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The Critical Components of Nursing Care

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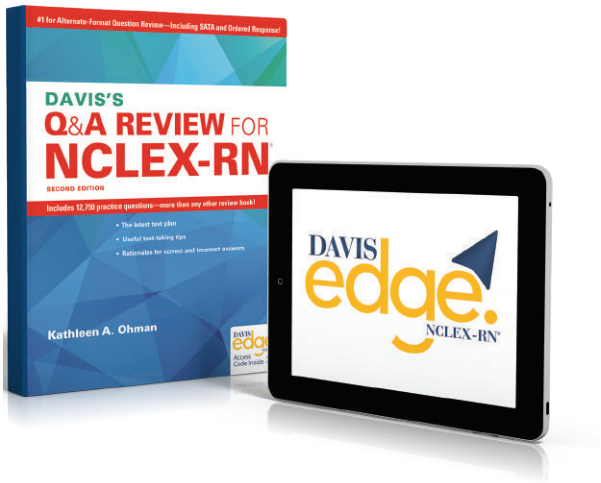

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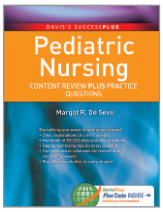

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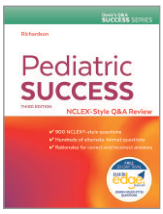

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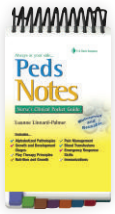

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SECOND EDITION

Pediatric NURSING

The Critical Components of Nursing Care

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To my husband, Daniel Rudd,
and
my mother, Joan Antesberger, for their love and support.
Kathryn Rudd

To my mother, Kathleen Kocisko, for her love,
encouragement, and affirmation.
Diane M. Kocisko

Preface

FOCUS

Pediatric Nursing: The Critical Components of Nursing Care is a pediatric nursing textbook that emphasizes fundamental pediatric nursing content focusing on evidence-based practice. This textbook with its accompanying ancillaries presents pediatric concepts that may be useful for programs designed to present the subject of pediatrics in an abbreviated or condensed manner. It was designed to address the contemporary changes in nursing education and to assist today's student who must juggle work and family responsibilities by providing clear and concise content while maintaining the integrity of the content. Developing knowledge in pediatric nursing is essential to all nurses, regardless of whether they ultimately become pediatric nurses. Our focus is not to have the student memorize terms and data. We want students to learn how to apply the information to the clinical setting. We encourage the use of electronic devices during the learning process. We believe that learning is not memorizing information for a test. Learning is the ability to apply new information to the clinical situation. For this reason, we have included features within each chapter to facilitate the application of information.

Most pediatric texts contain detailed information about every aspect of pediatric care. As pediatric nurses, we have found that this information can quickly become outdated. We revised this textbook based on the recommendations of those who have used it—faculty from across the United States, students in all types of programs, and through our own experiences. Today's technology provides the nurse with the opportunity to look up information within minutes. We included multiple web links to encourage the reader to quickly validate and reference information. We recognize that student nurses must synthesize data from texts and life, laboratory, and clinical experiences to care for children. This text is organized to first present foundational information followed by complex information. Our concise format facilitates teaching pediatric nursing at all licensure levels and within varying time frames. We have updated content to keep current in standards of practice, including new guidelines for blood pressure monitoring, obesity, cultural diversity, growth and development, common childhood illnesses, common medications and treatments for children, safety, preventative care, and end-of-life issues. Professional standards of care for pediatric nursing are also discussed that are based on current practice guidelines and research.

CRITICAL COMPONENTS

Our text is titled *Pediatric Nursing: The Critical Components of Nursing Care* because our aim is to provide the most crucial information in pediatric nursing. This text, although not all-inclusive, does provide the critical components and major areas of knowledge essential for a basic understanding of pediatric nursing that is crucial for students and new pediatric nurses to know. The text is intended for prelicensure students and may be used for pediatric certification preparation. The critical components were derived from the authors' combined 50 years of teaching pediatric nursing in both traditional and accelerated programs, and years of laboratory and clinical practice in a variety of pediatric settings. Current guidelines and standards are integrated and summarized to present not just what is "normal," but to anticipate deviations from the norm. Early detection, especially in children, will lead to early interventions and improved outcomes.

ORGANIZATION

This text uses theory and evidence-based clinical knowledge of pediatric nursing according to systems, but can be easily used in concept-based curriculums. Professional practice, ethical principles, family theories, and cultural aspects of pediatric family-centered nursing are strong features of this edition. The text includes many online references to allow students to get up-to-date information in the rapidly changing landscape of health care. *Pediatric Nursing: The Critical Components of Nursing Care* reflects current knowledge, standards, and trends in pediatric nursing, including census data trends, projected population, and racial changes.

FEATURES

This textbook presents the critical components of pediatrics in a pragmatic, condensed format by using the following features:

- *Bulleted format:* For easy-to-read content
- *Figures, tables, and boxes:* Summarizes information in a visual way
- *Learning Outcomes:* Identifies what the reader will know and be able to do by the end of the chapter
- *Critical Components:* Highlights critical information in pediatric nursing
- *Evidenced-Based Practice:* Highlights current research and practice guidelines related to nursing care
- *Case Studies:* Ties it all together by applying critical components in clinical context
- *Safe and Effective Nursing Care (SENC):* Highlights safe and effective nursing care concepts as they apply to the chapter content
  - *Cultural Competence:* Stresses the importance of cultural factors in nursing care
  - *Understanding Medication:* Highlights commonly administered medications during childhood

- *Promoting Safety:* Focuses on important safety concepts
- *Clinical Pearl:* Provides tips on applying critical thinking in a clinical setting

APPENDICES

The appendices include:

- Asthma Action Plan
- 2018 Recommended Immunization Schedule
- Car Seat Safety
- Growth Charts

RESOURCES AVAILABLE

Instructors will have access to:

- *Active Classroom Instructor's Guide:* Maps resources and activities for an active classroom approach
- *PowerPoints:* Fully customizable slides summarizing key concepts from each chapter
- *Test Bank:* NCLEX®-style questions with rationales for correct and incorrect answers in ExamView Pro
- *Davis Edge + e-book:* Create assignments, track your students' progress, and access the complete text with our online Q&A review platform
- *Image Bank:* Includes all images from the text

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Kathryn Rudd

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Diane Kocisko

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Contents in Brief

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Pediatric Nursing: An Overview

1

Issues and Trends in Pediatric Nursing

Diane M. Kocisko, MSN, RN, CPN
Lillian Kohler, MSN, RN

LEARNING OUTCOMES

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

1. Define *pediatric nursing*.
2. Describe the differences between nursing care of infants, children, and adolescents and care of the adult population.
3. Describe the history of pediatric nursing.
4. Describe the projected racial population changes in the United States.
5. Identify models of care applied to pediatric nursing.
6. Describe the roles of the pediatric nurse.
7. Identify the different fields of pediatric nursing and the education required for each.
8. Identify current issues and trends in pediatric nursing practice, education, and research.
9. Identify evidence-based resources that are available for pediatric nurses.

INTRODUCTION TO PEDIATRIC NURSING

The nursing care of children from birth through adolescence includes health promotion, disease prevention, illness management, and health restoration (Fig. 1–1).

Nursing Care for Children Versus Care for Adults

Pediatric nursing care requires the nurse to use assessment and evaluation tools that are unique to infants, children, and adolescent populations.

- Pediatric nurses must assess attainment of developmental milestones (see Chapter 6).
- Pediatric nurses monitor growth and development, including:
  - Physical maturation
    - Development and mastery of gross and fine motor skills
    - Height, weight, and head circumference, tracked via growth charts that are adapted as needed for specific populations (e.g., Down syndrome)
    - Physical maturation of each body system (see Chapters 8–10)
    - Onset of puberty using the Tanner scale
    - Required immunizations
  - Cognitive maturation (see Chapter 6)
    - Erikson's stages of psychosocial development
    - Piaget's stages of cognitive development
    - Freud's psychosexual stages of development
    - Kohlberg's stages of moral development
    - Language development
    - Presence of learning and developmental disabilities where indicated

CRITICAL COMPONENT

Role of Development

In pediatric nursing, the unit of care is the child and the caregiver(s). Caring for children is not just caring for "little adults." The needs of children will vary by developmental level.

HISTORY OF PEDIATRIC NURSING

Before pediatrics became a specialty, newborns were delivered by midwives and cared for in the home (Fig. 1–2). The first pediatric hospital in the United States was the Children's Hospital of Pennsylvania, founded in 1855. As early hospitals became more industrialized, the following were common practices in infant and child care:

- Nursing care focused on preventing the spread of infectious disease and was often cold and rigid.
- Parents were unable to visit or stay at the bedside of their children, relinquishing all care responsibility to the staff.
- Including the family in the plan of care was believed to be detrimental to patient outcomes.
- The emotional and psychological needs of children were not considered in care planning.

In the late 19th and early 20th centuries, nurses became involved in many public and private health-promotion initiatives, including the care of children (Fig. 1–3). As the field of pediatric nursing progressed, efforts were made to improve nursing education. In 1917, the *Standard Curriculum for Schools of Nursing (Standard Curriculum)* suggested that special educational preparation should occur when training nurses to care for children. The curriculum included content on diseases of infants and children, nutrition and cookery, therapeutics, orthopedics, gynecology, psychology, and ethics, to name a few (Committee on Education of the National League of Nursing Education, 1917). The content covered is similar to the diverse nursing courses that are taught in today's schools of nursing.

FIGURE 1–1 Nurse engaged with a child who requires health care.

FIGURE 1–2 Family in early 1900s. *(Courtesy of D.M. Kocisko)*

FIGURE 1–3 Child from the late 19th century. *(Courtesy of D.M. Kocisko)*

Research conducted in the mid-20th century indicated the negative effects of separating parent from child, resulting in a push toward more family-centered care. The early field of pediatric nursing influenced the later development of advanced practice roles (e.g., neonatal nurse practitioner, pediatric nurse practitioner). Pediatric nurse practitioners were the first nurse practitioners. In the latter half of the 20th century, the nursing profession continued to define itself through:

- Development and publication of professional standards of practice
- Availability of certification programs
- Formation of professional organizations
- Continued nursing research
- Continued educational opportunities

RACIAL MAKEUP OF AMERICAN CHILDREN

The racial population of the United States continues to evolve, which in turn changes the demographics of the pediatric population. It is important for the nurse to identify the illnesses and chronic diseases the child is at risk for acquiring based on his or her cultural and ethnic background. These are the projected demographics for the U.S. pediatric population in 2020 (Federal Interagency Forum on Child and Family Statistics, 2016):

- Less than half of children aged 0 to 17 years will be white non-Hispanic. This is the first time in history that non-Hispanic whites do not account for 50% or more of the population.
- Hispanic children will represent 26% of the pediatric population. This is an increase from 25% in 2015.
- Black, non-Hispanic children will represent 14% of the pediatric population. No change from 2015.
- Asian, non-Hispanic children will represent 5% of the pediatric population. No change from 2015.
- Non-Hispanic children who represent two or more races will reflect 5% of children. This is an increase from 4% in 2015.
- American Indian and Alaska Native, non-Hispanic children will reflect 0.8% of the pediatric population. This is a decrease from 0.9% in 2015.
- Percentage of Native Hawaiian and other Pacific Islander, non-Hispanic children will remain unchanged from 2015 at 0.2%.

MODELS OF CARE IN PEDIATRIC NURSING

Family-centered care, relationship-based care, and pediatric medical home are three models of care for providing nursing care to children. In all models, the importance of the family to the child is emphasized.

- Core concepts of family-centered care include the following:
  - Dignity and respect for the child and family
  - Information sharing with the family
  - Family participation in care, including collaboration in care planning and provision
- Core concepts of relationship-based care include the following:
  - The child and family remain the focal point in the plan of care.
  - The nurse strives to develop a relationship with the child's family members and engages in one-to-one conversations with the child and family on each shift.
  - Care is individualized to meet the specific needs of the child based on issues that arise in these one-to-one conversations with the child and family.
  - All staff members strive to respect, understand, and address the child's and family's concerns.
  - Children and families are actively engaged in all aspects of care, including decision making.
  - Open communication must occur between child, family, and staff.
  - The child's well-being and dignity must be safeguarded in all aspects of communication and care.

Health-care reform has driven development of initiatives to improve population health. Pediatric medical homes provide children with better health outcomes and a better patient experience. This is especially important for children with socioeconomic, racial, and ethnic health disparities.

Core concepts of pediatric medical home-care coordination include:

- Proactive outreach to ensure timely well-child care
- Comprehensive care during vulnerable patient care transitions
- Care coordination, including hospital discharge to primary care
- Referral from primary care to community services for additional nonmedical needs
- Care coordination to enrollment in available home visiting programs (Brown, Perkins, Blust, & Kahn, 2015).

ROLE OF THE PEDIATRIC NURSE

When caring for children and their families, the pediatric nurse must assume several critical roles. He or she:

- Incorporates knowledge of human growth and development when providing care to children
- Recognizes the physiological differences between children and adults
- Provides care in a developmentally appropriate manner to promote the optimal physical, psychological, and social well-being
- Recognizes the integral role of family in a child's health and incorporates the family in the plan of care
- Provides culturally sensitive care by integrating knowledge of cultural and religious practices into the plan of care
- Implements models of care that are specifically applicable to infants, children, and adolescents

Where Pediatric Nurses Work

Pediatric registered nurses with undergraduate preparation work in many settings and capacities. Some of the most common include:

- Acute care—bedside nurse
- Hospital nurse manager (BSN or MSN required for some positions)
- Hospice and palliative care
- Surgical care

- Ambulatory care
- Outpatient care
- Home care
- School nurse
- Camp nurse
- Travel nurse
- Day-care consultant
- Community educator
- Public health nurse
- Research trial coordinator
- School-based health centers

Pediatric nurses with master's degree preparation are often employed in the following settings and capacities:

- Pediatric nurse practitioner (inpatient/outpatient)
- Family nurse practitioner (inpatient/outpatient)
- Neonatal nurse practitioner (inpatient/outpatient)
- Clinical nurse specialist (inpatient)
- Nurse educator (hospital/college or school of nursing)

Pediatric nurses with doctoral preparation may be employed in leadership roles. They develop and implement research programs for hospitals, colleges, or schools of nursing. The focus is more global and directs the paths of evidence-based practice. Many doctoral nurses work in colleges and universities. Many academic settings that teach nursing require instructors to have a nursing doctorate or be actively working to obtain a doctorate degree.

Additional Training and Certification

Pediatric nurses at all levels who wish to further specialize their careers can obtain additional certification in many practice areas. Available programs include:

- Neonatal Resuscitation Program (NRP)
- Pediatric Advanced Life Support (PALS)
- End of Life Nursing Education Consortium—PEDS (see Chapter 5 for more information on death and dying)
- Pediatric nursing certification:
  - Certified Pediatric Emergency Nurse (CPEN)
  - Certified Pediatric Nurse Practitioner (CPNP; acute and primary care)
- Pediatric Primary Care Mental Health Specialists (PMHS through the Pediatric Nursing Certification Board, Inc.)
- Certified Pediatric Oncology Nurse (CPON)
- Neonatal/pediatric and critical care nurse certification (CCRN)
- Maternal Child Nursing RN-BC (American Nurses Credentialing Center)
- S.T.A.B.L.E. Program (post-resuscitation and pretransport stabilization care of sick infants)
- National Certified School Nurse (NCSN through the National Board of Certification of School Nurses)
- Sexual Assault Nurse Examiner (SANE-P through the Forensic Nurse Certification Board)

Additional certifications for advanced practice nurses include:

- Certified Pediatric Nurse Practitioner (CPNP; acute and primary care)
- Certified Neonatal Nurse Practitioner (NNP-BC)
- Certified Clinical Nurse Specialist (CCNS; neonatal or pediatrics)
- Certified Clinical Nurse Specialist (PCNS-BC; pediatrics)

ISSUES IN PEDIATRIC NURSING

Nurses considering a career in pediatrics must become familiar with common issues in this area of health care. In general, there is an expected nursing shortage in the United States due to an aging population and many nurses near the age of retirement (American Association of Colleges of Nursing, 2017). The shortage will impact all areas of nursing, including the subspecialty areas. As a result, many children who need ongoing medical care must remain in a hospital setting longer than necessary while a pediatric home-care nurse is located and trained.

There may also be a lack of nurses who are equipped to carry out research projects in the pediatric population. Ethical considerations in pediatric nursing research impact clinical practice. Children aged 7 years and older can assent (agree) or dissent (disagree) to be in a clinical trial. This means that even if the caregivers want the child in the study and signs the consent, the child can refuse and the researcher will not include the child in the study. Caregivers of infants and children younger than 7 years may be hesitant to participate in a drug study because of the potential risks of injury to the child's vital organs. The caregiver may be more inclined to want the child to receive medications that have been tested in children.

In addition, the lack of research studies using ethnically and culturally diverse participants means that the indications of research results from studies with participants of one ethnic/cultural group are often applied to infants, children, and adolescents of another ethnic/cultural group in clinical practice.

Additional issues in pediatric nursing include the following:

- As the number of chronically ill children continues to increase because of medical advances, continuity of care between hospital, home, and school must improve. Children are now exceeding previous life expectancies for chronic illnesses, but still require ongoing medical management.
- Maintaining communication with families and caregivers has become more challenging with the increased number of divorced parents, blended or reconstituted families, and grandparents as primary caregivers.
- Pediatric nurses must also consider the special issues in working with foster parents, extended families, single-parent families, lesbian/gay/bisexual/transgendered (LGBT) families, cohabitating families, and families with adopted children.

- Ensuring adequate health education and follow-up services for children and families is a primary nursing responsibility that becomes more challenging when working with those with limited health literacy and/or for whom English is a second language.
- As health-care costs continue to increase, families' adherence to recommended therapy and treatments may be negatively affected by having little or no health insurance. Uninsured and underinsured families may be unable to afford follow-up care.

TRENDS IN PEDIATRIC NURSING PRACTICE

Pediatric nurses should be aware of existing trends in this area of practice and consider how these factors impact their roles and responsibilities. These include:

- Increased numbers of children who require mental health services
- Increased numbers of children becoming ill because of antibiotic-resistant organisms
- Increased usage of blood conservation techniques for hospitalized children
- Increased emphasis on provision of safety education (e.g., internet safety, dealing with bullying)
- Increased admissions based on environmental risk factors, such as dangerous living environments, unstable households, and risky behaviors
- Increased admissions based on deficient knowledge base of caregivers, such as not following or understanding the treatment regimen
- Increased admissions based on lack of primary care access
- Earlier onset of puberty and its ramifications for adolescent sexual health
- Shift in the focus of medical/nursing care from disease treatment to health promotion and disease prevention
- Provision of health education in the school system
- Increased incorporation of families in the overall care of children
- Increased numbers of children who require home care
- Increased prevalence of autism spectrum disorders and childhood depression, requiring more education and research in these areas
- Increased childhood incidence of:
  - Obesity
  - Hypertension
  - Diabetes
  - Asthma
- Increase in children and adolescents who identify as transgender

The prevalence of obesity among adolescents has doubled since the 1990s, increasing from approximately 10% (in 1990) to 20% in 2014 (Federal Interagency Forum on Child and Family Statistics, 2016). Childhood obesity can be difficult to overcome in adulthood. Obese children are at increased risk for poor health outcomes, including diabetes, stroke, heart disease, arthritis, and certain cancers. Hypertension, early puberty, and asthma often result from adolescent obesity. The psychosocial impact can also be significant and include issues such as impaired body image, decreased self-esteem, and eating disorders (see Chapter 14). Pediatric caregivers have an opportunity and responsibility to promote health and wellness in the obese population by:

- Promoting the intake of healthy foods and avoidance of unhealthy foods
- Promoting physical activity and reducing sedentary behaviors in individuals and families
- Providing guidance and support for healthy diet, sleep, and physical activity
- Promoting healthy school environments, health and nutrition literacy, and physical activity in school-aged children and adolescents
- Providing family-based, multicomponent weight-management services for obese and overweight children (Pizzi, 2016).

Lesbian, Gay, Bisexual, and Transgender Youth

Although individuals are born with a biological sex, this is separate from gender identity—the awareness and sense of oneself as male or female that develops in early childhood. Transgender is a term used to describe individuals whose gender identity differs from their biological sex.

Pediatric caregivers have an opportunity and responsibility to promote health and wellness in individuals with gender discrepancy by:

- Protecting the health, well-being, and civil rights of transgender children and adolescents in society
- Providing nondiscriminatory care with equal treatment
- Providing inclusive care that prevents feelings of isolation
- Assessing risk factors for depression, suicidal thoughts and behaviors, and substance abuse
- Assessing, educating, and supporting youth who are at risk for or experiencing bullying, violence, victimization, or discrimination
- Supporting and educating children and families on gender identity and transgender youth (National Association of Pediatric Nurse Practitioners, n.d.)
- Providing anticipatory guidance to specialized care
- Supporting healthy emotional development
- Providing comprehensive, inclusive sexual education, including HIV prevention and treatment options
- Providing gender-affirming care to transgender youth
- Following evidence-based best practice guidelines for LGBT youth
- Considering interpersonal and structural stigma that may impact equity in health-care resources, training, and competencies (Adelson, Dowshen, Makadon, & Garofalo, 2016).

Nonheterosexual orientations and nonconformity in gender expression are not new concepts, but they are more visible in

society than ever before. Competence in caring for LGBT youth and their families' unique needs must be a core skill provided by pediatric caregivers.

TRENDS IN PEDIATRIC NURSING EDUCATION

As pediatric nursing practice and patient population evolves, education programs for aspiring nurses in this realm must keep pace with new initiatives. Some of these include:

- Inclusion of multicultural care topics and family theory in nursing programs
- Incorporation of growth and development concepts into nursing curricula
- Clinical experience in a range of settings, including acute care, community, school, and well care
- Increased focus on health promotion and disease prevention in nursing programs (e.g., screenings and preventive education)
- Increased focus on community-based nursing education through events such as health fairs and public screenings
- Clinical education supplemented with simulation as fewer pediatric clinical sites are available for nursing students (Fig. 1–4)

TRENDS IN PEDIATRIC NURSING RESEARCH

Research initiatives have the potential to improve health outcomes for children worldwide and have a significant impact on pediatric nursing practice. In 2007, the U.S. Congress reauthorized the Best Pharmaceuticals for Children Act, the Pediatric Research Equity Act, and the Pediatric Medical Device Safety and Improvement Act. These laws require that medications, medical devices, and interventions be tested on children if they are intended for use in children. This represents a new direction for research, as children were rarely used as research subjects before the passage of these laws. Because research studies now more frequently involve child participants, interventions will be safer for children because they are no longer based on data from adult response to treatment. For example, more medications are being researched for off-label use. Recently, tiotropium bromide and lurasidone hydrochloride have been approved for pediatric patients by the U.S. Food and Drug Administration (U.S. Department of Health & Human Resources, 2017).

RESOURCES FOR PEDIATRIC HEALTH DATA

The following reliable resources contain valuable pediatric health data for nurses:

- Child Stats
- CDC Wonder
- Data Resource Center for Child and Adolescent Health

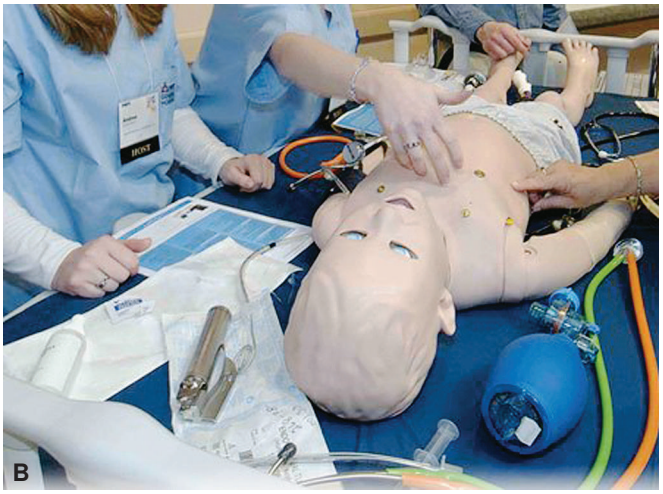

FIGURE 1–4 **A,** Infant and **B**, child patient simulators.

- National Database of Nursing Quality Indicators
- National Children's Study
  - The study is intended to determine how environmental factors influence health and development.
  - Participants in the study will be tracked from birth until age 21 years.

RESOURCES FOR EVIDENCE-BASED PEDIATRIC NURSING PRACTICE

- Pediatric nursing journals:
  - *Journal for Specialists in Pediatric Nursing (Journal of the Society of Pediatric Nurses)*
  - *Journal of Child Health*
  - *Journal of Pediatric Nursing*
  - *Pediatric Nursing*
  - *Journal of Child and Adolescent Psychiatric Nursing*
  - *American Journal of Maternal/Child Nursing* (MCN)

- Online resources for pediatric nursing:
  - American Academy of Pediatrics (AAP). (2008). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* (3rd ed.)
  - Agency for Healthcare Research and Quality (AHRQ) resources:
    - Innovations Exchange, a review of innovations and quality tools
    - Research updates
  - Child Health Care Quality Toolbox
  - U.S. Food and Drug Administration (FDA), information on pediatric pharmaceuticals
  - National Institute of Child Health and Human Development (NICHD)
  - National Institute of Nursing Research
  - Immunization Action Coalition
- Pediatric professional organizations:
  - American Academy of Pediatrics (AAP)
  - Academy of Neonatal Nursing
  - Association of Camp Nurses
  - Association of Child Neurology Nurses
  - Association of Pediatric Hematology/Oncology Nurses
  - National Association of Neonatal Nurses
  - National Association of Pediatric Nurse Practitioners
  - National Association of School Nurses
  - Society of Pediatric Nurses

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Standards of Practice and Ethical Considerations

2

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LEARNING OUTCOMES

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

1. Identify and describe sources of standards of practice relevant to the day-to-day practice of pediatric nurses.
2. Identify and elaborate on the key themes related to pediatric nursing standards of practice.
3. List the six standards of practice and 11 standards of professional performance highlighted in *Pediatric Nursing: Scope and Standards of Practice* (American Nurses Association [ANA], 2015e), and discuss associated measurement criteria.
4. Describe the value and functions of the *Code of Ethics for Nurses* (ANA, 2015c).
5. Identify the nine provisions of the *Code of Ethics for Nurses* and relate them to practical situations encountered in the day-to-day practice of pediatric nursing.
6. Identify ethics controversies commonly encountered in the practice of pediatric nursing, and discuss relevant principles, duties, rights, and virtues.
7. Differentiate consent, permission, and assent, and discuss how promoting the best interests of children in the issue of consent differs from obtaining informed consent from a competent adult.

INTRODUCTION

The care of children and their families requires the application of the nursing process in accordance with accepted standards of practice, professional performance, and ethics. Quality pediatric care is developmentally appropriate, family centered, culturally sensitive, and evidence based. Compassion, advocacy, care coordination, continuity of care, and a holistic approach are additional hallmarks of quality care, and together provide the context for standards that direct the practice of pediatric nurses.

ETHICS IN NURSING PRACTICE

Codes of ethics and standards of practice and professional performance serve as benchmarks of quality and accountability, providing protection for the public and guidance for professionals. Although *Code of Ethics for Nurses With Interpretive Statements* (American Nurses Association [ANA], 2015c) and *Pediatric Nursing: Scope and Standards of Practice* (ANA, 2015e) must be considered primary, the sources of standards relevant to the practice of pediatric nursing are actually many and varied. Table 2–1 provides a representative listing of just a few of these sources.

Familiarity with codes of ethics and standards of practice fosters decisiveness, consistency, empowerment, and accuracy in the practice setting. Pediatric nurses must also develop an understanding of basic principles of ethics and consider the types of ethical dilemmas they will likely encounter in nursing practice, have a process for resolving ethical issues, and know the resources to consult when ethical issues arise.

ANA *Code of Ethics for Nurses*

The *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015c) outlines and elaborates on the values and moral standards

CRITICAL COMPONENT

Public Perception of Nursing

Nursing is a highly trusted profession. As of December 2016, nursing was ranked in first place for the last 13 of 14 years in the annual Gallup survey of professional honesty and ethics. The only time the profession was ranked in second place was following the terrorist attacks of 9/11 in 2001 (see the later "Additional Resources" section for a link to this study). This is largely a testament to the relationships nurses develop with patients and their families, as well as the principles, values, and standards by which they aspire to conduct themselves (Norman, 2016).

that should guide nurses in practice. It is a formal and public declaration of the principles of good conduct expected of members of the profession. The ANA *Code of Ethics for Nurses* can be characterized as:

- A foundation for all we do, serving as a source of guidance for and empowerment of individual nurses and for the profession as a whole
- A covenant between the profession and the patients who nurses serve
- A reflection of key ethics philosophies, principles, rights, duties, and virtues as they apply to interactions with patients, their families, and the broader community, as well as colleagues and other stakeholders in the promotion and facilitation of quality health care
- An evolutionary document that responds to and anticipates a constantly changing health-care delivery environment, emergent scientific knowledge and technological capabilities, the demands of increasingly better-educated and outcome- and quality-focused health-care consumers, and the realities of resource availability

The *Code of Ethics for Nurses* has a relatively short history, and yet has changed significantly over time (Box 2–1). The "legacy and vision" (Ellenchild Pinch & Haddad, 2008) of the Code are instructive, motivating, and deserving of exploration in greater detail than possible here. The Nightingale Pledge (1893), based largely on the Hippocratic Oath, was an early predecessor of today's Code and was often unofficially referred to as the code of ethics for the profession. The first formally sanctioned version of the Code, which included 17 provisions, appeared in 1950. Today, the

TABLE 2–1 Sources of Standards That Inform Pediatric Practice

TYPES AND SOURCES OF STANDARDS		SELECT EXAMPLES
Laws Rules of law Policies Codes of ethics Position statements Professional standards Practice standards Clinical standards Administrative standards	International federal legislation and regulatory agencies	• UN Convention on the Rights of the Child • Department of Health and Human Services (DHHS): *Healthy People 2020* • Food and Drug Administration (FDA) • Centers for Disease Control and Prevention (CDC) • Health Insurance Portability and Accountability Act (HIPAA) • Patient Self-Determination Act (PSDA)
	State and local legislation and regulatory agencies	• Nurse practice acts • State boards of nursing • State pharmacy boards • State chapters of the American Hospital Association (AHA)
	Nongovernmental organizations/ not-for-profits and public advocacy groups	• The Joint Commission (formerly Joint Commission on the Accreditation of Hospitals) • National Association for Children's Hospitals and Related Institutions (NACHRI) • National Association for Children's Hospitals (NACH; NACHRI policy affiliate) • National Institute for Children's Healthcare Quality (NICHQ) • 5 Million Lives Campaign: Institute of Healthcare Improvement (IHI) • Institute for Safe Medication Practices (ISMP) • The Leapfrog Group
	Professional associations	• American Nurses Association (ANA) • Society of Pediatric Nurses (SPN) • National Association of Pediatric Nurse Practitioners (NAPNAP) • National Association of Neonatal Nurses (NANN) • National Association of Neonatal Nurse Practitioners (NANNP) • National Association of School Nurses (NASN) • American Professional Society on the Abuse of Children (APSAC) • American Academy of Pediatrics (AAP)
	Hospitals and other health-care settings	• Institutional review boards that approve and monitor research • Institution-specific policies (clinical and administrative)

CRITICAL COMPONENT

The Code of Ethics: A Source of Nursing Character and Strength

The ANA *Code of Ethics for Nurses* is so fundamental to our practice and so richly developed that every nurse should own and periodically reread a copy. The Code takes on new meaning as the nurse gains professional experience, so each rereading has the potential to reveal nuances that further enlighten personal practice. The *Code of Ethics for Nurses* serves as a source of both inspiration and professional pride (ANA, 2015c; used with permission).

Code's provisions have been reduced from 17 to 9, and modified in terms of content, emphasis, language, and format.

PEDIATRIC NURSING SCOPE AND STANDARDS OF PRACTICE

Standards are statements that carry varying degrees of authority, impose responsibilities, outline correct processes, identify target outcomes, specify acceptable levels of performance, and/or define desirable professional attributes and qualifications. Other notes about standards include the following:

- A distinction can be made between "standards" and "guidelines," but for the purposes of this chapter, the terms will be used interchangeably.
- Standards may be labeled as such or may be embedded in laws, rules, policies, position statements, and codes of ethics, among other documents (see Table 2–1).
- Many standards of practice and professional performance are derived from and/or reflect principles embodied in codes of ethics. In some instances, to separate discussions of standards from discussions of ethics is to draw an artificial distinction.

Primary Source of Standards

Although far from the only source of standards of practice for nurses who care for children and their families, the ANA publication *Pediatric Nursing: Scope and Standards of Practice*, 3rd ed. (2015d) is a definitive and primary source. This compilation of standards results from a collaborative effort between the National Association of Pediatric Nurse Practitioners, the Society of Pediatric Nursing, and the ANA to modify and unify previously distinct documents. The revised version specifies 6 standards of practice and 11 standards of professional performance (Box 2–2), elaborating on both with meaningful measurement criteria. It reflects key themes and trends that impact all pediatric health-care settings, and provides the framework for specific standards to emerge.

The scope and standards of pediatric practice are relevant to both nurse generalists and advanced practice nurses, and should be used in conjunction with *Nursing: Scope and Standards of Practice*, 3rd ed. (ANA, 2015e), *Nursing's Social Policy Statement: The Essence of the Profession* (ANA, 2010), and Population-Focused Nurse Practitioner Competencies (Nurse Practitioner Core Competencies Content, 2013).

BOX 2–1 | The Nine Provisions of the ANA *Code of Ethics for Nurses*

"The Code of Ethics for Nurses was developed as a guide for carrying out nursing responsibilities in a manner consistent with quality in nursing care and the ethical obligations of the profession" (ANA, 2015b, para. 1). This code is nonnegotiable.

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The patient's right to self-determination must be upheld. Limitations to self-determination must always be seen as a deviation from the standard of care, justified only when there are no least restrictive means to preserve the rights of others, justified by law, and maintain public safety.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving health-care environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

BOX 2–2 | Pediatric Nursing Standards of Practice and Professional Performance

"The six Standards of Practice describe competent levels of nursing care, as demonstrated by the nursing process, including assessment, diagnosis, outcome identification, planning, implementation, and evaluation" (ANA, 2015e, p. 6). The 11 Standards of Professional Performance describe competent behavior in a professional role that relates to "quality of practice, outcome measurement, education, communication, ethics, collaboration, research and clinical scholarship, resource utilization, leadership, accountability, and advocacy" (ANA, 2015e, p. 7).

Practice

#1 Assessment: The pediatric nurse collects comprehensive data pertinent to the patient's health or the situation.

#2 Diagnosis: The pediatric nurse analyzes the assessment data to determine the diagnoses or health-care issues.

#3 Outcomes identification: The pediatric nurse identifies expected outcomes for a plan of care individualized to the child, family, and the situation.

#4 Planning: The pediatric nurse develops a plan of care that prescribes strategies and alternatives to attain expected outcomes.

#5 Implementation: The pediatric nurse implements the identified plan of care.

- **5a** Coordination of care and case management: The pediatric nurse coordinates care delivery.
- **5b** Health teaching and health promotion, restoration, and maintenance: The pediatric nurse employs strategies to promote health and a safe environment.
- **5c** Consultation: The pediatric nurse provides consultation to health-care providers and others to influence the identified plan of care for children, to enhance the abilities of others to provide health care, and to effect change in the health-care system.
- **5d** Prescriptive authority and treatment: The advanced practice pediatric nurse utilizes prescriptive authority, procedures, referrals, treatments, and therapies in providing care.
- **5e** Referral: The advanced practice pediatric nurse identifies the need for additional care and makes referrals as indicated.

#6 Evaluation: The pediatric nurse evaluates progress toward attainment of outcomes.

Professional Performance

#7 Ethics: The pediatric nurse integrates ethical considerations and processes in all areas of practice.

#8 Education: The pediatric nurse attains knowledge and competency that reflects current nursing practice.

#9 Research, evidence-based practice, and clinical scholarship: The pediatric nurse integrates research findings into practice and, where appropriate, participates in the generation of new knowledge.

#10 Quality of practice: The pediatric nurse systematically enhances the quality and effectiveness of nursing practice.

#11 Communication: The pediatric registered nurse communicates effectively in a variety of formats in all areas of practice.

#12 Leadership: The pediatric nurse provides leadership in the professional practice setting and the profession.

#13 Collaboration: The pediatric nurse collaborates with the child, family, and others in the conduct of nursing practice.

#14 Professional practice evaluation: The pediatric nurse evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules and regulations.

#15 Resource utilization: The pediatric nurse considers factors related to safety, effectiveness, cost and impact on practice in planning and delivering patient care.

#16 Environmental health: The pediatric registered nurse practices in an environmentally safe and healthy manner.

#17 Advocacy: The pediatric nurse is an advocate for the pediatric client and family.

Role of Therapeutic Relationships

In pediatrics, as in other nursing specialties, the relationship formed between the nurse and the patient/family provides the framework for care delivery. Professional boundaries must be respected but can at times be difficult to define. Therapeutic relationships are respectful, caring relationships between the patient, family, and the child's nurse that are bound by ethical and professional boundaries. These relationships are guided by the six Cs: care, compassion, competence, communication, courage, and commitment (Roberts, Fenton, & Barnard, 2015). (see Chapter 3 for details). Therapeutic communication should be mutually positive and acceptable to all stakeholders, and recognize the individualism and uniqueness of the child, family, and health-care situation. Therapeutic relationships include these characteristics:

- Goal-directed
- Mutual respect and trust
- Empathy
- Advocacy
- Avoidance of the extremes of the relationship continuum (i.e., enmeshment and disengagement)
- Resultant empowerment of the patient/family (McAliley, Lambert, Ashenberg, & Dull, 1996)

Enmeshment occurs when the nurse becomes personally involved with the patient and/or the family unit without regard for professional boundaries. Disengagement is a protective measure used by nurses to protect themselves from difficult situations that

may result in patient neglect. Disengagement can also be a professional measure to end the nurse–patient relationship at the conclusion of care.

Therapeutic Relationship Challenges in Pediatric Care Settings

Infants and children are innately vulnerable, and this vulnerability increases when parents or guardians are not present and/or unable to participate in the child's care. This inherent vulnerability may lead the nurse to either distancing or overinvolvement, especially in cases that involve children who are:

- Abused and neglected
- Terminally ill
- Addicted to drugs
- Chronically ill with a condition such as cystic fibrosis, cancer, or sickle cell anemia that leads to repeated hospital admissions
- Tough, street-wise adolescents who challenge everything and everyone
- Children or families who are perceived as noncompliant or nonadherent
- Children of parents diagnosed with borderline personality disorder or other types of mental illness

As in any field of nursing, the cultural background, life experiences, and values of the nurse can result in biases and blind spots—especially when they differ from those of the patient or family. The Safe and Effective Nursing Care: Clinical Pearl box describes potential pitfalls for the pediatric nurse and strategies he or she can use to develop a truly therapeutic patient/family relationship.

Professional Boundaries and Personal Authenticity

Provision 2.4 of the ANA *Code of Ethics for Nurses* acknowledges the challenge of maintaining appropriate professional and personal boundaries while supporting positive outcomes for the patient (ANA, 2015c). Discovering and respecting professional boundaries and the keys to a therapeutic relationship are lifetime pursuits, but very few studies about boundaries provide specifics as to where the boundaries should be drawn.

Policies and rules governing professional boundaries sometimes conflict, making it necessary for the pediatric nurse to use professional judgment and collaborative decision making. It is prudent to articulate a shared concept of what constitutes a therapeutic relationship and to identify explicit guidelines for interactions with patients, families, and colleagues in the workplace. Individuals should commit to holding themselves and their colleagues accountable for maintaining boundaries and revisit agreements as problems arise or staff turnover occurs.

The Roots of Challenging Patient and Family Behaviors

Because of the fiduciary nature of the connection between nurse and client, the nurse bears greater responsibility than the family for promoting and sustaining a therapeutic relationship; however, this does not imply that the patient and family have no responsibility,

SAFE AND EFFECTIVE NURSING CARE: Clinical Pearl

Therapeutic Relations, Family-Centered Care, and Relationship-Based Nursing: A Cautionary Note

The elements of family-centered care and relationship-based nursing are key to quality care, but they are also associated with potential hazards, the avoidance of which requires thoughtful analysis and application of self as the nurse develops a therapeutic alliance. Common issues include the following:

- Some nurses may believe that an interaction or intervention that feels "warm and fuzzy" and makes patients and families happy must be therapeutic and laudable, when in fact, these moments can actually result in boundary violations and staff splitting, create unrealistic expectations of staff on the part of the family, and interfere with achievement of key outcome goals
- Lack of distinction between being a friend and being a friendly professional
- Lack of distinction between being a parent substitute and being a caring, nurturing professional
- Lack of distinction between using good nursing judgment and being prejudiced or judgmental

Recognizing these distinctions and acting accordingly is where some of the "art" of nursing comes into play. This can be particularly challenging in the pediatric setting because of patient vulnerability.

or that the nurse has total control over the outcome. Nurses should avoid the use of labeling and instead use assessment skills to determine the roots of a problematic relationship, which will:

- Reduce the impulse to personalize the patient/family behavior.
- Help the provider maintain compassion.
- Avert a defensive or adversarial response.
- Facilitate identifying and addressing personal contributions to the situation.
- Provide insights regarding appropriate intervention.

Once contributing factors have been identified, the nurse must use judgment with respect to whether the primary focus should be on addressing the underlying factors, more directly addressing the disruptive behaviors, or taking a combined approach (Box 2–3).

FAMILY-CENTERED CARE

Family-centered care recognizes that families are central to the well-being of children and, subsequently, the impact a child's illness may have on the family. This type of care promotes a partnership between patients, families, and health-care professionals to the benefit

SAFE AND EFFECTIVE NURSING CARE: Clinical Pearl

Therapeutic Relations: Sorting Out Boundaries

Nurses must consider boundaries and guidelines regarding:

- Sharing/disclosure of personal information with patients/families
- Accepting gifts from and giving gifts to patients/families
- Loaning money to patients/families
- Offering rides to family members
- Babysitting for or socializing with patients/families outside the workplace
- Assignments and patient contact when a patient or family member is a relative, friend, or acquaintance
- Visiting the patient when he or she is admitted or transferred to another clinical location
- Funeral attendance when patients die

Criteria for Analysis

- What objectives do these actions meet, and whose needs do they serve?
- What are the potential impacts on others?
- How do these actions impact outcome goals?
- How do these activities relate to workplace mission and policies?
- What safeguards must be put in place?
- Would you do the same with or for every patient/family in your care under similar circumstances?
- When nursing judgment suggests the usual standard may or should be ignored, what issues should be considered and who else (if anyone) needs to be involved in the decision?

(ANA, 2015c; McAliley et al., 1996)

of all. The presence and involvement of the family can be as important to the child in some respects as any medication or treatment.

Family may be defined in a variety of ways. Nurses should be prepared to accommodate single-parent families, adoptive families, foster families, blended families, second-generation (grandparenting) families, same-sex partners or marriages, families involving mixed cultures or religions, and other family configurations (see Chapter 3).

Overview of Family-Centered and Family-Focused Strategies

When caring for patients and families, the pediatric nurse should keep in mind family-centered strategies to improve outcomes and build a therapeutic relationship. For example:

- Involve parents in medical rounds, nursing change-of-shift reports, and the child's plan of care.

BOX 2–3 | Potential Contributing Factors to Challenging Family Behaviors

As the nurse cares for children and their families, many factors influence how these children or families respond or cope. Some external factors cannot be controlled by the nurse but affect the health-care environment.

- Anxiety regarding the child's condition/prognosis, unexpected changes in condition, the risks and burdens of treatment, transfers to a new environment
- Guilt over child's condition
- Family is in possession of inadequate information or misinformation
- Fear of loss of control (common among people with professional/leadership backgrounds)
- Unmet expectations (realistic or otherwise)
- Competing work/family/financial worries/concerns
- Altered thought process (mental health, substance abuse)
- Previous bad hospital experience or fears inspired by national focus on hospital errors and hospital-acquired infections
- Conflicting communications from professionals involved in the child's care
- Delays in availability of care/equipment
- Failures/errors of health-care team
- Environmental issues (dirty, lack of parental accommodations and privacy, noisy)
- Staff rude, impatient, slow to respond to need for assistance
- Unreasonably inflexible hospital/unit rules that fail to permit individualized care

- Adapt schedules as possible to suit the patient/family's routines and preferences.
- Implement noise-reduction efforts, including quiet hours and placing cellphones and other devices on vibrate mode.
- Decrease lighting during evening hours.
- Plan periods of "quiet time" when diagnostic and therapeutic intrusions are limited.
- Implement programs that provide free or reduced-cost food for breastfeeding mothers.
- Provide access to refrigerators and the means to prepare and heat food brought from home.
- Provide dedicated family space in patient rooms, and laundry and lounge facilities for rooming-in parents.
- Place signs on doors reminding providers to knock.
- Consider whether family-centered initiatives of other organizations and similar programs could be adopted in your workplace. For example, for more than 35 years Ronald McDonald House Charities has sponsored "Ronald McDonald Family Rooms" that provide free access to a living room environment and host/hostess services. Many hospitals offer their own version of a hospitality center.

- Create staffed "Family Resource Centers" with library and computer services to facilitate access to medical educational information, health-care support groups, and special services.
- Create staffed "Family Learning Centers," where families can learn common procedures such as blood glucose testing and administration of insulin injections. The center should include:
  - Dedicated instructors
  - Formal teaching modules and videos
  - Simulated, hands-on practice with anatomically correct dolls
  - Consistent educational practices
  - Opportunities to develop confidence and competence to perform required care procedures in a low-pressure setting
- Create "Family and Patient Advisory Councils" that permit input into policies, programming, building renovation or design, food services, or other areas.
- Create "Foster Grandparent" or "Special Visitor" programs that provide visitors for children who do not have family members rooming-in or visiting with frequency.

Rewards of Family-Centered Care

The benefits of family-centered care are:

- Enhanced patient and family learning of new information and skills
- Decreased levels of patient and family stress
- Increased likelihood of adherence to plans of care
- Reduced likelihood of medical error
- Improved patient/family sleep and nutrition
- Decreased disruption of normal patient/family routines and responsibilities
- Increased patient and family satisfaction

For additional information about family-centered care, visit the websites of the Institute for Patient- and Family-Centered Care and the Family Voices (see the later "Additional Resources" section for links).

Like nurses, child life specialists are key proponents of family-centered care, and their presence in inpatient settings, clinics, emergency departments, intensive care units, rehabilitation settings, procedural planning, and other areas is of incalculable value. Child life specialists possess expertise in the field of child development, including a 4-year degree in child psychology or a related field. After 480 hours of field experience, they are eligible to take an examination to achieve Child Life Specialist Certification from the Child Life Council. They promote effective coping, ongoing development, and normalization for children and families by:

- Preparing children and families for and supporting them through procedures
- Providing therapeutic play and self-expression opportunities
- Helping design and maintain child- and family-friendly environments
- Working closely with art and music therapists, and acting as liaisons with hospital- and community-based teachers

DEVELOPMENTALLY APPROPRIATE CARE

Children are not simply mini-adults. They are in the process of developing in the physiological, motor, cognitive, psychosocial, psychosexual, moral, and spiritual realms. In addition to facility with child development, the pediatric nurse must also recognize that families go through stages of development. (See Chapters 3 and 6 for overviews of family and child development theories.) A complex interplay of genetic, experiential, and environmental factors influences the developmental course and outcomes of a given child and family. Familiarity with developmental theories, principles, and milestones enables:

- Effective communication and support that maximizes cooperation and minimizes anxiety
- Developmentally appropriate and effective assessments, goals, plan of care, and education
- Safely structured environments, routines, and procedures
- Facilitation or minimal disruption of ongoing development

Child Development and Pain Management

Prompt and effective pain management is an absolute moral imperative, and there are definite developmental implications for the assessment and management of discomfort in children. Children differ from adults in physiological responses to pain; ability to describe, localize, and quantify pain; and tolerance of and response to medications.

Many tested tools are available for assessing the need for and response to pain management interventions in children of different ages or stages of development (see Table 2–2). Assessment tools can be classified as behavioral observation scales (infants) or self-report rating scales (young child through adult).

Infant behavioral scales rely on specifically defined indicators, such as vital signs, need for oxygen, breathing patterns, facial expressions, presence and nature of crying, and movement of extremities (Hamil, Lyndon, Liley, & Hill, 2014). Use of infant behavior observation tools requires staff training and achievement of interobserver reliability, which means similar results are obtained by different observers.

Self-report rating scales necessitate preliminary teaching with the child and family, and assessment of the child's readiness to use a specific tool. These scales may require a child to:

- Point to drawings or photos of facial expressions reflecting varying degrees of pain.
- Pick up a number of poker chips that correlates with the amount of pain.
- Point to a spot on a visual scale that is associated with a number (usually 0 to 10) and/or words that describe pain feelings.

Success in using the self-report rating scales necessitates preliminary teaching with the child and family, and assessment of the

TABLE 2–2 Overview of Select Pain Assessment Scales

BEHAVIORAL AND PHYSICAL INDICATOR SCALES

PIPP: Premature Infant Pain Profile (Stevens, Johnston, Taddio, Gibbins, & Yamada, 2010)	**NIPS:** Neonatal Infant Pain Scale (Srouji, Ratnapalan, & Schneeweiss, 2010)	**CRIES** (Krechel & Bildner, 1995)	**FLACC** (Voepel-Lewis, Zanotti, Dommeyer, & Merkel, 2010)
Neonates (28–40 weeks of gestation)	Preterm and full-term neonates	Preterm and full-term neonates	2 months to 7 years of age
0–3 points each for gestational age, behavioral state, heart rate, O_2 saturation, brow bulge, eye squeeze, nasolabial furrow	0–1 (2 for cry) points each for facial expression, cry, breathing patterns, arm movements, leg movements, state of arousal	0–2 points each for **c**ry, **r**equires O_2, **i**ncreased vital signs, **e**xpression, **s**leeplessness	1–3 points each for **f**ace, **l**egs, **a**ctivity, **c**ry, **c**onsolability

SELF-REPORT SCALES

FACES (Witt, Coynor, Edwards, & Bradshaw, 2016)	**Oucher** (Beyer, 2009)	**VAS: Visual Analogue Scales (variety of scales and descriptors)**	**Adolescent Pediatric Pain Tool** (multidimensional) (Savedra & Crandall, 2005)
3 years through adolescence	3 years and older	6 years and older	8–17 years
Six line drawings of faces with expressions from happy to neutral to crying, each associated with a number from 1 to 6	Series of photographs of facial expressions from neutral to crying (Caucasian, Hispanic, African American, First Nation, Asian) associated with ratings of 0 to 10	Horizontal or vertical line with linguistic pain descriptors and equidistant markings associated with numbers (usually 0–10)	Body outline (draw location of pain); word-graphic scale (mark on a line closest to the intensity descriptor); word list (circle the sensory, affective, and evaluative words that apply)

child's readiness to use a specific tool. Growth and developmental status also influence choice of pharmacological and/or nonpharmacological pain management techniques:

- In the first few months of life, nonnutritive sucking and/or the administration of small amounts of 24% sucrose solution have been demonstrated to effectively reduce physiological and behavioral responses to pain and hasten the recovery from simple procedural pain.
- Distraction (e.g., toys, television, video games) can work to some extent with children of almost all ages who are experiencing pain at the lower end of the pain scales.
- Hypnotherapy, biofeedback, and other complementary and alternative treatment approaches may be suitable for children able to follow instructions and use their imaginations.

Medication dosages are calculated based on weight or body surface area, and formulations of oral medications depend on the child's ability to swallow pills versus liquid. Most children's pain medications are flavored to increase acceptance, but some may need to be disguised further (American Academy of Pediatrics, Committee on Fetus and Newborn, 2006; Butchelor & Marriott, 2013; Ivanovska, Rademaker, vanDijk, & Mantel-Teeuwisse, 2014; Lopez, Ernest, Tuleu, & Gul, 2015).

Patient and Family Education

The nurse provides children and their families with learning opportunities related to health maintenance and promotion, illness and injury management, and decision making and coping. In the role of patient educator, the nurse is responsible for:

- Assessing learning preference styles with guidance from parents when possible
- Assessing learning readiness (interest and motivation; freedom from pain, anxiety, distractions)
- Provision of accurate, useful information that is developmentally appropriate and culturally sensitive, as well as tailored to individual needs
- Assessment of information understanding and retention, as well as the need for reinforcement and/or additional education
- Documentation of the above

Children are active learners and should be provided with developmentally appropriate and culturally sensitive health-care education materials such as videos, comic books, drawings, reader-friendly diagrams, computer-assisted learning, and hands-on experience with anatomically correct dolls and actual materials and equipment.

Evidence-Based Practice: Adult Literacy and Readability of Health-Care Education

Healthy People. (2017). Health communication and health information technology. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology

Healthy People 2020 identified health literacy as one of its core objectives. In 2017, the Centers for Disease Control and Prevention (CDC) estimated that 90 million adults have low health literacy (CDC, 2017). In 2011, 64.1% of people aged 18 years and older reported that instructions from health-care providers were easy to understand (Healthy People, 2017).

Objectives of *Healthy People 2020* include:

- Improving the health literacy of the population
- Increasing the proportion of patients who indicate that communication with health-care providers was satisfactory
- Increasing the proportion of patients who use electronic health management tools
- Increasing individual internet access
- Increasing the number of quality health-related websites
- Increased social marketing in health promotion and disease prevention
- Increased crisis and emergency risk messages to protect the public health (CDC, 2017)

Background

Multiple studies have demonstrated a correlation between low literacy and poor health-care behaviors and outcomes, such as frequent emergency care visits and hospital admissions, decreased compliance with medications, improper use of metered-dose inhalers, incorrect installation of infant car seats, failure to seek screening and later diagnosis of cancer, and poorer glycemic control, to name just a few examples (CDC, 2017).

According to the CDC, health literacy is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (CDC, 2016, para. 1)

Recommendations

- Health education materials intended for *adults* should be created at a reading level no higher than eighth grade, although most are written at a more difficult level.
- Try the SMOG (Simple Measure of Gobbledygook) approach to assess and adjust readability. Details on this method and a SMOG calculator are available through a website belonging to its originator, Harry McLaughlin (see the later "Additional Resources" section for the link.)

Child Development, Privacy, and Confidentiality

Privacy and confidentiality are related but distinct concepts that must be addressed from a developmental perspective, because both give rise to challenges of an ethical nature in the pediatric setting. Standards require increasing respect for the needs for privacy and confidentiality as children get older. With maturity, minors become increasingly more involved in providing their own medical history and begin to approach health-care professionals with their own agendas.

Older children cannot be expected to provide reliable information or request education or services with respect to sensitive subjects if not provided with privacy and some assurance of confidentiality. Such sensitive subjects include:

- Family violence
- Substance use/abuse
- Depression and suicidal thoughts
- Struggles with weight or eating disorders
- Gender identity issues and sexual activity

Privacy measures must also be taken with respect to the physical examination, and the older child or adolescent may request confidentiality of some clinical findings and even diagnoses.

Conflicting Duties to Child and Parents

Respecting the privacy and confidentiality of pediatric patients may create some tension for nurses when they experience a sense of conflict with between duties owed to the child and those owed to the parent. Parents must instill values and provide for the health and safety of the child, which can be difficult to do if they have limited information. The pediatric nurse must educate parents and older children and adolescents about privacy and confidentiality. Education in this area supports the child in developing identity and autonomy through the protection of that child's privacy.

It is also important to specify practical limitations and legal exceptions. Although pediatric nurses should encourage frank and open discussion about sensitive matters between adolescents and their parents, they must also be aware that sometimes such discussions will not happen, and, in select cases, that honest discussion could be dangerous for the child. When unable to convince the child to disclose to parents or provide consent to do so on his or her behalf, confidentiality will be maintained to the degree that is practical and legal. Even though information may sometimes be withheld from parents, the professional should not lie on behalf of the child.

Practical Limitations and Legal Exceptions Regarding Confidentiality

Practical considerations may preclude confidentiality. These include:

- Parental right to access medical records: Although some confidential information may be omitted by the nurse when documenting histories and examinations, other sensitive information must be documented to justify care given, direct the care of others, record responses to treatment, or as required by law or professional standard.
- Parental financial responsibility: Parents are not obligated to pay for nonemergency care for which they did not provide consent. This is a major practical barrier to confidentiality for minors without access to a free clinic or funds to pay for treatment. When insurance is used, parents may receive billing information that discloses the nature of the visit/condition.

- Mandatory pregnancy testing: Some important diagnostic procedures and treatments or medications require pregnancy testing and may have to be withheld or significantly modified if the test results are positive. Adolescents and their parents must be informed of the need for the pregnancy testing and told what will be done with the results before the test is performed.

In certain circumstances, the health-care provider is required by law to break confidentiality. Professionals have legal and moral obligations to disclose "reasonable concerns" that a child may intentionally harm himself or herself or another person, as well as suspicions that the child may be the victim of any form of abuse. The child should be given the option to participate in telling his or her parents if that is the professional's intended course of action. Health-care providers should anticipate, prepare the child for, and help mitigate potential fallout from disclosure to family.

In the case of suspected abuse, a report must be made to a child protective services agency and/or to law enforcement (depending on local requirements). There is no need to have proof when reporting suspicions, and the individual who is making the report is immune from liability regardless of the investigation's outcome if it can be shown that the report was made in good faith and not frivolously or maliciously. If it is workplace policy that such reports are filed by a social worker, the nurse must confirm that the patient's record contains documentation of the report, thus fulfilling his or her obligation as a mandated reporter.

SAFE AND EFFECTIVE NURSING CARE: Clinical Pearl

Source of Information Regarding State Parental Consent Requirements

The Alan Guttmacher Institute is a research, policy analysis, and public education organization with the stated aim of advancing sexual and reproductive health on a worldwide basis. Regularly updated state-by-state summaries of adolescent consent regulations are available through its website, along with fact sheets, research articles, policy updates, media kits, slide shows, and other educational aids. Materials for and about adolescents are available. (See the later "Additional Resources" section for link.)

Use of Chaperones

Although their presence can be viewed as a barrier to privacy and confidentiality, an offer of a medical chaperone is highly advisable under potentially sensitive circumstances such as the following:

- Any examination or procedure involving exposure and/or touching of breasts or anal-genital areas
- Examinations involving children/parents known to be anxious, suspicious, seductive, mentally or cognitively impaired, and/or litigious
- A medical history that requires detailed questions of a sensitive nature that could be misinterpreted as inappropriate by the patient (e.g., a history specific to sexual abuse)

Chaperones are an equally wise precaution for nurses as for physicians because they afford protection for both the patient and the professional regardless of whether they are of the same sex or opposite sex. Parents make effective chaperones in most cases with infants and young children, but are often not acceptable to older children and adolescents for privacy reasons. Chaperones must be aware of the responsibility to witness safe and appropriate care delivery, and to maintain privacy and confidentiality. The presence and identity of the chaperone should be documented in the medical record. The patient/family and chaperone should receive a full explanation of the nature and purpose of the examination or procedure so that surprises, misperceptions, and charges of impropriety are less likely. They should also be informed that the same confidentiality safeguards apply to the chaperone as to the examining physician/nurse.

If the offer of a chaperone is declined, the professional should use judgment as to whether the examination/procedure should take place without one or be canceled or deferred to someone else. When possible, the wishes of the patient/family should be honored. The offer and the refusal should be documented.

SAFE AND EFFECTIVE NURSING CARE: Clinical Pearl

Child Development and Health-Care Decision Making

The extent and manner to which children of various ages can be involved in their own medical decision making is the source of abundant ethical controversies in clinical settings. The concepts, principles, and legalities involved in these issues deserve serious attention. Nurse familiarity with bioethics basics is valuable.

Confidentiality and the Health Insurance Portability and Accountability Act of 1996

Among other provisions, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires standards for electronic health-care transactions and mandates the security and privacy of personal health information.

HIPAA imposes obligations with respect to how we dispose of personal health information, shield information on computer screens from the view of others, and afford privacy when registering a patient at a desk in a public lobby or when obtaining a medical history; what we talk about in hospital elevators and hospital cafeterias; and how and where we give change-of-shift nursing reports and make patient rounds.

HIPAA has implications for policies about what we can do and say in front of grandparents who are visiting, how we respond to a telephone caller claiming to be a parent, what we do when a patient asks for an update regarding another patient with whom he or she is friendly and shares information, and how we protect parts of the record the patient wishes to remain confidential.