CHILD HEALTH CONTENT IN THE UNDERGRADUATE CURRICULUM

INTRODUCTION/PROBLEM STATEMENT

Baccalaureate and associate degree nursing programs continue to decrease pediatric nursing didactic content and clinical learning experiences. Revisions in the pediatric nursing undergraduate/pre-licensure curriculum are recommended to emphasize existing content and concepts related to children and their family and to strengthen undergraduate pediatric nursing education. Families are recognized as the constant in an individual’s life and are particularly vital to the health of infants, children, and adolescents. The Essentials of Baccalaureate Education for Nursing (American Association of Colleges of Nursing [AACN], 2008) makes the assumption that “the baccalaureate generalist is prepared…to care for diverse populations with a family scope” (p. 32). Essential IX specifically states that the generalist nurse “is prepared to practice with patients including individuals, families, communities, and populations…” and family-centered care is recommended as course content to meet this objective (p. 32).

DEFINITION(S)

RATIONALE AND SUPPORTING INFORMATION

Critical changes have affected health care in the 21st century and continue to create challenges in educating pediatric nurses. Some major influencing factors include:

- Changes in the structure of the National Council Licensure Examination (NCLEX) have resulted in the integration of pediatric questions, rather than a specifically designated section on care of children (National Council of State Board of Nursing, 2016). This integration has created the perception that critical analysis and application of child and family content is not essential for preparation for pre-licensure education

- Market competition, faculty salaries, and aging of faculty, make it difficult to recruit qualified nurse educators to teach pediatric content (Kaufman, 2007; Leonard, Fulkerson, Rose, & Christy, 2008).

- Pressure from accreditation bodies and professional demands to include expanded information related to bioterrorism, ethical/legal dilemmas, risk behaviors, genetic innovations, and other issues while, at the same time, limiting the length of programs of study take away from pediatric curriculum content (AACN, 2008; Roberts & Glod, 2013); Steed, Howe, Pruitt, & Sherrill, 2004; Tanner, 2010).
The acuity of hospitalized children has accelerated markedly. Lifesaving surgeries and therapies result in children living with complex and chronic conditions or diseases (Broussard, Myers, & Lemoine, 2009). Current changes in health care delivery now bring complex pediatric care into the home and ambulatory care settings, as only the very sick are admitted to hospitals (Broussard, Nyers, & Lemoine, 2009; Curry & Samawi, 2011).

Consolidation of acute pediatric clinical care into larger health science centers has decreased the ability of programs of nursing to provide clinical student learning opportunities in caring for acutely ill children. Nursing programs not in proximity to larger pediatric nursing health care centers and the number of nursing programs seeking pediatric experiences creates competition and limitations on access to student clinical experiences in pediatric nursing (Ohio Board of Nursing, 2016).

The use of alternative pediatric clinical experience has been supported by research. Kubin, Fogg, Wilson, and Wilson (2013) conducted a study evaluating students’ preparedness to care for children and their families and compared three clinical teaching schedules (all acute care experiences, half acute care and half alternate experiences, and all alternative experiences). The researchers found no statistically significant differences between the student groups in knowledge or clinical reasoning abilities (Kubin et al., 2013). Therefore, alternative learning sites such as special needs camps and community-based clinics have been supported as an excellent way to maintain contact with real pediatric patients and meet the course objectives.

Many programs of nursing are moving to concept driven curriculums in which pediatric exemplars may be omitted as programs focus on preparing nurse generalists (AACN, 2008).

In 2014 there were an estimated 73.6 million children in the United States making up 23.3% of the population (Federal Interagency Forum on Child and Family Statistics [FIFCFS], 2014). Pediatric nurses play a significant role in delivering health care to children. In 2012 there were nearly 5.9 million hospital stays for children in the United States (Witt, Weiss, & Elixhauser, 2014). Three-quarters of all children had contact with a health care professional. Approximately 8.8 million children had an ER visit. Over 10 million children have been diagnosed with asthma and two-thirds of school-aged children (aged 5 to 17 years) missed school due to illness or injury (Bloom, Jones, & Freeman, 2013). Hospitalizations for suicide, suicidal ideations, and self-harm increased 104% during (2006-2011) for all children from 1 to 17 years of age and 151% for children from 10 to 14 years of age (Torio, Encinosa, Berdahl, McCormick & Simpson, 2015). In addition to other health concerns, 19% of the pediatric population (6 to 17 years of age) is obese (FIFCFS, 2014).

Communication errors are one of the leading causes of patient harm in healthcare (Joint Commission, 2012). Healthcare interactions with infants and children present unique challenges due to differing developmental stages and limited communication skills.

Research continues to strongly supporting the efficacy of family-centered care in pediatrics (Aronson, Yau, Helfaer, & Morrison, 2009; Chernoff, Ireys, DeVet, & Kim, 2002; Curley, Hunsberger, Harris, 2013; Harbaugh, Tomlinson, & Kirschbaum, 2004; Harrison, 2010; MacKean, Thurston, & Scott, 2005; Wertlieb, 2003).
Children have unique growth, developmental, and physiological differences that require specialized knowledge related to their care. Any reduction in nursing education related to the pediatric population can have a negative impact on the quality of pediatric nursing care. Due to a variety of factors, pediatric nursing curriculum content has shown a decline in addressing pediatric learning concepts especially in the following areas: growth and development (especially with focus on nutrition and bio-psychosocial factors); family concepts, social determinants, physiology, pharmacology and pathophysiology specific to children; and health promotion, prevention, and safety (McCarthy & Wyatt, 2014). Basic principles and content that prepare every nurse to care for children is an expectation of program accreditation in basic nursing education. This is evidenced by frequent references in accreditation language and in the baccalaureate essential competencies that refer to education across the lifespan (AACN, 2008, 2012). Family centered care content must be part of the curriculum to ensure a lifespan approach to family-centered care.

1. Required curricula in all professional (undergraduate/pre-licensure) nursing education programs must have readily discernible pediatric nursing content built upon theoretical and empirical knowledge; as well as current evidence-based information including:
   a. Growth and development, bio-psychosocial, genetic, cognitive development, lifestyle, nutrition, and exercise/activity.
   b. Family stress and coping, communication, and parenting issues.
   c. Social determinants related to knowledge and advocacy for families’ cultural, religious, spiritual, social, economic, and/or environmental needs.
   d. Physiology, pathophysiology, and pharmacology concepts that include acute, congenital, and chronic pediatric alterations.
   e. Health promotion and prevention, including risk and behavioral assessments with continuous focus on safety promotion and injury prevention (McCarthy & Wyatt, 2014).

2. Theoretical and clinical educational experiences should reflect integration of current evidence-based information related to ethical, moral, and political-legal changes occurring within society that affect the child and family.

3. Clinical experiences should provide opportunities to use basic nursing skills, apply critical thinking skills, and implementation of evidence-based practice with children and families in settings that may include inpatient/acute care, ambulatory, rehabilitation care, community, school, camp, home; any environment where the health and well-being of the child and family are central (Texas State Board of Nursing, 2013). Alternative learning sites are an excellent way to meet course objectives (Kubin, Fogg, Wilson, & Wilson, 2013).

4. Clinical experiences should occur in an environment that allows students to collaborate with interdisciplinary health care providers who role model an exemplary practice of family-centered care. Nursing students must learn to develop the necessary knowledge, skills, and abilities to assess development and
effectively communicate with pediatric patients and their families; the hardest
skills to learn in pediatric nursing.

5. Nursing educators should have advanced educational background and clinical
experience in caring for children in order to provide educational experiences in
family-centered nursing care of children.

6. Nursing curricula should provide evidence of both classroom conceptual learning
and clinical hours in family-centered nursing care of children, which are
consistent with those allocated to other age-related groups in the lifespan.

7. Nursing educators must implement and evaluate innovative approaches to
teaching family-centered care across life span.

8. Nursing programs must ensure pediatric undergraduate curriculum focuses on
current health issues experienced by children including development of clinical
learning experiences to settings where children live, learn, and play (McCarthy &
Wyatt, 2014).

9. Curriculum must prepare nurses to be advocates for family-centered care. Clinical
settings and experiences must be assessed to ensure the inclusion of family-
centered care.

10. The use of technology driven educational opportunities (e.g., clinical
simulations) can also enrich and support clinical learning. A landmark research
study by the National Council of State Boards of Nursing has validated that up to
50% of clinical experience may be replaced with simulation training while
achieving the desired student learning outcomes (Hayden, Smiley, Alexander,
Kardong-Edgren, & Jeffries, 2014). Simulation can be used to enhance pediatric
nursing education, but SPN does not support replacing any single pediatric
clinical experience with 100% simulation.

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