we would recommend the potent corticosteroid (eg betamethasone) be used daily, followed by every alternate day, then twice weekly, again over the same four- to six-week period. We believe this approach to be more intuitive for the patient (‘increase treatment frequency with severity, reduce it with improvement’). This is in contrast to a page of written instructions for the ‘standard’ regimen.

Andre Khoo, Norfolk & Norwich University Hospitals NHS Foundation Trust, and Faisal Ali, St John’s Institute of Dermatology, Guy’s & St Thomas’ Hospital NHS Foundation Trust

References

Jean Robinson responds:
Given the huge importance of topical corticosteroids (TCS) in the management of eczema in children, it is good to have encouraged further debate and discussion about their use. The reducing strength “standard” regimen discussed by Drs Khoo and Ali is perhaps not that widely used but as they suggest is very open to misinterpretation and likely to result in poorly controlled eczema. The basic premise behind their suggested regime of increasing frequency with severity and reducing frequency with improvement is a much more intuitive regime.

However, by advising frequency reductions by set time frames there is the possibility that active areas of eczema may go untreated. Mooney et al (2015) advocate that topical corticosteroids should only be stopped once active inflammation has resolved and restarted when inflammation again develops. The latter approach, which is based on assessment of the individual child’s eczema and not related to time frames, has been shown to achieve good clinical outcomes.

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1 Contains 1.89g/100kcal of protein, including α-lactalbumin, making the protein level and quality closer to that found in breastmilk (1.7g/100kcal). Nommsen LA et al. Am J Clin Nutr 1991; 53: 457–465.

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Reflections on a #DayWithDave

On a grey February day, CPHVA professional officer Dave Munday hosted student health visitor Hayley Vernon, providing an insight into his and the wider organisation’s work. Hayley reflects on her DayWithDave.

I APPLIED TO UNDERTAKE THIS VALUABLE learning opportunity to broaden my knowledge beyond a local level and onto the national health visiting agenda. The opportunity arose at an appropriate time during the transformational leadership module for my postgraduate diploma in specialist community public health nursing and I was interested in considering innovative ways of meeting the competencies in my portfolio around contributing to policy development.

London calling
Having always kept one eye on the political climate with a prior academic interest in sociology, I had an abundance of questions for Dave in preparation for our day in London. For instance, who is leading on representing and protecting the interests of health visitors? How do unions bring current health visiting issues to the attention of those with the power to influence? Do CPHVA professional officers wholly understand the real and current experiences of those working on the ground?

We began our day by heading to the Unite offices in Holborn where I was introduced to the friendly and welcoming team. From there I experienced a thought-provoking insight into a day in the life of a CPHVA professional officer. This included a meeting with Lord Phil Hunt in the House of Lords (pictured) to discuss current issues facing the health visiting profession, as well as #HVweek, which takes place on 26 to 30 September.

I also joined a telephone discussion with The Lullaby Trust (CPHVA’s Charity of the Month for March) and talked about creating engaging print and web-based content with the editor of Community Practitioner.

It was fantastic that Lord Hunt was interested in my experience of funding for post-registration health visitor training in light of recent discussions around scrapping nursing bursaries. I was also pleased to hear Helen, the journal editor, talk of her intentions to include the voice of more students in future issues.

Engaging expertise
The highlight of the day for me was meeting with Clair Rees, executive director at Parent Infant Partnership UK, who leads on the cross-party 1001 Critical Days manifesto. Clair talked engagingly about her career and specialism in perinatal and infant mental health, and how she brings her passion for art and art therapy into her work in this field.

Baby brain development and the importance of promoting infant mental health has been regularly highlighted during the SCPHN programme, with my practice teacher passionately leading on the delivery of the Solihull Approach training at our trust in Leicester. As a result the message is firmly etched on my mind when engaging with families to promote reciprocity in the parent-child relationship, starting in the antenatal period.

On a wider level, Clair is working on ensuring that the messages from 1001 Critical Days are presented in a manner that is accessible to families during Infant Mental Health Awareness Week, which will run from 6 to 10 June. She emphasised that the messages need to be delivered in a sensitive, non-critical way to mothers who are experiencing perinatal mental ill health and therefore may already be feeling guilty about their ability to be a good parent.

As an aside, since I’m a paediatric nurse with a pre-nursing career in the early years and children’s centres, I experienced another noteworthy moment when Dave and I spotted MP Frank Field as we had coffee with Clair at Portcullis House.

Take-home message
I took away a key learning point from my DayWithDave, which I reflected upon considerably on the train home. As individual practitioners, we each hold a responsibility to influence decision-makers and ensure that our concerns about the current issues facing health visitors are heard. If we are dissatisfied it is far more productive to express this concern (through making contact with our local MP, for instance) rather than to stay quiet and become increasingly disillusioned.

What’s more, as Dave reassuringly enthused, even new practitioners who are starting out on this health visiting and leadership journey (and not just those experienced in lobbying) are capable of this and can make a difference. The message seemed somewhat poignant in the current political climate, particularly with the proposed Trade Union Bill that is currently before parliament.
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*Out of 96 paediatricians

My journey started in April 2015 when I saw a poster looking for people to trek 67km through India to raise funds for the cancer unit in Bath. In the late 1980s I had worked on the ward as a nurse and saw first-hand how important the environment is to the care that patients receive.

I was born in India and came to live in the UK as a small child. My father had lived and worked in the Himalayan area in the 1960s and I recall him telling me stories about the region as I was growing up. I had already visited India twice but this was an opportunity to connect with a part of my heritage and explore a rural area that I had lived in as a child.

I decided I would find out more about the trek. It was something I had always wanted to do so I put any nagging concerns to one side and signed up. I didn’t know anyone else who was going but we exchanged details and did a few training walks together.

We landed in Delhi after a nine-hour flight and were taken by coach to a hotel where we spent a few hours before heading to the railway station. The overnight sleeper train took us to Panthakot, North India. We then had another five-hour journey by taxi to Dharmasala, spiritual home of the Dalai Lama. Travelling through the countryside I found myself wondering what my life may have been like if my parents had not moved to the UK.

Our trek began in the heart of the Himalayas. We faced tough terrain, snow, thunder, lightning storms and two nights in temperatures of minus five at an altitude of 3,500 metres. We crossed rivers, bridges and landslides, which were at times very frightening. The scenery and views were breathtaking and a stark contrast to the hustle and bustle of Delhi. At the end of the day I wanted to climb into a hot bath to soak my aching limbs; instead we had to manage with a hole in the ground for a toilet and could only dream of showers.

Travelling through rural India I saw how difficult life is for people in such isolated communities. We came across a dispensary to which, our guide told us, local people walk for days to get medicine. There was no doctor available, so people often buy medicines that might be inappropriate. Health and safety does not appear to exist in India. The narrow roads leading up to the Himalayas made for a harrowing experience: there did not appear to be any highway code or rules for road users.

A lot of the work is done by hand as it is difficult to get machinery to such mountainous areas. It was a common sight to see the land being farmed by hand or with animals and basic tools. Travelling through rural villages we walked past houses and communities where children walk up to 10 miles each way to attend the nearest school. It was commonplace for older siblings to be in charge of younger children. Child safety equipment seemed non-existent, with very young children making their way up and down stairs with no rails. While in the UK we are focused on accident prevention, children in India need to learn to be aware of dangers and to look out for themselves in order to survive. This is something as a health visitor I am only too aware of when people from other cultures bring parenting practices from their countries of origin that may not comply with expectations in the UK.

Before flying back to London we visited the stunning Taj Mahal. Each member of the team had their own personal reasons for taking part in the 67km trek and as a group we raised more than £30,000 for the new cancer centre. It was an amazing personal achievement and an experience that I will treasure for the rest of my life.
Tension mounts with only a few days to go before all the winners are announced at this year’s CPHVA Awards ceremony held at the prestigious Plaisterers’ Hall.

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What's in the pipeline?

As April arrives we ask the Unite/CPHVA professional officers what exciting projects they'll be focusing on in the coming months and why they need you, the members, to feed back on your experiences and concerns.

Dave Munday

As we move towards #HVweek in September (26-30) I’ve been working with a colleague, Leona Sanders, to identify as many organisations as possible that could become supporters. By the start of March we had 20 and I’m hoping to increase that this month.

I’ve also been working with my fellow professional officers who lead on Scotland, Northern Ireland and Wales to ensure that we make #HVweek truly UK-wide. The way we hope to achieve this is by assigning specific days to different countries.

The challenge now is to consider the logistics of moving around the UK during the week. For the England day, I’m hoping to run a fully virtual conference where any member will be able to watch online. Over the next few months I’ll be testing out the different ways in which we can achieve this.

Health visitors will find they are often asked: ‘What is a health visitor?’ I’ve asked supporters of #HVweek to help us answer this question. Health visitors have a huge range of skills and I want them to tell us what they are. You can do this by sending us a short video, tweet or email.

Jane Beach

As it’s April, I’m focusing on revalidation this month. Revalidation is the new process that those on the NMC register need to go through when they renew their registration.

I’m planning two revalidation events in the West Midlands this month for those who haven’t been able to attend workplace sessions. One will be in Stoke and the other in West Bromwich. The revalidation events will go through the requirements in more detail so attendees feel more confident in being able to demonstrate how they meet them. We are also doing sessions in members’ workplaces.

In addition I’m planning the Wales day for #HVweek 2016, which will involve an event on 27 September with the Department of Health.

In the West Midlands, the issue of local authorities putting health visiting/early years services out to tender has arisen. I would ask members to keep us informed of changes to services and in particular to ensure they raise concerns with their local rep in case plans need to be challenged!

Obi Amadi

I will be contributing to a piece of work looking at safe staffing for district and general practice nursing. This has come about from the NHS Improvement working group for safe caseloads in community and primary care as part of the TDA/monitor programme for safe sustainable staffing. The group will develop guidance for safe caseloads for district nurses and practice nurses and it will include AHPs and HCAs.

I will be continuing with work around female genital mutilation. I am in the process of getting a research survey out to members, which I hope will be out this month. I am also hoping to plan for a series of roadshows to raise awareness with professionals who fall under the mandatory reporting requirement.
Gavin Fergie

Our biggest event of the spring is the Unite/CPHVA Awards, which takes place on 8 April. This is an important event in the calendar that brings the spotlight on excellent practice and clinicians. It is a celebration and an event enjoyed by all.

Also this month, I will be attending the third programme planning meeting for our 2016 Unite CPHVA Annual Professional Conference, being held in November in Telford. By the end of this meeting the annual conference themes and speakers will have been identified building on the excellent work and conference in 2015.

In Scotland I will be attending the Transforming Nursing Roles group on behalf of Unite’s nursing membership. This group is chaired by Professor Fiona McQueen, chief nursing officer for Scotland. There is a changing practice landscape in nursing and the purpose of the group is to oversee the development of innovative approaches to these changes.

We need to ensure that practitioners are equipped with up-to-date training and education to address the transforming requirements.

In March we launched a joint initiative with Emma’s Diary to fill the space left by the funding cut for the Birth to Five book.

Despite the concerns we raised on behalf of our members, this hugely important and relied upon resource was withdrawn from print circulation in England.

To address the situation a new, improved publication has been developed with our partners at Emma’s Diary called A Guide to Your Baby’s First Years.

The new text will focus on birth to two years and will be reviewed and updated twice a year to include the most relevant, evidence based information for parents and carers.

The publication is being piloted in North West England, with the plan being to launch the guide to all parts of the UK in the autumn of 2016.

My duties also include Northern Ireland where, in addition to the ongoing strategic work, we are organising meetings with members to listen to their concerns and give them a platform to share their ideas, especially in this difficult time of cutbacks.

Looking ahead we need to ensure that the members’ views are heard by the candidates seeking your vote for the Scottish Parliamentary and Northern Ireland Assembly elections on 5 May. Politicians and their actions affect your terms, conditions and practice. What will they do to secure your trust and vote?

As always, I'm looking for communication from members. I want you to be vocal and get in touch. There are so many issues affecting our members’ practice and if you don’t share your opinion it may not be heard when decisions are being made. I encourage you to contact myself or any Unite CPHVA professional officer to voice your issues and ideas and stay engaged. I look forward from hearing from you.

Rosalind Godson

As we move into summer I really want to link back into health sector and CPHVA branches in the East Midlands and South West region. Harried reps are keen to run branches and I am happy to support with items for the agenda, advertising etc.

This year we are offering updated training on Duty of Candour in the same way that we offered the NMC revalidation training. You can invite me to your venue rather than having to travel too far. I can still deliver the previous year’s sessions on record keeping, NMC revalidation or raising concerns if members wish.

At the end of last year I asked to hear from members who were keen on becoming involved with Unite’s safeguarding agenda, both adult and child. There have been many new demands and expectations from both the public and the governments – safeguarding has moved on so we will be developing Unite’s guidance and position on these.

There is our regular health liaison meeting with the NSPCC in April, and we need to get our members supporting their campaigns in the workplace.

Due to annual leave in April I will miss several of our regular Tuesday Twitter chats: #CPHVAtt. I do hope that by the time I get back, many of you will have decided to join in at 7pm every week; Community Practitioner is a good source of advice and inspiration.

I won’t, however, be missing the CPHVA Awards, and can’t wait to see our winners – it’s such a privilege to reward those who ‘just do the day job’ but contribute that extra bit.
Q: How long do the reflective practice accounts need to be?
A: As part of your revalidation process you have to write five reflective accounts. These are written insights into your CPD, practice-related feedback and/or an event or experience from your practice. There is not a minimum or maximum word limit, but they are not intended to be lengthy, academic-style essays. The important thing is that they cover what you learned from the experience and how it relates to the Code. You must use our form for recording your reflective accounts, and you can download this from our website. You can also see examples of reflective writing written by nurses and midwives who took part in the revalidation pilot.

Q: How do we know the date of revalidation?
A: You will revalidate every three years, at the point when your registration is due for renewal. You can find out when you need to revalidate using your NMC Online account. We will also write to you 60 days before your revalidation application is due to let you know exactly what you have to do and when.

Q: Who can act as a confirmer and ensure that you have completed the process? Should it be your manager or a colleague?
A: The role of the confirmer is to look through the evidence that the nurse or midwife has collected which proves that they have met each of the revalidation requirements. We recommend that it is your line manager who acts as your confirmer. Even if your line manager is not another registered nurse or midwife, they are probably still the most appropriate person to take on this role. Where this is not possible we recommend you ask another nurse or midwife to be your confirmer. If neither of these are possible please refer to our confirmer tool, which can be found on our website. It is important to remember that the confirmer is being asked to declare that you have met all of the requirements of revalidation. They are not being asked to declare that you are fit to practise or decide whether you should remain on the register; that is the role of the NMC.

Q: What are participatory CPD hours, how many do I need to undertake and what do these constitute?
A: Under revalidation, as with the old Prep system, you will have to undertake 35 hours of continuing professional development. Twenty of these hours must now include participatory learning. Participatory learning is any learning activity in which you personally interact with other professionals, either one-to-one or in a larger group. The NMC does not prescribe CPD, but guidance sheet 3 in our ‘How to revalidate with the NMC’ guidance sets out examples of both individual and participatory CPD activities. It is important to remember that any activity you chose to undertake must be relevant to your scope of practice.
Q: What evidence can I use for my practice related feedback?
A: As part of the process of revalidation we require you to obtain at least five of pieces of practice-related feedback. Feedback can come from a variety of sources and in a variety of forms. We recommend that you keep a brief note of any feedback you receive, and we have published a template for recording feedback. This template includes examples of sources of feedback, which can include colleagues, students, your annual appraisal, and patients or service users. The feedback can come in the form of a verbal conversation, a letter or card, a survey or a report, among others.

Q: What happens if someone has been off sick for some months and can’t meet the requirements?
A: We have special arrangements in place for people who haven’t been in practice for a sufficient period of time to meet the new revalidation requirements, either because they have been on sick leave or maternity leave or have taken a career break. For more information see the alternative support arrangement guidance sheet at: revalidation.nmc.org.uk

Q: I have two jobs: one as a travel health nurse for a private charity and one as a bank nurse for an NHS trust. Does revalidation cover both jobs?
A: All nurses and midwives will revalidate according to their current scope of practice. If you work in two roles, you will be meeting the requirements for revalidation across both of these roles. It will be up to you to decide how you approach this, but you might want to think about obtaining feedback about your practice from both of your roles, undertaking a mixture of CPD that is relevant to your practice in both roles etc. Please note that you do not need to meet the requirements for revalidation twice (i.e. once in each role). You only need to undertake 35 hours of CPD, obtain five pieces of feedback, and write five reflective accounts. You can use the forms and we have provided to record your evidence. There are also completed examples of these documents on our revalidation microsite.

Q: Can we store forms and templates electronically? Will we have to send in our revalidation evidence to the NMC?
A: The revalidation forms and templates can all be completed and stored electronically. Alternatively, you may choose to print them out, fill them in by hand and keep them in a paper portfolio. It is entirely up to you how you choose to store your revalidation evidence.

You will need to show this evidence to your confirmer but you will not need to send it to us by post or email, or upload it to NMC Online at any point in the revalidation process. The application process is very straightforward. You will log on to your NMC Online account and make a series of declarations that you have met each of the requirements. You will also provide some information about your practice, and details of your confirmer and your reflective discussion partner.

Q: Can we have more clarity around the practice hours to be counted by practitioners who are registered midwives and health visitors?
A: We have produced a guidance sheet for midwives who are also registered as health visitors, which you can find in our “How to revalidate with the NMC” guidance. This guidance sheet clarifies the practice hours requirements for midwives who are also registered as specialist community public health nurses.

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For more information and FAQs on revalidation, visit the NMC’s dedicated microsite at: revalidation.nmc.org.uk

A Twitter Tuesday #CPHVAtt session on revalidation will also take place in April: see www.communitypractitioner.com and @CommPrac and @Unite_CPHVA
Mobile devices as ‘calming tools’ for children

Parents are more likely to use mobile technology to calm children with behaviour difficulties, a new study in the Journal of the American Medical Association for Paediatrics has shown.

Children with social and emotional difficulties are more likely to be given mobile devices, such as iPads, to calm them down, according to the study of 144 children aged 15 to 36 months in low-income families.

The study was led by a child behaviour expert at the C.S. Mott Children’s Hospital at the University of Michigan.

A link has previously been established between parents of babies and toddlers with difficult behaviour and disproportionate use television as a calming tool.

The new evidence indicates the same is true of mobile technology.

“We need to further study whether this relationship between digital technology and social-emotional development difficulties applies to a more general population of parents as well, and what effect it might have on kids’ longer-term outcomes,” lead author Jenny Radesky said.

Other studies have shown that increased television use can hinder language and social development in young children.

Radesky aims to research further the ways in which mobile devices “interfere with family dynamics”, as well as how they can be used as “a tool to increase parent-child connection”.

Study links asthma with fertility

Asthma is associated with fertility problems, a new clinical observation study has found.

The paper, published in the European Respiratory Journal, showed that women who experience asthma have on average an increased time to pregnancy and a lower birth rate than those without.

The study looked at 245 women with unexplained infertility for a minimum of 12 months while they went through fertility treatment. The women, aged between 23 and 45 years, also underwent asthma and allergy testing and questionnaires during their treatment.

Just under 40 per cent of the women had previously been diagnosed with asthma or received a diagnosis when they entered the trial.

Results showed that the median time to pregnancy for non-asthmatic women was 32.2 months and 55.6 months in those with asthma.

It was also found that women with asthma had fewer successful conceptions and only 39.6 per cent achieved pregnancy compared to 60.4 per cent in non-asthmatic women.

The trend was more apparent as the women got older.

Dr Elisabeth Juul Gade, lead author of the study, noted that the connection between asthma and fertility problems could be dependent on different types of asthma, psychological wellbeing, asthma medication and hormones.

“Given this new evidence, we believe that clinicians should encourage women with asthma to become pregnant at an earlier age and optimise their treatment for asthma pre-conception,” she said.

Help needed

Refugees At Home is a matching service to find generous hosts for recent refugees and destitute asylum-seekers.

The service aims to ensure this is done safely and with the support of the whole household. It arranges a home visitor to assess, against a set of criteria, each potential host before we assign a guest to them.

The charity is looking for people across England and Wales with experience of home-based assessment and a background in health visiting, district nursing and other community visiting to carry out this essential work.

If you can help, email: info@refugeesathome.org
Which First Infant Milk is most in line with expert opinion on growth?

The Department of Health recommends exclusive breastfeeding for the first six months of life.1

Protein and the importance of slower growth rates
Because the protein in breast milk is adapted to a baby’s needs, a breastfed baby tends to grow more slowly than a formula fed baby.2 This slower growth rate has shown to have significant long-term health benefits, including a lower risk of obesity, cardiovascular disease and diabetes.3

We’ve responded to expert opinion about proteins in SMA® PRO First Infant Milk

“Protein intakes of infants are generally well above the requirements, so protein content of Infant Formula and Follow-on Formula could be reduced”
European Food Safety Authority 2014

“The breast milk content of amino acids is the best estimate of infant amino acid requirements”
WHO/FAO/UNU 2014

Of the essential amino acids, four have been shown, when supplied in excess, to be associated with increased release of insulin. This may trigger a cascade of reactions in the body which may result in faster growth.
European Childhood Obesity Trial Study Group 2015

Getting the right quantity and quality of protein in infant and toddler diets has lifelong health benefits.
With SMA PRO First Infant Milk, you can help build a nutritional foundation for life in the first 1000 days.

SMA PRO First Infant Milk is the only first infant milk clinically proven to achieve a growth rate comparable with a breastfed baby as defined by WHO growth standards10

SMA PRO First Infant Milk versus WHO growth standard z-scores at 4 months

SMA PRO First Infant Milk is the lowest protein formula available at 1.25 g*/100 ml (1.87 g*/100 kcal)

*Powder only, liquids will vary

SMA PRO First Infant Milk has an essential amino acid profile similar to that of breast milk

SMA PRO First Infant Milk has lower levels of insulinogetic amino acids compared with other first infant milks


Visit us: smahcp.co.uk or smahcp.ie

Supporting you to support parents

IMPORTANT NOTICE: Breast milk is best for babies and breastfeeding should continue for as long as possible. Good maternal nutrition is important for the preparation and maintenance of breastfeeding. Introducing partial bottle-feeding may have a negative effect on breastfeeding and reversing a decision not to breastfeed is difficult. A carer should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant formulae and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant formulae should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.

8Registered trademark
WSIHVA formally becomes a trade union and affiliated to the National and Local Government Officers’ Association and to the National Union of Women Workers. The Maternity and Child Welfare Act makes every local authority responsible for setting up maternity and child welfare committees. The target ratio is to have at least one health visitor to every 400 births. By 1934 this is reduced to one health visitor to every 250 births; the WSIHVA advises that this is the optimum ratio.

The WSIHVA adopts the role of a pressure group to influence government policy and legislation. The organisation has developed into a vociferous and well-organised professional body, trade union and women’s campaigning organisation.

The association initiates a course of training and an examination for the Board of Education Diploma for health visitors.

The association has a total of 437 members. The Ministry of Health becomes responsible for the training of health visitors, requesting for the Royal Sanitary Institute (RSI) to become sole central examining body. The RSI continues as the designated examining body, maintaining a register of those who achieve the qualification.

Full membership rights are granted to all health visitors, superintendents of maternity, child welfare centres and tuberculosis visitors, allowing the association to grow even more.

The Nurses Registration Act formally recognises health visiting as a profession, thus empowering local authorities to provide services such as day nurseries, health visitors and child welfare clinics.

Membership expands to include school nurses and others in various branches of public health work, including clinic nurses, municipal midwives and infant life protection visitors. Led by its chairperson Amy Sale and president Gertrude Tuckwell, the WSIHVA becomes the first health service union to affiliate to the Trades Union Congress (TUC).

The first full-time general secretary is appointed to the association.

The first meeting of the Executive Committee outside London takes place in Birmingham.
One for all

This month, our look back at the history of the CPHVA visits the decade from 1916 to 1926, when the association and its activities began to gain momentum at a rapid pace.
Seeing the signs

When two-year old Faye Burdett died of meningitis B in February after being refused vaccination, support for the public plea to vaccinate all children up to age 11 soared. Charity Meningitis Now describes the signs and symptoms healthcare professionals should look out for in order to identify and respond to cases quickly and effectively.

JANE BLEWITT
Research and information adviser
Meningitis Now

The recent introduction of a meningococcal group B (Men B) vaccine, Bexsero, into the UK routine immunisation schedule is another positive step towards the prevention of invasive meningococcal disease. The vaccine has taken many years to develop and was granted marketing authorisation by the Committee for Medicinal Products for Human Use (CMPH) in January 2013. In March 2014, the Joint Committee on Vaccination and Immunisation (JCVI) recommended the introduction of the vaccine into an infant programme subject to price negotiations with the manufacturer(1). From 1 September 2015, all children born after 1 May 2015 became eligible for this vaccine as part of the UK routine immunisation schedule.

WHAT IS MENINGOCOCCAL DISEASE?
Invasive meningococcal disease, caused by the bacterium Neisseria meningitidis (meningococcus), usually presents as meningitis, septicaemia or a combination of both. Although the disease can affect anyone, around half of all cases occur in children under five years, with those under one year being most at risk(10).

Meningitis and meningococcal septicaemia are feared by parents and health professionals because the early signs and symptoms are often non-specific; they can progress very quickly and can kill within hours. A significant proportion of survivors are left with lifelong disabilities(10).

Even with effective vaccines to protect against some groups of meningococcal disease, there are still other bacterial, viral and fungal causes of meningitis that can’t be prevented by vaccination. It is therefore vital that everyone knows the signs and symptoms, and understands the need for urgent action.

SIGNS AND SYMPTOMS

Babies and toddlers
- Refusing feeds, vomiting
- Drowsy, unresponsive, difficult to wake
- Floppy with no energy or stiff with jerky movements
- Irritable when picked up
- High-pitched moaning cry
- Rapid breathing, grunting
- Fever
- Cold hands and feet
- Pale, blotchy skin
- Shivering
- Spots or a rash that doesn’t fade under pressure
- Convulsions/seizures
- Bulging fontanelle
- Stiff neck
- Dislike of bright lights(10).

These symptoms can appear in any order and some may not appear at all. Parents need to be reminded to trust their instincts and seek appropriate advice if they are concerned about their child’s health.

The rash caused by meningococcal septicaemia usually starts with red pinpricks which can spread rapidly to look like purple bruises. It does not fade under pressure. Not everyone will get this rash, or it may not appear until the septicaemia is well advanced(10).

PREVENTION OF MENINGOCOCCAL DISEASE
There are 12 identified serogroups, with groups B, C, W and Y historically the most common in the UK. Meningococcal disease naturally occurs in cycles and in the past 20 years the number of cases each year in the UK has ranged from over 2,800 in 1998 to 750 in 2014(5, 6, 7).

The introduction of the meningococcal group C (Men C) vaccine in 1999 rapidly reduced the incidence of disease caused by this serogroup; from over 1000 cases in 1999 to approximately 30 to 40 cases per year in the past decade(5, 6, 7).

Constant surveillance of meningococcal disease has identified a significant increase in meningococcal group W disease over the past five years. This has resulted in changes to the routine immunisation programme, with the Men ACWY vaccine replacing the Men C vaccine for teenagers and young people, including new university students up to 25 years old(10).

Meningococcal group B (Men B) bacteria are now the most common cause of meningococcal disease in the UK, and are also the most common cause of all bacterial meningitis. Over half of all Men B disease occurs in babies and children under five years old(5, 6, 7). The recent introduction of a Men B vaccine (Bexsero) for infants is a positive step towards reducing the burden of disease caused by this serogroup.
Harmonie-Rose was 10 months old when she became ill with meningococcal group B disease in September 2014. Her parents explain what happened:

“We were initially worried about her because she had a cough and difficulty breathing. She was kept in hospital for observation, but later that day she seemed to be improving and was sent home. The next morning, we were worried again because her lips were blue and we thought she might have had a fit. We took her back to A&E where she was examined again. The doctor thought she had a viral infection so we were sent home. However, we were told to come straight back to the children’s ward if we were still worried. At lunchtime, Harmonie started to cry, became very floppy and we could see a rash developing across her face and spreading down her chest and arms. We rushed her back to the hospital.

“Harmonie had to be urgently transferred to another hospital where she could receive specialised care, and by the time she reached there, her arms and legs looked black. We were told that she may not survive.

“Against all the odds, she did survive. However, the damage caused by the septicaemia meant that she had to have both arms and both legs, plus the tip of her nose, amputated. She has had more than 10 operations already and will face many more as she grows up.”

Against the odds

SUMMARY

Invasive meningococcal disease, causing meningitis and/or septicaemia, can kill within hours and leave a significant number of survivors with lifelong disability. Even though there are now three meningococcal vaccines in the UK routine immunisation schedule, not all cases will be prevented. There are also other bacterial, viral and fungal causes of meningitis that are not prevented by vaccines. It is too early to assess the impact of recent changes to the schedule and it is vital that everyone is aware of the signs and symptoms, and remains vigilant.

FURTHER INFORMATION

Meningitis Now is a charity with almost 30 years’ experience of raising awareness, funding research and supporting those who are living with the impact of this devastating disease.

Visit www.meningitisnow.org or call the helpline on 0808 80 10 388.

References

Men B vaccine has different fever management advice

- The Joint Committee on Vaccination and Immunisation (JCVI) recommends the use of prophylactic paracetamol at the time of immunisation.

- Liquid paracetamol products, such as CALPOL® Infant Suspension, are the only recommended treatment for post-immunisation fever related to the Men B vaccine at 2 and 4 months.

To order your own free immunisation support pack, including advice on how to converse with anxious parents, post immunisation guides for parents, waiting room posters, stickers and more please telephone CALPOL® customer care line on 01344 864 042 or send an email to calpoluk@its.jnj.com. While stocks last.

https://www.calpol.co.uk/illnesses-symptoms/post-immunisation-fever
Childhood epilepsy: a clinical update

GEORGE THOMAS DAVIDSON, Medical Student Year 4, University of Bristol

DR MEGAN EATON, Consultant Paediatrician, Yeovil District Hospital

DR SIBA PROSAD PAUL, Consultant Paediatrician, Torbay Hospital, Torquay

INTRODUCTION

Epilepsy is a common neurological disorder characterised by recurring seizures (National Institute for Health and Care Excellence [NICE], 2012). Epilepsy can affect individuals of all ages and ethnicities and represents one of the most common serious neurological conditions. Currently, epilepsy affects one in 60 years (Joint Epilepsy Council, 2011).

There is, however, a peak incidence noted in the first year of life, with a drop in the number of new cases until 10 years of age, after which the number of new cases plateaus (although a second peak in incidence is seen at the age of 60 years) (Joint Epilepsy Council, 2011).

The word ‘seizure’ is derived from a Greek word meaning ‘to take hold of’ and is currently used for any sudden or severe event (Fisher et al, 2014). The Epilepsy Foundation defines seizure as ‘a sudden surge of electrical activity in the brain, which usually affects how a person appears or acts for a short time’.

An epileptic seizure can be defined as ‘a transient occurrence of signs and/or symptoms due to abnormal, excessive or synchronous neuronal activity in the brain’ (Fisher et al, 2014: 476). A crucial point of understanding is that a seizure is an event, while epilepsy is the condition characterised by the increased tendency for the brain to generate epileptic seizures – one seizure, however, does not equal epilepsy.

WHAT IS EPILEPSY?

The clinical definition of epilepsy was updated in 2014 by the International League Against Epilepsy (ILAE) and is highlighted in Box 1 (Fisher et al, 2014). Previously, the definition of epilepsy described in 2005 only encompassed two unprovoked seizures more than 24 hours apart (Fisher et al, 2014). Although this component remains an important feature of epilepsy diagnosis, this definition alone was found not fit-for-purpose in certain clinical scenarios.

Hence other parameters have been added to the clinical definition by ILAE (see Box 1) to give specialists a wider scope for diagnosing epilepsy in some special circumstances.

Studies have shown that risk of further seizures after a single, unprovoked seizure is 40 to 52 per cent, which increases to 60 to 90 per cent in the next four years after having had two unprovoked non-febrile seizures (Fisher et al, 2014). The revised ILAE definition of epilepsy has allowed epilepsy specialists to manage patients such as if epilepsy is present following a single unprovoked seizure, so long as their risk of a second seizure is greater than or equal to the risk of a seizure in an individual who has had two unprovoked seizures. An example of this would be a child with a single seizure but with structural brain abnormality and/or clear specific epileptiform changes in an electroencephalogram (EEG) study. The revised recommendations, however, are not applicable in all circumstances, eg a single unprovoked seizure after a remote brain insult, trauma or infection and should be decided on an individual basis by specialists (Fisher et al, 2014). A diagnosis of epilepsy can also be made in the presence of complex signs and symptoms that define a unique epileptic condition, such as West Syndrome, Dravet Syndrome or Myoclonic Epilepsy of Infancy (MEI), however, these diagnoses must be made by a specialist.

Sudden unexpected death in epilepsy (SUDEP) is defined as the sudden, unexpected, witnessed or unwitnessed, non-traumatic and non-drowning death in patients with epilepsy, with or without evidence of a seizure, with exclusion of documented status epilepticus, and when post-mortem examination does not reveal a structural or toxicological cause for death (Nashef, 1997). SUDEP accounts for nearly half of all epilepsy-related deaths (Joint Epilepsy Council, 2011). It is important to provide tailored information to the family and have an age-appropriate discussion with children and young people taking into account the small but definite risk of SUDEP (NICE, 2012).

CAUSES OF EPILEPSY

Epilepsy is not a single condition, with more than 40 types reported, including 29 syndromes and 12 types classified according to an underlying cause (Joint Epilepsy Council, 2011; Paul and Eaton, 2012). A cause cannot be identified in up to 40 per cent of cases (NICE, 2013). In those cases where a cause is identified, either a brain injury or chemical imbalance may be responsible (Cross, 2012; NICE, 2012). An abnormality in the brain (such as a stroke, tumour, or malformation) can be responsible and in a small number of cases, the cause of the epilepsy can be inherited with a

Box 1: Clinical definition of epilepsy [ILAE] (Fisher et al, 2014)

Epilepsy is a disease of the brain defined by any of the following conditions
1. At least two unprovoked (or reflex) seizures occurring >24 hours apart
2. One unprovoked (or reflex) seizure and a probability of further seizures similar to the general recurrence risk (at least 60 per cent) after two unprovoked seizures, occurring over the next 10 years
3. Diagnosis of an epilepsy syndrome

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genetic condition (e.g. Dravet syndrome, whose estimated incidence is 1:40,000 live births (Wolff et al, 2006)). Examples of chemical imbalances that can trigger seizures include low blood sugar levels (hypoglycaemia), low oxygen levels (hypoxia), low blood sodium concentration (hyponatraemia), certain drugs and substance misuse (alcohol and cocaine). Some medical conditions, such as tuberous sclerosis, will increase the likelihood of a child having epilepsy; however, in the majority of cases, it occurs without any pre-existing ill-health (NICE, 2013; Cross, 2012). Box 2 highlights those children who may be at risk of developing epilepsy. NICE guidelines recommend that all children and young people who have had a first non-febrile seizure should be seen as soon as possible by a specialist in the management of epilepsies to ensure precise and early diagnosis and initiation of treatment (NICE, 2012).

### HISTORY AND CLINICAL FEATURES

A first-hand witness account is crucial to diagnosing epilepsy. It is often more important than the history from the patient themselves, as in many cases the patient will not remember what they experienced. Here, the role of the community practitioner is vital as they may be the first person to be consulted after a seizure and by the time the parents are seen by a paediatrician some vital information may not be remembered. Confirming or ruling out epileptic seizures is largely guided by a detailed but focussed history, as it prevents potentially dangerous and unnecessary investigations and treatments being initiated. Box 3 highlights a few helpful points which health professionals may find useful while trying to find information regarding a seizure event.

Owing to the wide range of different forms of epilepsy, the condition can present in a variety of ways, from generalised tonic-clonic seizures, to single abnormal movements to vague changes in awareness or regular ‘blank-spells’ (absence seizures). While some symptoms are more obvious than others, epilepsy must be considered if (Paul and Eaton, 2012):

- A child demonstrates recurrent ‘loss-of-awareness’ or regular ‘blank-spells’ (absence seizures)
- There are changes in a child’s behaviour, which are progressively getting worse

### INVESTIGATING SUSPECTED CASES

After referral to a specialist, an electroencephalogram (EEG) or ‘brainwave test’ may be performed. This test may show specific changes that can aid diagnosis and common specific EEG changes with the associated type of epilepsy is highlighted in Table 2 (Sheth, 2015). An EEG should be ordered by a specialist and is performed only to support a diagnosis of epilepsy in children and young people (NICE, 2012). However, quite often the EEG may be inconclusive. It may be noted that epilepsy is diagnosed in other cases based on the history and a negative EEG study does not rule out epilepsy (NICE, 2012).

Neuroimaging in the form of an MRI or CT scan is not indicated in every case of a child with a diagnosis of epilepsy. An MRI scan is the modality of choice to identify suspected structural abnormalities. This would be children who develop seizures before the age of two years, who have any suggestion of focal onset from history, examination or EEG (unless benign focal epilepsy), individuals in whom seizures continue despite maximum doses of first-line anti-epileptic drugs (AEDs) (NICE, 2012). In situations where MRI may not be available or children would require general anaesthetic to stay still for the MRI procedure, a CT scan may be used as an alternative to identify any gross pathology (NICE, 2012). An electrocardiogram (ECG) should be performed to rule out cardiac causes for the symptoms such as arrhythmias. It is also important to look for any electrolyte imbalances (e.g. hyponatraemia, hypoglycaemia, hypocalcaemia, etc.) and actively correct such abnormalities before diagnosing epilepsy in a child.

Recording so-called ‘epileptic spells’ on a mobile phone video (by parents at home) can provide a valuable supplement to the history in making the correct diagnosis and parents should be encouraged to record one where the history is not clear and investigations have remained inconclusive (Wilmshurst et al, 2015). In children with severe epilepsy or an epilepsy syndrome, in specialist settings ‘epilepsy gene panel’ (genetic blood test) testing may be considered (Chambers et al, 2015).

A diagnosis of epilepsy can have important physical, economic and psychosocial implications for the child in years to come. The

### Box 2: Risk factors for developing epilepsy (Cansu et al, 2007; Wei and Lee, 2015)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurodevelopmental delay</td>
<td>Low Apgar scores</td>
</tr>
<tr>
<td>History of recurrent atypical febrile seizures</td>
<td>Strong family history of epilepsy</td>
</tr>
<tr>
<td>Severe traumatic brain injury</td>
<td>Previous CNS infection (e.g. meningitis, encephalitis)</td>
</tr>
<tr>
<td>Genetic conditions (e.g. tuberous sclerosis)</td>
<td></td>
</tr>
</tbody>
</table>

### Box 3: Key points when assessing children with possible epilepsy (Ahmed and Spencer, 2004)

**When was the first seizure?**

- Were there warning signs or an ‘aura’ immediately before the seizure? If so, what were they?
- What happened during the seizure? (Often relies heavily on a collateral history from a witness)
- What happened immediately after the seizure?
- Are there any known trigger factors for seizures?
- If the child has had multiple seizures, were they similar or different?
physical or economic implications may appear obvious (injuries or fewer job opportunities) but the psychosocial impact is often subtler and probably underestimated. A recent study compared two groups of teenagers (aged 15 to 19 years) who were questioned to determine their knowledge and attitudes towards epilepsy (Friedrich et al, 2015). The two groups were given identical questions, except the words 'person/child with epilepsy' were replaced with 'epileptic/epileptic child’. The study found significantly 'more negative' attitudes in the second group, in particular in relation to sharing a room with a person with epilepsy (p<0.005) and marrying someone with epilepsy. This is clear evidence of the stigma that surrounds epilepsy, especially in relation to the word 'epileptic' and therefore a correct diagnosis is key and highlights the need for specialist involvement.

### DIFFERENTIAL DIAGNOSIS

Most recent estimates for the adult and child population show that misdiagnosis rates were between 20 and 31 per cent in 2011 (Joint Epilepsy Council, 2011), which represented 138,000 people with a diagnosis of epilepsy and receiving AEDs who actually did not have the condition. Common conditions that may be mistaken as an epileptic seizure are (Tolaymat et al, 2015; Zuberi and Symonds, 2015; NICE, 2012):

- Non-epileptic staring spells (52.8 per cent)
- Psychogenic non-epileptic seizures (10.3 per cent)
- Syncope (3.4 per cent)

### Table 1: Seizure type

<table>
<thead>
<tr>
<th>Seizure type</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERALISED EPILEPSY</td>
<td>Neuronal activity throughout entire cortex. Features do not allow localisation to single hemisphere</td>
</tr>
</tbody>
</table>
| Tonic-clonic | Loss of consciousness  
May pass urine or bite tongue  
Tonic phase: the muscles contract, the body stiffens  
Clonic phase: uncontrollable jerking of the body  
Cannot remember anything  
Will need time to recover (post-ictal state) |
| Tonic | Muscles in the body contract and the entire body stiffens  
Can cause the patient to fall |
| Absence | Momentary lapse in awareness  
More common in children and teenagers  
Patient may stop what they are doing, stare, blink or look vague for a few seconds then carry on with what they were doing  
It can go unnoticed and onlookers may think that the patient is just ‘daydreaming’ |
| Myoclonic | Brief, forceful jerks  
Can affect arms, legs, or sometimes the whole body |
| Atonic | Loss of muscle tone, spontaneous falls |
| FOCAL EPILEPSY | Neuronal activity focussed in one area of the brain. Features referable to area of activity. |
| Temporal lobe | Motor phenomena with decreased awareness and no recollection afterwards eg lip smacking, fumbling, picking at clothes, singing or wandering around  
Dysphasia (ictal or post-ictal)  
Déjà vu/jamais vu  
Emotional disturbance  
Hallucinations of smell or taste (olfactory)  
Complex auditory hallucinations  
Delusional behaviour |
| Frontal lobe | Posturing, versive movements of the head or eyes, peddling movements of the legs  
Motor arrest  
Subtle behavioural disturbances (often diagnosed as psychogenic)  
Dysphasia  
Todd’s Palsy (post-ictal focal limb weakness) |
| Parietal lobe | Sensory disturbance (tingling, numbness, pain) |
| Occipital lobe | Visual disturbances (spots, lines, flashes) |
If the seizure happens outside the hospital, breathing, circulation, disability (including epilepsy) (Tolaymat et al, 2015). In these situations, specialist treatments will not fall within the realms of this article. Throughout this process, the child and parent should be involved and the patient should have an agreed and comprehensive written epilepsy care plan (NICE, 2013).

Acute management of a seizure in a hospital setting should follow the ABCDE (Airway, Breathing, Circulation, Disability (including blood glucose testing) and Exposure) approach. If the seizure happens outside the hospital, the child should be laid down in a safe place (preferably on the floor), clothes loosened around the neck, placed in the recovery position. Emergency care and treatment should be given to any child or young person experiencing prolonged (>5 minutes) or repeated (>3/hour) convulsive seizures in the community (NICE, 2012). Prescribed rescue medication (bucloc midazolam or rectal diazepam) should be administered by trained clinical personnel or by family members or carers with appropriate training (if specified by an individually agreed protocol drawn up by the specialist) (NICE, 2012).

Care must be taken to secure the child or young person’s airway and nothing should be introduced into the child’s mouth in an attempt to stop tongue-biting (Paul and Eaton, 2012). An ambulance should be called if (NICE, 2012):

- The seizure is continuing five minutes after the emergency medication has been administered
- The person has a history of frequent episodes of serial seizures or has convulsive status epilepticus, or this is the first episode requiring emergency treatment
- There are concerns or difficulties monitoring the child’s airway, breathing, circulation or other vital signs.

It may also be necessary to call an ambulance if there is a previously agreed plan with the specialist that the child should be brought to the hospital (preferably in an ambulance) after any seizure episode. It is important to bear in mind that witnessing a child having a seizure can be a traumatic experience for anyone involved, especially the parent and so they will need to be approached with empathy and professionalism (Paul and Eaton, 2012).

PROGNOSIS

It is possible to ‘grow out’ of epilepsy. After two seizure-free years, discontinuation of AEDs should be trialled (tapered slowly over six weeks) (Tolaymat et al, 2015). Epilepsy is considered to be resolved for individuals who had an age-dependent epilepsy syndrome but are now past the applicable age, or who are seizure-free for 10 years, having been off their medication for five years (ILAE, 2015). Discussion on SUDEP and response to treatment has been discussed in earlier sections. The risk of SUDEP can be minimised by optimising seizure control and by the family being aware of the potential consequences of nocturnal seizures and thereby report these to the specialist who will aim to minimise these events (NICE, 2012).

ROLE OF COMMUNITY PRACTITIONERS

Management of epilepsy needs specialist skills and expertise. Community practitioners, however, can play a vital role in early recognition and referral and later supporting the management of the condition in the community. A few useful practice points are highlighted below, which may be helpful and are derived from the available literature and experience in managing such children (NICE, 2013; Cross, 2012; Paul and Eaton, 2012; Wilmhurst et al, 2015; Zuberi et al, 2015):

- Provide first aid advice in the instance that a seizure occurs again (outlined above).
- Advise parents to video record the event as it is a valuable link to be shown to a specialist.
- Lifestyle modifications and health and safety advice pertaining to hygiene (avoiding baths and taking showers instead; keeping toilet door unlocked), leisure activities (wearing a helmet while cycling and avoiding busy roads; swimming with one to one monitoring; not climbing trees), contraceptives, drugs and alcohol and the need to maintain a healthy lifestyle are crucial.
- Monitor adherence to AED – ensuring adequate seizure control, monitoring side effects and checking compliance by checking with parents when they give...
medicines, what do they do if they have forgotten to give a dose (ie whether they give it again as soon as they realise that a dose got missed), how they ensure that there is a regular supply of AED (ie whether the AED is on repeat prescription and is set up with the local pharmacy to deliver the medicine at home on a regular basis, etc), all with an aim of improving the quality of life for the child, reducing admission to hospital due to recurrent seizures and improving attendance at school.

- Give parents and children information leaflets and advise to join support groups, such as Epilepsy Action and the Epilepsy Society. These organisations are able to improve understanding of the disease and hopefully decrease levels of anxiety and stress in parents and children.

- Supporting and administering rescue anticonvulsant medication to a child if a prolonged seizure happens at school or nursery. This includes ensuring the child is safe during an epileptic seizure, putting the child in recovery position, calling an ambulance, updating the specialist about change in seizure types of increased frequencies of events (some of these children may be in a special school where seizure management is part of the care provided).

- Supporting smooth transition of care from paediatric to adult services, as outlined in the NICE guidelines (2012). This is from their previous experience in supporting the families and notes written by colleagues in the community team where specific difficulties such as finances, transportation, education, getting regular supply of medicines, etc. may have become evident. The medical team planning transition will need to know this information so as to plan the best package suitable for the young person.

References

CPD questions (visit www.communitypractitioner.com/CPD to submit your answers)

1. The main feature of epilepsy is ……… seizures.
   a) Tonic-clonic
   b) Focal
   c) Recurrent
   d) Neverending

2. Epilepsy is a condition that only affects people below the age of 18 years.
   a) True
   b) False

3. The occurrence of one unprovoked seizure is always diagnostic of epilepsy.
   a) True
   b) False

4. Epilepsy is caused by:
   a) Brain injury
   b) Chemical imbalances in the brain
   c) Epilepsy syndromes, such as Dravet syndrome
   d) All of the above

5. Epilepsy is best diagnosed using:
   a) An electrocardiogram (ECG)
   b) An MRI scan to identify seizure origin
   c) An electroencephalogram (EEG)
   d) A detailed history from the patient or a first-hand witness account of the event

6. It may be possible for the patient to lose urinary continence during an epileptic seizure.
   a) True
   b) False

7. Childhood absence seizures may be identified by teachers or school nurses who notice their pupil having recurrent ‘blank spells,’ where they may appear to be daydreaming for a moment and then continue what they were doing.
   a) True
   b) False

8. The main treatment for epilepsy is:
   a) Electro-convulsive therapy (ECT)
   b) Cognitive behavioural therapy (CBT)
   c) Anti-epileptic drugs (AEDs)
   d) Brain surgery

9. Anti-epileptic drugs work by altering the brain structure, therefore eliminating the possibility of further seizures.
   a) True
   b) False

10. Children diagnosed with epilepsy should be advised to:
    a) Take showers not baths
    b) Wear a helmet when riding a bike and avoid busy roads
    c) Join support groups, such as Epilepsy Action
    d) All of the above
Performing school nursing: Narratives of providing support to children and young people

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ABSTRACT
Child and adolescent mental health is an important public health issue within the UK. Providing support to young people to help them cope with everyday life is a key aspect of the school nurse’s role. Yet there is a paucity of published research within the UK and internationally about how this support is provided. Using a narrative inquiry approach this study set out to address the following research question, ‘How do school nurses provide support to young people?’ Stories were gathered from 11 school nurses identified through purposive sampling to explore their experiences of providing support to young people. Poetic representations were used to tell the stories of individual school nurses; an approach seen to be innovative within school nursing research. Spatiality theory was used as a framework to explore different spaces used when providing support to young people. This study extends the current school nursing literature about what it means to provide support. The importance of regular support and building trusting relationships is identified. Yet challenges exist in terms of the amount of emotional investment required by the nurses, as well as a lack of workforce capacity and organisational demands.

KEYWORDS
School nurses, support, young people, narrative inquiry

INTRODUCTION
Many children and young people require support for a variety of reasons as they attempt to deal with particularly difficult situations, such as peer pressure, parental expectations, family conflict, bullying, low self-esteem, depression, abuse and sexual exploitation (The Children’s Society, 2014). Within the UK one in 10 school age children and young people will experience a mental health problem (The Children’s Society, 2014). Indeed, it has been identified that half of those who have a lifetime mental health problem will have exhibited symptoms before the age of 14 (DH, 2011). Palfrey et al (2005, p.1121) suggest that mental health and emotional issues within young people have now become so prevalent that they can be described as the “new millennial morbidity.”

School nurses play a vital and important role in providing emotional support to school-age children and young people and helping to reduce the development of potential mental health issues (DH/DCSF, 2009; DH, 2012). They are often the people to whom young people choose to disclose a wide range of issues and can facilitate improvements in young people’s physical health and psychological wellbeing, as well as helping to ensure that as far as possible they are safe (HM Government, 2013).

LITERATURE REVIEW
A review of the literature, both national and international, established that school nurses can and do provide emotional support to young people (Chase et al, 2010; Haddad et al, 2010; Kendal et al, 2011; Membridge et al, 2015). However, much of the literature focuses on ‘what’ school nurses do and there is a significant gap about ‘what it means’ to provide support. Little attempt has been made to gain a more nuanced insight into school nurses’ everyday experiences at grass roots level, and issues relating to a crisis of identity and a lack of freedom within the role have been identified. Therefore a more focused attempt to capture the dynamism and vitality of their practice was needed, to offer a detailed and contextualised understanding of their everyday experiences and provide a more authentic and robust evidence base to influence and enhance future practice.

METHODOLOGY
This study employed narrative inquiry, which focuses on the way in which human beings make sense of their subjective reality and then attach meaning (Holloway and Wheeler, 2002). Narrative inquiry is a flexible methodology that contextualises nursing practice to make sense of experience, facilitate learning and creates opportunities to illuminate the way ahead (McCance et al, 2001).

The overall aim of this research study was to contribute towards a more insightful and meaningful understanding of how school nurses provide support in the context of their everyday practice. Therefore the following research questions were formulated:

1. What stories do school nurses have to tell about providing support to children and young people?
2. What insights do their stories reveal into how they perform school nursing?
3. How can these stories connect with the school nursing community?
4. What work do the stories do in terms of enhancing and developing practice?

The study centred on gathering stories from specialist community public health school nurses working for two NHS Trusts. Within qualitative research the focus is on a richer and deeper exploration of a small number of cases in a specific context, as the purpose is
not to generalise but to address the research question (Bold, 2012). Purposive sampling was used to identify school nurses with the necessary knowledge and experience of providing support to young people (Bryman, 2008). All qualified school nurses within the two Trusts were invited to participate. The first 12 to volunteer were included in the study. Data were gathered using unstructured interviews and these were then transcribed verbatim.

**ETHICS**
Ethical approval was sought and granted from the University of Wolverhampton Ethics Committee and from the Research and Development Units of two NHS Trusts. Permission to interview the school nurses was also gained from line managers and informed consent was obtained. The school nurses were able to withdraw at any time and their names changed to ensure anonymity.

**ANALYSIS**
A data analysis model (Savin-Baden, 2004) was adapted and revised to deconstruct, reconstruct and interpret the stories (see Figure 1). Its interactionist-interpretivist nature encourages analysis within two phases: analysis of the individual stories and then identifying key themes across all of the stories as a collective whole.

Phase 1 of the model requires dialogic interpretation by engaging with the content of the story, including how the story was told and finding the dramatic heart of the story to find out what holds this particular story together. Following this is a biographical rewriting of the story, but the challenge was to present each narrative event in an evocative and memorable way (Richardson and St. Pierre, 2005) using poetic representations. Using poetry can help to gain a deeper understanding of clinical situations to enhance client care (Raingruber, 2004). For each interview a poem was constructed using the actual words of the school nurse. This provided an overall picture of the interview as opposed to quotes selected by the researcher, and also allows for the individual’s voice to be heard. Two of the poems can be seen in Boxes 1 and 2.

**COLLECTIVE FINDINGS**
Being visible and providing regular, consistent support
The need to be more consistently visible was a recurring theme within all the stories. In order to provide support on a practical level, school nurses need to be physically visible to young people, so they know who to contact and how to access them.

“It is so important to be in your schools and visible to them so they recognise you and say ‘Hi Jo’ when they see me in school. That means a lot to me.” (Joanna)

Although support may be a one-off contact, the increasing complexities of young people’s emotional health needs suggest that support often needs to be provided consistently and regularly over a period of time (CAMHS, 2008; Pryjmachuk et al, 2011). However, as there are conflicting demands on their time, school nurses need to consider how they can maximise their potential in schools as the practicalities of providing support regularly can be challenging.
Once support was initiated, it was deemed important to provide it consistently, and to not let young people down because of other workload commitments.

“It is important to be able to consistently work with young people. Problem is we end up having to let them down sometimes as we are called to a child protection conference and so have to go… If you say I am going to see you next Thursday at 1pm that’s what they expect. ” (Joanna)

Joanna indicated that she would like to be more proactive and extend her practice by collaborating with other agencies to raise her profile. However, she appears to face a dilemma: “You are afraid too because that will generate more work and we won’t be able to cope. … We just can’t cope with the number of referrals.” (Joanna)

Structure and agency

Structure and agency terms are often used to describe the levels of power, autonomy and locus of control ascribed or experienced by an individual(s) within a particular situation (Bourdieu, 2000). They are also terms associated with a sense of having a voice, which in this context relates to their collective identity as school nurses within the wider nursing and health community. A key feature within the stories related to beliefs about not being valued by other professionals, leading to feelings of disempowerment.

Diane focused on how she tried to support parents with learning difficulties, who were struggling to cope with the demands of parenting and everyday family life.

“This is not my job. I’m a school nurse. I shouldn’t be doing this but there was nobody else who was going to do it… I felt frustrated.” (Diane)

The importance of building trusting relationships was also highlighted. Laura’s story recalled how it took a young teenage girl almost 12 months to tell her she had an eating disorder. Having a trusting and respectful relationship is a key aspect in the provision of support, and to the success in delivering health promotion messages (Holmstrom et al, 2013). Being visible was an issue that many highlighted as fundamental to whether young people accessed available support. Several school nurses discussed how they try to raise their visibility with the young people, including putting up posters, speaking at assemblies, working more collaboratively with teachers and other staff, being in the playground when parents fetched their children and walking around the school at lunchtime.

“It is so important to be in your schools and visible to them so they recognise you and say Hi Jo when they see me in school. That means a lot to me.” (Joanna)

The British Youth Council (BYC, 2011) identified that young people also want school nurses to be more visible. In response, some school nursing services are reverting back to wearing traditional nurses’ uniforms to heighten their visibility and raise their profile (Shervin, 2015).

Personal emotional investment

Personal emotional investment was a common theme to emerge from the stories. Some spoke about how they worry about the vulnerable young people they support emotionally, and that they often take these worries home with them. It would appear that it is difficult at times for school nurses to be able to detach their own emotions from some of the complex situations. This can be seen in the poetic representations in Boxes 1 and 2, which bear a powerful witness to this difficulty.

Jackie and Daniella, for example, share how they worry about the current difficulties that some young people face daily:

“Sometimes she’s that distressed that I get upset. She doesn’t see I get upset but I do get upset. I feel like there’s nothing anybody can do to help her.” (Jackie)

“You go home and you hope they’re alright and you worry about them and it can be quite difficult.” (Daniella)
Empathetic caring and feeling within nursing involves emotional and mental effort, in looking after and supporting others (DH/NHS Commissioning Board, 2012). Diane described how a family were “pretty much always on my mind and often on my mind even when I wasn’t at work”. At times the emotional investment and labour of nursing can be a sorrowful experience (James, 1993). A variety of terms were used to describe this emotional labour such as: “You just keep going…” (Daniella); “It was a real emotional cost … to work with such a vulnerable family…” (Diane). Bolton (2000) suggests that is the emotional involvement with their patients/clients that causes nurses the most anxiety, yet paradoxically it is also this that gives them the greatest job satisfaction.

Coping with the emotional demands of the role was also acknowledged as being important. Several spoke of how they sought out collegial support to help them cope - some of which was informal, offered by peers, as well as that offered by the organisation - but voiced that they required more, especially newly qualified school nurses.

**Role containment versus role diffusion**
The majority of school nurses spoke of a tension in what they could potentially provide as a service and what they were actually able to provide. They felt frustrated that they were contained by restrictions on their role (role containment) and at times they felt this compromised the level of care and support they were able to offer. Yet conversely, at policy level there is a drive to diffuse the school nurse role further into areas of practice such as supporting 16- to 19-year-olds (DH/DCSF, 2009). There is an expanding need for the school nurse to support the emotional health of young people and this appears to be leading some nurses to provide additional support. This can be described as ‘role diffusion’, ie spreading in many directions. As a result, to outsiders, school nurses’ work can appear muddled and undefined, ie the ‘swampy lowlands’ of professional practice as identified by Schon (1991). Hence ‘role diffusion’ may be a positive characteristic of practice, but one that may not always be congruent with the objectives of the organisation and commissioners.

**Making a difference**
School nurses told of how they feel they ‘make a difference’ by supporting individual young people to help them transform and cope with situations. Making a difference can be intangible, yet helping to make life better for someone and witnessing positive change is very rewarding, and it is why they do what they do (Hudacek, 2004). Laura told a story of how she has supported a 12-year-old boy being bullied due to being overweight. “School were saying, ‘he’s just so different now, he’s walking along confidently and he’s laughing and he’s not upset’, which is what I like about school nursing – it is about making a difference and it is thinking outside the box.” (Laura)

The stories also uncovered that school nurses felt they needed to be more politically active to influence and shape services to help meet their population’s needs. However, being such a small workforce hindered this. Working at a strategic level can be ‘risky’ as it can involve speaking out.
and acting as an advocate for those who are vulnerable. Within this theme school nurses allude to the extent of their freedom (mitigating risk) or perceived lack of it. Yet as qualified school nurses they have a responsibility to work at a more strategic level providing clear leadership to lower band grades within the team to bring about political transformation (NMC, 2004). Therefore school nurses need to decide whether to embrace their role and act as leaders, proactively accepting the challenges that lie before them, or to passively accept their current position. It may be that they require more support after qualifying to assist them in their new roles as specialist practitioners and leaders.

Virtual space
It is suggested that school nurses also now operate in and provide support using an additional space to that proposed by Soja (1996) (see Table 1). Virtual space, such as using smartphone technology and the internet are now a means of communicating with and supporting young people. “She has got my work mobile phone number so she knows she can text me if she’s struggling.” (Caroline)

Technology is now being used to gather young people’s views about school nursing services, and this is a more objective and confidential way of collecting feedback.

“It’s easier in a way if you’re in front of a screen to say what you genuinely think ‘cause I think sometimes that the young people would be say what they think we want to them to say when we really want them to be honest” (Susan)

Following analysis of the data, Soja’s ideas and collective themes (1996) were then combined and portrayed as a visual representation to demonstrate how school nurses provide support (see Figure 2).

CONCLUSION
The aim of this study was to explore how school nurses provide emotional support to children and young people. The findings highlight that although school nurses feel they have suffered from a lack of investment, they play a significant role in supporting young people. The difference they can make in helping young people cope is clearly displayed in the stories they tell. Storytelling can aid the development of personal resilience and is recognised as having therapeutic benefits for practitioners (East et al, 2010). The school nurses found telling their stories to be a cathartic experience, which reflects their own need for support and resilience in dealing with highly emotional and complex situations. They recognised that involvement in the study gave them space to reflect and recontextualise what they do subconsciously on a daily basis. However, school nurses as a community of practice must imagine their self-belief. This is fundamental to the progression of the profession in terms of influencing commissioning and in the development of future services. To help achieve this school nursing requires further evidence-based research (which should also involve service users), clear leadership, firm commitment and the courage to move forward.

Key points
- One in 10 children and young people within the UK experience a mental health problem
- School nurses make an important difference by providing emotional support to children and young people to help them cope with everyday life
- A reduced workforce capacity and a relatively invisible service can have an impact on the amount of support offered
- Gathering stories is a useful way of collecting rich and meaningful research data. It can aid the development of personal resilience, as well as providing a therapeutic benefit for the practitioner
- Using poetic representations can be a valuable form of reflection and helps to enhance practice.

References

We’re cutting down on sugar

- New sugar reduction programme
- Strict sugar targets for new products

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www.kelloggsnutrition.com/cuttingsugar
Something fishy about home-cooked infant feeding recipes

INTRODUCTION

Dietary patterns beginning in early childhood can play a vital role towards future eating habits (Nicklaus et al, 2004; Skinner et al, 2002). Developing taste preferences for a healthy balanced diet has been suggested to begin in childhood (Birch et al, 1990; Birch and Fisher, 1998; Sullivan and Birch, 1994) during the introduction of solid foods, also known as weaning and complementary feeding. This is the period when the milk diet no longer solely meets the nutritional needs of the infant and solids foods are required to bridge the nutritional gap (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005). It can be suggested that the timing and repeated exposure to healthful foods during this key period is fundamental to the child’s later acceptance of these or similar foods (Birch et al, 1998; Caton et al, 2014), thus it is vital that infants are offered a variety of different nutrient-dense foods.

Home-cooked meals are seen by many parents as the ideal option for feeding their child (Hoddinott et al, 2010). Despite the perceived convenience of commercially prepared complementary foods, home-cooked meals are often thought of as the cheaper option, better for the child, and without the additional chemicals that could be present in commercial products (Hoddinott et al, 2010). National dietary surveys indicate that 34 per cent of British children aged four to nine months ‘always’ or ‘almost always’ eat meals prepared by, but not the same, as their parents (DH, 2011). During the first months of infant and young child feeding (IYCF) parents often seek and use many different sources of information (Hoddinott et al, 2010; Carruth and Skinner, 2001; Horodynski et al, 2007; Gildea and Sloan, 2009; Moore et al, 2012; Savage et al, 1998) collecting tips and suggestions during this transitional period (Carruth and Skinner, 2001; Gildea and Sloan, 2009).

There is a vast number of specifically targeted IYCF cookbooks available on the market that can provide parents with guidance and ideas for infant meals. These cookbooks may be bought, borrowed or given as a gift during the first months of complementary feeding, and are often recommended by other parents (Hoddinott et al, 2010). There is currently no evidence available indicating whether these popular cookbooks provide nutritious options for home-cooking, what the most common food types are within the main meal recipes, or what accompanying dietary advice is provided. This study aimed to examine the prevalence and nutritional content of main meals within IYCF cookbooks and to investigate what dietary messages are portrayed towards parents on giving different food types to their child during the early years period.

METHODS

Data collection

IYCF cookbooks were identified from a search of local (North East of Scotland) online library catalogues (May 2013 to July 2013) and a survey of Amazon’s (www.amazon.co.uk) top 20 bestselling IYCF cookbooks (June 2013). Search terms included the keywords: infant recipes; baby recipes; toddler recipes; infant food; weaning; infant feeding; early years; complementary feeding. Duplicate books and those that did not contain recipes were excluded from the investigation. Breakfast, dessert, snacks and recipes aimed towards children aged five years and older were excluded from this investigation.

Recipe names were used to identify the primary food type within each recipe, ie vegetables, poultry (chicken and turkey), red meat (beef, lamb, pork) and seafood (fish and shellfish), as it was assumed that parents would use the title of the recipe when selecting options for their child. Recipes were

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ABSTRACT

There is no evidence available indicating whether popular infant and young child feeding (IYCF) cookbooks provide nutritious options for home-cooking, what the most common food types are within the recipes, and what accompanying dietary advice is provided to parents. This study surveyed available IYCF cookbooks from local libraries and Amazon UK’s top 20 bestsellers (May to July 2013) to examine the prevalence and nutritional content of cookbook recipes comparing these to recommendations whilst investigating the messages portrayed towards parents on giving different foods to their child during IYCF.

Vegetable-based recipes (median=29) predominated main-meal options while a proportional number of red meat (12), poultry (10) and seafood-based (13) recipes were included providing parents with options of protein-rich recipes for their young child. These home-cooked recipes adequately met or exceeded age-specific dietary recommendations. Mixed messages were apparent on the inclusion of foods during IYCF within and across these cookbooks, in particular for seafood, highlighting a lack of consistent advice portrayed to parents during the early years. Community-based health professionals should advise parents of the inconsistent and incorrect messages on food inclusion portrayed in some IYCF cookbooks and guide them towards formal recommendations.

KEYWORDS

Infant feeding, home-cooked, early years, child feeding, seafood
DATA ANALYSIS

The data was not normally distributed thus the non-parametric Mann-Whitney U test was conducted to compare the differences between each food type (seafood, poultry, red meat, vegetable) in the occurrence of recipes, nutritional content, and beneficial and cautionary messages. P-values <0.01 were considered statistically significant due to multiple comparison testing. Statistical analysis was conducted using IBM SPSS Statistics 23.0 software (IBM Corp, 2015).

RESULTS

General characteristics

Fifty five IYCF cookbooks were identified for inclusion with a total of 4,438 main meal recipes. The cookbooks were published between 1993 and 2013 with 38 (69 per cent) cookbooks published after the publication of the current IYCF recommendations set in 2003 (contact the author for list of cookbooks).

Various age categories were used in the cookbooks to define each stage of IYCF. The first stage, often cited as ‘first tastes’, was primarily stated as beginning from six months but with many cookbooks also stating prior to six months (n=24; 43.6 percent, nine published after current recommendations (16.4 per cent)). The subsequent stages varied greatly between books dependent on how many stages they included and so the number of recipes for each food type is presented as ‘infant’ (up to 12 months) and ‘toddler-plus’ (one to four years) recipes (Figure 1).

Overall there was a significant reduction in the median number of recipes available for the toddler-plus years (4) compared to the infant recipes (7; p<0.001). Vegetable-based infant recipes (20) were significantly higher than its toddler-plus counterparts (7; p<0.001) and were significantly higher than the other food type recipes for this stage (p<0.001) (Figure 1). No significant differences were found between food types in toddler-plus recipes (p=0.375).

FOOD TYPES

There were significantly more vegetable-based original recipes (median=22) and total recipes (including variations) (29) than red meat (9 and 12), poultry (8 and 10), and seafood (7 and 13) (p<0.001) (Table 1). The number of variations to recipes was significantly higher for vegetables (4) than red meat and poultry (both 2; p<0.0005), and seafood (3) had significantly more than poultry (p=0.002).

NUTRITIONAL CONTENT

Vegetable-based meals contained significantly less energy (81.5kcal/100g) than the other food types (p<0.003) and seafood contained significantly more (122.5kcal/100g) than poultry (103.0kcal/100g; p=0.009) (view Table 2 online). Vegetables provided significantly more fibre than all other types (1.8g/100g; p<0.001) and contained significantly more carbohydrate content (10.7g/100g) than poultry and red meat recipes (7.5g and 8.1g/100g respectively; p<0.001),

classified as either original or variations – variations occurred where the original recipe stated the use of one ingredient but then listed alternatives that could be added as replacements. The number of original and variations to recipes were collected for each food type using a piloted data extraction form. A stratified sample was randomly selected to include for nutritional analysis. Using a randomiser software (Urbaniaik and Plous, 2007), 408 recipes were selected from the total recipes with 102 from each of the categorised food types (seafood, poultry, red meat, and vegetables). The sample of 408 recipes with equal shares of each food type was deemed sufficient to provide a 90 per cent statistical power assuming a significance level of 0.01 for nutritional comparison. Netwisp 3.0 Dietary Analysis software (Tinuviel Software, 2006) was used to provide the nutritional compositions of the sample of recipes per 100g. The nutritional content of raw rather than cooked ingredients was used because of the limited published data on the nutritional composition of cooked foods. Where the option of salt and pepper was stated within the recipes, 1g of the optional condiment was included to ensure it wasn’t underestimated by omitting salt completely. Average energy density (kcal/g), protein content (g), percentage of dietary fats from total energy, and the percentage contribution of salt were calculated for each meal type and used to compare to age-specific dietary recommendations (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005; DH, 1991; Scientific Advisory Committee on Nutrition, 2003). Messages specifically regarding individual food types, but not those for whole recipes within the cookbooks were recorded and included for investigation. These messages were then identified as being framed as beneficial or cautionary. Beneficial claims were defined as any information that highlighted a nutritional, health or any other benefit for any of the food types. Cautionary messages were defined as those that cited any warnings or risks towards the consumption of the food types by infants and young children. A random 10 per cent sample of the data underwent double data extraction and checking (SC and DM).
Table 1: The number of main meal recipes in IYCF cookbooks by food type

<table>
<thead>
<tr>
<th>Home-cooked recipe type</th>
<th>Seafood (S)</th>
<th>Poultry (P)</th>
<th>Red meat (M)</th>
<th>Vegetable (V)</th>
<th>Post-hoc comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median (interquartile range)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original recipes</td>
<td>7 (6, 13)</td>
<td>8 (4, 13)</td>
<td>9 (5, 17)</td>
<td>22 (14, 37)</td>
<td>V&gt;S,P,M</td>
</tr>
<tr>
<td>Variation recipes</td>
<td>3 (1, 9)</td>
<td>2 (1, 3)</td>
<td>2 (1, 5)</td>
<td>4 (2, 10)</td>
<td>V&gt;P,M,S</td>
</tr>
<tr>
<td>Total recipes</td>
<td>13 (8, 21)</td>
<td>10 (6, 18)</td>
<td>12 (8, 21)</td>
<td>29 (18, 50)</td>
<td>V&gt;S,P,M</td>
</tr>
</tbody>
</table>

"Presence of ‘>’ in post-hoc comparison indicates a significant difference at p<0.01 between groups.

and more total sugars (2.6g/100g) than seafood (1.8g/100g; p=0.001). Seafood-based meals contained significantly more protein (8.5g/100g; p=0.002) than red meat (7.6g/100g) and vegetable recipes (2.8g/100g) while poultry (7.7g/100g) and red meat contained significantly more than vegetable recipes (p=0.001).

Vegetable recipes contained significantly less salt (0.2g/100g) than other food types (all 0.3g/100g; p≤0.001) and less total fats (3.4g/100g) than seafood (5.9g/100g) and red meat (5.4g/100g; p<0.001). Seafood and red meat contained significantly more saturated fats (1.9 and 2.0g/100g respectively) than poultry and vegetable meals (both 1.0g/100g; p=0.004).

In terms of age-specific recommendations (Table 3), both poultry (1.0kcal/g) and vegetable-based (0.8kcal/g) home-cooked meals had an energy density within the recommended range (0.6-1.0kcal/g) with seafood and red meat-based home-cooked meals exceeding recommendations (both 1.2kcal/g). The median intake of percentage of total energy from total fats was within the recommended intake of 34 to 45 per cent all meal types, ranging from 34 per cent in poultry to 43 per cent in seafood recipes. Vegetable-based meals achieved the lowest percentage of protein reference nutrient intake (RNI) (20 per cent) whilst seafood-based dishes achieved the highest (61 per cent), and vegetable meals contained the lowest salt contribution to recommended maximum (10 to 20 per cent).

BALANCE OF MESSAGES
Total beneficial claims for poultry in IYCF cookbooks (median=4) were significantly lower than other food types (p=0.002), and beneficial claims for red meat (7) were significantly lower than those for vegetables (14; p=0.003) (Figure 2). Cautionary messages within complementary feeding cookbooks were significantly higher for seafood (median=12) than the other food types (p=0.001), while vegetable recipes had significantly lower cautionary messages (1) than poultry (4) and red meat (3) (p=0.001) (Figure 2).

BENEFICIAL CLAIMS
The types of beneficial claims made within the complementary feeding cookbooks were categorised into two main groups, namely ‘high in specific nutrients’ and ‘generally nutritious’. The high in specific nutrient category identified claims that specified high levels of macro and micronutrients, and in some cases linking these nutrients to a specific health benefit. An example from this category was: “Firm is a good source of B-vitamins, iron and zinc”. Poultry received significantly fewer ‘high in specific nutrients’ claims (median=4) compared to red meat (7), seafood (10), and vegetables (13; p=0.001) (see Figure 3 online).

‘Generally nutritious’ claims specified a food type to be nutritious, wholesome and good for you, for example: “Not only is this deliciously smooth purée [pumpkin and pea] highly nutritious, but it also has a sweet, mild

flavour that your baby will love”. Vegetables were cited with significantly more ‘generally nutritious’ claims than poultry (p=0.006) and red meat (p=0.001), and seafood had significantly more than red meat (p=0.008) despite median values of zero for all food types.

CAUTIONARY MESSAGES
Three main cautionary messages were identified, namely: ‘avoid/limit’; ‘allergy risk’; and ‘physical properties’. Avoid/limit messages were defined as an advisory note which specified an avoidance of particular varieties of food types (excluding avoiding for allergy risks), age limits for the inclusion/ avoidance of certain foods, and limits to the amount of foods to be given. Examples from this category are: “It’s best to avoid swordfish, shark and marlin because they may contain unhealthy levels of mercury”; and “Don’t give pork and processed meat until 12 months”. Seafood and red meat both showed significantly higher avoid/limit cautions (both median=2) than poultry and vegetable (both 0; p=0.001) (Figure 4).

Within the ‘physical properties’ category, the presence of bones and skin was often suggested as a choking risk, eg “To avoid your child choking check carefully for bones”, but also included notes to make sure pieces of food were cut into appropriate sizes to avoid choking and to remove gristle, seeds etc. Seafood received significantly more ‘physical properties’ cautions (6) than all other food types (p=0.009) and poultry (2) received significantly more than red meat and vegetables (both 0; p=0.001) (Figure 4). ‘Allergy risk’ cautions were significantly higher for seafood (median=1) than other food types (p=0.001) and vegetables had significantly more than poultry and red meat (p=0.003) despite zero median values for each.

DISCUSSION
To the researchers’ knowledge this is the first study investigating the prevalence and nutritional adequacy of different food type recipes, and the messages portrayed on these foods in IYCF cookbooks. During the first months of IYCF feeding, guidelines recommend providing infants with single ingredient meals, such as cereals and vegetables as the first tastes (Pan American Health Organization and
World Health Organization, 2003; World Health Organization, 2005). It is apparent from the findings of this study that vegetable-based meals were predominant in first stage (up to 12 months) recipes compared to seafood and meat types matching recommendations (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005). The predominance and then subsequent lowering of vegetable-based recipes for the later toddler-plus (one to four years) stages may also be a result of the concentration of the cookbooks on the first stages of IYCF feeding and providing parents with numerous different single and multiple vegetable combination recipe options. The lower overall inclusion of recipes targeted for the toddler-plus stages (one to four years) suggests that cookbook authors are aware of the guidance (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005) and common practice (Public Health England and Food Standards Agency, 2014; Scottish Government, 2015) of moving onto shared family meals in the later stages of IYCF. The proportional contribution of seafood and meat-based recipes found in this study opposes previous findings within commercial IYCF meals (Carstairs et al, 2015), but indicates the cookbook authors’ adherence to guidelines to encourage a balance of different foods within the early years diet (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005; 2009).

The lower contribution to recommended salt intake ranges found in vegetable-based recipes could be a result of the prevalence of these recipe types being targeted towards the early stages of infant feeding. Meat and seafood-based recipes are often promoted after the first tastes (World Health Organization, 2009) and often replace the availability of vegetable-based meals in the later stages of IYCF (Carstairs et al, 2015). In comparison to age-specific recommendations, each of the recipe types adequately met or exceeded energy density recommendations for infants and young children while providing fat contents within the recommended range of 30 to 45 per cent of percentage of total energy (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005). The higher total and saturated fats apparent in red meat and seafood-based recipes contribute to energy densities which exceed recommendations (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005), and complement previous findings that indicate greater saturated fat contents in commercial infant feeding meals of the same types (Carstairs et al, 2015). On further investigation the researchers determined that the high saturated fat and higher protein contents within seafood-based meals was contributed to by the high presence of dairy products, mirroring previous findings on IYCF meals (Carstairs et al, 2015; Zand et al, 2015). The presence of high fats within seafood and red meat meals is not, however, a major concern for children under the age of two years, who require additional fats for development and growth (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005).

This study reveals that each of the food types were promoted as beneficial within the early years diet, stating ‘high in specific nutrients’ claims to encourage the inclusion of these foods into the diet of an infant. Cautionary messages were apparent for each of the food types investigated but were significantly greater for seafood,
overwhelming the number of beneficiary messages portrayed for this healthful food – findings similar to those found in formal IYCF information leaflets. The contradictory seafood messages found in this study support previous published work discussing the benefits and risks associated with its consumption (Nesheim and Yaktine, 2007). In particular, the cautionary messages identified in this study often cited the risk for high methylmercury from the consumption of specific seafood species, ie shark, marlin and swordfish, following recommendations to exclude these from the diet of children (Scientific Advisory Committee on Nutrition, 2004). However, these are rarely consumed species within the European population, (European Commission, 2014) and a lack of easily available, non-risky alternatives may act as a barrier to fish consumption after exposure to contradictory messages on the safety of fish (Vardeman and Aldoory, 2008).

The inclusion of messages on the avoidance or limitation of other foods highlighted sometimes incorrect information and was inconsistent across the range of IYCF cookbooks, including those books published after current complementary feeding guidelines (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005). The avoidance of both shellfish and offal was cited throughout the range of cookbooks, with advice to delay the introduction of these foods until one year and some books citing two years of age, although no such advice is stipulated in current guidelines (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005). The avoidance of both shellfish and offal was cited throughout the range of cookbooks, with advice to delay the introduction of these foods until one year and some books citing two years of age, although no such advice is stipulated in current guidelines (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005). Despite a lack of evidence for allergy-preventing effects from the early restriction of key foods in an infant’s diet (ESPGHAN Committee on Nutrition et al, 2008) and guidelines stating no restriction of common allergenic foods (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005), seafood consistently received ‘allergy risk’ messages and was often advised to be avoided until one year of age within IYCF cookbooks. The ‘allergy risk’ messages received for vegetables indicated that some cookbook authors also felt the need to inform parents of oral allergy syndrome (NHS, 2014), an issue not specified in current recommendations (Pan American Health Organization and World Health Organization, 2003; World Health Organization, 2005), which occurs when key proteins in fruits, vegetables, nuts and spices which are similar to those found in trees are mistaken by allergen antibodies as pollen and result in itching and mild swelling in the mouth and throat (NHS, 2014).

The cookbook authors lacked discussion on the vital consequences of omitting foods from the diet of a child and should be made clear to readers so they can make a fully informed decision. It is possible that the cautious nature of messages portrayed in these cookbooks has been considered by the author and are included to cover themselves from possible litigation.

**STRENGTHS AND LIMITATIONS**

This study surveyed an extensive sample of available IYCF cookbooks in local lending libraries and also combined these lists with a top 20 bestseller list to ensure that the books investigated included the most popular purchased resources. The researchers assumed that parents select meal options for their infant based on the title of the recipe and so the classification was not based on the full ingredient content. The exclusion of messages portrayed for whole meals may have underestimated the number of beneficial messages portrayed to parents; however, these did not identify separate sources of nutrients. It should be considered that parents may use cookbooks prescriptively or only as guidance and thus variations in the nutritional content of home-cooked meals can vary greatly and this can be augmented further by natural variations in the nutritional composition of raw ingredients. The authors may have additionally overestimated the values for salt within the recipes, since it was often cited as optional to the recipe. Finally, the authors note that the consistency and micronutrient content of IYCF meals will be an important aspect to consider in meal selection.

**IMPLICATIONS AND RECOMMENDATIONS**

Parents should continue to be encouraged to provide a varied selection of foods, including different animal and fish sources, and provide home-cooked meals as the findings indicate that recipes provided in these cookbooks are energy and nutrient-dense and meet nutrient recommendations for their infant and young child. It is important that health visitors and community practitioners in contact with parents of infants and young children are aware of the discrepancies in information portrayed to parents in the specialised IYCF cookbooks. Health professionals should ensure that parents are guided towards current feeding recommendations and guidelines on food inclusion during the early years as outlined in Box 1 (see online). It is also vital that parents are informed that avoidance of any food from their child’s diet may result in consequences, such as a restricted diet and the lack of key nutrients. To conclude, the prevalence of vegetable-based early stage meals and the...
proportional contribution of animal and seafood-based recipes provide parents with a wide variety of meal options in which to expose their child to different tastes. Despite the adequacy of all home-cooked meal types to meet age-specific nutritional recommendations, incorrect and mixed messages were apparent within the IYCF cookbooks. The lack of consistency in the messages portrayed to parents is apparent in both older and more recently published IYCF cookbooks, highlighting a need for health practitioners and advisors to discuss and reiterate current dietary recommendations with parents and discuss the consequences of omitting any food from their child’s diet.

References

Key points

- Savoury-meal recipes in specialised infant and young child feeding cookbooks are dominated by vegetable-based recipes with equal proportions of red meat, poultry and seafood-based meal options.
- Recipes met or exceed age-specific energy-density recommendations and on average contained dietary fats and proteins within dietary recommended ranges.
- Seafood-based recipes provide more dietary fats and protein than other savoury recipe types.
- An imbalance of beneficial and cautionary messages was portrayed in infant and young child feeding cookbooks especially for seafood which received an abundance of cautionary messages which often contradicted formal recommendations.
- Community health professionals should advise parents of the inconsistent and incorrect messages on food inclusion portrayed in some infant and young child feeding cookbooks and guide them towards formal recommendations.

Figure 6: The number of avoid/limit and physical properties messages in IYCF cookbook. Median values are presented with range and IDR. * denotes a significant (p<0.01) difference to other food types and † denotes a significant (p<0.01) difference to food type linked. Statistical test: Mann-Whitney U.

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Best practice at the new birth review?

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INTRODUCTION
Health visitors have a 150 year history of working with families and their work has always been public health focused (Cowley, 2007). A universal health visiting service has been available to all families with pre-school children since before the NHS was established in the UK. A ‘home visit’ is undertaken by a health visitor and takes place between 10 to 14 days post-delivery (Dingwall, 1982). This follows discharge from maternity services at 10 days if there are no complications for either the mother or infant. This is still in practice today (HCP, 2009).

The health visitor role is primarily focused on early intervention, prevention and health promotion for young children and their families through a public health approach. There is a range of evidence about which interventions best support ‘needs’ arising during infancy and early parenthood; studies by Cowley et al (2007) and Belsky et al (2006) agree about the value of promoting healthy early child development, providing support and offering needed interventions as soon as required.

Health visitors lead the Healthy Child Programme (HCP) (DH, 2009), offering a universal service to all. Some families may require a package of care (universal plus) or a series of interventions with specialist health services, local authorities or voluntary sector (partnership plus) (DH, 2011). Using their professional judgement, the health visitor makes the decision on the service offered. To do this they require skills to collate, analyse and critique information on the family at each contact, this is particularly relevant at the new birth review, which is the first contact with the new infant. Health visitors must ensure that they are able to maintain the health, wellbeing and safety of the mother, baby and family (Chalmers, 1994). Good health visiting practice is an effective, universal preventative and early intervention service, which has a crucial role in working collaboratively with partners to identify the children who may be at risk (HM Government, 2015).

Health screening or child health surveillance still forms a large part of the health visitor’s role today at the universal contacts. The term ‘child health surveillance’ was used in the late 1970s to describe a systematic overview of the developing child and family. The evidence base for child health surveillance was a series of published reports from expert academics and practitioners referred to as the Hall Reports (1989, 1990 and 1996) which informed practice. This was replaced by the Child Health Promotion Programme (2006) and in 2009 by the Healthy Child Programme (DH, 2009). These were based on evidence drawn from a range of sources, including Hall and Elliman (2006), Barlow et al (2008) and various forms of National Institute for Health and Care Excellence (NICE) guidance.

The Rapid Review of the Healthy Child Programme (Public Health England, 2015) looked at more recent evidence including key areas of practice: parental mental health, smoking, the transition to parenthood, attachment, parenting support and the promotion of child development. The latter is still considered the ‘raison d’étre’ of health visitors and has remained in various forms within practice, largely influenced by the government of the day’s vision of public health nursing. This is fitting since it was national concern recognising both neonatal mortality and infant morbidity that triggered the birth of the health visiting profession (Robotham and Sheldrake, 2000). The intention of assessing development, as with all screening procedures, is adhering to the principles of beneficence with the early detection of health problems.

The literature appears to be in agreement...
iGrow was put in place and links very neatly to the electronic records. When iGrow came on line, I was initially sceptical as to how easy it would be to use. From the first time I tried it, however, I found it extremely easy to navigate and really very intuitive. Entering data is painless and quick and it is impressive to see the new plots appearing almost instantly on the relevant chart. I’d say that it is as quick as plotting measurements on the paper charts, but with the very real bonus that there is less margin for error than with the paper charts, where there is always a risk that a set of measurements will be plotted incorrectly.

Because my special interest is in neurodisability, it is also wonderful that my cohort of children who have Down Syndrome is catered for, with an electronic version of the specific chart for children with the syndrome.

The product is extremely satisfying to use. Many thanks to you and all the team at Harlow for having developed it.

Marian McGowan
Consultant Paediatrician
St. George’s Hospital

The unanimous feedback from my colleagues re the iGrow system is that it has definitely been a positive move. iGrow operates well linked to our EDM and it populates the demographic data from EDM well. We value the way in which the corrected age is calculated and plotted for pre term infants … much easier and reliable than the manual method.

Dr Yogi Thakker
Consultant Paediatrician
Milton Keynes Community Health Services

A try before you buy version is available online. Although fully functional, the demonstration site is not NHS secure so please do not use real patient data during your assessment.

Simply go to www.igrow-software.com
Create your user name and password for a full and free 30 day access. If you wish to discuss the application please contact one of our specialist iGrow team on: 0191 4554286
on the value of promoting early child development, providing support to new parents and offering early interventions as soon as possible if risks are identified (Appleton and Cowley, 2004; Hall and Elliman, 2006).

The HCP (2009) defines the service that should be offered universally to all children. This includes a programme of immunisations, developmental reviews, information and guidance to support parenting and healthy choices. The programme aims to ensure that every child receives the support and level of intervention needed to achieve their optimum health and wellbeing.

NEW BIRTH REVIEW

The new birth review is one of the five mandated universal contacts cited in the Healthy Child Programme (2009) and in the National Heath Visiting Core Service Specification (2015):

- Antenatal
- New birth review
- Six-week contact
- One-year contact
- Two- to two-and-a-half-year contact.

In addition the infant has two routine physical examinations undertaken at birth and six to eight weeks post-delivery. These are undertaken predominately by medical practitioners or the general practitioner (GP), although some midwives are trained to undertake the newborn and physical examinations at 72 hours old. Those undertaking these examinations follow the Newborn and Infant Physical Examination (NIPE) standards (www.newbornphysical.screening.nhs.uk).

The new birth review has also been referred to historically as the new birth visit, the primary birth visit, the health visitor initial assessment and the 10- to 14-day check. An infant assessment or infant observation is a small component of the new birth review, while other aspects of this contact include the family being introduced to the health visiting service, breastfeeding, infant feeding, attachment, immunisation, parental capacity, family and environmental factors and maternal mental health and wellbeing (NHS England, 2015). The new birth review is the first contact from the health visiting service to the whole family following discharge from midwifery services, although the HV may have seen the mother at the universal antenatal HCP contact introduced following the Health Visiting Implementation Plan 2011-15.

Through discussions in health visiting practice, national forums and through reviewing other provider organisational standards online, the author has found that not only is the approach different but there is different terminology to describe the health visitor’s remit with the infant at this contact. Some documents refer to it as a ‘check’, some a ‘review’, while some ‘observe’ and some ‘assess’. The words are defined quite differently in the Oxford Dictionary. To observe is to ‘notice or perceive something and register it as being significant’. To assess is ‘to evaluate’. To check is ‘to examine in order to determine its accuracy quality or condition’, and to review is ‘a formal assessment of something with the intention of instituting change if necessary’.

The National Health Visiting Core Specification for 2015/2016 (NHS England, 2014: 33) states that the health visitor should be able to undertake ‘An assessment of baby’s growth, ongoing review and monitoring of the baby’s health’.

Newland (2008: 2) stated in a briefing paper on the then-new birth visit that the HV role is to develop a professional relationship, to undertake a holistic assessment of the family and ‘to undertake a holistic assessment on the growth and development of the baby’, but the criteria for the assessment was not detailed.

The evidence underpins the health visitor’s role at the new birth review is based on the published HCP (2009), which reflected the previous Health for all Children (Hall and Elliman, 2006). More recently the HCP (2009) evidence has been reviewed and supplemented by regular guidance from NICE.

THE INFANT ASSESSMENT

For the purpose of this paper the author is referring to an ‘infant assessment’ and has taken the definition from the Midlands and East Regional Operating Standards (2013: 9), which describes it as ‘an outward observation of the whole baby by means of a visual review to identify for example skin infections, jaundice, oral thrush, with a focus on health promotion and education on minor ailments’.

The Healthy Child Programme (2009, p.40) clearly states that at the new birth review ‘if parents wish or if there is professional concern an assessment of the baby’s growth should be carried out’. This involves accurate measurement, interpretation and explanation of the baby’s weight in relation to length, growth potential and to any earlier growth measurement and monitoring of the infant to include important health problems and progressive (prolonged) jaundice. The New Birth Briefing paper produced by the CPHVA (2008) describes one of the purposes of the new birth visit functions as an assessment of the baby’s growth and development. It goes on to stipulate that the new birth visit allows the health visitor to see and examine the baby (CPHVA, 2008). The HCP (2009) provides guidance to everyone who works with children in the health and children’s sector, not only health visiting services, and was not specifically intended to inform organisational procedures (National Nursing Research Unit, 2013).

The evidence around why some health visiting services still offer a universal assessment appears unclear. It may be historic; it may be that the HCP is not explicit leaving it to providers and professional leads to interpret it in different ways. However, regardless of whether an assessment is undertaken universally it is evident that the health visitor should be skilled in assessing the baby’s growth and be able to undertake an ongoing review and monitor the baby’s health, whether it is at the parents’ wishes or because of their own professional concerns (NHS England, 2014).

It could be argued that as trained public health nurses who undertake holistic assessment of the whole family a baseline assessment of the infant should be routine practice, following the transition from midwifery service to health visiting. The contrasting perspective is that the infant is examined at 72 hours and at six weeks as part of the NIPE and that there is no requirement for the health visitor to offer an assessment unless the parent has concerns or there are professional concerns. Conversely, unless the infant is undressed and observed the health visitor cannot ascertain whether there are concerns. As qualified nurses and/or midwives who have undertaken further postgraduate study and have knowledge.
and skills in this area – this is a unique selling point and sets the profession apart from other services who deliver the HCP. One of the rationales given for offering a universal infant assessment is the health visitor’s role with prolonged jaundice (NICE, 2010). To undertake a prolonged jaundice screen the infant is required to be undressed and the eyes (sclera), gums and skin observed. Another factor for undertaking an assessment is birthmarks, which are common during infancy and often develop within the first few weeks of life, between the two NIPE examinations. To provide the best service and support to families it is vital that health visitors have the knowledge on the management of birthmarks to enable them to identify, educate, observe and record accurate details (Coutts, 2015; 2015). In addition there is further evidence that parents value the health visitor undertaking assessment, including monitoring the infant’s growth and answering any concerns the parents have regarding their infant (Vehvilaiinen-Julkunen, 2005).

With the Health Visitor Implementation Plan (DH, 2011) and the launch of the Institute for Health Visiting (iHV), there has been a refocus on the evidence that underpins health visitor practice at HCP contacts, including new training to support health visitors and their teams. Both the iHV and CPHVA provide evidence-based training on, for example, perinatal mental health, domestic violence and are developing an online community of practice. The annual CPHVA conference provides practitioners across the UK with the opportunity to hear about, discuss and debate public health nursing practice.

Many health visiting services have adopted the Ages and Stages Questionnaire (third edition) (www.agesandstages.com) as a tool to assess the development of the child. This is acknowledged as an accurate measurement tool to screen children for development delay from one month to five years and is used widely at the HCP universal contacts at one year and two years. The tool is not used at the new birth visit as this is before one month of age. Therefore for the neonatal period Sheridan et al (2014) is still cited as the developmental assessment reference by both higher education training establishments and in practice.

Other evidence-based training developments that support health visitors and have been adopted within health visitor programmes include the Brazelton Centre Newborn Behavioural Observations (NBO) (www.brazelton.co.uk). This is a structured set of observations designed to help clinicians and parents together to observe the infant’s behavioural capacities and identify the kind of support the infant needs for successful growth and development. It is a relationship-based tool designed to foster the parent-infant relationship. The NBO consists of a set of 18 neurobehavioural observations, which describe the newborn’s capacity and behavioural adaptation from birth to the third month of life. While it describes the infant’s capacities, the NBO provides parents with individualised information for them to meet their infant’s needs. Although an invaluable tool, it does not cover some of the day-to-day clinical issues that are identified through an infant assessment.

Day et al’s (2014) promotional guide, strengths and needs assessment training on the importance of infant mental health and attachment, is also recommended within the implementation plan but again this focuses on parent-infant relationships rather than the clinical components that health visitors are asked to recognise as part of their role.

The six early years high-impact areas, published by the Department of Health (DH) in England (2014), have been designed to articulate the health visitor’s contribution to the 0-5 agenda. The high-impact areas are described as aspects of practice where the health visitor can have a significant role to play in improving outcomes for families and children. One of the six high-impact areas focuses on the minor illnesses, reducing accidents and reducing hospital admissions. Being able to identify, for example, mild infantile skin rashes or oral thrush (candida albicans) in the neonatal period is central to health visiting practice in terms of advising accordingly and referring appropriately.

It could be argued that one of the benefits of a health visitor undertaking an initial assessment of the infant is that it provides an opportunity to give anticipatory guidance, intervene early and give support to parents at this crucial time, therefore allowing them to deliver better outcomes for the families and children on their caseload.

**THE LEICESTERSHIRE APPROACH**

The author is a professional lead for health visiting responsible for reviewing health visitor practice standards. These must be evidence-based following the Healthy Child Programme (DH, 2009), NICE guidelines CG45 (2007), CG62 (2008) and CG192 (2014), National Service Specifications NHS England (2014), evidence-based developmental tools such as the Ages and Stages Questionnaire and encompass both the new vision for health visiting (DH, 2011) and the four principles of health visiting activities (Cowley and Frost, 2006):

- Search for health needs
- Stimulate an awareness of health needs
- Influence policies affecting health
- Facilitate health-enhancing activities.

In Leicestershire a universal infant assessment through observation and handling of the infant (Standard Operating Guidance, 2015) is part of health visiting practice. Leicestershire Partnership NHS Trust’s health visiting services have been through many organisational changes over the past few decades and when reviewing local historic standards an infant assessment appears to have remained as a constant part of health visiting practice. The local university, which trains the Specialist Community Public Health Nursing health visiting students, includes the theory component to this assessment and this is underpinned by the practice teachers during the student experience in practice. All new starters in Leicestershire receive a training session as part of their induction as it is acknowledged that new health visitors may have trained where an infant assessment and growth monitoring assessment is not offered as standard practice.

The assessment is recorded in the Personal Child Health Record (2015) documented within the child’s electronic record on Systmone.

The Leicestershire infant assessment includes:

- Weigh naked baby. Head circumference
- Fontanelles – tensions, birth injury
- Eyes – signs of infections, fixed squint, jaundice, conjunctival haematoma
- Mouth – signs of infection, comment on visually observed abnormality (tongue-tie)
- Breasts – presence of swelling/infection

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This paper has discussed health visiting based tool that all health visitors are trained to use. Community Public Health Nursing education institutes that train Specialist provider organisations and local authority give reassurance to health visitors, what aspects of the infant assessment should support families. Part 1. Journal of Health Visiting, 3(11): 590-596.

The author would value the opinion of other health visitors as to whether an infant assessment is best practice and whether an evidence-based tool or standard guidance around the infant assessment would support practitioners. If a tool was to be developed, what aspects of the infant assessment should be included?

Clarity over this field of practice will give reassurance to health visitors, provider organisations and local authority commissioners. It would also support higher education institutes that train Specialist Community Public Health Nursing health visiting students in having a core evidence-based tool that all health visitors are trained and skilled to use.

CONCLUSION

This paper has discussed health visiting practice at the new birth review infant assessment. It acknowledges that there is different practice at this contact in different provider organisations. The rationale for some provider organisations continuing to offer an infant assessment appears historic but there is evidence that service users value it. The paper has identified different terminology used in practice, including assessment, checking, reviewing and observation. Although not all infants receive a universal assessment it highlights that all health visitors should have the knowledge and skills to undertake an infant assessment if required, either at the request of their client or if they have professional concerns, but there is no current assessment tool determining what should be included in a generic assessment, despite the existence of NICE and WHO guidance to evidence practice.

References


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Young Epilepsy is a national charity working exclusively for the 112,000 children and young people aged 25 and under with epilepsy and associated conditions and their families. We work tirelessly to improve the lives of children and young people with the condition to enable them to fulfil their potential and ensure they have the best quality of life. With over 100 years’ experience, Young Epilepsy provides diagnosis, assessment and rehabilitation services for children and young people with epilepsy as providing support and information on a national scale. Our campus is also home to St Piers School and College as well as the Neville Childhood Epilepsy Centre – the only rehabilitation unit in the UK that specialises in young people with epilepsy.

We are excited to be chosen as CPHVA’s Charity of the Month for April. We work closely with community health practitioners and health visitors across the country to help improve the lives of the young people and families we support.

CPHVA members play an important role in helping us care for young people with the condition. Adjusting to life with epilepsy can be a difficult time, particularly for children, so the primary care they receive is vital to maintain their health and wellbeing. Community practitioners are there every step of the way and we would like to thank members of the CPHVA for supporting our work and helping us create better futures for children and young people living with epilepsy.

It’s important for professionals to understand the many issues that epilepsy can cause families, including diagnosis, treatment, emotional impact and living day-to-day with the condition. Young Epilepsy provides training to professionals as well as organising conferences and workshops to aid further understanding about epilepsy and its associated conditions.

This year during National Epilepsy Week (16-20 May) we will host our fourth annual Young Epilepsy Champions Awards to celebrate the achievements of children and young people with epilepsy. It also recognises those who have made a positive impact in supporting children and young people who have the condition. Last year Whittington health nurse Tessa Walker was presented with the best practice award for her work to develop a self-management programme that Young Epilepsy has been able to support young people to use. This gives back some control to those youngsters over their own condition.

Our joint national campaign ‘Everyone knows someone’ in association with River Island also runs through National Epilepsy Week. The campaign aims to raise awareness and dispelling the myths associated with the condition. The message ‘Everyone knows someone’ reminds people how the condition is more common than they may think and how everyone may know someone with the condition but they may not choose to disclose it. We aim to raise awareness of epilepsy so those affected feel more confident to speak about the condition.

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For more information on epilepsy and Young Epilepsy’s services visit: www.youngepilepsy.org.uk
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If working in Edinburgh and the Lothians appeals, visit our dedicated website at www.nhslothian.scot.nhs.uk/HealthVisitors.

For more information or an informal chat please contact: Lynda A Cowie, Associate Nurse Director, Children and Young People Tel: 0131 536 0004, email: lynda.cowie@nhslothian.scot.nhs.uk

For further information and to apply please visit www.jobs.scot.nhs.uk or call 0131 536 3030 (24 hrs) quoting ref: LOTH/GENERIC/B6/HV/M123 or email: recruitment@nhslothian.scot.nhs.uk

Closing date: 1st April 2016.
Updated guidelines for authors and contributors to *Community Practitioner*

Articles are considered for publication on the understanding that they are not being offered to any other journal and have not been published or accepted elsewhere. Manuscripts should be submitted with full author contact details to the editor via email to: katie.osborne@tenalps.com and authors should keep a copy of the material they submit.

**PRESENTATION AND HOUSE STYLE**
The following information should always be included: title of article, first name and surname of author(s), qualifications, details of position held, number of words in article.
- Where either ‘s’ or ‘z’ can be used, use ‘s’ (eg organisation)
- One to nine should be in words, 10 and over in figures
- Percent should be written as %
- Full stops should not be used to indicate abbreviations: CPHVA, eg, ie, NHS
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- Capitals should not be used for role titles or professions, such as ‘health visitor’ or ‘nursing’.

**ARTICLE CONTENT AND LENGTH**
Articles should be written with our readers in mind – health visitors, school nurses and community nursery nurses, and others working in primary care and community settings. We welcome the inclusion of relevant figures, tables and images, though original work on paper is submitted at the owner’s risk. Electronic images should be at least 300dpi resolution and in tif, jpg or eps format.

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Papers should be between 2000 and 3500 words in length (including references), and are subject to double-blind peer review following submission. Papers should begin with an unstructured abstract of 150 to 200 words, and up to five key words or terms that reflect the article’s subject and focus accurately. Research articles should be arranged in the usual order of introduction, background, study aim/purpose, method including confirmation of ethical approval, results, discussion, implications and recommendations, conclusion, acknowledgments and references.

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Either 1400 or 2100 words in length, these should review clinical management, present case studies etc.

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The content of first-person articles (700 words) and general features (1400 words) should be discussed with the editor prior to submission.

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Letters of up to 300 words in length are always welcome, and any readers interested in writing reviews of resources should contact the editor.

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Check that references are complete, accurate and in the Harvard style – author and year of publication referred to within the text, and listed alphabetically at the end, eg:

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Diary

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For patients who want the convenience of self-selection, handy sized packs are available for purchase in pharmacies.

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Marketing Authorisation Numbers: Cream: PL 00010/0658; Ointment: PL 00010/0659.

Marketing Authorisation Holder: Bayer plc, Consumer Care Division, Bayer House, Strawberry Hill, Newbury, Berkshire, RG14 1JA, U.K.

Date of Revision of Text: March 2015

Active Ingredients: None.

Legal Category: Medical device.

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