Advanced Practice Nursing in Child Maltreatment: Practice Characteristics

Gail Hornor, DNP, CPNP, & Pamela Herendeen, DNP, CPNP

ABSTRACT

Introduction: Child maltreatment is a problem of epidemic proportions in the United States. Pediatric nurse practitioners and other advanced practice nurses (APNs) have been caring for maltreated children for decades, yet to date no comprehensive assessment of their practice characteristics or their clinical and academic contributions to the field has been performed. The purpose of this study is to describe the practice characteristics of APNs who care for maltreated children.

Method: A descriptive design was used for this study. Child advocacy centers and children's hospitals were contacted to inquire about employment of child maltreatment APNs in their institution, and contact information for the lead APN was obtained. The Nurse Practitioner Survey was then sent to lead APNs by e-mail.

Results: The majority of APNs who work primarily in child maltreatment are pediatric nurse practitioners who work in child advocacy centers. They are providing care to children with physical and/or sexual abuse concerns; however, APNs provide care for children with all types of child maltreatment concerns.

Discussion: APNs play a vital role in the care of abused/neglected children. Their important contributions include not only clinical care but also the provision of clinical and didactic education to other professionals, parents, and the public. Research and publication are also essential to their role. J Pediatr Health Care. (2014) *28*, 438-443.

KEY WORDS

Advanced practice nursing, child maltreatment

Child maltreatment is a problem of epidemic proportions in the United States. During 2011, approximately 681,000 children were victims of child maltreatment (U.S. Department of Health & Human Services, 2013). An estimated 1,570 children died nationally as a result of child abuse or neglect, a rate of 2.10 deaths per 100,000 children. Reports indicate that in 2011, 78% of victims experienced neglect, 18% were physically abused, 9% experienced sexual abuse, and 8% were psychologically maltreated. Finkelhor, Ormrod, & Turner (2007) and Turner, Finkelhor, & Ormrod (2010), in nationally representative samples of 2,030 children and 4,053 children, respectively, found that 69% and 66% of the children had experienced more than one form of child maltreatment. In an acknowledgment of the scope of the problem, the American Academy of Pediatrics has recognized child abuse pediatrics as a subspecialty, and the inaugural board certification was offered in 2009. The National Association of Pediatric Nurse Practitioners (NAPNAP) also recognizes the significance of the problem and sponsors a Special Interest Group dedicated to child maltreatment and neglect.

DESCRIPTION OF PRACTICE CHARACTERISTICS LACKING

Although authors have described the global pediatric nurse practitioner (PNP) role, as well as specific practice specialties such as inpatient, preoperative, cardiology, endocrinology, early intervention settings, and others (Borgmeyer et al., 2008; Freed et al., 2010; Katz et al., 2007; & Vaughese et al., 2006), no studies to date have described the practice characteristics of

Gail Hornor, Pediatric Nurse Practitioner, Center for Family Safety and Healing, Nationwide Children's Hospital, Columbus, OH.

Pamela Herendeen, Pediatric Nurse Practitioner and Associate Professor of Nursing, University of Rochester, Golisano's Children's Hospital, Rochester, NY.

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Correspondence: Gail Hornor, DNP, CPNP, Center for Family Safety and Healing, Nationwide Children's Hospital, 700 Children's Dr, Columbus, OH 43205; e-mail: Gail.hornor@nationwidechildrens.org.

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PNPs and/or other advanced practice nurses (APNs) in child maltreatment. PNPs and other APNs have been working in the area of child maltreatment for decades, yet to date no comprehensive assessment of their practice or their clinical and academic contributions to the field has been performed. For purposes of this study, a child maltreatment APN is defined as an APN who works as a member of a team dedicated exclusively to the assessment, diagnosis, and treatment of children and adolescents for whom there is a concern of suspected child maltreatment.

PURPOSE OF THE STUDY

The literature describes the practice characteristics of PNPs and other APNs in a variety of specialty roles, substantiating their contributions to the field. The practice characteristics of APNs working in the area of child maltreatment remain unexplored. The purpose of this study is to describe the practice characteristics of APNs in the area of child maltreatment in terms of the following:

a. Type of APN educational preparation (e.g., PNP vs. family nurse practitioner [FNP])
b. Educational level
c. Years practicing as an NP and practicing in child maltreatment
d. Practice site
e. Type of abuse concern addressed in practice
f. Number of NPs in the facility
g. Clinical education provided
h. Academic appointment
i. Academic activities
j. Sexual assault nurse examiners

REVIEW OF LITERATURE

The PNP is an APN specializing in pediatric health care (NAPNAP, 1995). The PNP is a registered nurse who has completed a program of NP preparation at a school of nursing as part of a masters in nursing degree program. This education provides PNPs with advanced knowledge and clinical skills in child health care, which allows them to provide a wide range of health care services for children from birth through adolescence. The PNP collaborates with other health care professionals and practices as an interdependent member of the health care team to provide pediatric care. The PNP role emerged during the mid 1960s as registered nurses prepared at the certificate level through a formalized advanced educational program and evolved in the 1990s to nurses prepared at the masters-degree level (NAPNAP, 1995). The role continues to evolve with the development of the doctorate in nursing practice (DNP) as the proposed terminal credential and level of education for the PNP originally anticipated by 2015 (NAPNAP, 2008).

PNPs are important members of the health care team that provides care to children (Freed, Dunham, Lamarand, Loveland-Cherry, & Martyn, 2010). Currently nearly 13,000 PNPs practice in the United States (Pediatric Nursing Certification Board, 2010). Freed and colleagues (2010) surveyed a stratified random sample of 1200 PNPs to gain a better understanding of the role, primary care versus subspecialty focus of practice, professional setting, and responsibilities. A structured questionnaire was developed by Freed and colleagues (2010) and administered by mail. Of the 1200 surveys mailed, 905 were returned for a response rate of 82.4%. More than half of the participants (59%) worked in primary care, and the majority (64%) did not work in an inpatient setting. Most PNPs reported that they often perform general and specialty practice roles such as patient assessment and diagnosis, development of treatment plans, and immunizations. Freed and colleagues (2010) concluded that PNPs have an important role in pediatric primary and subspecialty care.

Reider-Demer, Widecan, Jones, & Goodhue (2006) point out the continued evolution of the PNP role to meet the ever more complex health care needs of the pediatric population. The PNP role was initially developed to provide pediatric primary care. PNPs now practice in a variety of settings: private practices, hospital clinics, school clinics, and inpatient settings, including emergency departments (EDs) and intensive care units. PNPs are now providing not only primary care but secondary and tertiary care as well.

PNPs practice in a variety of settings, and their effectiveness has been evaluated in these settings (Frisch, Johnson, Timmons, & Weatherford, 2010). As in the adult health care arena, more and more pediatric surgical procedures are being performed in outpatient settings. Children and parents report not feeling emotionally and educationally prepared for outpatient surgery (Frisch et al., 2010). Developmentally appropriate preoperative educational programs and parental involvement in the surgical experience have been found to help alleviate the anxiety of both parents and children. PNPs are being used in preoperative settings to perform physical examinations and provide preoperative education. A longitudinal study was conducted at Cincinnati Children's Hospital by Vaughese, Byczkowski, Wittkugel, Kotagal, and Kurth (2006) to evaluate quality of care after the implementation of preoperative physical examinations and education performed by PNPs. Data were collected over 1 year at 3 months, 6 months, 9 months, and 12 months after commencement of the PNP program. Quality of care was evaluated on the basis of respiratory complication rate, preoperative preparation time, parental satisfaction, and staff satisfaction. Using a scale of 0 (worst care) to 10 (best care), an average overall rating of care was obtained at each data collection point. Overall mean scores were 9.49 (baseline), 9.50 (3 months), 9.48 (6 months), 9.29 (9 months), and 9.44 (12 months).