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Use of Anticipatory Guidelines in Late Infants and Toddlers 12 to 24 Months in Primary Care

Introduction of the Problem

Parents or guardians play many roles in their children's lives including caregivers, coaches, teachers, taskmasters, and role models. Primary care providers can also play similar roles as caregivers, educators, and trainers. For patients to thrive, a synthesis of those functions is necessary. However, due to the multitude of responsibilities and time constraints, primary care providers often find themselves compromising education for efficiency. The basic knowledge that needs to be offered to parents is anticipatory guidance. Anticipatory guidance is the foundational knowledge based on pediatric development that highlights their child's well-being, needs, safety concerns, and milestones during each stage of life (Hagan et al., 2017). When provided to parents, they can anticipate their child's growing needs, monitor their development, and address safety concerns (Hagan et al., 2017). The American Academy of Pediatrics (AAP) estimates that approximately 30% of children experience learning or behavioral difficulties (Dosman & Andrews, 2012). Primary care providers are the most sought after professional for advice on child rearing (Dosman & Andrews, 2012). Providing this education at key points of development allows primary care providers to care for their patients by helping those who care for them. The AAP conducted a survey of over 700 pediatric providers. The participants reported an increase in wait times for new patient appointments, burnout among clinicians, an increase in patient complexity, and a staggering 50% increase in time spent on non-clinical care activities (Bridgemohan et al., 2018). While education can be lengthy, delivery of education can be

indirectly provided via videos, handouts, and websites. This allows more topics to be covered and does not compromise timeliness.

Literature Review

Anticipatory guidance covers a broad range of themes: safety, communication, nutrition, social development, and behavior. It is expected that primary care providers, specifically those in pediatrics, can provide this guidance to their patients and their caregivers. According to the American Academy of Pediatrics, “optimal child development requires the active engagement of adults” (Sege et al., 2018, need page number with direct quote). This education is for the benefit ultimately of the child, but it also benefits the caregiver or parent. One observational study illustrated this with results concluding that there was a decrease in maternal stress after the implementation of anticipatory guidance that centered on discipline and safety (Hsu et al., 2018). A monopolizing and recurrent educational topic surrounding safety was identified in the literature. Safety was a well-covered and studied theme that encompassed: bike safety, medicine and cleaning product safety, car safety, stranger safety, sexual safety, gates, guards, safety latches, padding, outlet covers, and adjusting thermostats (Hsu et al., 2018; Nansel et al., 2002). There is typically emphasis on car seats and motor vehicle preventative measures due to the number of accidental injuries related to motor vehicle crashes (Insurance Institute for Highway Safety, 2019). According to the AAP, anticipatory guidance also covers milestones which are specific developmental markers that occur over a child’s lifetime in a predictable pattern (Dosman & Andrews, 2012). If education is given on age-based milestones, the parent or caregiver can better understand where the child is development-wise, where they are going, and how to help them grow towards the next milestone (Dosman & Andrews, 2012). Furthermore,

anticipatory guidance consistently covers nutrition, social development, and communication. Their respective emphasis centers on obesity and sugar consumption, parental intervention and modeling for communication, and the relationship between social development and the impact on the whole family (Hagan et al., 2017).

Project Methods

This project aimed to demonstrate the increase in meeting educational needs when educational material is distributed via handouts and videos in a rural pediatric clinic. The goal was to improve the quality of educational materials that were provided at wellness visits and acute visits. The educational material included anticipatory guidance for the patient population between the ages of 12 and 24 months. The stakeholder identified previous benefits from implementing videos and handouts that were reviewed, updated, and created. The objective was to also create a continuity in formatting to create an expectation for their patients. Handouts were distributed to the correct age group and the videos were played prior to the appointment either in the waiting room or in the exam rooms. For these guidelines the rural clinic requested vaccinations, introducing solid food, car safety, general safety concerns, communication, nutrition, social development, potty training, and behavior to be covered. Anticipatory guidelines help parents and caregivers to nurture their child's growth, health, and prevent injury or illness.

Evaluation

Qualitative and quantitative measures were employed to evaluate the efficacy of this project. Quantitative measurements included the number of times the intervention was applied and the group size. Numerical measurements included the number of caregivers or parents who

receive the education as well as the number of times the video was viewed throughout implementation. Post-distribution of the educational materials, a survey was given to parents, caregivers, and providers that assessed their general satisfaction with the videos and handouts. These post-educational surveys consisted mostly of Likert scales. The scales measured satisfaction with the material, ease or difficulty of the content, relevance they found it applied to them, general helpfulness, if they found the material visually and mentally engaging, and their overall experience. At the end of each survey there were two open-ended questions to procure feedback.

The educational videos were viewed a total of 17 times and 15 surveys were distributed to participants. Of the allocated surveys, 14 were completed. 64% of the participants strongly agreed that the educational material was clear and organized and that the material was easy to understand. Data collected also showed 79% percent of participants strongly agreed that it was pertinent to their child's life, helpful, and that they were altogether satisfied with the educational material. The open-ended questions yielded similarly positive results. Respondents reported that they found the dental information, sleep education, safety, car seats, nutritional, and potty training to be the most beneficial topics. Respondents also stated the material was beneficial because it provided up to date information, was "overall" helpful, and straight to the point. Constructive responses requested more information on 2% milk and for the handouts to be in color to add to their appeal.

There were multiple limitations noted during the project's implementation and upon review after its completion. Limitations of this project comprised of timing, sample size, lack of ability for providers to record number of views/recipients, and participation. There was also inadequate participation of respondents, staff, and the respective patient's responsible party. The

stakeholder identified limitations to their participation as increased workload due to current RSV levels in the area, intermittent access to internet, and issues with their television as well as playback of the videos. The timeframe of the project was not observed which created a diminished window for data collection.

Hypothetically, improvements could have been made if barriers had been identified prior to its application. These included recognizing the office's need for adequate TVs or handheld devices for the project to be viewed as well as identifying early that internet connection could pose an issue. This could have allowed for compensation in the form of video playback that was not dependent on an internet connection. Ideally a lengthier discussion on barriers with the previous project's implementation could have been done with the stakeholder. The stakeholder did identify that a YouTube channel could help with ease of viewing, and this allowed for a numerical data set to be created on number of views. Lastly, a larger timeframe for data collection should have been implemented to increase the sample size.

Impact on Practice

The influence of the project is not identifiable at this time due to limitations and barriers that were previously discussed. Theoretically, based on limited data, the project was found informative and useful to the respective beneficiaries. Long term influence, based on what is known, should remain positive and worthy of continued use. Education is vital to building strong parenting practices (Hsu et al., 2018). Introducing multiple modes of education should, in theory, increase the likelihood of understanding and adherence. To improve the use of the educational materials, a more convenient means of viewing the material should be considered. As one respondent identified, potentially adding color to the handouts will make them more visually

appealing. Each clinic and healthcare setting is unique and presents their own distinctive complications. Immersion into the setting and identification of barriers prior to enactment of quality improvement projects should be considered.

Conclusion

How people learn and develop lasting habits is complex. An increase in opportunities to learn and multiple types of teaching methods will increase parental and caregiver knowledge. This understanding of anticipatory guidance will decrease children's risk for injury, illness, and can improve developmental end results (Zachry et al., 2021). With well-summarized topics, handouts, and educational videos, primary care providers can meet educational needs while maintaining efficiency.

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