Current practice in pediatric nursing

Edited by
Brandt · Chinn · Hunt · Smith

Volume Two

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Preface

This, the second volume of *Current Practice in Pediatric Nursing,* presents contemporary selections by practicing nurses concerning nursing concepts, theories applied in practice, strategies, and examination of pediatric nursing practice. These discussions reflect a core value established in the first volume—that of a humanistic focus on the child and family. They reflect an increasing concern for the merging of the art and science of nursing practice, and the reader will find within this volume advances in each of these dimensions of practice.

The art of nursing practice in these chapters is expressed as the concern for the child as a person and for the family as a unit. Such a focus is essential for the success of the nurse-family relationship, but it is also of great significance in terms of obtaining valid scientific data. As the nurse increasingly functions as a collector of clinical data recorded for each child and family, the means used to obtain the data become increasingly significant to the profession. When an attitude of genuine concern for the child and family is demonstrated and when the feelings and messages of the child and family are considered, not only as factual data but as true and valid concerns, the scientific importance of the nursing record will increase.

The science of nursing practice is reflected in this volume primarily through the conscious use of theory in practice. In each section the theories that are relevant to nursing practice are reported by the writers, and the manner in which the theory is implemented is described to the reader. This approach is intended to stimulate scientific debate and investigation within the profession; the embryonic stage of development of theory for nursing practice requires open critique and uninhibited response to various ideas and approaches. The reader is invited to offer alternate approaches to the ideas presented herein and to enter into clinical investigation to substantiate, further develop, or discover preferred approaches to nursing care.

This volume is divided into three sections. Part I concerns basic approaches to care from a theoretical, philosophical, and organizational standpoint. Part II includes chapters related to care of children who are hospitalized or chronically ill, with care of their families of major consideration. The chapters in Part III are related to nursing care of children in ambulatory or community settings, whose primary needs are treatment for acute illness, restorative care, or health maintenance.

As editors we wish to express appreciation to all the nurses who have contributed their work. Each chapter represents a major effort in sharing professional prac-

tice and ideas, an effort involving both pleasure and risk. The authors have revealed the very nature of their practice, and in so doing have provided for the profession substantial evidence of the present state of nursing art and science in the area of pediatrics. It is hoped that this effort will provide a healthy stimulus for change in practice and continued improvement in health care delivery for children and families.

Patricia A. Brandt
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Contents

part I

THE PEDIATRIC NURSE: APPROACHES TO CARE

The first chapter of this volume is a thought-stimulating examination of the question: Is communication with children and adolescents diminishing through the assessment process? Teresa Chopoorian discusses the multiple ramifications of the skill and technique-oriented fad of physical assessment, as well as its effect on the quality of nurse-child interaction and communication. This discussion leads to a presentation of ways in which nurses can use communication and assessment skills as a vital, integrated unit.

Carolyn C. Hames presents a description and interpretation of adaptation-level theory and illustrates the use of the theory in nursing care of a child with juvenile diabetes mellitus. Included is a detailed description of the nursing assessment, interpretation of the assessment data, and the nursing care plan based on the theoretical framework.

The chapters by Pamela Austin and Patricia J. Johnson introduce two approaches to organization of care, with emphasis on primary nursing. Each author offers a rationale for the organization of care and the way in which nursing articulates with other health care professionals. Johnson's chapter describes care of the newborn infant, with particular concern for the high-risk newborn and family. Austin's chapter discusses care for the older hospitalized child and family.

1 Communication beyond the assessment process

TERESA CHOPOORIAN

Three-year-old Jessie is helping his mother fold napkins. He exclaims, "Mommy, Mommy—look! Two triangles make one square."

Two-year-old Jason frequently reminds his parents, "Teddy Bear wants to talk to me." In this way, while engaging an adult in communication, he explores his world through fantasy and imagination.

Ten-year-old Maura astonishes her mother on Christmas Eve when she disdains the myth of Santa Claus: "Come on Mom—we know all about those stockings hung by the chimney and the cookies that Santa eats."

Six-year-old Peter, in constant motion, chatters incessantly. While watching television, he either laughs in a high-pitched voice or explains the action on the screen. Recently his parents separated. He has not as yet verbalized in specifics his reactions to this changed situation in his life. Erratic behavior might be his mode of responding to the decay of a previously more certain social structure.

These examples vivify the various ways that children relate their experiences. Exploring with children the meaning of their experiences is a requisite for those who have important roles in the lives of children. Nurses and other health practitioners are among those who, from time to time, play a significant role in the experiences of children. This involvement can be episodic during health evaluations, immunization sessions, school health visits, or occasional illness; or the involvement can be more extensive when children are hospitalized or have long-term chronic illness or health problems that are life-threatening.

In recent years, as nursing practice has evolved into a more central force in primary care, nurses have developed more qualitative and sustained involvement with children. This extension of the nursing role has occurred amid a major refinement in methods for the planning of health services. The assessment process has become an important and utilitarian way to discover and uncover health problems and design intervention modalities planned from a data base. Increasingly, the provision of health services is based on a data base compiled through an assessment of problems, issues, concerns, etc. The process of assessment thereby has become a central concept in the education of health professionals and a major focus in clinical practice. Thus formats, tools, protocols, and guides for assessment have become common. The current health literature includes a variety of these formats, each reflecting particular values and priorities.

In the area of child health, assessment of motor development, nutritional status,

peer and sibling relationships, speech and language, and socialization are some of the domains for assessment. Assessments of children are performed in a variety of settings: recreational programs, day-care establishments, schools and hospitals, and a host of other environments. Increasingly, studies are being conducted utilizing children as subjects with the intention of developing more comprehensive ways of identifying problems or needs. As nurses participate more, become more adept in child health maintenance, and assume more responsibility in the care of children with special health problems, more formats designed for the nursing assessment of children will appear.

Although increased focus on the assessment process in health care is encouraging, at the same time it appears necessary to critically examine certain ramifications of the "assessment craze." In the area of child care, an important consideration is the potential effects of the assessment process on the child. Efforts to assess the status of a child's health prior to planning services are obviously essential. In the process, however, factors that enhance or diminish the acquisition of the data base must be analyzed.

One such factor that can enhance or diminish the qualitative process of data gathering is the communication process. An essential dimension of the assessment process is the quality of interaction between the nurse and the child or adolescent. Central to the interaction is the quality of communication shared by the participants in the interaction. The process of communication that develops between the nurse and the child is one means by which knowing the child can become possible. When nurtured, the communication process enables exploring and sharing of information and ideas and helps to clarify ways of knowing about the child, leading to a more comprehensive assessment of the child's health status. In addition, while engaging the child in such an interaction, the possibility of the child understanding the health or illness is heightened. If communication is adeptly established, a climate can be fostered that transcends the gathering of information and includes giving and providing through an understanding of the child's experiences. In many other instances, qualitative communication serves as a prologue for a nurse-child relationship that can stimulate a growth-producing environment within which therapeutic intervention modalities can be implemented. Depending on the nature of the child's health problem, the development of the environment in which health services are rendered is a central goal of nursing.

It is suggested that, as a sequel to the overzealous attention to assessment in recent years, the quality of communication between children and adolescents and nurses is being diminished. This diminution is occurring, in part, from rigid adherence to the structured protocols for information gathering suggested by the assessment format or guide. In directing attention to the assessment guide, the nurse (and others) focuses on the categories of the guide and tends to place less emphasis on the child's particular experiences that have resulted in a need for health care. As the nurse concentrates on securing the information for the data base, the child's experiences that have prompted health care intervention are necessarily forced to conform, adjust, or modify to the ideas suggested by the assessment format. As a result, the child's experiences and the nurse's attempts to discover them are relegated to a secondary level of consideration. These experiences of pain, an inflicted wound, an

angry episode with an adult or peer, or prior or impending surgery adhere to the categorical responses suggested by the assessment format.

As a sequel, the level of communication and thus the quality of interaction between the nurse and the child become distorted. This distortion can interfere with the child's ability to communicate authentic and complete information about the issues that have brought him in contact with the nurse. Ultimately, this interference in the communication process affects the quality of the data gathered, which forms the basis for intervention modalities. It is ironical that the very purpose of the assessment process, securing more comprehensive information, has the potential of blocking communication, which then prevents access to more pertinent and authentic factors of the experiences of the child.

To further develop this consideration of the communication problem in the assessment process, consider how the child or adolescent perceives it. Assessment is a practice familiar to health providers but not necessarily to the recipients of health services. The young patient usually experiences this process in the form of a physical examination and/or a battery of questions. The child or adolescent is placed in the position of being "talked at" and is expected to give personal information, often to a stranger. During the process, the patient is asked many questions, most of which are viewed as probing, personal, or intrusive, and sometimes awkward or embarrassing. The questions often require the child or adolescent to respond in an unknown language or with symbols missing from his repertoire of words or experiences. Whether the questions are specific or broad, the child or adolescent is directed to locate a particular experience in his domain and respond to the questioner. The control of the questions and the evaluation of the adequacy of the response usually rests with the questioner.

Part of the assessment often includes a physical examination. A superficial knowledge of child and adolescent growth and development should make the nurse aware that even approaching the child's or adolescent's body to touch or feel can be traumatic or at least extremely disconcerting. Questioning the adequacy of a child's body part, concentrating attention to a body part, or directing the child to locate a body part are experiences the child might consider intrusive or inexplicable. These kinds of experiences, occurring in the presence of an unfamiliar person, only heighten the tentativeness experienced when coming to receive services in the health care system. The potential loss of self-control, which most adults fear when seeking health care, is also experienced by children, and particularly by adolescents. The experience of being assessed ought to be considered by those who are the assessors.

Nurses often forget or fail to appreciate that in the experience of most children, health care personnel do not necessarily assume individual importance. As such, prior contact with the health care system becomes part of the accumulative experience of children. But they do not often individualize the persons of the nurse, physician or social worker, etc. Unlike the health care personnel, children do not benefit from available health records stored with information about the hospital or health clinic. The child's experiences with the health care system become part of his life experiences. When the nurse sees the child infrequently with the health record as a resource, the child's identity through recorded data may appear to be more substan-

tive. But the child's recollection of the nurse is often based on a fused identity with the entire health care setting. Children and adolescents with long-term chronic problems or with life-threatening illness frequent health centers and hospitals. In their more sustained involvement with specific practitioners in the health care system, familiarity with particular nurses may result. However, this familiarity often results in more guarded behaviors and protection of self, particularly in censoring shared information. Thus, even though the child or adolescent knows the nurse as a constant element of the health care system, questioning and physical examination are still imposing.

For example, during the yearly health maintenance visit of a preadolescent or adolescent, questions are often asked to gather information about the status of sexual development. Healthy adolescents often dread these inevitable questions about physical and emotional changes. The intensity of the dread often parallels their need for facts from which adjustment and adaptation can follow. In certain aspects, seeking information about sexual development from a standardized tool in a standardized format is commendable. However, comprehensive assessment cannot be accomplished without considering the individuality of each adolescent's growth pattern and particular needs.

Other examples of children and adolescents who are embarrassed and often stultified by leading questions are obese children who need assistance with weight control, children who are aggressive and act out in school, or children with long-term chronic illness or other serious health problems such as diabetes, arthritis, or cancer who recognize the routines of the health system and abhor certain aspects of it. Hospitalized preschoolers, often separated from parents, are asked daily by a variety of individuals, most of whom the child has never seen, to explain where they hurt, where they are, and who brought them to the hospital. The initiation of a physical examination after much questioning is not unusual; the response is often fearful, tense, and threatening.

Assessing children and adolescents under these circumstances, in minimal interactive modes, yields data which might not be as comprehensive as that collected from a more qualitative interactive mode. Although most nursing philosophies value the uniqueness of individuals, methodologies for practice are still being developed that tend to restrict individuals to the universal pattern. The potential of questions that inevitably comprise the assessment process to intrude on the child or adolescent should never be minimized. Thus recurrent experiences with nurses and others in these minimal interaction modes thwart the ultimate gains or inherent positive outcomes that can be a potential in any nurse-child encounter. When relationships and interactions are structured into the restrictiveness of the assessment format, communication is minimized.

It seems reasonable to consider, then, that in the assessment process certain characteristics might serve to diminish the interaction mode between the child and the nurse, thus blocking communication. The following six characteristics of the assessment process ought to be seriously scrutinized by practitioners of nursing, particularly from the perspective of identifying inherent factors that might influence or restrict the communication process. Sensibility about these factors might lead to discovering ways to modify or transcend these restrictions and thereby lead to more qualitative interaction models during the assessment process.

1. *The assessment process packages the responses of children.* Although the intent of the process is to determine the scope of the individual child's problem or the status of health, specifics or particulars are often placed secondary to the informational needs of the system. The data accrued from children are more useful to the system if packaged and streamlined into a common format that serves as a comparative base with established normative values. On the surface this practice is acceptable. However, an outgrowth is that nurses begin to expect responses to fit into descriptions of normative categories. Thus the interest in packaged responses often precludes the seeking of other kinds of information or giving particular attention to responses not easily translated categorically. It is more conducive, then, to categorize responses if the child is asked certain questions, such as his grade at school, whether he enjoys school, or whether he has many friends. These kinds of questions elicit meager responses, and children often wonder why they are necessary. Often they answer by anticipating an expected response by the nurse or their parents. Questions requiring the child to describe school, activities of interest, and what his friends are like will reveal information relative to socialization, but in ways more appealing to the child. Often the nurse assumes that eventually the response to questions can be categorized into broad areas. Thus in the process of the development of assessment formats, the prime consideration in the construction of the questions often becomes the categorical areas. Accordingly, nurses use the categories as the questions rather than developing questions that presuppose knowledge of the experiences of the child's world.

2. *The assessment process concentrates more on examining universals than on individual needs.* Although this concentration on universals is apropos to the purpose of assessment, nevertheless, an individual's specific concerns may fail to be elicited or given an opportunity for expression. In child care, this dimension of the assessment process might serve to block access to qualitative information. For example, in assessing the sleep patterns of a child as a baseline for planning care for his hospitalization, questions are often restricted to gathering information about the number of hours the child sleeps. However, to ensure maintenance or restoration of the patterns of daily activities for hospitalized children, especially those admitted for surgery, discovery of the child's sleeping experience is most important. What is the child's usual experience of sleep? Where does sleeping take place? Does the child sleep in a room with siblings or parents? Is the sleeping area on the same floor as that of the parents or siblings? Is the child accustomed to sleeping alone? On a bed? On a cot? With other children in one bed? Or is the child in an institution where sleeping is in a dormitory? Is being sent to bed part of the disciplinary routine for the child? Does the child associate restrictions to the sleeping place as a form of punishment? Such queries are not as apt to evolve from asking structured questions as much as from engaging the child in communication about his world. If the communication process becomes the focus, then universal questions from the perspective of individual variation can be explored.

3. *The assessment process tends to focus on the intentions and concerns of the nurse or parents more than on the child's experience of the health setting or health problem.* Often health appointments are for routine screening, immunizations, or the administration of medications. At other times, children are brought to a health center, hospital clinic, or emergency room because the parent has observed some