APPLETON PATIENT EDUCATION SERIES

Pediatric Care: A Guide for Patient Education

Susan E. Parker

Pediatric Care: A Guide for Patient Education

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Norwalk, Connecticut

The information contained in this book should be viewed as a guide. The author recommends that the reader obtain the necessary and appropriate administrative and/or medical guidance before implementing the systems or before using the teaching aids provided.

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Introduction to the Patient Education Series

A great deal of development has occurred in patient education in the last decade. Programs are much more widespread; valuable experience has been gained in applying general educational theory and practice in many areas of clinical practice.

It seemed propitious to reflect that development in a series of books aimed at sharing the emerging body of knowledge gained by practitioners in specialized fields. The authors are pioneers in developing practical tools to evaluate and document patient learning. The emphasis is on clinical usability, focusing on patient assessment for desired behavior, educational interventions, evaluation and outcome criteria, and recording. Also in the series is a book on issues and concepts in patient education with an abbreviated review of teaching, learning and motivation theory, and a focus on issues I perceive to be important in the development of the field. A second book focuses on examples of strategies for institutional change and of systems for delivery of patient education. Strategies of this kind have been very important in dealing with systems that have been resistant and unresponsive to incorporation of patient education into practice.

Producing the series has been educative for those involved. By history and tradition, patient education has been better developed conceptually and more completely accepted and incorporated into some clinical areas than into others. One realizes that this has sometimes occurred because of patterns of delivery of services and because of the predominant medical approaches to problems, and not necessarily on the basis of patient need and ability to profit from education. I hope that the series helps to identify areas needing development and that the imaginative clinicians with whom we are blessed will find the ideas of use in further maturation of the field.

It is important not to underestimate the significance of the patient education movement. Along with other related practices and philosophies, it reflects a very basic change in the standard of care and in the relationship between providers and clients. Like all basic changes, its processes for development are sometimes agonizingly slow and are conglomerations of rational and political processes, and its structures are

often loosely coupled and disconnected. However, the movement does reflect the commitment of many lay people and professionals who believe patient education yields more humane care and is also effective as a treatment modality.

A word must be said about the contribution to the series of Leslie Boyer at Appleton-Century-Crofts. The series was her idea, and she was a major partner in its development at every stage.

BARBARA KLUG REDMAN
Washington, D.C.

Preface

Nurses have an important role in teaching health principles to children. It is important that children learn the necessary concepts for maintaining wellness and that, when illness strikes, the nurse can be trusted to give factual and truthful information to help the child cope with new or altered situations.

Working with children, whether they are well or ill, implies working with the family. Much of the nurse's teaching in pediatrics is directed toward the parents or others, who care for the child on a daily basis. These "significant others" need to understand the child's health problem, how to care for him during an acute illness, and/or how to modify the home environment to provide the healthiest possible approach to living.

Although we recognize the essential part of parent education in pediatric nursing, emphasis will be on giving the nurse useful guidelines for working directly with children from the preschool age through adolescence. We as nurses still fail to adequately teach children all that they have a right to know and a need to understand when they enter the health care system. Often explanations of diagnoses, procedures, and treatments are given in detail to parents while the frightened child about to be admitted to the hospital stands by trying to understand what is actually about to happen. Too often, a child is taken for a checkup and is not properly prepared. The child admitted for "minor" surgery does not always receive enough information to aid in coping with a myriad of new experiences. A child may be fascinated or frightened by all the new equipment that can be seen in the hospital. The equipment may never be used or needed by or for the child, yet he has a vivid imagination, which can turn equipment into good or bad robots and machines that help or destroy little people.

We would be doing a disservice to both the child and his family if we were to separate the needs of the child from those of the family. To concentrate on only one avenue of education, with the expectation that positive results would follow, is a futile attempt. However, much more has been written in nursing literature about teaching the parents than teaching the child—whether it be about normal growth and developmental stages, such as toilet training and sexual development, or about understanding and coping with the demands of a chronic illness. All too

often, the nurse working directly with a pediatric client must rely on her own intuition and sense of the child's needs and understandings to guide her in this teaching–learning process. In fact, many times it is easier for the nurse *not* to deal directly with the child, especially when it involves a life-threatening problem.

This book presents an overview of normal growth and development, how children learn at different stages of development, and how to develop, implement, and evaluate a useful teaching plan. This basic information is then applied to limited examples of teaching the well child, the acutely ill, hospitalized child, and the child with a chronic illness. Examples of teaching tools, needs related to specific illnesses, and needs of children at various levels of development are presented. These examples are meant to be illustrative and helpful to the reader. It is hoped that they will also stimulate new and more creative ideas.

Because of the complicated teaching–learning problems of children with mental retardation or severe brain damage and the limitations of this book, materials will be limited to the task of teaching the child with normal intellectual and physical growth and development.

Acknowledgments

Writing and completing a text or book is not the sole effort of one person, rather it is the culmination of a person's life-experiences—many of which are greatly influenced by a host of others. I wish to thank these special influential people: my family, friends, neighbors, and colleagues who have provided support, enthusiastic prodding, and encouragement for my efforts to move forward, developing new ideas and endeavors over the past years. The words of encouragement and support, especially in terms of time freely given to provide that support, are treasures that have not only sustained me through the short-term difficulties, but will remain with me for years to come.

Special thanks are due my children, who had to compromise their time and desires to allow for my "pushing the pencil." Special thanks also to my extended family for their concern and encouragement. I wish to thank my chairperson, Dr. Katherine Nuckolls, Department of Primary Care of the School of Nursing, University of North Carolina; Elizabeth Tournquist, for her assistance with the "writing process;" and Shirley Mason, who has not only shared many work–related experiences, but has been a warm, supportive friend.

A note of thanks is extended to all the contributors who so patiently provided or developed teaching care plans. Thanks also to North Carolina Memorial Hospital for granting permission to reprint some of their existing teaching plans.

To my students, who have given permission to share their creative teaching plans, especially Sandy Sleeman, pincer grasp board; Donna Renee Sink, good health game; Marsha Coggins, Miss May Credé; Marsha Coggins and Beverly Harrell, Mildred the Midget; Gabriella Bergen, block printing; and Dotty Jo Martin, the space ship for range of motion exercises, I am very grateful. Thanks also to our photographer, Bud Bynum.

It is with deep appreciation that I thank Leslie Boyer for initiating this teaching series and Richard Lampert for encouragement and positive feedback for the completion of this task.

Finally, a special thanks to the typists who worked on or completed the manuscripts (with smiles no less): Gilda Stanley, Joan Holt, and Doris Arvin.

SUSAN E. PARKER

Pediatric Care

Contents

PART I

THE CHILD AND HEALTH TEACHING

This section takes into consideration some of the prerequisites essential for the successful planning of health teaching for children. Children are not small adults; their experiences are limited and their tasks in development differ at different times in their lives. Thus, it is important here to include growth and development, play, culture, and the developing of teaching plans or protocols for children.

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OVERVIEW OF GROWTH AND DEVELOPMENT

COGNITIVE, EMOTIONAL, SOCIAL DEVELOPMENT, AND THE IMPLICATIONS FOR HEALTH TEACHING

Nancy M. Hunter, Susan E. Parker

INTRODUCTION

Health teaching for children can occur in a multitude of settings: the classroom, doctor's office, clinic, home, or hospital. Teaching in community settings may focus on the prevention of diseases or the maintenance of wellness; information on the healing process may be covered in the acute care setting; and rehabilitative aspects of chronic illnesses and principles of management of chronic disorders may be taught in any of these settings.

Nurses and other health care providers, who care for children and prepare plans for health teaching, need a sound understanding of normal growth and development. Teaching must be based not only on individual needs and motivation, but also on the cognitive, emotional, and social development of the individual. Although there are childhood characteristics of each stage of development (preschool, school age, preadolescent, adolescent), there are also certain characteristics of the child for each year within these stages. Teaching must be appropriate to the child's developmental age, which may differ from his chronologic age. Although developmental stages may vary depending on culture, environment, and experiences, all children progress through predictable stages in a predictable order. In order to individualize teaching it is helpful to have guidelines for the behaviors of each stage.

This chapter gives an overview of the "norms" for each stage of development, beginning with the preschooler and going through adolescence. Because of the complex and specialized needs of the infant and toddler, the book does not cover these two age groups. Considerations for health teaching and the areas to teach are covered in each stage, with appropriate emphasis on play. Because play is so important, it will be discussed in depth in the chapter, "Play in Relation to Health Teaching." The reader is encouraged to refer to Appendix A for a quick reference to the developmental theories of Erickson, Freud, and

Piaget, and to the bibliography for further details on normal growth and development.

PRESCHOOL (THREE TO SIX YEARS)

COGNITIVE DEVELOPMENT

The preschooler is egocentric in his thinking. He will readily give his point of view on any topic, believing that everyone else has the same viewpoint. He cannot understand another's point of view. Piaget describes the preschool child's reasoning as neither inductive nor deductive but "transductive," which means that the child reasons from particular to particular. One aspect of a situation will stand out or be remembered rather than the whole. For example, when an aunt visits her niece in a hospital she brings a doll; the child reasons that when her aunt visits she will get presents.

The child is able to think of only one thing at a time, a concept known as "centration." Parts are seen separately rather than as a whole, as is evident when the preschooler draws pictures of his body. The child will draw a man with only three to five parts, focusing on the face and extremities, but not including details. The three- to four-year old is in the preoperational stage according to Piaget. Mental functions are limited to what can be seen, and objects and events are interpreted in terms that are significant to the child's own individual use. The child's thinking processes have not yet achieved the level of what Piaget calls "reversability and conservation." That is, the child may think something through from beginning to end, but cannot reverse the process. He cannot understand that mass can be changed and yet be the same; for example, he cannot realize that one cup of liquid water is the same as one cup of frozen water (ice).

In the intuitive period, which according to Piaget extends from approximately four-and-a-half to seven years of age, thinking is dominated by immediate perceptions. Logical explanations for certain types of events cannot be comprehended; for example, the child thinks the sun moves because he moves, or that anyone with a white coat and white pants is a doctor. Even simple relations are confusing. He thinks that people (adults, parents, or himself) make everything happen. If the event is not caused by a person, it is caused by a supernatural power. He sees intention and purpose in everything and yet cannot comprehend accidents or natural phenomena (floods, fire). If he is hospitalized and receives injections, he feels that it is because of some wrongdoing on his part. However, the child's opinions of events may change, or even be contradictory, as his perception (even of an unchanged event) changes.

The inability to derive relationships results in confusion of the meaning of the words "some" and "several," "north" and "south," "left" and "right." The child will define them absolutely but cannot generalize from one situation to another.

Children usually learn to tell time by a clock at seven or eight years old, but

preschoolers' abilities to understand time and age is very limited. Explanations, therefore, need to be within the child's frame of reference. Rather than saying to the hospitalized child, "Your mother will be here at ten o'clock," explain that she might come to visit shortly after breakfast.

Language development is very rapid in the preschool period. The child loves talking and musical toys and will readily imitate new words and phrases. He will ask many questions and talk incessantly whether anyone is listening or not. He can follow simple commands, carry out simple tasks, and comprehend simple explanations. However, though his use of words and sentences is becoming quite complex, the child may not grasp the full meaning of what is said, especially when adults converse with him. This is important for the nurse to remember, because complicated instructions or explanations may only confuse or frighten the child.

EMOTIONAL DEVELOPMENT

The child's emotional development and the behavior he displays will depend on his family and psychologic and socioeconomic experiences to which he has been exposed. Because the preschooler is egocentric, he cannot understand the necessity to restrain unacceptable behavior. He wants to be in control of all events and to be the center of attention. This abates as he nears school age and gains more control over impulsive behavior.

He may use a variety of coping behaviors to deal with events that he does not understand: crying, acting out, or regressive behaviors. To work effectively with this age group, realistic limits must be set on undesirable behavior. Encouragement and interaction with other children are most effective. Opportunities to control the situation, such as with puppet play or dolls, are useful in trying to impart information to this age group.

The fears of a preschooler are many because magical thinking is characteristic of this period. Imitating, fantasy, and make-believe are all part of this developmental phase. The child believes that his thoughts and wishes will come true. If he wishes that his newborn sibling were dead and then the infant dies, the child believes that it was his wish that caused the death. Such powerful thinking can easily lead to feelings of guilt. Punishment for being "bad" is often equated with illness and intrusive procedures. Fear of body mutilation, nightmares, monsters, and the dark are common at this age. All objects seem capable of coming alive to the preschooler. The preschooler fears abandonment but does not act out with the same intensity that the toddler does. The child may cry or withdraw from interaction. Specific activities that allow freedom of expression need to be planned to assist the child in acting out his feelings and concerns; otherwise he may withdraw completely. The developmental task identified by Erikson for this period is development of initiative versus guilt. Therefore, the child needs to be able to play out his feelings in an atmosphere that allows him freedom of expression, without a sense of shame for his actions.