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Pediatric Nursing

Caring for Children and Their Families

Third Edition

Nicki L. Potts
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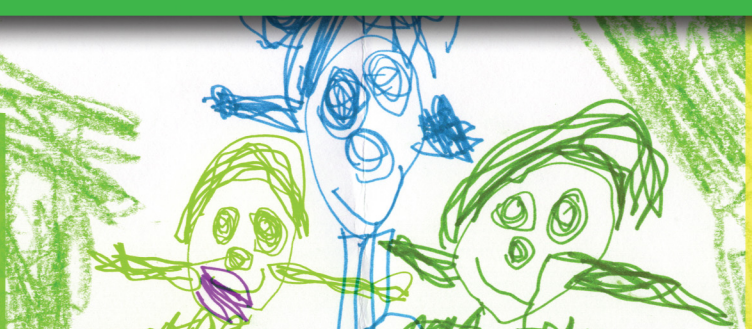

Pediatric Nursing: Caring for Children and Their Families, Third Edition
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CHAPTER 1

Overview of Pediatric Nursing

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COMPETENCIES

Upon completion of this chapter, the reader will be able to:

- Discuss current societal trends and describe their influence on children in the United States.
- Describe some of the effects of immigration, poverty, homelessness, migrant farm work, and violence on children and their health.
- Discuss the current status of children's physical and social health.
- Identify five strategies to prevent unintentional childhood injuries.
- Discuss the effects of problems with access to health care and lack of health insurance on children's health status.
- Identify elements of family-centered care.
- Discuss the influence of professional standards on pediatric nursing.
- Describe and discuss the importance of each role of the pediatric nurse.
- Successfully complete the games and activities in the online student StudyWARE.

During the 20th century and the first decade of the 21st, amazing progress has been made in scientific and technological fields. The genetic code has been catalogued, people are living longer than ever before, and very low birth weight infants are surviving. However, the status of children and their health has not kept pace with these accomplishments. Today, more than 1 in 6 children in the United States is poor, and almost 1 in 13 lives in extreme poverty; 1 in 9 children is uninsured, and most of these are from ethnic minority races (Black, Hispanic, Asian, American Indian). In addition, about 1 in 12 newborns is of low birth weight; about 1 in 15 teens between 16 and 19 years of age have dropped out of school; two-thirds of public school fourth graders cannot read or do math at their grade level; and only about 3% of those infants and preschool children eligible for Head Start programs are enrolled in those programs. Finally, two-thirds of two-year-olds are not immunized, two out of three mothers of preschool children and three out of four mothers of school aged children are working, more than 2.5 million grandparents are raising their grandchildren, and the birth rate for teens is higher in the United States than in any other industrialized nation (Children's Defense Fund, 2009). Table 1-1 provides a view of the reality for American children today.

On the positive side, improving child health is a work in progress. Child health care is changing from a strictly curative approach to a disease prevention and health promotion model with expanding access (primarily federal and state efforts via State Children's Health Insurance Program, or SCHIP, legislation). The role of the pediatric nurse has expanded from child caretaker to child advocate. Today, pediatric nursing focuses on preventing acute and chronic illness while promoting normal growth and development. This focus requires a broad knowledge base consisting of an understanding of the culture at large, a host of health and illness issues, and a wide range of clinical competencies.

Today, more than ever, every nurse must be familiar and knowledgeable with pediatric nursing. In 2008, there were nearly 74 million children ages 0–17 in the United States, about 1 of every 4 persons. Demographic projections suggest this ratio will remain stable through 2021. Hence, given increasing access for children, more than one of four patient encounters will be with an infant, child, or adolescent (Federal Interagency Forum on Child and Family Statistics, 2009).

TABLE 1-1 Moments in America for All Children

- Every second a public school student is suspended.*
- Every 11 seconds a high school student drops out.*
- Every 19 seconds a child is arrested.
- Every 19 seconds a baby is born to an unmarried mother.
- Every 20 seconds a public school student is corporally punished.*
- Every 32 seconds a baby is born into poverty.
- Every 41 seconds a child is confirmed as abused or neglected.
- Every 42 seconds a baby is born without health insurance.
- Every minute a baby is born to a teen mother.
- Every minute a baby is born at low birth weight.
- Every 4 minutes a child is arrested for a drug offense.
- Every 7 minutes a child is arrested for a violent crime.
- Every 18 minutes a baby dies before his or her first birthday.
- Every 45 minutes a child or teen dies from an accident.
- Every 3 hours a child or teen is killed by a firearm.
- Every 5 hours a child or teen commits suicide.
- Every 6 hours a child is killed by abuse or neglect.
- Every 15 hours a woman dies from complications of childbirth or pregnancy.

*Based on calculations per school day (180 days of seven hours each).

Used with permission of the Children's Defense Fund. (2009). "Moments in America for All Children" (Washington, DC: CDF, December 2009). Retrieved January 5, 2010, from http://www.childrensdefense.org/

This chapter begins with an overview of social changes as they affect children. It describes the status of children's health, their health problems, and their care. The focus of the chapter then turns to a discussion of the roles of pediatric nurses and concludes with a discussion of differentiated practice roles and advanced practice.

SOCIETAL TRENDS IMPACTING CHILDREN

Children are members of families, communities, populations, and overall society, which shape the context, experiences, and opportunities of their lives. Their well-being is inextricably linked to the well-being of their families, communities, and the society in which they live. In a world that is continually changing, emergent societal trends have profound effects on the environment surrounding children and their families, and now pose formidable challenges to children, their families, and their health.

During the first decade of the 21st century, notable trends are emerging that may provide further impediments to the well-being of children and their families in the United States of America:

1. a concentration of wealth last seen prior to the advent of the Great Depression of 1929 (Economic Policy Institute, 2009);
2. a weakened middle class that has faced upwardly spiraling costs while wages have stagnated (Economist, 2009);
3. deepened and broadened poverty affecting 40 million Americans (Economist, 2009);
4. increased obesity (up 37% over the decade) leading to an epidemic in diabetes (24 million) and pre-diabetes (57 million more) (CDC, 2008);
5. weakened environmental protections resulting in polluted air and unsafe levels of mercury in our lakes, rivers, and streams (Scudder et al, 2010);
6. consumer safety regulations and enforcement may not be protecting our children from unsafe chemicals used for food packaging and baby bottles, or defective products including toys, and even may include our food supply.

While the most recent data suggests improvements since 2000 in the infant mortality rate, the child death rate, the teen death rate, and the high school dropout rate, four other measures of life quality have worsened: (1) low birth weight babies; (2) children living with jobless or underemployed parents; (3) children living in poverty; and (4) children living in single-parent families (Annie E. Casey Foundation, 2009).

While these emerging trends are troubling, others remain among the most stubborn in the history of the United States of America. This chapter discusses in detail the issues of immigration, poverty, homelessness, migrant farm workers, and violence.

IMMIGRATION

Currently, 20% of children in the United States live with at least one foreign-born parent. In addition, children in these families are less likely to be enrolled in preschool programs, which puts them at risk for being ready for school and able to speak English fluently (Hernandez, Denton, & Macartney, 2007). However, they may face many challenges related to health status and education because they often have difficulty speaking English. This lack of skill in English has a direct impact upon their educational attainment, economic viability, and ability to enter the mainstream of U.S. society. In fact, many of their parents are not high school graduates and consequently less likely to help with their homework. In addition, the majority live in households where a language other than English is spoken and many live in households where no one older than adolescence speaks English well (Behrman, 2004).

With each new wave of immigrants comes debate about whether they contribute to the economy or create a drain on public and private resources. Concerns also include perceived threats to the public health and order from infectious diseases, increased crime, and diverse social mores. These debates have raised the issue of eligibility of immigrants for health, educational, and social services. Some have argued that this group should not be entitled to any local, state, or federal benefits. States that have a large number of immigrants (California, Texas, and Florida) have proposed removing eligibility for these services. Opponents of these efforts counter that denying children access to services is unwise public policy. For example, in health care, denial of preventive services such as prenatal and dental care and immunizations eventually results in spiraling costs for emergency medical services (for which immigrants are eligible).

The health status of immigrant children can be compromised due to conditions originating in their country of origin, and it is also at risk because of significant language, cultural, financial, and legal barriers to receiving health care. Their families often delay seeking care for minor conditions until they become more serious. Another factor affecting their underutilization of health services is the possibility that family members may have different immigration statuses. When one member is an illegal (undocumented) immigrant, the entire family may limit access to care for fear of an investigation.

The immigrant population's access to health care services also affects their psychological well-being. For many children and their families, the immigration process poses unique stresses. Individuals may be torn by conflicting social and cultural demands while trying to adapt to an unfamiliar environment. Other stresses include differences between social and economic status in their country of origin and the United States, separation from support systems, and, for illegal immigrants, fear of deportation.

However, we need to be aware that these families also have several strengths. For example, most families are healthy, two-parent, traditional families, and have lower infant mortality rates. In addition, almost 40% of the families

live with nonrelatives or relatives compared with less than 25% of U.S.-born families, and they are strongly connected and live close geographically to their ethnic community. They also have a strong work ethic and aspirations, with parents working hard and expecting the same from their children. Children tend to have a strong sense of ethnic pride and obligation toward their family. Even though they may have difficulty with English, the children often have high educational goals and drop out of school less frequently and spend more time doing homework than their U.S.-born counterparts (Behrman, 2004).

POVERTY

In 2008, the poverty rate for children under 18 years of age was 19% (up from 18% in 2007), and even though children represent just under 25% of the entire population, they made up over 35% of those living in poverty. In addition, 6.3 million children under 18 years old lived in families with an income below 50% of their poverty thresholds, and almost 10% of children under 18 years of age were without health insurance, the lowest since 1987, the first year data was collected. However, children 12–17 years of age were less likely to be insured than children less than 12 years of age (DeNavas-Walt, Proctor, & Smith, 2009).

The incidence of poverty may actually be higher than the official statistics (cited above) as published by the government of the United States. The Annie E. Casey Foundation in their annual publication, *2009 Kids Count Data Book*, urges the government to overhaul its formula for measuring poverty. The method for measuring poverty used by the government was developed in the 1960s. Then, food represented almost a third of the family budget as compared to one seventh today. The 1960s formula does not account for the increased costs of childcare, transportation, health insurance, or taxes; nor does it account for the value of food stamps, rent subsidies, or tax credits. Some argue these inaccuracies should reduce the poverty rate (Economist, 2009), others argue that these inaccuracies understate the poverty rate by 16 million persons (over 6 million of them children) (Economic Policy Institute, 2009). Using the official United States government statistics, as compared to our peers on the world stage (OECD, Organization for Economic Cooperation and Development, the top 20 economies in the world), the United States has the highest rate of poverty of all with a child poverty rate over twice as high as the average of the other 19 nations (Economic Policy Institute, 2009).

Family structure has an important bearing on child poverty. Poverty rates for children in married-couple families are much lower than for those in families headed by a single parent. The explanation for this fact is that when both spouses are present, there are two potential (and, frequently, actual) breadwinners. The risk of poverty in these single-parent households is high for several reasons, including low wages for women, the low educational attainment of many single mothers, and low rates and levels of child support from fathers.

Several factors are at the root of child poverty. Slow growth in wages, the rising inequality in earnings, significant loss of low-skill, high-wage jobs due to a decline in manufacturing industries, and workers' lack of education and skills account for much of child poverty in recent years. Educational level of adults in the family is another factor related to poverty. As education rises, the number of adults who are not in the labor force and who experience a period of unemployment during the year declines dramatically.

Family income also has significant effects on the well-being of children and adolescents. Poor children are at greatest risk for the physical, social, and emotional effects of living in poverty. Compared with non-poor children, poor children experience diminished physical health. They have higher than average rates of death and illness from almost all causes except suicide and motor vehicle accidents, which are most common among white, non-poor children. They also have a higher prevalence of illnesses such as asthma, respiratory infections, anemia, and gastrointestinal infections. Infant mortality rate is closely linked to poverty, and children born to poor families are at great risk of infant death. Deficits in children's nutritional status are associated with poverty. Stunted growth (low height for age), a measure of nutritional status, is more prevalent among poor than non-poor children.

Poverty also affects children's cognitive abilities and achievement. A child's poverty status at 3 years of age predicts the child's IQ at age 5, and persistent poverty has more adverse effects on a child's cognitive functioning than transitory poverty. In addition, children from lower socioeconomic status perform less well than non-poor children and middle-class children on test scores, grade retention, high school graduation rates, and the completed numbers of years of schooling; they also have higher rates of high school drop out, course failure, and placement in special education. School achievement also declines with the time spent in poverty, and the chance a child will be retained in a grade or placed in special education increases 2% to 3% for every year that the child lives in poverty. In fact, long-term poverty is associated with deficits in verbal, mathematical, and reading skills that are two to three times greater than those associated with current poverty status. Poverty also affects a child depending on when, during the child's life, poverty is experienced; poverty during the first five years of life will affect the completed years of schooling more than if poverty occurs during middle childhood and adolescence.

There is a higher prevalence of emotional and behavioral problems (e.g., externalizing, internalizing) among poor and low socioeconomic status children and adolescents than among children from families where there is higher income. The externalizing behavior problems include disobedience, fighting, difficulty getting along with others, and impulsivity, which become more prevalent the longer the children live in poverty. The internalizing behavior problems include anxiety, sadness, depression, and dependency.

HOMELESSNESS

An increasing number of children and families in all communities in the United States are homeless (Institute for Children and Poverty, 2010). Traditionally, the homeless population has been composed of single adults, mostly men. However, families raising young children now make up 40% of the nation's homeless population and over the course of any calendar year, more than 1.3 million children are homeless. In fact, the number of homeless families with children has increased significantly over the past decade, and families with children are among the fastest growing subdivision of the homeless population (National Coalition for the Homeless, 2008).

Homelessness was initially a phenomenon of large urban areas but more recently has swept across the nation, affecting midsize cities as well as suburban and rural areas. Contributing to the rise of homelessness in midsize cities is the migration of disadvantaged families from large urban settings to smaller towns and cities in search of a safer environment and a better life for their children. The homeless population is disproportionately represented by African Americans.

Several societal problems contribute to the increasing rate of homelessness among American families, including the following:

- Increases in poverty
- Lack of affordable housing
- Decreases in availability of rent subsidies
- Unemployment and underemployment, especially among those who have held only marginal jobs
- Personal crises such as divorce, domestic violence, and substance abuse
- Cutbacks in public welfare programs
- Deinstitutionalization of the mentally ill

Having been abused or neglected by a household member as a child is a risk factor for homelessness. Another factor is living in a foster home, a group home, or other out-of-home placement as a child, such as a residential treatment center or juvenile detention.

Homeless children experience the specific health effects directly related to homelessness, as well as the effects of poverty, the umbrella issue of homelessness. The most common physical health problems include upper respiratory, ear, and skin infections; gastrointestinal disorders (diarrhea); and infestations (scabies, lice). Compared with housed children, homeless youth have a higher incidence of chronic health problems such as asthma, anemia, visual and neurological deficits, eczema, and trauma-related injuries. The conditions in many private and public shelters place children at risk of lead poisoning and other environmental hazards. Many health problems may predate shelter entry, including crowding in doubled-up housing situations, or exposure to the elements and lack of sanitary facilities in public places. Access to health care, especially preventive care (immunizations, well-child services), is impaired for homeless families. Because caregivers are struggling to meet the family's basic demands for food and shelter, health becomes a lower priority. When they do seek health care, they are more likely to use emergency services for preventive and sick care than housed families.

To date, the struggle to provide adequate food and nutrition to homeless families has proven to be an overwhelming task. Homeless families have little access to cooking facilities, and families living in shelters report having less access to food than they previously had, with more children going hungry or eating once per day. The children are especially at risk for malnutrition. Inadequate benefits and difficulties in accessing food and entitlements are the major mediators of hunger and poor nutrition in the homeless. The vast majority of homeless families are headed by women who rely on Aid to Families with Dependent

RESEARCH Highlight

Children in Poverty

STUDY PURPOSE

To examine racial and ethnic disparities in medical and dental health, access to care, and use of services in a national sample of US children.

METHODS

A random sample of parents/guardians of 102,353 white, African American, Latino, Asian/Pacific Islander, Native American, and multiracial children/adolescents completed the National Survey of Children's Health to determine which health disparities occurred in these groups.

FINDINGS

Lack of insurance was highest for Latinos and Native Americans. In addition, health disparities were found for ethnic minorities including poorer overall health, being overweight and less active, having dental problems, asthma, behavior/speech problems, and emotional problems, and not having a source of usual health care nor receiving prescribed medications. In addition ethnic minorities had transportation difficulties that were barriers to them receiving care.

IMPLICATIONS

It would be important to provide services to ethnic minority children that meet their unmet needs related to care and access to care as well as to tailor preventative and routine care that reduces disparities according to ethnic or racial group.

REFERENCE

Flores, G., Tomany-Korman, S. (2008). Racial and ethnic disparities in medical and dental health, access to care, and use of services in U.S. children. *Pediatrics, 121*(2), E286–E298.

Children (AFDC) as their primary source of income, and problems are often compounded by failure to receive benefits to which they are entitled, erroneous case closings, and benefit reductions. Loss of these benefits has been shown to have directly contributed to loss of housing. In addition, the children of these women who are eligible to receive benefits under the federally funded Special Supplemental Food Program for Women, Infants, and Children (WIC) often do not receive benefits. Families with limited resources are often left with no other alternative than emergency food assistance facilities, and in many cities, such facilities have reported having to turn away people in need because of lack of resources.

Psychological problems identified most often among homeless children include depression, anxiety, and behavioral problems. Homeless children are more likely to exhibit poor attention span, trouble sleeping, delayed speech, aggressive behaviors, shyness, and withdrawal. Poor school attendance resulting from family transience is also a serious concern. Enrollment in school may be delayed for weeks because of lack of immunizations and records.

Poor school attendance and success in academics resulting from family transience is also a serious concern (Institute for Children and Poverty, 2009). For example, these children are more likely than other children to be held back a grade, and have higher rates of school mobility and grade retention than low-income housed children. In fact, frequent school transfers are the most significant barrier to their academic success.

Nurses, together with other service providers such as physicians, psychologists, and teachers, can increase the local and national awareness of the effects of homelessness on children and bring political attention to the underlying causes of widespread poverty. Nurses are also in a unique position to advocate for homeless children within the social services system concerning access to health care, mental health care, and essential housing, nutritional, and educational needs. Nurses can also advocate for making prenatal care available to homeless mothers. Lack of such care places unborn homeless children at risk of low birth weight, subsequent health problems, chronic diseases, and cognitive and developmental problems. In addition, health problems are associated with psychological problems, classroom performance, and dropout rates, all of which, if unaddressed, can seriously compromise the future of homeless children.

MIGRANT FARM WORKERS

Migrant and seasonal farm workers constitute a major portion of the labor force in the U.S. agricultural industry, and children make up almost one-fourth of all farm labor. The majority of adult workers are married and have children. Children of migrant workers constitute a population at high risk for many health problems because of their living conditions

RESEARCH Highlight

Homeless Adolescents

STUDY PURPOSE

To better understand health care experiences and perceptions of homeless adolescents in order to provide more effective approaches to health care, since they experience a number of health-related issues including physical, sexual, or emotional abuse, suicide ideation, depression, and other psychiatric disorders, substance abuse, increased rate of acute and chronic respiratory diseases, and high-risk sexual activity.

METHODS

A critical narrative was used to examine perceptions thirteen homeless adolescents (six female, seven male) between 14 and 19 years of age had about their health care experiences and barriers to receiving health care by asking them questions in a tape recorded semi-structured interview. The interviews were then transcribed verbatim and analyzed according to qualitative methods.

FINDINGS

Many of these interviewed adolescents had feelings of "being stuck" in their situation. They also did not feel safe and had similar backgrounds: grew up in a family where they experienced violence and poverty, and had parents with problems including mental health issues and drug abuse. The female participants experienced more violence than the male participants, and both genders believed health care and support was difficult to obtain because of the energy expended to get services. Finally, most did not have enough education to get meaningful work, leading them to maintain their homeless lifestyle.

IMPLICATIONS

It is important for health care providers to work collaboratively with homeless young people in order to provide sensitive health care based on their needs. Since female homeless adolescents are likely to be exposed to various forms of violence, it would also be important to offer these adolescents a safe haven where they can talk with each other and supportive health care providers about challenges faced as they live on the streets.

REFERENCE

Haldenby, A., Berman, H., & Forchuk, C. (2007). Homelessness and health in adolescents. *Qualitative Health Research, 17*(9), 1232–1244.

and limited access to health care. They suffer from many of the problems seen in homeless children: gastroenteritis, dental caries, inadequate immunizations, intestinal parasites, infestations, skin infections, pesticide exposure, and infectious diseases (Wilson, Wold, Spencer, & Pittman, 2000).

Agriculture surpasses mining and construction as the most hazardous occupation in the United States. Children of migrant families often are involved in farm work and, being physically weaker and less experienced with farm operations and machinery than their adult counterparts, are more at risk for injury. Each year some 24,000 children working in agriculture experience nonfatal trauma, and nearly 300 children die, primarily as a result of accidents involving farm machinery. Children are also at risk for pesticide exposure both in the fields where they work and play, and at home, where they can be exposed through pesticide drift. Although research on childhood exposures is limited, it is believed that children are at greater risk than adults for pesticide-related illnesses because of their higher metabolism, increased body surface area, and potential for long-term chemical exposure. Long-term exposure to pesticides has been implicated in several types of cancer, birth defects, sterility, spontaneous abortion, and cognitive deficits.

The conditions of migrant life place families, and especially children, at increased risk for contracting a variety of viral, bacterial, and fungal infections, including rabies, anthrax, Rocky Mountain spotted fever, tetanus, plague, typhoid, tuberculosis, HIV, and hepatitis. Crowded, unsanitary living conditions create the opportunity for rapid disease spread. Lack of access to health care services results in a high incidence of preventable disease in the migrant population. The high incidence of tuberculosis in this population has been linked with high rates of infection in migrants' countries of origin, substandard housing and overcrowding, poor baseline health status, malnutrition, and lack of access to preventive health care services. There are high rates of HIV infection in the migrant population. Specifically, the number of women with HIV is rising, putting children at risk for contracting the virus *in utero* or at birth. Migrant women are particularly at risk because of their lack of access to educational counseling, prevention, and treatment services.

Migrant children are frequently at risk nutritionally. Migrant communities often have limited choices for the purchase of food, and their low incomes may preclude them from receiving adequate amounts of nourishment. Furthermore, they often lack the means for properly storing or preparing foods (e.g., lack of refrigeration or potable water). Though many are eligible for supplementation through programs such as WIC and food stamps, many do not participate because of multiple barriers to these services. Iron-deficiency anemia is a common diagnosis reported by clinics serving migrant children. Child obesity is also raised as a major clinical concern given the link of obesity to diabetes and hypertension in adults.

The health status of these children is further threatened because of barriers to health care such as family mobility, financial constraints, and legal (fear of immigration penalties), language, and cultural barriers. The mobility of the families impedes adequate follow-up and referral for health problems for the children. Financial constraints stemming from being in a low-wage work group, being paid according to how much is harvested, and lack of health insurance hinder migrant farm workers from seeking health care for their children. Language is a major cultural barrier for Hispanic workers who speak little English and for health care providers who do not speak Spanish.

There is a critical need for nurses working with migrants to advocate for the health of migrant children. Nurses must not only act as health educators for migrant families, but they must also aid them in negotiating a complex and dynamic health care system that is unfamiliar. It is equally important that those familiar with the lives of migrant families educate the public and its leaders about the significant contributions of these workers to the economy. Further, the research literature on migrant children has many critical gaps. Basic information on the number and distribution of migrant children in the United States, prevalence rates for common causes of morbidity and mortality in this group, and measures of the impact of the migrant health system on child health status are lacking. Nurses and other clinicians are in key positions to fill these gaps and thus expand the knowledge base from which further target interventions may be developed.

VIOLENCE

As the 20th century ended, violence by and against children declined. Yet it still occurs. Today children and adolescents are more likely to be the victims of violent crime than the offenders. In fact, in 2007, the rate at which youth were victims of serious violent crimes (homicide, rape, aggravated assault, and robbery) was 10 crimes per 1,000 youth ages 12–17. However, rates are still significantly lower than in 1993 when they peaked (the serious violent crime victimization rate was 44 per 1,000

REFLECTIVE THINKING

Inquiring about Guns in the Home

Some families may not want to reveal the fact that they have guns in their homes. How can you approach the topic? How could you ask the family about ways that they keep themselves and their children safe?

Reflections from Families

My family has been devastated ever since my 12-year-old son, Henry, was shot in our home. But we were more fortunate than most. He survived. Henry was seriously injured when his best friend Jonah, also age 12, and he were playing and found my husband's loaded revolver on the shelf of our closet. They began playing with it, and the gun went off in Jonah's hand, hitting Henry in the shoulder at close range. Henry's doctors say the outlook is good and that he will regain full use of his arm, though he will require extensive medical care and long-term physical therapy. But the trauma of that night will never leave us. My husband and I blame ourselves for the shooting and want to do something to prevent other families from going through what we have. We have started working with the schools to help teach gun safety to parents and children. We could have lost our son simply because we didn't take responsibility for owning and keeping a gun in our home. No parent should ever have to find out what that feels like, especially too late.

KIDS WANT TO KNOW

I'm afraid that someone will bring a gun to school.

What should I do if I know someone has brought a gun to school?

- Report any guns brought by classmates to a principal, teacher, or a school nurse.
- When you report guns brought by classmates, your identity does not need to be revealed.
- Many schools have metal detectors so that guns cannot be brought to school without being detected.

youth) (Federal Interagency Forum on Child and Family Statistics, 2009).

Youth violence is common in the United States; it is the second leading cause of death for young people between the ages of 10 and 24. In fact in 2006, an average of 16 young people between 10 and 24 were murdered every day, and over 631,000 violence-related injuries were treated in U.S. emergency rooms during 2007 among youth of this same age (CDC, 2009a). Among homicide victims ages 10- to 24-years-old, 84% were killed with a firearm (CDC, 2009b). Juveniles accounted for 16% of all violent crime arrests and 26% of all property crime arrests in 2007. Specifically, 1,350 juveniles were arrested for murder, 3,580 for forcible rape, and 57,650 for aggravated assault (Puzzanchera, 2009). Risk factors for such violent behaviors in this age group include poor family functioning and grades in school, poverty, drug, alcohol, or tobacco use, history of violence, and associating with delinquent peers (CDC, 2009a).

Although in recent years a great deal of attention has understandably been focused on tragic school shootings and homicides, serious school violence rates have declined over the last few years (CDC, 2010). However, even though violent crimes in schools have decreased, physical fights, thefts, weapon carrying, teacher victimization, and fear of school environments continue to be an issue for some children and adolescents. The most effective strategies for reducing violence in schools involve reducing risk factors including a history of early aggressive behavior, associating with delinquent peers, being involved in gangs, poor academic performance, low commitment to school or school failure, antisocial beliefs and attitudes, poor behavioral control, experiencing rejection by peers, exposure to family violence/conflict, low parental involvement, and poor family functioning and comonitoring/supervision of children (CDC, 2010) as well as coordinating interventions by education, law enforcement, social service, and mental health systems.

FAMILYTEACHING

Firearm Injury Prevention

Home

1. Communicate the risks of keeping a firearm in the home.
2. Advise that it's safest not to keep a firearm in the home.
3. Review safe methods of storage.
4. Educate caregivers to teach children not to touch or handle firearms.
5. Explain that handguns and semiautomatic weapons pose the greatest risk of intentional and unintentional injury for children because they are often stored unsafely.
6. Explain to caregivers that it is easier to keep guns away from adolescents than to keep adolescents away from guns, which are often glamorized in the media. Caregivers should watch for signs of depression or changes in behavior since teens feeling this way are at increased risk for suicide.

School

1. Incorporate violence prevention programs in school curricula at an early age, including firearm violence. Examples of such programs include conflict resolution, alternatives to violence, anger management, risk awareness, and coping skills.
2. Have after-school programs for youths, and obtain community support for such programs.

Community

1. In an effort to reduce the romanticization of guns in the popular media, urge the development of violence-free programming among child health and education advocates and the television and motion picture industries.
2. Support legislation that regulates the manufacture and importation of classes of guns, such as handguns and assault weapons, and that requires background checks for weapons purchased at gun shows.
3. Improve playgrounds and parks to make safe play areas for children.

CURRENT STATUS OF CHILDREN'S HEALTH

Beginning in 1979, *Healthy People* has set and monitored national health goals and objectives to meet a wide range of health needs, engage people across the nation to work together, guide individuals toward making informed health decisions, and measure the impact of prevention activity. *Healthy People* embodies science-based, 10-year national objectives for promoting health and preventing disease (USDHHS, 2010). In January 2000, the U.S. Department of Health and Human Services (USDHHS) launched *Healthy People 2010: National Health Promotion and Disease Prevention Objectives,* a comprehensive, nationwide health promotion and disease prevention agenda. The document contains 28 focus areas and 467 objectives designed to serve as a guide for improving the health of all people in the United States during the first decade of the 21st century (USDHHS, 2000). Most of the objectives target the lifestyle choices and environmental conditions that cause 70% of premature deaths in this country. The overarching goals are to increase the quality and years of healthy life and eliminate health disparities between ethnic groups. The *Healthy People* framework allows governments to focus resources in the right place. A variety of indicators reflect the health status of Americans. Health status can be measured by birth and death rates, life expectancy, morbidity from specific diseases, and many other factors (see Box 1-1).

BOX 1-1
HEALTHY PEOPLE LEADING HEALTH INDICATORS

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunizations
- Access to health care

Healthy People 2020 continues the progress from *Healthy People 2010*. Advisory committees met during 2008 and 2009, and public comment has been solicited. By 2010, the goals, objectives, and action plans for *Healthy People 2020* will be launched (USDHHS, 2010). The *Healthy People 2020* vision, mission statement, and overarching goals are included in Box 1-2.

Because *Healthy People* has emphasized health promotion and prevention, almost all of it pertains to nursing.

BOX 1-2
HEALTHY PEOPLE 2020 FRAMEWORK

Vision

A society in which all people live long, healthy lives.

Mission Statement

Healthy People 2020 strives to:

- Identify nationwide health improvement priorities;
- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress;
- Provide measurable objectives and goals that are applicable at the national, state, and local levels;
- Engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge;
- Identify critical research, evaluation, and data collections needs.

Overarching Goals

- Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities, and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote quality of life, healthy development, and healthy behaviors across all life stages.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2020, Available at http://www.healthypeople.gov/hp2020/ accessed April 11, 2010.

Health promotion and education are central to nursing practice; therefore, nurses need to develop an awareness of the *Healthy People 2020* program and incorporate it as a benchmark for their interventions. Nurses are well educated and prepared to work with individuals, families, and communities to meet the special needs of vulnerable populations and to eliminate health disparities. The public, by and large, trusts nurses and is receptive to their teaching and intervention. Nurses can use their unique position to help meet the goals of *Healthy People 2020* and, in doing so, can improve the health of all Americans: adults, children, and adolescents.

INFANT MORTALITY

Infant mortality is an important measure of a nation's health and a worldwide indicator of health status. The **infant mortality rate** (IMR) is the number of infant deaths during the first year of life per 1,000 live births. IMR declined exponentially during the 20th century from 200 per 1,000 live births in 1900 to a record low of 7.2 per 1,000 live births in 1998. By 2006, the rate fell to 6.7 per 1,000 live births, an average that varies widely based upon ethnicity, race, and state in the United States. For instance, Black/African American infants suffer an IMR of 13.3 as compared to a low of 3.6 among Asian or Pacific Islander babies. Infants born in Washington State have an IMR of 4.7 and infants born in Mississippi are more than twice as likely to die before their first birthday (Annie E. Casey Foundation, 2009).

Compared to our international peers, the United States IMR rate ranked 30th in 2005. Chile ranked 32nd, Cuba ranks 26th, Canada ranks 25th, Singapore ranks 1st and Sweden ranks 2nd (CDC, 2008). One explanation for the low ranking of the United States may be that most countries with lower IMR have national health programs.

The ratio of low birth weight births in this country also continues to be a reason for its unenviable IMR, and the proportion of the smallest and most vulnerable infants increased during the 1990s. The IMR target goal for the year 2010 was 4.5 deaths per 1,000 live births, and continues to be an unmet goal for the United States. It has been reasoned that to achieve further reductions in infant mortality, the public health community, health care providers, and individuals must focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes. These include smoking, substance abuse, poor nutrition, lack of prenatal care, medical problems, chronic illness, and other psychosocial problems (e.g., stress, domestic violence). However, given the inability to improve access for prenatal care by health care providers and expand education efforts, any new approach must be more focused upon the financial, educational, social, and logistic barriers to receiving prenatal care in the first trimester for all women.

CHILD MORTALITY

Another indicator of children's health status is child mortality. Child mortality decreased by approximately half between 1980 and 2002 among children ages 1 to 4 (from 64 to 31 deaths per 100,000 children) and among children ages 5 to 14 (from 31 to 17 deaths per 100,000 children) (Federal Interagency Forum on Child and Family Statistics, 2005). In 2006, child mortality (deaths per 100,000 children ages 1 to 4 years) has improved more, falling to 28.4. The rate for children ages 5 to 14 has also continued a downward trend, falling to 15.2 in 2006 (CDC, 2008).

At the beginning of the 20th century the major cause of child mortality for 1- to 19-year-olds was infectious diseases. However, the mortality and morbidity from all of these diseases are dwarfed by the numbers of children who die or who are disabled as the result of unintentional injuries. Until recently, injuries were commonly termed *accidents,* suggesting that they were unpredictable and unavoidable events affecting unlucky children. Today, the term *injury* is favored because it more accurately suggests that the problem can be averted and prevented.

CRITICAL THINKING

Healthy People 2020

From the ten leading health indicators found in Box 1-1, choose four that you think would have objectives pertaining to children ages 1 to 18 years and list them. For each one of the four you have chosen, write down an idea for the specific area that the objective should address. For example, if you were to choose priority areas for adults, one area would be cancer, and the specific area the objective could address is to increase the number of adults who receive a colorectal screening exam each year.

CULTURAL CONSIDERATION

Infant Mortality Rate and Race Ethnicity

Racial and ethnic disparities persist for infant mortality, with whites having the lowest rate. The IMR for African Americans is twice the rate for whites. However, the gap between whites and nonwhites (excluding African Americans) is narrowing. For Hispanics and Asian Pacific Islanders, the IMR has decreased dramatically over the last 20 years (CDC, Health, United States, 2008). One reason for this disparity in IMR is the high rate of **low birth weight** (LBW) infants born to minority mothers, which suggests a decrease in the overall health status or health care access of these women. In 2007, low birth weight (LBW) babies (weighing less than 2500g or 5 lb 8 oz) represented 8.2% of all live births in the United States (Federal Interagency Forum on Child and Family Statistics, 2009).

During 2010, the World Health Organization began an ambitious country-by-country count for preterm birth rates (prematurity is currently considered as any live birth earlier than 37 weeks of gestation). Evidence suggests that worldwide one in every 10 of the world's babies is born preterm (March of Dimes, 2009). The United States has the highest percentage of premature births in the world, with the rate increasing 36% over the last quarter century (March of Dimes, 2009). Data suggests that more than 1 in 4 (28%) of premature babies will not survive (Lawn, Cousens & Zupan, 2006). Premature babies who survive have higher rates of learning disabilities, cerebral palsy, sensory deficits, and respiratory illnesses as compared to babies carried to term (IOM, 2007).

Injury is defined as damage or harm to an individual resulting in destruction of health, disability, or death. An injury is classified as intentional or unintentional, denoting whether or not it was meant to harm the victim.

Among children ages 1 to 4, unintentional injuries (9.9%) are responsible for more deaths each year than homicide (2.2%), congenital anomalies (3.2%), cancer (2.3%), heart disease (1%), respiratory illness, and HIV combined in 2006 (CDC, 2008). Although unintentional injuries are the leading cause of death for all children over 1 year of age, the incidence varies by age. More than half of all unintentional injury-related deaths occur in the 15- to 19-year-old group due to motor vehicle-related injuries. Common subcategories of motor vehicle injuries include (1) occupant (drivers and passengers), (2) bicycle-related, (3) motorcycle, and (4) pedestrian injuries.

There is considerable variation in injury rates among children depending on their age group. Among children under 1 year of age, suffocation is the leading cause of unintentional injury-related death, followed by motor vehicle occupant injury, choking, drowning, and fires or burns. Some suffocation deaths in infants are due to entrapment of the head and neck in cribs. Another cause is choking on food or an object, leading to airway obstruction. For children ages 1 to 4 years, drowning is no longer the leading cause of injury death. Drowning now is equal to motor vehicle occupant injury (each at 2.9%), followed by fires or burns (1.3%) and airway obstruction (1%) (CDC, 2008). Infants often drown in bathtubs, usually as a result of poor supervision or neglect, whereas toddlers and young children fall into a body of water such as a swimming pool, lake, or river, usually while unsupervised. Among children ages 5 to 14, motor vehicle traffic-related injury is the leading cause of death (3.0%), followed by firearms (0.9%), suffocation (0.8%), drowning (0.7%), and fires and burns (0.5%) (CDC, 2008). Pedestrian injury often occurs when a child darts out between parked cars or into the street to get a ball or another object. During adolescence (14–19 years), motor vehicle occupant injuries are the primary cause of injury-related deaths. Driver inexperience and alcohol use are key contributors to the high rate of fatal crashes involving adolescents.

Rates of unintentional injury deaths among children have declined by 43% over the past several decades. Decreases in injury deaths have been observed for every age group and for nearly all causes. Reductions have been most evident among adolescents and for poisoning deaths. Additionally, most unintentional injury deaths to children can be prevented. Simple proven interventions include: (1) using child car seats and bicycle helmets; (2) requiring that prescription medications have child-resistant caps: (3) installing smoke detectors in homes; (4) requiring that children's sleep wear be flame retardant; and (5) enclosing swimming pools with fences.

REFLECTIVE THINKING

The Cost of Keeping LBW Infants Alive

Hospitals and health care delivery systems have poured substantial amounts of money into neonatal intensive care units to care for LBW infants. These babies are usually technology dependent and often require extensive medical equipment and nursing care in their homes. How do you feel about this emphasis on high-tech solutions versus allocating some resources to preventive services?

These common sense tactics have annually saved the lives of thousands of children.

The key approaches to injury prevention are education, changes in the environment and in products, and legislation or regulation. Education to promote changes in individuals' behaviors has reduced the risk of childhood injuries. Education by health care professionals has increased individual safety behaviors, including seat belt and car seat use, smoke detector ownership, and safe hot water temperature. Nurses and other health care providers should incorporate education about safety practices into routine health visits. Pediatric nurses can play an important educational role by teaching caregivers about expected behaviors for their child's upcoming developmental stage. This alerts them to the types of injuries common to that age group and to potential environmental hazards. Nurses can initiate safety programs in schools, neighborhoods, and cities (Figure 1-1).

Changes in the environment and in products can make children's physical surroundings, toys, and clothing safer. Strategies that make children's environments safer such as traffic calming to reduce or slow the speed of traffic in neighborhoods and fencing to enclose swimming pools on all sides should be implemented in all communities and be mandated by law. Legislation and regulation are among the most effective tools to reduce injuries, and most environment and product modifications require legal action. However, some laws have not been adopted in every state; for example, 14 of 50 states (Arkansas, Colorado, Idaho, Indiana, Iowa, Minnesota, Mississippi, Nebraska, North and South Dakota, South Carolina, Utah, Vermont, and Wyoming) lack bicycle helmet laws (Bicycle Helmet Safety Institute, 2009). Most states do not require appropriate protection in automobiles for children between the ages of 4 and 8. For maximum effectiveness, laws, regulations, and policies must be supported by the public and enforced at the community level. A major challenge is to coordinate all groups involved in unintentional injury prevention to create a critical mass for action.

FIGURE 1-1 **The use of safety equipment such as helmets helps protect children from injury. What other measures can nurses suggest to parents that might protect children from injury?** DELMAR CENGAGE LEARNING.

ACCESS TO HEALTH CARE

For a growing number of children, access to health care is hampered by lack of health insurance. Children without health insurance are less likely to receive health services (CDC, 2008). In 2007, 89% of children (i.e., 8.1 million) had health insurance coverage at some point during the year. While government insurance coverage has continued its upward trend since 1999, the proportion of children covered by private insurance has dropped since 2000 (Federal Interagency Forum on Child and Family Statistics, 2009). Ethnic minority children are overrepresented among the uninsured, as they account for more than half of uninsured children. Three-quarters of uninsured children are among the working poor, that is, in families in which the head of the household is employed full time for all or part of the year. One unintended consequence it that only 77% of children age 19–35 months received a combined vaccination series protecting them against several childhood infectious diseases during 2006, thereby affecting public health in the United States (CDC, 2008).

Socioeconomic status largely dictates the source of children's health insurance. Those from higher income families are more likely to have private health insurance (90%) than are children from lower income families (40%). Uninsured children in low-income families experience substantial

Reflections from Families

Whenever I heard people say that the leading cause of death in teenagers is car accidents, I never thought it would happen to me. I am only 17, but I feel that my life is over since the day my best friend, Kamdin, was killed in the car I was driving. I was driving too fast, and we had the music on real high. We had just left a friend's house, where we had been drinking beer. We were just having fun, we thought, but suddenly when a car turned in front of us too fast, I lost control of my car, and we ended up rolled over in a ditch. Kamdin is gone, and her family will never be the same. Neither will mine. I just keep wishing I had one more chance to go back to that day and do it over again.

difficulties in accessing health care. They tend to lack: (1) the usual sources of routine and sick care, (2) a primary care provider, and (3) recent visits to health care providers.

Beyond the barriers created by lack of health insurance, other factors involved in access to and use of care include demographic factors such as family income, race or ethnicity, place of residence, and type of insurance. Institutional factors such as gate keeping by health plans, distance from families' homes to health site, availability of transportation, and waiting times are other factors. Nurses need to assess barriers for families in accessing health care beyond their insurance status in order to ensure that children will receive needed health care.

PERSPECTIVES ON PEDIATRIC NURSING

FAMILY-CENTERED CARE

All health care professionals recognize that quality health care of children must extend to the entire family. Thus, the focus of pediatric nursing must be on the child as well as the family. The term **family-centered care** describes a philosophy of care that recognizes the centrality of the family in the child's life and inclusion of the family's contribution and involvement in the plan for care and its delivery. It is a health care delivery model that seeks to fully involve families in the care of children. Family-centered care evolved in response to the critical need to maintain the relationship between hospitalized children and their families. Previously this relationship had been neglected or disrupted because of forced separation by the health care system.

In 1987, a revolutionary document that defined the elements of family-centered care was published by the Association for the Care of Children's Health (ACCH). Family-centered care was defined by this group as including eight equally important elements (see Box 1-3). Meeting the ever-changing needs of *all* family members, not just those of the child, is paramount to the concept of family-centered care. When families are incorporated into the care of their children, the physical and psychosocial health of the child improves and accelerated rates of progress have been seen. Additionally, these families have demonstrated enhanced learning, less stress, and more satisfaction with care.

The elements of family-centered care are based on principles that are designed to promote greater family self-determination, decision-making capabilities, control, and self-efficacy. Collectively, these attributes are said to reflect a sense of empowerment. In contrast, the medical model directs health care professionals to assume the roles of evaluator and controller of treatment interventions. This approach results in child and caregiver dependence on the health care providers. This position is in direct conflict with the conditions necessary for more active involvement of caregivers in the care of their health-impaired children.

Many health care providers respect and support the idea of family-centered care; however, the practice of this type of care has not been fully actualized. This discrepancy between their support and actual practice of family-centered care may be attributed in part to the model they employ (family empowerment versus medical approach). Additionally, professionals often inadvertently foster family dependency, alienation, and helplessness by taking control and administering care without family input for the convenience and expediency of the staff and the institution. However, in order to facilitate family-centered care, health care providers must seek caregiver input, suggestions, and advice; incorporate this information into the plan of care; and teach the family the appropriate health care interventions. By providing education and knowledge to the family, caregivers can be empowered to make informed decisions about their child's care. Other strategies that enhance family-centered care include removing limits on the ages or number of visitors (unless directed otherwise by the family); providing adequate sleeping facilities for caregivers in the child's room; offering meals or discounts in cafeterias and free parking or a discount for caregivers; and requesting family

BOX 1-3

KEY ELEMENTS OF FAMILY-CENTERED CARE

1. Incorporating into policy and practice the recognition that the *family is the constant* in a child's life, whereas the service systems and support personnel fluctuate.
2. Facilitating *family/professional collaboration* at all levels of hospital, home, and community care: care of an individual child; program development, implementation, and evaluation; and policy formation.
3. *Exchanging complete and unbiased information* between families and professionals in a supportive manner at all times.
4. Incorporating into policy and practice the recognition and *honoring of cultural diversity,* strengths, and individuality within and across all families, including *ethnic, racial, spiritual, social, economic, educational,* and *geographic diversity*.
5. Recognizing and respecting *different methods of family coping* and implementing comprehensive policies and programs that provide *developmental, educational, emotional, environmental,* and *financial supports* to meet the diverse needs of families.
6. Encouraging and facilitating *family-to-family support* and networking.
7. Ensuring that *hospital, home, and community services and support systems* for children needing specialized health and developmental care and their families are *flexible, accessible, and comprehensive* in responding to diverse family-identified needs.
8. *Appreciating families as families* and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

attendance at interdisciplinary conferences regarding the child's care.

ATRAUMATIC CARE

Atraumatic care is a philosophy of providing care that minimizes or eliminates physical and psychological distress for children and their families in the health care environment. In pediatric care, many interventions are traumatic, stressful, and painful; therefore, it is important for nurses to be cognizant of these situations and provide care that minimizes distress. Three principles provide the basis for atraumatic care: (1) identifying stressors for the child and family, (2) minimizing separation of the child from caregivers, and (3) minimizing or preventing pain. Examples of atraumatic interventions include:

- Preparing the child prior to every procedure using age-appropriate explanations
- For the child scheduled for surgery, preparing her or him prior to hospital admission (encourage child and caregivers to visit the hospital, allow the child to play with equipment and items such as a stethoscope, blood pressure cuff, IV equipment, masks, and gowns)
- Allowing caregivers to be involved and physically present as much as possible to provide support and comfort for the child
- Controlling pain by administering analgesics freely
- Using a euteric mixture of local anesthetics (EMLA) cream at least 1 hour prior to blood draws, insertion of IV needles, and injections

ROLES OF THE PEDIATRIC NURSE

The professional pediatric nurse has the responsibility to provide high-quality care no matter the setting nor the role practiced. Settings where pediatric nurses are involved in caring for children include schools (see Chapter 5), acute care settings, clinics, physicians' offices, home health agencies, rehabilitation centers, hospice programs, day care centers, psychiatric centers, and summer camps. Nurses may also work as administrators or nurse executives. Although each setting may have separate roles and responsibilities, the roles that nurses take are universal. Specifically, the primary roles include caregiver, advocate, educator, researcher, and manager or leader. Secondary roles include behaviors related to coordinating, collaborating, communicating, and consulting, and are embedded within the primary roles. Other roles seen in the acute care setting involve **differentiated practice** (a philosophy that delineates a nurse's role and functions according to experience, competence, and education) and include the clinical care coordinator, care manager, and clinical nurse. In addition to these, nurses function in expanded roles as pediatric nurse practitioners, clinical nurse specialists, and case managers. For the most part, these expanded roles require advanced preparation. See Box 1-4 for a list of the various roles of the nurse in pediatric practice. A discussion of the roles follows.

The roles that the nurse takes in these settings are based on the level of performance expected by practice authorities.

BOX 1-4
ROLES OF THE PEDIATRIC NURSE

Primary Roles
Caregiver
Advocate
Educator
Researcher
Manager or leader

Secondary Roles
Coordinator
Collaborator
Communicator
Consultant

Differentiated Practice Roles
Clinical care coordinator
Care manager
Clinical nurse

Advanced Practice Roles
Nurse practitioner
Clinical nurse specialist
Case manager

The Standards of Maternal and Child Health Nursing Practice as developed by the American Nurses Association describe these standards and set expectations for the general behaviors of pediatric nurses while caring for children and their families. These standards were developed in 1983 and are out of print; therefore, they are not included in this textbook.

Caregiver

Patricia Benner (1984) identified several domains of nursing practice that are inherent in the **caregiver** role. They include helping, patient diagnosing and monitoring, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, organizational and work role competencies, and effectively managing rapidly changing situations. More specifically, the caregiver delivers direct nursing care to children and their families based on the nursing process that considers the child's developmental level, meets the child's emotional and physical needs, and encourages the child to participate in self-care as appropriate. Caregivers also provide family-centered care that embraces diverse cultures and family structures, empowers and encourages families to participate in the care their child needs, and supports families at home, in the acute care setting or in other settings. This requires skills in critical thinking, coordinating, collaborating, and consulting, as well as the ability to incorporate and integrate knowledge of pathophysiology, pediatric illness, human growth and development, and the biological sciences, and findings from the physical, cultural, and spiritual assessment into a plan that accurately reflects child and family needs. Care provided also should demonstrate knowledge of pediatric pharmacology, including methods of administration, dosage, and side effects, and the ability to accurately administer medication by various routes to children of all ages.

REFLECTIVE THINKING

Caregiver

Describe the responsibilities of caregivers you see on the pediatric unit where you have experience. Of all the responsibilities nurses have as caregivers for children and their families, which are the most important? Why?

Advocate

The **advocate** pleads causes for and assists others in making informed decisions that are in the child and family's best interest. Generally, pediatric nurses acting as advocates inform clients and families of their rights and options as well as the consequences of those options. Pediatric nurse advocates allow clients and families to make their own informed decisions and then support those decisions. Even though advocates do not need to approve the decision, they do need to respect that decision and the right to make that decision. In fact, advocates shouldn't make decisions for clients, but rather facilitate decision making.

Typically, advocates in pediatrics are concerned with informing children and their families about their health care decisions, and providing information about research, experimental protocols, and alternative treatments. They also provide complete, clear, concise, understandable, and accurate information concerning treatment, procedures, and inherent risks; provide for privacy and respect; and allow clients and families to refuse a drug, treatment, test, or procedure. Advocates also need to be careful not to impose their own personal values and standards, but rather allow the child and family to make autonomous decisions.

CRITICAL THINKING

Advocate

What would you do if the client or family has values and beliefs different than yours regarding treatment decisions? How would you respond?

BOX 1-5

UNITED NATIONS DECLARATION OF THE RIGHTS OF THE CHILD

All children need:

- To be free from discrimination
- To develop physically and mentally in freedom and dignity
- To have a name and nationality
- To have adequate nutrition, housing, recreation, and medical services
- To receive special treatment if handicapped
- To receive love, understanding, and material security
- To receive an education and develop his or her abilities
- To be the first to receive protection in disaster
- To be protected from neglect, cruelty, and exploitation
- To be brought up in a spirit of friendship among people

Used with permission from Office of the United Nations High Commissioner for Human Rights (http://www.ohchr.org) (1959). *Declaration of the Rights of the Child*. Proclaimed by General Assembly Resolution 1386 (XIV) of November 20, 1959.

Nurses also advocate for clients and families who are vulnerable or cannot speak for themselves; for those who do not know how to speak for themselves because of lack of knowledge, difficulty articulating needs and ideas, physical or mental disability, or perceived lack of power; and for those who are afraid to speak out. The more dependent the client is on the system, the more diligent the advocate should be on his or her behalf. Effective advocates should be assertive, attentive, knowledgeable, and trustworthy, and have the ability to openly communicate with members of the health care team, as well as remain educated about current legal and ethical trends. Finally, the advocate should be aware of the United Nations Declaration of the Rights of the Child (refer to Box 1-5), which ensures children receive optimal care by providing nursing practice guidelines.

Educator

One of the most important roles the pediatric nurse assumes is that of **educator**, or teacher, because education is one of the major avenues that the nurse uses to enable clients and families to make informed decisions. In fact, Florence Nightingale emphasized the role of the nurse as an educator, and today, nurses spend most of their time teaching, informally and formally. Nurses teach children and their families in a variety of settings, on a fairly wide range of topics, and in many circumstances. Although discussed as a separate role, teaching is inherent in the caregiver role (Figure 1-2).

To be an effective educator, the nurse must initially have knowledge of cognitive development since teaching a preschool child and family about an experience will be different than teaching an adolescent and family about the same experience. Teaching techniques based on developmental levels include imitation, repetition, association, trial and error, conditioning, and concept development, and each developmental level requires particular strategies. For example, infants and toddlers are best taught by their caregiver, and prefer to explore their environment or handle equipment. If toddlers are not interested in learning, it would be better to just delay the session. Most preschool children want to learn, and even though they might have limited verbal abilities, they do like to practice and manipulate equipment. Preschoolers will ask many questions, and answers should be short, at an understandable level, and not imply punishment. Since young children often imitate others, imitation would be an appropriate method of teaching this age group. School-age children have a short attention span and learn best in brief stages and at frequent intervals where they can handle objects, draw pictures, and color in books. Since the school-age child asks many "why"

Figure 1-2 Pediatric nurses have a number of opportunities to teach, including teaching adolescents about contraception or risky behaviors that should be avoided. DELMAR CENGAGE LEARNING

questions, explanations should meet their needs and use words they understand. Adolescents often learn by associating new information with what they already know and may not want parents present during educational sessions. Adolescents also learn best when they see an immediate personal benefit. For example, if they understand taking medicine regularly will permit continuation of current activities, they often will comply.

Typically, nurses working with children and families will act in the educator role as they prepare children and families for procedures, surgery, or the hospitalization experience itself. Educators will also answer questions about experiences and treatments, help interpret and integrate information received from the health care team, and help parents learn how to care for their child. They also may provide information related to child rearing; answer questions about human development; discuss injury and illness prevention, health promotion and maintenance, and immunization schedules; clarify diagnoses or treatment plans; supply children and their families with appropriate literature; and refer to helpful lay or professional groups.

Since learning takes place in three domains—cognitive, affective, and psychomotor—the nurse educator must integrate all domains into teaching if it is to be effective. **Cognitive learning** is concerned with intellectual activities, can be compared to thinking, and involves describing or explaining something, or answering questions. **Affective learning** is learning that takes place in relation to feelings and emotions; as, for example, in role-playing, modeling, or one-to-one discussion where learners are asked to share their feelings and ideas about the information taught. **Psychomotor learning** is concerned with physical skills; as when the opportunity to actually practice what is being taught is offered. Often psychomotor learning is accompanied by explanation, demonstration and then practice with hands-on experiences, repetition, and immediate feedback.

An example of these types of learning could be applied to learning how to use an inhaler. Cognitive learning would include information about when to use the inhaler, how much medicine to use in the inhaler, and how to evaluate the effectiveness of the treatment. Affective learning occurs when the child recalls feelings before and after the treatment and the effects of using the inhaler. Psychomotor skills are needed to correctly administer the inhaler therapy and encouraged by allowing practice in front of the nurse.

Nurses may also be responsible for teaching their colleagues. For example, they may need to teach other nurses or health care providers about new information relative to a specific disease or condition, treatment, or intervention, or how to improve their skills and troubleshoot when things go wrong. Finally, the physical environment, the child or family's previous experiences, the culture, and the teacher's skill and organizational ability need to be considered if the nurse is to be an effective educator. The place where the teaching occurs should be carefully chosen so there is sufficient lighting, comfortable seating, an appropriate room temperature, and opportunities for either privacy or group discussion as needed. If children or families already know about the topic, the information should be tailored to their needs and not be redundant. If children and their family are from a culture with specific beliefs that impact the information presented, those beliefs need to be incorporated into the presentation. Finally, if the presentation is disorganized or the presenter is not skilled in teaching, the material may not be easily understood by the audience.

REFLECTIVE THINKING

Educator

How often do you see pediatric nurses teach their clients? Families? Other staff? What can we do to improve teaching effectiveness? What needs to be done to increase client and family teaching opportunities?

CRITICAL THINKING

Teaching a 4-Year-Old

A 4-year-old boy has been admitted to the same day surgery department for a tonsillectomy and adenoidectomy. How would you prepare him for the experience both prior to surgery and after surgery?

Researcher

One criterion for a profession is the existence of a body of knowledge that is distinct from other disciplines. Nursing has traditionally borrowed from the natural and social sciences, and has only recently begun to concentrate on establishing a unique body of knowledge allowing clear identification as a distinct profession. Scientific research is a valid way to develop this knowledge, and pediatric nurses are in an important position to improve this knowledge. Nurses have a responsibility to identify problems that warrant scientific investigation and provide evidence-based practice. In fact, professional accountability demands nurses determine the usefulness of this evidence before integrating it into practice. Pediatric nurses are also called upon to evaluate the methods used to carry out research projects and estimate how confident they are in the results.

There is now an emphasis in health care on determining whether interventions are cost effective and provide positive client outcomes. The evidence-based practice movement,

REFLECTIVE THINKING

Researcher

Think of a project you might become involved in that would improve pediatric client outcomes. Describe three different reasons why nursing research is difficult for staff nurses to integrate into their role at the bedside.

one outcome of this emphasis, involves not only identifying clinical questions needing to be answered, but also analyzing published research on interventions and then using his/her knowledge and integrating patient/family preferences and values into practice. The pediatric nurse, therefore, needs to always be aware of or identify clinical practice questions needing answers, examine the literature for answers to these questions, and then determine whether those answers (interventions) are appropriate for practice.

The ANA has differentiated the investigative function of nurses at various educational levels, from the associate degree through the doctorate. Although certain responsibilities have been spelled out specifically, it is not uncommon for nurses at all levels to work together on teams investigating a particular practice problem. In fact, involving all levels of education improves the project since each nurse brings different knowledge and skills to the team. More specifically, nurses can be principal investigators on a research project (although special preparation is often necessary, usually a doctorate) or a member of a research team. As team members they could be involved as a data collector; be responsible for administering a new nursing intervention; create, manage, and analyze data files; develop questionnaires; interview and observe subjects; transcribe and analyze audio tapes and interviews; analyze diaries, journals, photographs, and drawings; conduct literature searches; synthesize and critique articles; or assist in writing proposals and editing manuscripts. Being a member of a team may also raise interest and enthusiasm for nurses to conduct their own research (Polit & Beck, 2010) and should be encouraged.

Manager/Leader

Another role discussed is **manager**, which includes management of one's own clients if caring for more than one client, as well as managing staff. Typically, managing requires prioritizing, planning, and organizing comprehensive and accountable nursing care for a group of clients. It also requires one to differentiate care that is important from care that is urgent, so children and their families have needs met in a timely fashion.

Managing also means delegating aspects of care to others on the nursing staff, consistent with their level of expertise and education. However, the nurse is always held accountable for delegated tasks to be sure that there is adherence to ethical and legal standards. Since managing also requires that one assume a leadership role in health care management, effective pediatric nurse managers need to have knowledge of the care requirements of children and their families even though they may not be personally delivering the care in order to efficiently and effectively supervise the care others give. Effective nurse managers interact with clients and their families both directly and indirectly by visiting clients on rounds, reviewing records, receiving reports on client status, and answering questions from staff and requests from clients and families.

Nurse managers are also responsible for representing the institution to the client and family and the client and family to the institution, and must also work within the bureaucratic environment, which sometimes means subordinating the needs of individuals to the needs of the institution. This may cause serious conflicts for professionals attempting to give individualized care and may require the manager to step in to help staff handle the conflict. Finally, nurse managers determine the character of the unit, attitudes and behavior of staff, and relationships with other professionals at the agency. For example, if the managers' interactions with other health care providers and housekeeping are professional, the relationships these departments have with the staff will also be professional. The atmosphere of the unit also mirrors the manager's. That is, if the manager is quiet and efficient, those feelings will be communicated to children and their families; if the manager is stressed and seemingly unorganized, this too will be communicated.

DIFFERENTIATED PRACTICE ROLES

Differentiated practice, a nursing practice model implemented in some care settings, refers to a philosophy that delineates a nurse's role and functions according to experience, competence, and education (Boston, 1990). It also promotes contributions, and recognizes and values all nursing personnel delivering care to clients regardless of their role, position, or educational preparation. This integrated care delivery system was developed to improve use of resources, care quality, and career satisfaction, and seeks to divide work responsibilities according to educational preparation. For example, the clinical nurse (who holds an associate degree in nursing) provides care for clients in structured settings where procedures and policies are established and followed. Specifically, that means being responsible for managing the care of pediatric clients for one shift; monitoring, evaluating, and documenting responses to treatments and the plan of care; performing nursing skills within the scope of practice; delegating aspects of care to other team members according to their role and responsibilities;

actually implementing the individualized plan of care; assessing clients to determine needs and learning readiness; and networking with team members to enhance continuity of care.

The care manager (who holds a baccalaureate degree in nursing) is responsible for integrating client care from preadmission to post discharge and uses independent nursing judgment. This nurse may or may not work in a structured environment, where there may or may not be established procedures and policies. Specifically, this means assessing and developing a plan of care reflecting client discharge needs; designing, implementing, and evaluating teaching plans that restore, maintain, and promote health; determining long-term goals for clients in collaboration with the family; collaborating with health care team members to implement care plans both within and outside the acute care setting; assuming responsibility for care plan outcomes; completing discharge planning assessment; and collaborating with other disciplines as needed to facilitate referrals to other agencies within the community.

The clinical care coordinator (who holds a master's degree in nursing) provides leadership; functions in a variety of settings; uses independent nursing judgment based on specialized knowledge, research, and theory; and promotes health care outcomes for clients. Specifically, this means assessing nursing resources and staffing needs and then implementing a staffing plan reflective of this assessment; facilitating communication within the health care team; serving as a resource to clients, families, and the health care team; fostering development and education of students and staff; using unit resources effectively; and providing administrative and clinical assistance as needed.

ADVANCED PRACTICE ROLES

Advanced practice or expanded roles include the pediatric nurse practitioner, clinical nurse specialist, and case manager. For the most part, these roles require a master's degree and additional skills in assessing and managing children.

EYEON...

Alternative Treatment Modalities

Many pediatric nurse practitioners use alternative or complementary modalities, either by themselves or in conjunction with conventional medical therapies. One example is herbal therapy, which uses plant extracts for therapeutic outcomes. In pediatrics, infants who are teething may experience pain, fever, diarrhea, and inflamed gums. Traditional medical treatment involves medications such as analgesics, sedatives, or local anesthetics. Many PNPs utilize herbs such as chamomile in conjunction with medications and have found this therapy effective.

Pediatric Nurse Practitioner

The **pediatric nurse practitioner** (PNP) role evolved to meet the need in the 1960s and 1970s for primary care providers of routine health maintenance and preventative services in ambulatory settings. The PNP usually is a registered nurse who has received advanced education (often a master's degree) and graduated from a nurse practitioner program. In the past, the PNP traditionally worked in ambulatory or clinic settings and focused on disease prevention, minor disease management, and well children and families. Today, the PNP may be employed in acute care settings and focus on management of particular disease entities, or partner with physician groups, HMOs, or other types of managed care organizations.

Practitioners are independent, autonomous, and highly skilled at performing nursing assessments and physical examination, counseling, treating minor health problems, and teaching. The PNP also is able to order, carry out, and evaluate laboratory studies; discriminate between normal and abnormal findings that require treatment, referral, or collaboration with other health care professionals; serve as a consultant to other health care professionals; and identify topics, interpret results, and implement evidence-based findings into practice.

Clinical Nurse Specialist

The **clinical nurse specialist** (CNS) "provides an expert approach to health focused on a refined body of knowledge and specialized practice competencies" (ANA, 1980) and usually has a master's degree in nursing. When initially developed, the CNS role was seen as a way for the nurse who wanted to maintain direct client contact to remain at the bedside and still advance in the profession. The CNS provides expert physical, social, and psychological support and care, consults with nursing staff and other health care personnel, educates clients and families in health care management, conducts practice outcome research, serves as a role model for staff, and validates the nursing observations and interventions that staff make. It is not unusual for the CNS to be competent in providing care during all stages of an illness and function in any setting where clients are found, such as clinics, community agencies, or long-term care facilities. Many work in acute care facilities and have prescriptive practice privileges. Others are used as staff educators or consultants to the health care team, managers, expert clinicians, or researchers. They may also specialize in oncology, neurology, cardiology, or orthopedics.

Case Manager

Case management is a practice model initially developed to minimize fragmentation of services and maximize individualization of care. Both quality and cost outcomes are important in case management, which promotes continuity of care by using an interdisciplinary team (nurses, physicians,

physical and occupational therapists, social workers). The case manager, often the nurse, coordinates the interdisciplinary care plan which is based on evidence-based research and past medical decisions, so the most effective practices, considering the client's condition, are used. Typically, the case manager obtains services the client needs, and then monitors the effectiveness of the services provided. Case management uses a systematic approach that ensures optimal outcomes for clients, including decreasing length of acute care stay, by developing clinical pathways which are designed to achieve specific client outcomes in a defined time frame. These critical pathways guide the team through the client's course of therapy, indicating key events that must occur each day in order to achieve an appropriate length of stay. Case management also allocates and coordinates services for individuals who cannot manage their own care or cannot negotiate the health system.

STANDARDS OF CARE AND STANDARDS OF PROFESSIONAL PERFORMANCE

Professional nurses, as well as all health care professionals, are being held more accountable for their actions. This change is translating into more emphasis on adherence to standards of care. The **standard of care** is the accepted action expected of an individual of a certain skill or knowledge level. It is considered the minimal level of functioning and what a reasonable and prudent person would do in a similar situation. Standards are a tool for determining if the care provided was adequate or negligent (less than adequate). Professional standards are derived from regulatory agencies, nursing practice acts, professional nursing organizations, and state or federal laws. Additionally, they come from scientific literature, which is typically research-based or evidence-based, and from health care institutions' policies and procedures. Standards are used not only to evaluate the effectiveness of nursing care provided, but also are used in litigation as a legal yardstick to determine if care can be considered acceptable nursing practice.

Specific standards of care and professional performance have been developed for pediatric clinical nursing practice by the American Nurses Association (ANA) and the Society of Pediatric Nurses (SPN). Other standards of practice have been developed by pediatric nursing specialty groups, such as oncology and emergency nursing.

MEETING THE CHALLENGES OF THE 21ST CENTURY

Child health care has changed considerably over the past 20 years. Health care systems were previously focused on the treatment of disease. Health care personnel placed a greater emphasis on treating disease while neglecting early detection and treatment of illness as well as health promotion and maintenance. Disease treatment usually involved invasive procedures through medical technology in acute care settings, a costly approach. Financing and reorganization of services has changed to a managed care system. With managed care, the traditional physician-oriented focus has shifted to a payer-oriented focus emphasizing health promotion, disease prevention, and cost containment. Cost cutting in health care institutions is currently pervasive in the market-driven system of the United States, resulting in a move from inpatient acute care to more ambulatory and community-based care. Health promotion has always been an area of strength for nursing practice. Nurses are in an excellent position to be leaders in today's health care market. Additional major shifts have occurred in providing health care, including:

- Children in inpatient facilities having conditions that are more acute
- Shorter length of stay in these facilities
- Increased incidence of chronic illnesses
- Constraints on delivery of care, including reduced human and material resources
- Advances in telecommunications and information technology

These changes in the health care delivery system have resulted in unprecedented challenges for nurses who care for children and their families.

IN THE REAL WORLD

I have been so impressed with the attention paid to the prevention of disease and the promotion of health here at the hospital even though many children have an already existing disease like diabetes. I also have begun to realize that when working with children who have a disease like diabetes, as much if not more attention is directed toward teaching and advocating for the patient and family than toward administering medications and performing other nursing activities. Yes, I know that medical expertise is important, but the teaching from nursing staff and the encouraging of the family to ask questions of the staff and give input regarding what will work for them in managing the disease is so important. Physicians and nurses must realize that patients (and their families) who do not understand how to control their disease will have problems and may return to the hospital for care. Taking the time to answer questions over and over again is so important. Indeed, being an educator and an advocate are important roles for the nurse when working with children and their families.

Broad access to the Internet has made available vast amounts of health information for health care providers as well as for caregivers. The public is becoming so well informed about its health problems that the mystique and, therefore, the power of medical providers is diminishing. Clients are challenging clinicians with information obtained on the Web, and the increasing available health information is changing the nurse's role from health expert to information broker. Pharmaceutical manufacturers are widely advertising benefits of their latest medication, generating additional questions. Yet this information is of variable quality. Nurses caring for children will need to be able to use critical appraisal skills to evaluate health information and to help caregivers interpret it. They can direct families to valid websites, identify reliable sources of information, and teach evaluation skills.

KEY CONCEPTS

- Current societal trends affecting children, their health, and their families include many challenges; among the most persistent in the United States are immigration, poverty, homelessness, migrant farm work, and violence.
- *Healthy People 2010 and 2020* sets forth national health goals and objectives for adults and children, and focuses on disease prevention and health promotion.
- The aggregate health status of infants, children, and adolescents is determined statistically by keeping records of indicators such as infant mortality rate, low birth weight, child mortality rate, and immunization rate.
- The infant mortality rate remains stubbornly high in the United States, and low birth weight is considered the leading cause of infant mortality.
- The leading cause of death in children 1 to 19 years of age is unintentional injuries, with the majority of deaths resulting from motor vehicle occupant injury.
- Family-centered care is based on principles that are designed to promote greater family self-determination, decision-making capabilities, control, and self-efficacy.
- The primary roles of pediatric nurses include caregiver, advocate, educator, researcher, and manager or leader.
- Diversity of pediatric health care settings and a shift in focus of health care from treatment of disease to promotion of health have led to nurses functioning in advanced practice or expanded roles such as pediatric nurse practitioners, clinical nurse specialists, and case managers.

REVIEW ACTIVITIES

1. Describe how poverty affects children.
2. Define infant mortality and child mortality.
3. What can nurses do to prevent firearm-related injuries and deaths in the home, school, and community?
4. Which of the following is the leading cause of death in children under 19 years of age?
   a. Cancer
   b. Heart disease
   c. Congenital anomalies
   d. Unintentional injuries
5. Name a few major health protection measures that have reduced the incidence of childhood mortality.
6. What strategies can nurses include in their practice that relate to family-centered care?
7. Describe each of the roles that nurses take when interacting with children and their families, and explain how they are connected to one another.
8. Define differentiated practice, and describe why it was developed.
9. Discuss the differences between the pediatric nurse practitioner and the pediatric clinical specialist.
10. Describe case management, and discuss why it was developed.

STUDY QUESTIONS

1. Parents and children from immigrant families face several challenges. Which of the statements below related to these children and families is true?
   a. These parents are able to help their children with homework.
   b. These parents have an excellent understanding of the English language.
   c. These children often are not enrolled in preschool programs that prepare them for school.
   d. These children rarely face challenges related to their health status.

2. Children growing up in poverty are affected by their situation in a number of ways. Which one of the following statements is correct?
   a. Children living in a two-parent home are more likely to live in poverty than children growing up in a single-parent home.
   b. Compared with non-poor children, poor children experience diminished physical health, and suffer such ailments as asthma, respiratory infections, and anemia.
   c. Stunted growth (low height for age), a measure of nutritional status, is more prevalent among non-poor than poor children.
   d. A child's poverty status at 3 years of age is not related to the child's IQ at age 5, and transitory poverty has more adverse effects on a child's cognitive functioning than persistent poverty.

3. An increasing number of children and families in all communities in the United States are homeless. Which one of the following statements is true?
   a. Families with children are among the fastest growing subdivision of the homeless population.
   b. Homelessness is rarely seen in suburban and rural areas.
   c. Compared with housed children, homeless youth have a lower incidence of chronic health problems.
   d. Homeless families rarely have difficulty accessing health care and most homeless children receive adequate preventive care including immunizations and well-child services.

4. Which of the following is a true statement related to violence?
   a. Schools need to have violence prevention programs in schools starting at the middle school level, since if presented earlier the children do not have the cognitive ability to understand the message.
   b. Physical fights, thefts, weapon carrying, teacher victimization, and fear of school environments are no longer the issues they once were for children and adolescents.
   c. Risk factors for violence include history of early aggressive behavior, associating with delinquent peers, involvement in gangs, poor academic performance, low commitment to school, or school failure.
   d. It is easier to keep adolescents away from guns than to keep guns away from adolescents.

5. There are several roles pediatric nurses can take in practice. Which of the following statements is true?
   a. Researchers inform clients and families of their rights and options as well as the consequences of those options.
   b. Nurses working with children and families in the advocate role will prepare children and families for procedures, surgery, or the hospitalization experience itself.
   c. Educators identify clinical practice questions needing answers, examine the literature for answers to these questions, and then determine whether or not those answers (interventions) are appropriate for practice.
   d. Caregivers diagnose and monitor patients, administer therapeutic interventions and regimens, ensure quality health care practices, and effectively manage rapidly changing situations.

6. A pediatric nurse fulfills one or several different roles in practice. These roles are described as primary or secondary. Select the secondary role.
   a. advocate
   b. educator
   c. coordinator
   d. caregiver

7. The terminology "accident" has been replaced with "injury, intentional or unintentional" for the purposes of gathering statistics. Select the one answer below which is the primary reason for this change.
   a. "Injury" is easier to chart than "accident."
   b. "Accidents" are the leading cause for mortality or morbidity among the pediatric population.
   c. "Accident" suggests a lack of predictability or avoidability, whereas intentional or unintentional injury suggests avoidance or prevention is possible.
   d. Infectious disease, not accident, is the leading cause of mortality among children today.

8. Several key tactics have been credited as critical in reducing the incidence of unintentional injuries of

children. Which of the following is NOT one of these tactics?
a. using child car seats and bicycle helmets
b. requiring child-resistant caps for prescription medications
c. suggesting that all guns be stored unloaded with bullets in a separate place
d. enclosing swimming pools with fences

9. The health status of children in the United States can be assessed using statistics gathered by public health agencies and organizations around the world. When compared to the developed economies of the world, the United States:
a. has the lowest percentage of children living in poverty.
b. has the lowest infant mortality rate (IMR).
c. has the highest percentage of premature births in the world.
d. has a lower infant mortality rate than Canada or Cuba.

10. In the prevention of unintentional injuries among children, several key strategies have been identified as very important for parent education. Which of the following is NOT one of these strategies?
a. Nurses need to educate caregivers to promote safe behaviors for themselves and their children.
b. Nurses need to educate caregivers about expected behaviors for the child's current developmental stage and the upcoming developmental stage (anticipatory guidance).
c. Nurses need to educate caregivers about making the home environment safer for the child.
d. Nurses need to educate caregivers about making the school environment safer for the child.

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SUGGESTED READINGS

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RESOURCES

Refer to the online student StudyWARE for Potts & Mandleco at http://www.CengageBrain.com for additional content and study aids.

Organization: **Agency for Health Care Research and Quality**
Description: The federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans; offers information on current research, approved surveys/data collection methods, and customer/patient safety policies.
Website/Resource: http://www.ahrq.gov

Organization: **American Academy of Nurse Practitioners**
Description: The only full-service national professional membership organization for NPs; continually advocates at local, state, and federal levels for the recognition of NPs as providers of high-quality, cost-effective, and personalized health care.
Website/Resource: http://www.aanp.org

Organization: **American Academy of Pediatrics**
Description: Offers general information related to child health, specific guidelines concerning many pediatric issues, information regarding AAP programs, activities, policies, guidelines, publications, and other child health resources.
Website/Resource: http://www.aap.org

Organization: **American Nurses Association**
Description: Offers access to information regarding registered nurse career updates, professional nursing practice guidelines, nursing ethnics, current health care policies, government affairs, and occupational environment information.
Website/Resource: http://www.ana.org

Organization: **Annie E. Casey Foundation**
Description: Dedicated to helping build better futures for disadvantaged children, this website offers information regarding Foundation initiatives, child and family services, and publications.
Website/Resource: http://www.aecf.org

Organization: **Case Management Society of America**
Description: Offers information regarding individual/employer/partner case management options; information regarding current policy and local outreach efforts pertaining to case management.
Website/Resource: http://www.cmsa.org

Organization: **Centers for Disease Control and Prevention (CDC)**
Description: Offers information regarding current disease conditions, emergency preparedness/response, life stages/populations, healthy living, workplace environment/health.
Website/Resource: http://www.cdc.gov

Organization: **Children's Defense Fund (CDF)**
Description: A nonprofit child advocacy organization; website offers information regarding CDF's policies and mission, child advocacy resources, and child research data.
Website/Resource: http://www.childrensdefense.org

Organization: **Maternal and Child Health Bureau (MCHB)**
Description: Offers information regarding current MCHB programs, funding opportunities, reports and resources/publications.
Website/Resource: http://mchb.hrsa.gov

Organization: **National Association of Pediatric Nurse Associates and Practitioners (NAPNAP)**
Description: Offers information regarding NAPNAP's mission/efforts, upcoming events, associated programs and access to NAPNAP's online store.
Website/Resource: http://www.napnap.org

Organization: **National Safety Council**
Description: Offers information regarding safe practices at work, home and on the road as well as information concerning current safety news/resources and safety products.
Website/Resource: http://www.nsc.org

Organization: **Office of Juvenile Justice and Delinquency Prevention (OJJDP)**
Description: Offers information regarding OJJDP partnerships/programs, statistics, publications, funding, and events.
Website/Resource: http://ojjdp.ncjrs.org

Organization: **Society of Pediatric Nurses (SPN)**
Description: Offers access to information regarding SPN committees, conventions, chapters, awards/scholarships, and much more.
Website/Resource: http://www.pedsnurses.org

Organization: **The Brady Center to Prevent Handgun Violence**
Description: Offers blogging opportunities as well as general facts and legislation regarding gun violence.
Website/Resource: http://www.bradycenter.org