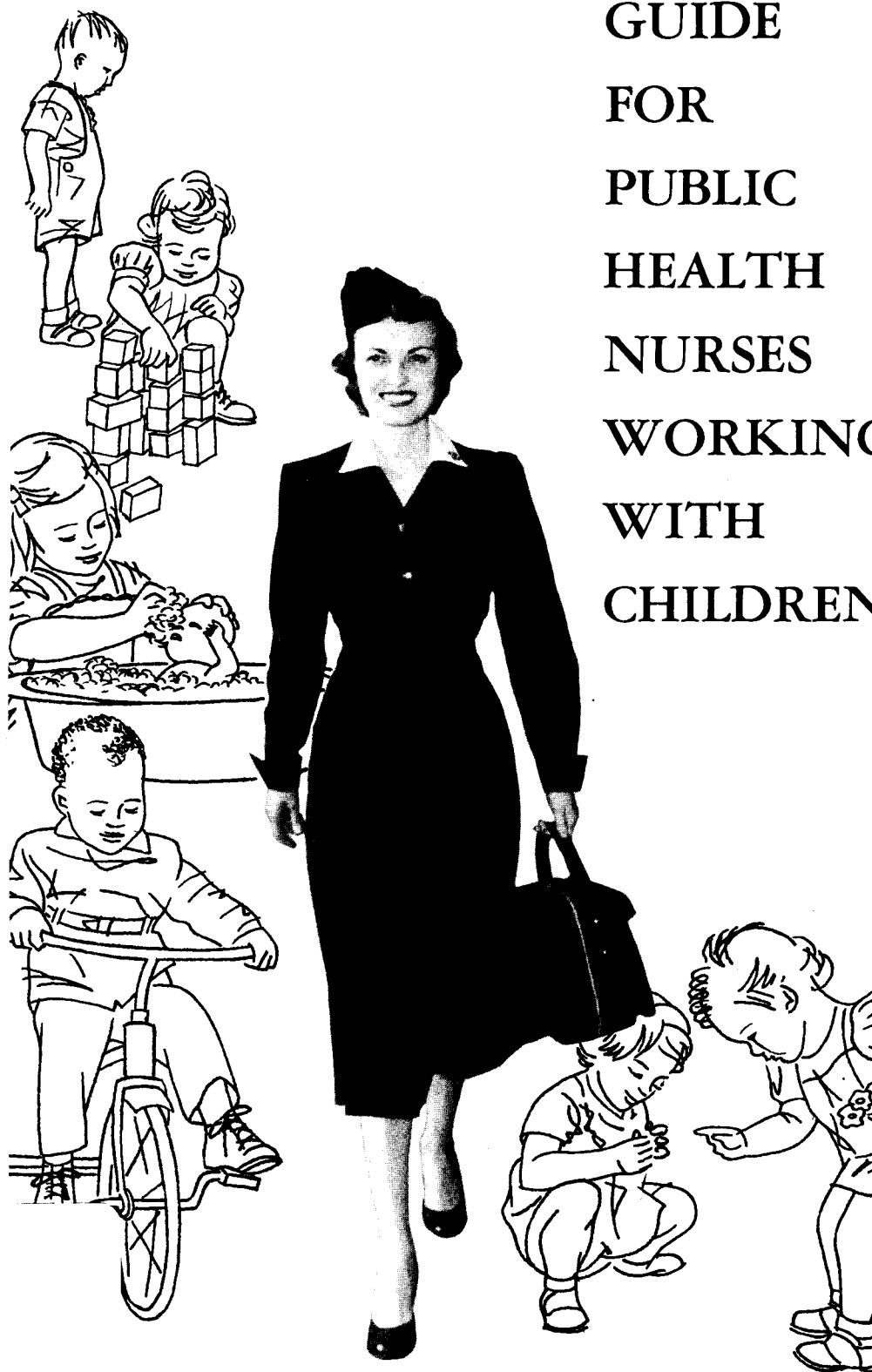


GUIDE  
FOR  
PUBLIC  
HEALTH  
NURSES  
WORKING  
WITH  
CHILDREN



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GUIDE  
FOR  
PUBLIC  
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NURSES  
WORKING  
WITH  
CHILDREN

from the developmental point of view

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
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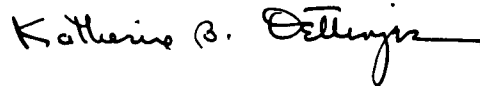
## foreword

The Children's Bureau believes that the information contained in this Guide will be valuable to all nurses working with children and of much interest to other professional personnel whose main concern is the health and welfare of children.

Approaching this subject from the developmental point of view, this pamphlet draws together various facets entering into work with children, such as case finding, recording, analysis of families, appraisal of the mental, physical and social development of boys and girls, and the formation of plans for working with families.

With the assistance of other public health nursing specialists, this material was developed on the job by its author, Miss Martha M. Borlick, public health nursing specialist in child health in the Bureau of Public Health Nursing, Department of Public Health of the District of Columbia. For several years, this Guide has been used in the District and more and more nurses are finding it to be helpful.

Because of their interest in improving services for mothers and children not only in the Nation's capital but also all over the country, Miss Borlick and the D.C. Department of Public Health are permitting the Children's Bureau to issue this material.



KATHERINE B. OETTINGER  
*Chief, Children's Bureau*

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# GUIDE FOR PUBLIC HEALTH NURSES WORKING WITH CHILDREN

from the developmental point of view

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## POLICIES ON WORKING WITH CHILDREN

### General policy in relation to children in a family health service

In a family health service, public health nursing assumes the responsibility for being alert to the health and welfare needs of all members of the family, no matter where individual family members may be encountered. Part of this health service to families includes an appraisal of the mental, physical, and social development of children in the family and the formation and carrying out of a definite nursing care plan for followup of those children who are found to have problems in any of these areas.

### Policy in relation to developmental appraisals of children in the home

Appraisal of children should be done *in the home* for:

1. All children whom the public health nurse, in the performance of her function of case finding.
  - a. Has found in the home and who are not receiving the health supervision of any private physician or clinic service, or
  - b. Has reason to observe closely for suspected deviations from normal mental, physical, and social development.

2. All children who have been referred from any source to the public health nurse because of problems which may involve the state of their mental, physical, and social development.
3. All children newly accepted for nursing service in the home, such as those children with rheumatic fever, cleft palate, cerebral palsy, etc.
4. All children who have previously been known only to clinic services (such as child health clinics) and:
  - a. Who have been placed under close observation of that clinic service for suspected abnormalities of mental, physical, and social development, or
  - b. Who are being referred by the clinic service to a special diagnostic resource for consultation or for further study of suspected or obvious deviations from normal mental, physical or social development.

## PURPOSES FOR APPRAISAL OF CHILDREN IN THE HOME

Children are appraised in the home for the purpose of:

1. Detecting as soon as possible any incipient deviations from normal health and development.
2. Providing an instrument for implementation of health teaching and anticipatory guidance to parents concerning growth and development.
3. Contributing a public health nursing appraisal to a more complete understanding of children who are being evaluated by child health clinics, schools, or special consultative and diagnostic resources for suspected problems of mental, physical, or social development; or of children who have been diagnosed and are on continuing treatment.
4. Preparing an initial record of developmental activities of children to serve as a basis, along with other diagnostic and medical information, for future periodic assessments of progress or change in these activities.
5. Providing a basis for plans for continued nursing care and

health instructions to individual families in a family health service.

## PREPARATION FOR APPRAISAL OF CHILD IN THE HOME

Each home visit should be planned around a specific purpose although the actual situation found may alter this. Visiting in the home is permissive and adaptability is always required. However, in relation to visiting in the home for the specific purpose of a developmental appraisal, the following preparation is suggested:

1. Obtain and review all information which is readily available concerning the child and his family, including clinic medical records, nursing records, developmental histories, school records and results of any tests given.
2. Review the approximate developmental picture generally expected of a child of the patient's age and/or of a child of his known mental, physical or social limitations.
3. Review various guides for observing areas of levels of skills and achievements.
4. When necessary obtain consultation from the nursing supervisor or a nursing specialist, if possible, in relation to such questions as how to implement the information obtained concerning the child and his family, and how to give public health nursing services to this particular child and his family.

## GENERAL COMMENTS CONCERNING APPRAISAL OF CHILD AND FAMILY

The family's responses to appraisals of their child vary, depending on many complex reasons, such as:

- a. How concerned they are about the child and their particular ways of expressing this concern;
- b. How understanding they are of the purposes of the appraisals and how much they became involved;

- c. Their feelings about public health nurses; and
- d. How skillful the nurse is in obtaining relevant information.

The comments which follow, the areas for observation which are itemized in the remainder of this guide and the discussion on conferring with the family are given only as a general guide for appraisals. The *ways* in which observations are made, information obtained, and health teaching implemented should be individualized according to each child and his family.

The following approaches have been identified as being useful and applicable in a public health setting where limited time is allotted with the family either in the clinic or in the home.<sup>1</sup> They involve not only skills in listening and in wording questions and comments, but also in interest and understanding which are conveyed in manner and tone of voice.

A "preparatory" visit may be required before beginning the appraisal, particularly if this is the first contact with the family. This preparatory visit provides an opportunity for the public health nurse:

- a. To begin to establish rapport with the interviewee,
  - b. To interpret purpose of the appraisal, or if this has been done by another, to permit discussion of the appraisal,
  - c. To gain some understanding of the parent as a person, as a parent, and as the caretaker of the child, and
  - d. To observe the parents and the family freely without concentrating on the child as the "unit of observation."
1. Try to establish a friendly relationship with the child and observe his general reactions and activities at the time of the visit, rather than depending entirely on descriptions given by the family. The physical inspection of a child is often the easiest way for a public health nurse to approach the child and to establish rapport with the parent.
  2. Encourage spontaneous responses from the family to such questions as "How does he usually spend his day?" and follow up general comments with questions which will elicit more details as to his habitual performance in a routine day.
  3. Phrase the questions in a way which avoids putting words into the parent's mouth. Avoid indicating the answer expected

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<sup>1</sup> See items listed in bibliography by Korsch and Levy and by the American Public Health Association, Committee on Child Health.

from the parent. In general, begin more questions with "What" and "How" and begin fewer with "Is," "Does" or "Did." For example:

<i>"Yes" and "No" type question:</i>	<i>Better phrasing:</i>
"Is Johnny getting along all right?"	"How is Johnny getting along?"
"Is Johnny drinking milk?"	"What is Johnny getting to eat now?"
"Is he shy?"	"What is he like with strangers?"
"Does his sister like him?"	"What is his sister like with him?"
"Does he play, sleep well?"	"What about play? What about sleep?"
"Does he stand alone yet?"	"What does he do by himself?"

4. Avoid asking whether the child *can* do so-and-so since this may lead to "yes" and "no" answers. Rather, emphasize what the child *does* usually or habitually, but avoid as much as possible beginning the questions with "Does" or "Did." Begin more questions with "How much," "In what ways" and "To what extent." For example:

- "How much *does* he do for himself in dressing each morning?"
- "To *what extent does* he feed himself at breakfast?"
- "How *does* he tell you he needs to go to the bathroom?"
- "In *what ways does* he help around the house each day?"

5. To assess the parents' adequacy and needs and ability to cope with their problems and to help parents search out and develop their own inner resources, use certain key questions which may bring this out, such as:

- "What do you think?"
- "What would you like to do?"
- "What are you planning to do?"
- "What are you doing about it?"
- "What is it you really want?"
- "How do you explain that?"
- "Why do you suppose he does it?"

6. At all times present a sympathetic manner toward whatever particular problems the family may feel that they need to bring out in order to qualify or to explain their description. These comments may be significant in presenting a picture of the family's feeling toward the child and their understanding of him as an individual.

7. A complete initial appraisal may need several visits to the home. If possible, try to schedule some visits during the time when such activities as feeding or dressing may be in progress so that an observation may be made of actual performance in the physical setting and atmosphere provided by the home.

## AREAS OF OBSERVATION AND EVALUATION

### Evaluation of family relationships

Try to assess the way in which this child is viewed by parents, adults, and siblings in the family, and how the child may see himself in the family setting. Initial impressions may change with continued contact with the family, but the following suggestions may provide some beginning clues. They must, however, be considered very carefully in relation to the *age* of the child since behavior consistent with one level of maturity may be inappropriate in another. In addition, generalizations cannot be obtained from isolated observations since different motivations and circumstances alter behavior, but the same behavior observed several times in the home and in other settings, such as child health clinics, along the remarks which follow the same pattern, may provide beginning insights.

It should be remembered that the area of relationships involves very emotionally charged material. Our culture expects mothers to have strong maternal feelings and actions. This expectation is well known to parents. Many women—particularly those who are not natural-born mothers—recognize their shortcomings and feel guilty about them. Because of this, some mothers often conceal facts from the doctor or nurse or any other person they feel to be in authority in order to meet with approval. For this reason, try to phrase comments and questions in an open-end, non-judgemental manner which will let parents feel your acceptance and understanding of their individual feelings and problems.

It should be remembered that in some agencies, the services of a child development specialist and/or a medical social worker may also be involved in service to the same family. In such instances, it is assumed the public health nurse will work closely with each discipline to coordinate their services with hers, and the families will benefit from the combined efforts of these professional people.

### *Impression of parents' attitude toward child*

1. From observation of manner in which a child is handled physically:
  - a. Carried like a baby, a doll, a package; under circumstances appropriate or unappropriate for child's age and abilities.
  - b. Held on lap comfortably; allowed to sit stiffly without support; confined or given freedom to squirm and wiggle.
  - c. Physical closeness and reassurances given to child during physical inspection.
  - d. Protective arm placed around child as he stands near parent when being discussed; appearance of unawareness of his near presence.
  - e. Glances directed at child when he is being discussed; apparent disregard of child when in room.
2. From listening to responses to comments and questions related to discipline, responses to handling, etc.:
  - a. "How often do you find you have to spank him? What else have you tried?"
  - b. "Many mothers find that some of their children take to cuddling better than others, or at different times when they are growing up. Have you noticed this difference in your children?"
3. From listening to verbal terms and tones used in discussing child:
  - a. As a normal child with respect for his individuality.
  - b. As the central focus in family planning.
  - c. As a toy to be played with, but no demands to be placed on in regard to controls and achievements.
  - d. "Different" from other children and to be treated differently.
  - e. Like other children, just "slower" and may outgrow slowness.
  - f. Like other children in the family, so must "measure up" to same demands.
  - g. As a "punishment," as a "catastrophe," as a "puzzle," as something to be hidden if child is handicapped or of deviant development.

### *Impression of sibling relationships*

1. From observations of physical activities of siblings and child:
  - a. One child trying to squeeze into mother's lap while she is holding another child; mother's way of handling this by either shoving child away or somehow making room for two.
  - b. Dramatic changes in one child's actions and demeanor when a sibling leaves the room or is taken up on the mother's lap.
  - c. Pairing off of siblings in play and the way this includes or excludes the child.
  - d. Child who stays in the background, appearing unresponsive and despondent, or who employs extensive tactics to be noticed.
2. From listening to responses to comments and questions related to activities of siblings and child:
  - a. "Does he show the usual jealousy children of his age have?"
  - b. "What is his sister (or brother) like with him?"
  - c. "Can you leave the children in a room together?"
  - d. "Most children feel pushed away when a new baby comes. How did he take to it?"
3. From listening to verbal terms and tones used in discussing child in relation to siblings:
  - a. As the center of attraction in the family.
  - b. As a "baby" to be petted and protected by others.
  - c. As an object of "comparison" and rivalry with siblings.
  - d. As a "big helper" in taking over care of other siblings.
  - e. As a "danger" to other children and a "problem" in the neighborhood.

### *Impressions of parental interaction in relation to child*

1. From observations of physical activities of parents when both are present:
  - a. Refer to each other for support or verification; development of arguments and accusations on points of child's care.

- b. Interest and attention given by both parents.
  - c. One parent withdraws from the discussion, causing anger in other parent, or apparent acceptance of this as the usual situation.
2. From listening to responses to comments and questions related to family support :
- a. "You have a large house (several growing children, etc.). How much help do you get?"
  - b. "Do you get any help in the care of the children?"
  - c. "What does his father do with him? His grandmother?"
  - d. "How does your husband feel about having your mother-in-law live with you?"
  - e. "How do you feel about having to stay home now instead of going out to work?"
  - f. "How often does your husband find he has to step in to discipline the children?"
  - g. "What do you do when things get too much for you?"
3. From listening to verbal terms and tones used in discussing marital partner :
- a. As a person who "likes to bother" or "doesn't want to bother" with the children.
  - b. As a person who "gives me lots of help with the children."
  - c. As a person who "sides with the relatives" against me.
  - d. As a person to whom no decisions, some decisions or all decisions are referred.

### *Impression of child's relationship to family*

1. From observations of physical activities of child in relation to:
- a. Dependency needs and expressions of growing independence :
    - 1. No apparent indications that he is aware of existence of parents.
    - 2. Insistence on physical contact with mother throughout visit.

3. Various gradations of willingness to separate from mother, from playing in same room, to leaving room completely.
  4. Answers simple questions by himself; turns to mother for support before risking an answer.
  5. Various gradations of assertion of independence.
- b. Adjustment to demands of daily family living:
1. Progress of child's play with siblings during visit in relation to give-and-take of sharing, pushing, quarreling.
  2. Evidences that child shares in particular cultural pattern of family in relation to social manners and household care.
2. From listening to responses to comments and questions related to child's self-expression :
- a. "What is he usually like with strangers?"
  - b. "How does he usually act when people come to the house?"
  - c. "What new things have you noticed he is doing at home?"
  - d. "What does he like to do best around the house to help?"
  - e. "How do you feel when he screams to have his way (or 'answers back')?"
  - f. "Of course, he may be reaching the age when he likes to show his independence, and that's always hard on a mother at first."
3. From listening to verbal terms and tones used in discussing child's relationships to family :
- a. As a child who is not able to be "out of my sight for a minute," or "always hanging on me," or "always somewhere else."
  - b. As not to be "trusted" to do anything for himself; or "quick to catch on if given a chance."

## DESCRIPTION AND PHYSICAL APPRAISAL OF CHILD

An initial description and physical assessment of the child is important as an identification of the individuality of each child,

as a measuring guide against future assessments, and as a tool for establishing relationships with the child and his family. It is also very important for early detection and correction of physical impairments and for health teaching. Although an attempt to understand a child goes beyond a superficial and descriptive approach to his physical appearances, undetected physical impairments may have a serious effect on deeper emotional needs, and serious emotional problems may be reflected in a child's physical appearance.

### Initial general impression of child

1. Body structure and posture.
2. Tempo of activity.
3. Facial expressions.
4. Distinctive physical characteristics.
5. Appearance of clothing.
6. Apparent state of physical care being received.

### Physical appraisal of child

If the child is not under any medical supervision or has not been inspected within the past year, or the record does not contain any findings of recent physical appraisal, inspect child from head to foot as follows:

1. Preparation :
  - a. Select area of room where temperature is around 72°.
  - b. Wash hands and see that they are warm.
  - c. Put on apron.
  - d. Select well-lighted spot for appraisal.
  - e. Appraise child not only at close range, but observe also the total general appearance of the child in his activities about the room.

- f. Engage child's interest; use approach appropriate to stage of development of child.
- g. Handle gently and firmly.
- h. Think of involving child and family in the inspection with concurrent explanations and health teachings which are appropriate for the child's stage of development and the family's level of understanding.

2. Nursing Appraisal:

- a. In activity about the room, note particularly:

Posture and symmetry of body.

Position of feet.

Musculature; freedom or limitation of movements.

Weight appropriate for height and body structure.

Physical accomplishments appropriate for stage of development.

- b. Inspect head and face carefully for:

Position, shape and size of head in relation to chest and abdomen.

Condition of scalp.

Appearance of hair.

Condition of skin.

Symmetry of face.

Eyes: clear, bright, pupils equal, focusing; red, watering, discharging, crossed.

Nose: unobstructed, clear breathing, discharging, wheezing, evidence of mouth breathing.

Mouth: color good, breath sweet; tongue, uvula, palate and throat appear to be normal. Teeth clean, sound and appropriate for stage of development. Tongue coated, cracks and sores about lips.

Ears: clean, well-placed, responding to normal tones; discharging, clogged with cerumen.

- c. Examine hands and arms:

Condition of nails, cuts, abrasions.

Grasping and releasing ability.

d. Remove shirt and observe neck, chest, abdomen and back:

Neck: contour, flexibility, swelling of glands.

Chest: normal, barrel, flat, rosary, Harrison's groove.

Abdomen: normal, lax, distended, tender; condition of umbilicus.

Back: straight, spine straight, curves normal; shoulders level and even.

Skin: texture and condition of cleanliness; bruises; abrasions, rashes.

e. Examine genitalia depending on age of child and if mother reports difficulties, such as:

Tight foreskin, discharges, rashes.

Swelling, lumps in inner thigh and groin.

f. Remove shoes and socks and examine feet:

Position when standing or walking.

Excoriations, callouses, rashes, swellings.

Examine condition of shoes and socks and size in relation to size of child's feet.

3. Behavioral Appraisal:

a. Observe child's reactions toward experience:

Shy, diffident, clinging to mother, angry, resistive.

Eager, curious, friendly.

Employment of mannerisms, such as thumbsucking, and nail biting, ear or hair pulling, masturbation.

b. Observe child's actions in undressing and redressing:

Ability to handle dressing in relation to stage of development. Extent of assistance given as needed.

### History of early development

Developmental histories are taken at the child's admission to clinic services, such as child health clinics or consultative and diagnostic services. If the child is not under such supervision or if the records do not contain a report of such a history, a history of the

child's birth and early developmental history should be included as an important part of the information necessary for understanding the child and his family and for evaluating growth :

1. Prenatal history :
  - a. History of previous pregnancies and medical supervisions.
  - b. History of pregnancy and medical supervision for this child.
2. Birth history :
  - a. Type of delivery.
  - b. Premature or full term.
  - c. Birth weight.
  - d. Condition at birth.
3. Early development :
  - a. Sat up.
  - b. Walked.
  - c. Talked.
  - d. Feeding.
  - e. Dentition.
4. Health history :
  - a. Previous illnesses, injuries, operations, hospitalizations.
  - b. Age and dates of prophylaxis care.
5. Habits.

## EVALUATION OF PRESENT STATUS OF CHILD'S DEVELOPMENTAL ACTIVITIES

In order to obtain a general idea of how the child compares with average children, it is important to obtain a picture of his present activities in various areas of development. This is not to be considered an intelligence test; rather it is an appraisal which is helpful in seeing where the child may fit into the definite patterns of growth which are followed by most children as they develop. Also, it is not expected that this overall estimate will result in a clear-cut picture of the child, since children frequently do not develop

evenly in all phases of activities. The types of activities listed below are those which can be readily observed in everyday situations:

### Physical behavior

1. Habitual Physical Activity:
  - a. Report of family of child's habitual physical activity:
    - Lying quietly in crib for most of the day.
    - Out on floor moving about.
    - Active about room, house or outdoors in aimless or in purposeful manner; in hyperactive or sluggish manner.
  - b. Activity of child observed at time of home visit.
2. Coordination, Comprehension and Visual Acuity:
  - a. Report of family of child's awareness and use of objects:
    - Completely unaware of strangers, family members and objects.
    - Reaching out for but not grasping objects.
    - No interest in object except mouthing of it.
    - Uses of grasping, releasing, rolling, shoving, pushing, throwing, tearing motions.
    - Awkward or good use of fingers and hands.
    - Crawling, walking, running toward objects.
  - b. Observation of child's responses to objects presented to him at time of home visit.
3. Locomotor Activities:
  - a. Report of family of child's locomotor abilities:
    - Lifting head, moving about in crib, sitting up, creeping, crawling, toddling, walking, running.
    - Going up and down stairs, going out unattended in yard, neighborhood, or to school.
  - b. Locomotor activity of child observed at time of home visit.
4. Sleep Patterns:
  - a. Report of family of child's sleep habits and patterns:
    - Sleeping most of day; sleeping and crying patterns.
    - Regular nap and bedtime schedules; out of bed and restless at night.

## Self-care activities

### 1. Feeding:

- a. Method of feeding: Still on bottle; not feeding self in anyway; able to finger feed self; managing cup, spoon, fork, knife.
- b. Physical skills: Ability or difficulty in masticating and swallowing food.
- c. Diet: New foods being added and accepted; on strained, chopped or table foods; food jags; in between meal snacks: quantity consumed consistent with size of child.
- d. Physical setting: Seating and table arrangements comfortable and appropriate for child and parent.
- e. Atmosphere: Pleasant and relaxed; rushed and disturbed; family participation.
- f. Training: Family's approach to training child in self-help in feeding.

### 2. Dressing:

- a. Undressing: Extent of ability to remove some clothing as an act of undressing and not merely as means of play.
- b. Dressing: Extent of accomplishments with large pieces of clothing, socks, shoes, zippers, buttons, clothing with simple fastenings.
- c. Time: Amount of time and patience required by family during child's attempts at dressing and undressing.
- d. Training: Family's approach to training child in self-help in dressing and undressing and care of clothing.

### 3. Toileting:

- a. Control: Extent of bowel and bladder control, during day and night.
- b. Awareness of function: Child's interest in own toileting, stools, puddles and family's reaction to this; actions, sounds or speech child uses to indicate desire to go to toilet.
- c. Physical functioning: Patterns of constipation or diarrhea.
- d. Accidents: Frequency of soilings and wettings and reactions of family.

- e. Training: Family's approach to toilet training.
4. Personal Hygiene:
- a. Self-activity: Extent of self-activity in washing hands and face, taking bath, brushing teeth, combing hair.
  - b. Training: Family's approach to development of habits of personal hygiene.
5. Avoidance of Hazards:
- a. Awareness: Extent of awareness of such household and play hazards as stairs, stoves, water, knives, climbing heights, swings, etc.
  - b. Management: Extent of self-management in crossing streets, reading traffic and warning signs, etc.
  - c. Training: Family's approach to teaching protection from accident hazards.

### **Play and occupational activities**

1. Play Activities:
- a. Report of family of how child amuses himself:  
Crib play, playpen activities, table and floor play.  
Active amusements indoors and outdoors.  
Activities child initiates himself; those he performs with group or with family.  
Child's favorite object or play at present.
  - b. Observation of play material and recreational provisions at hand in home at time of visit.
2. Occupational Activities:
- a. Report of family of child's purposeful, helping activities:  
Performs simple useful errands and household tasks.  
Initiates simple useful activities by himself.

### **Social responses**

1. Response to Adult Strangers:
- a. Report of family of child's reactions to adult strangers:

Appears unaware of existence of new person.  
Frightened, screaming, seeking reassurance from family members.  
Shows interest in new person; tried to attract attention.  
Aware and accepting of strangers but prefers children.

- b. Observation of child's response to nurse at time of visit.
2. Response to Children:
    - a. Report of family of child's socialization with other children:

Solitary or parallel play; cooperative imaginative play as member of group.  
Can share and understands taking turns.

### Communication activities

1. Communication Skills:
  - a. Report of family of child's activity in speech sounds, language, writing:

Involved only in chewing or mouthing motions, droolings.  
Imitative sounds, isolated words or sentences, stuttering.  
Special peculiar noises, such as shrieks, grunts, etc.  
Skills and problems of articulation of voluntary speech.  
Skills and problems of reading and writing.
  - b. Observation of methods of communication, speech sounds or language child uses at time of home visit.

### EVALUATION OF PHYSICAL SETTING OF HOME AND NEIGHBORHOOD

During the appraisal, assess the physical setting of the home and neighborhood in relation to meeting the developmental needs of the child in such areas as healthy physical growth, training, self-care, socialization, play, etc. It should be kept in mind, however, that general conclusions from the findings of experimental investigations agree that it is the *attitudes* of the parents which contribute

more to the development of a well-adjusted personality in the child, no matter how physically or mentally he may be limited, than do external factors of the environment. Some of the areas for which to begin to observe are:

1. Physical condition of home in relation to such external factors of good hygiene as adequate light, proper ventilation, temperature, heating, etc.
2. Physical setting for sleeping, eating, dressing, washing, toileting in relation to space, time and opportunities for the child to learn self-care and good habits of hygiene.
3. Physical surroundings in the home which provide space for the child to roam about and play freely and also to have some area of his own, or which may confine him to a crowded room or small apartment.
4. Physical surroundings outside the home which provide space for the child to play freely, such as fenced yards or play areas, or which may confine him to the house because of open sidewalks on busy streets, or crowded commercial areas.
5. Neighborhood facilities for group play, such as playgrounds, supervised play groups, settlement houses.
6. Accident hazards in the home and in the neighborhood for a child of the patient's age and development or apparent mental, physical or social limitations.

## EVALUATION OF FAMILY'S USE OF RESOURCES AND OF THEIR ABILITY TO IMPROVISE

Assessment of the physical setting and environment also includes an assessment of the family's ability to improvise and to make use of resources. Some areas which may indicate the family's understanding of developmental needs of the child and their resourcefulness in providing for these needs are:

1. Arrangements family has made within the physical setting of the home and neighborhood to allow the child to let out energy in free, vigorous play and in relation to his stage of development.
2. Arrangements family has made to meet difficult physical set-

tings for sleeping, toileting, dressing, eating, washing, so that space, time and opportunity for teaching and practicing self-care and healthful habits are provided.

3. Knowledge family appears to have of neighborhood parks, playgrounds or recreational facilities and the use they are making of these facilities.

4. If parents work, provisions family has made for care of child and the understanding that family has given to the person who cares for the child as to the extent of her responsibilities.

5. Indications in home that family is providing child with stimulating materials such as appropriate toys (either improvised at home by family or child, or purchased), picture books, records, etc.

6. Plan of daily living which family has developed in relation to providing child with security of routines, opportunities for varied interesting activities and experiences, adequate rest and responsibilities in accordance with child's capacities and abilities.

7. General atmosphere of home; warm, relaxed, with evidence of toleration and understanding of a growing child's activities, or cold, bare, cheerless, with strong evidence of emphasis on adult standards.

## EVALUATION OF SCHOOL EXPERIENCES

Try to assess the meaning of school experiences to child and family. If the child is of school age, but not in school, try to obtain a picture of what this may mean to the child and his family. For better understanding of the child's school experience, information should be obtained about his classroom activity from the school public health nurse or the teacher.

1. Kind of school and class which child attends:
  - a. Regular class in public, private or parochial school.
  - b. Special class; nursery school; special kindergarten.
2. Reactions of child to school, or to non-attendance at school:
  - a. Upset, rebellious, apathetic, indifferent.
  - b. Enthusiastic, willing.

3. Impression of parents' attitude toward child's school experience:
  - a. Understand school experience from child's point of view.
  - b. Emphasize academic achievement only.
  - c. Consider child's time in school as restful period while child is out of the home.
4. If child is not in school, impression of parents' attitude:
  - a. Never applied for school admission.
  - b. Shocked, resentful of non-acceptance or exclusion of child by school.
  - c. Accepting of child's deviant development.
  - d. Concerned about long range plans for special education or special schools.
  - e. Understanding and acceptance of reasons given for exclusion or non-acceptance by school.

## NURSING CARE PLAN AND RECORDING

### Tentative identification of problems and classification of family

On the basis of the assessments being made and the information being obtained either by the generalized public health nurse or the nurse in a specialized service, tentative identification of the problems found should be made. Also, try to make a tentative classification of the family in relation to the most productive areas with which to work. It should be kept in mind that problems and families do not, in most instances, fall into clear-cut patterns, but these tentative groupings will be helpful in setting short-term and long-term goals and plans for further public health nursing care which will best serve this family. These goals and plans must be flexible enough to allow for shifts in emphasis and for changing impressions of the family, but should be specific enough to make ongoing judgments for continued action:

*Identification of kinds of problems if any have been found*

1. Those which the family is aware of and for which assistance has been requested.
2. Those which are urgent and serious because they may threaten life.
3. Those which have very serious implications for a normal mental, physical, and social future of the child but which do not seem, at present, to be a threat to life.
4. Those which fall within the range of normal mental, physical, and social development and for which parents want and can accept help.
5. Those which need continued careful observations and followup to see whether they persist and whether or not the family is ready to discuss them.

*Classification of family in relation to needs and to areas of productive and nonproductive concentration*

1. Those families with a child who has severe pathological conditions (medical, emotional, social, developmental, etc.) and whose relationship with the child is severely disturbed :
  - a. Areas of productive work in terms of :
    - Case finding.
    - Referral to appropriate medical, psychiatric, social agencies.
    - Support while other specialized agencies give direct services for the pathological conditions.
    - Liaison between family, school, and agency.
    - Specific nursing care and prescribed treatment in the home.
    - Guidance toward general good physical health which is as normal and as well supervised as possible under the circumstances.
  - b. Areas of nonproductive work in terms of *excessive* time spent with :
    - Pathological attitudes.
    - Minor emotional problems.
    - Child rearing practices which appear to be of doubtful value under the circumstances.
2. Those families who fall within the range of what appears

to be normal, but who are interested only in such direct services for their children as physical examinations, prophylactic immunizations, followup of medical problems and handicapping conditions and certain specific medical health and social information, such as dietary advice, economic assistance, etc.:

a. Areas of productive work in terms of:

Direct exchange of health information as requested by the family.

Reassurance in relation to the good physical health and care of the child.

Anticipatory guidance in relation to normal growth and development and to more simple interpretations of child care.

Assistance in helping family through minor emergency situations.

Assistance in helping family work out plans for followup of medical and handicapping problems.

Encouragement to discuss what appears to be objective evidences of existing problems.

Continued careful observations and followup of problems, such as found in child-parent or school relationships, areas of development, etc., to see whether these problems persist and whether family may be ready to discuss them on subsequent occasions.

b. Areas of nonproductive work in terms of *excessive* time spent with:

Attitudes and insights *until* requested by family.

Emotional and developmental problems, particularly those as yet not recognized or accepted by the family.

3. Those families who, like the second category above, fall within the range of what appears to be normal, but who in addition *want* and *can accept* help in the area of developmental, emotional and relationship problems with their children:

a. Areas of productive work in addition to those listed above for the second category of families, in terms of:

Direct services of support and reassurance in areas of developmental, emotional and relationship problems.

Assistance in helping parents gain insight into their own attitudes as related to their care of the child.

Anticipatory guidance in relation to deeper interpretation of normal growth and development and of child care.

Referral to appropriate agencies when objective evidences

are present of anxieties and guilts about the child which are persistent and which do not appear to be relieved by ordinary releases.

## Recording of plan

In relation to recording the appraisal of the child and his family, the areas of nursing service being given, and the on-going plans for continued public health nursing care, the following points are suggested as a guide:

### *Evaluations*

1. Initial Evaluation:
  - a. On each visit during the initial total evaluation, record assessments in detail.
2. Subsequent Evaluations:
  - a. At periodic intervals, evaluate in detail, recording signs of change in the activities of the child and his family.
  - b. On each subsequent visit, observe and record:
    - The particular area of development that the child and his family seem to be working with the most.
    - An estimate of their efforts and understanding.

### *Followup*

1. Record your impression of the family's or child's willingness to follow through with their own planning or with the suggestions and recommendations made by yourself and any agency or diagnostic/treatment service working with the family.
2. Look for and record any indications as to whether or not the family really understands what these recommendations mean and what it means to put them into practical operations.
3. Record any new materials or teaching introduced and how these were accepted by the family.
4. Record any objective evidences of changes in nurse-family-child relationships.

### *Liaison*

1. If the child and the family are currently under the intensive care of any diagnostic or treatment service, record periodic communications with the nurse or other liaison person in these services in relation to observations and to information concerning changes in diagnosis and in present and long-term goals for treatment.
2. If the child is active in community services which are contributing to his development, such as schools, record periodic communications with the nurse or other liaison person or teacher in relation to observations and followup.
3. At all times, sufficient copies of records should be made to reach all services concerned with the child and his family.

### *Public health nursing care plans*

1. On each visit, attempt to assess and record your plans for future visiting around such possible goals as:
  - a. Case finding in relation to continued appraisal of the child in his home setting for better understanding of his patterns of activities in case it is suspected that his development deviates from normal.
  - b. Guidance of parents to reliable diagnostic and evaluation services, as well as to general health supervisory services such as child health clinics, or top private pediatricians.
  - c. Assistance to family in understanding and following recommendations made by the diagnostic and treatment sources.
  - d. Support and reassurance.
  - e. Specific information and help to families in:
    - Applying existing knowledge of hygienic measures directed toward the promotion of health.
    - Understanding child at his individual level of development.
    - Looking for signs of behavior indicating readiness for next step in development.
    - Preparing child for new experiences.
  - f. Consultation with the nursing supervisor or nursing specialist on different aspects of work with the family.

2. On the basis of identification of problems found and classification of family, record plans for the most productive areas and goals, as listed above, in which to concentrate public health nursing care.

### *Records*

Cumulative records of public health nursing work with children and their families should include:

1. Relevant family history.
2. Appraisal of the socioeconomic background and problems of the family.
3. Information concerning such health problems of the whole family as may have come under the nurse's observation and care.
4. Developmental and physical appraisal of the child and his family as outlined in this guide.
5. Tentative identification of problems found.
6. Tentative classification of the family in relation to the kind and amount of productive followup that public health nursing can render which will best meet the needs of the family.
7. Recommendations for the most appropriate public health nursing care plan at this point for the child and his family.
8. Progress of nursing care plan with family.
9. Contacts with other agencies also working with the family.
10. Reassessments and changes in plans.

## GENERAL COMMENTS CONCERNING CONFERRING WITH FAMILY ABOUT THEIR CHILD

The primary medium through which public health nursing service is given to the family in relation to the child is the conference with the family. It is the medium through which the kind of acceptance and warmth of human interest is conveyed to the family

which is important in establishing rapport with the family. This rapport is of paramount importance in productive work with the family in relation to obtaining accurate relevant information without causing feelings of threat, to advising and reassuring the family when needed without causing feelings of guilt and anxiety, and to assisting the family to plan for the care of the child without causing resentment.

While there are no "gimmicks" which can be utilized to bring about this good relationship between the family and the public health nurse, there are certain general approaches which have been found to be helpful in conferring with the family. They have also been identified as being useful and applicable in a public health setting where limited time is allotted with the family in the clinic or in the home.<sup>2</sup> They involve not only skills in listening and in wording questions and comments, but also an interest and understanding which are conveyed in manner and tone of voice. It must be remembered, however, that each child and his family are unique; each having an individual personality and set of problems. These suggestions for conferring with parents are only tentative guides which must be individualized with each family.

1. Try to provide an environment which may build a cooperative relationship, not only by selection of words and comments but by the physical setting. A conference in the nursing office with the nurse seated behind a desk places her in a position of authority rather than that of being a partner. Unless the family specifically seeks this kind of interview, try to hold all conferences in the home where the family may feel more relaxed and secure. If the conference is held in a clinic, such as the child health clinic, or in the school, try to provide a physical setting which has some degree of privacy and a comfortable relaxed atmosphere. Seating the parents beside yourself, rather than across the desk, and keeping note taking to an unobtrusive minimum during the conference, may help to encourage the feeling of "sharing" the problem.

2. Try to recognize what you, as a nurse, may mean to each family for some understanding of what they may want from you: an authoritarian person who will make decisions for them concerning the child? an authoritative person who has the professional knowledge they wish to know? an "older-sister" figure to whom they can talk freely? Also, try to understand something of how you are reacting to these expectations. Although it may be necessary, especially at first, to assume different roles to try to fit the family's varying needs, it

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<sup>2</sup> See items listed in bibliography by Korsch and Levy and by American Public Health Association, Committee on Child Health.

should be done with some self-knowledge of the dynamics of each particular situation.

3. A compliment to the parents about the child or about the job they are doing with the child helps to establish a friendly relationship, but the compliment must be *sincere* and *appropriate*. The following comments may indicate to the parents that they are recognized as persons, not just caretakers of a child :

"I think you're doing very nicely."

"My, but you've done a fine job."

4. Avoid types of comments, especially at the beginning of the conference or visit, which could be interpreted as scoldings or disapprovals, such as "I've come to see why you haven't been to well baby clinic", or "I want to talk to you about that appointment you broke for Johnny at the clinic. Haven't you taken him for that examination yet?" or "The clinic called me to see you at home because the doctor wants to know how you take care of him at home." Try a more relaxed, general opening which may encourage parents to talk more freely, such as :

"How are things going with Johnny? We haven't seen him for some time."

"I haven't seen you for some time. Tell me how are you getting along?"

"How's Johnny doing these days?"

"Did they tell you in the clinic when you registered there last week that we like to know the children both in the clinic and at home?"

"Last week in the clinic the doctor talked to you about Johnny's not walking as yet and suggested that we see him at home. We usually visit families who have children who are late in walking."

5. Avoid the assumption that parents want help or advice with the child. If the family does not want it or is not ready for it, they may take the advice as criticism and refuse to cooperate. Find out how they feel about the situation and what they have already planned to do with such questions as :

"What are you planning to do?"

"What would you like to do?"

"How can I help you?"

6. Listen carefully to what the parents tell you. Avoid taking over the conference. Listening in an accepting fashion to the parents' account of their situation and their reactions does not necessarily imply *approval*, but it can indicate *interest* and *understanding* before any specific advice is given which might indicate criticism of the

parents' current practices with the child. Encourage parents to talk with such comments as:

"How are you managing now that Johnny is toddling into everything?"

"Tell me about it."

"Tell me more about it."

7. Try to learn what the mother and father think and feel about their child. The child's behavior cannot be understood until something is known about the parents' attitudes. Questions which might bring out more details of feelings are:

"Why do you think he did that?"

"Why does that trouble you?"

8. Look for clues pointing to the fact that the parents may need more than a simple explanation or a few words of reassurance. These clues often indicate a deeper probing of the way the parents act and feel is needed. Some of these clues are: apparent inability or refusal of the parent to take in a commonsense explanation or reassurance; and, when the feelings of the parents about the problem is all out of proportion to its size and seriousness.

9. Remember that some parents may express hostility toward medical, nursing and educational persons. Do not be too quick to offer an explanation or to correct a possible false impression. Give parents sufficient time to express these feelings; they may have need to express the negative aspects of the situation before they are emotionally free or ready to talk of the positive side. Sympathetic rejoinders during a period of hostility might be:

"That wasn't an easy experience for a mother to go through."

"It must have been a difficult time (experience, feeling, etc.) to go through in the clinic."

"You've had it pretty tough in getting help for Johnny."

"I can see where you might feel that way under the circumstances you describe."

10. Accept the parents' feeling about the child, whatever it is and however they express it. Remember, parents are prejudiced in favor of their children. So avoid any kind of criticism when they express their feelings about the child. Sometimes it helps parents to clarify some of their thinking yet not indicate any criticism if some of their comments are restated, such as:

"You think Johnny does this to be mean to you?"

"You can't understand why he does that."

11. Avoid using personal examples of your own experience to try to explain to the family what they are feeling and what they should do. This is often resented as "not applying to our case" or as intruding on their preoccupation with their own problem. It is better to remove the problem from personal comparisons and to phrase the comment in a way to make it sound universal, such as "Many mothers have found that ——," or "Most children like to ——." This places emphasis on accepting and generalizing the feeling expressed so as to permit the parents an opportunity to face it and see it in perspective.

12. Listen willingly to anything the parents may say and follow up with replies which do not put you in a position which sounds as if you are arguing with the parents over the child as this arouses resentment and resistance and a feeling that the nurse is "siding with the child against us."

13. If the parents voice a worry or a problem, find out the reason behind it. It is best not to assume that you know the reason why; the real reasons as they are uncovered may surprise you. Sympathetic rejoinders which may indicate to parents that their feelings and worries have been accepted and taken seriously and which may lead to expressions of what is really disturbing them so much in the situation are:

"You are concerned about this, aren't you?"

"What is it that worries you about his doing that?"

"Why does that trouble you?"

14. Give the parents your undivided attention in a relaxed, friendly manner. Try to forget all the other families which must be visited during the day. This particular child and his problems are of the greatest importance to the parents and to the nurse at this time.

15. Withhold direct advice when parents ask you to solve the problem after they have described it to you. Talk over the situation and jointly arrive at a decision with such helpful questions as:

"What do you think?"

"How do you explain that?"

"Why do you suppose he does it?"

16. The major idea behind counseling parents is to encourage them to be self-reliant and to act on their own. So when a parent has his own idea about what to do, accept it if you possibly can. If their

plan fails, it is always possible to work on another approach to the problem by asking questions which may obtain further information concerning the parents' and child's reaction to the plan. Minor changes may be made to the parents' original plan. Questions might be asked such as:

"Why do you think it didn't work out as you planned?"

"Where along the way do you think the plan didn't work?"

17. If the parents do not know what to do, suggestions may be given for working together on the problem. Such suggestions are:

"Maybe this will work. Do you think it will?"

"We can do this and see how it comes out."

18. Utilize the parents' own ideas and resources whenever possible. Help parents grow in finding and using their own strengths with such verbal indications of your belief in them as:

"What have you tried to do about it so far?"

"What have you found helps so far?"

"What are you planning to do?"

"What did you find helped you before?"

"You know the facts of the situation so much better than I—what do you think might help?"

19. Gear your thinking to that of the parents and do not push too far nor too fast. Think objectively about the *problems* in the family, but be subjective about the *parents and the child*; that is, try to stand in their shoes and look at problems through their eyes in order to find the proper words and acts to help them.

20. There are times when the conference needs to be set back on another track or when it would get out of hand if not brought back to the purpose of the conference. One way to guide the discussion is to pick out a key phrase, "You were saying that Johnny fights ——" and carry the parents' story back to a fork in the conversation in order to keep them from wandering too far afield. However, in restating a point, it is essential to catch the parents' own meaning and not inject your own point of view in the wording.

21. Try to understand your own feelings in relation to this specific family and whether or not you are becoming too emotionally involved and more identified with one or the other member of the family.

22. If it is necessary to terminate the interview before the parents

have stopped talking, try to do so on an accepting, forward-looking note, such as:

"I'm very interested in these things you've been telling me, but I'm sorry our time is about up for today."

"The next time you come back we'll continue."

"This may take us some time to find out why Johnny does this, so let's make another appointment for us to continue."

23. As you end the discussion, try to leave the parents with a feeling of having accomplished something and of going ahead in meeting the problem by:

Briefly summarizing the points covered.

Setting the next date to meet.

Pointing out some positive aspects of the situation.

Restating the joint undertaking for attacking the problem.

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