CHILD HEALTH NURSING.

Placement: Third Year.

Time: Theory-90 Hrs.
(Class 80 + Lab 10 hrs)
Practical-270 Hrs.

Course Description: This course is designed for developing an understanding of the modern approach to child-care, identification, prevention and nursing management of common health problems of neonates and children.

Specific objectives: At the end of the course, the students will be able to:

1. Explain the modern concept of child care and the principles of child health nursing.
2. Describe the normal growth and development of children in various age groups.
3. Explain the physiological response of body to disease conditions in children.
4. Identify the health needs and problems of neonates and children, plan and implement appropriate nursing interventions.
5. Identify the various preventive, promotive and rehabilitative aspects of child care and apply them in providing nursing care to children in the hospital and in the community.

Unit	Learning Objectives	Content	Hrs : allocation.
I	*Explain the modern concept of child care & principles of child health nursing. *Describe national policy progammes & legislations in relation to child health & welfare. *List major causes of death during infancy, early & late childhood. *Describe the major functions & role of the paediatric nurse in caring for a hospitalized child. *Demonstrate various paediatric nursing procedures	**Introduction : Modern concept of child care.** • Introduction to modern concept of child care & history, principles & scope of child health nursing. • Internationally accepted rights of the Child National policy & legislations in relation to child health & welfare. • National programmes related to child health & welfare. • Agencies related to welfare services to the children. • Changing trends in hospital care, preventive, promotive & curative aspects of child health. • Child morbidity & mortality rates. • Differences between an adult & child. • Hospital environment for a sick child. • Impact of hospitalization on the child & family. • Grief & bereavement. • The role of a child health nurse in caring for a hospitalized child. • Principles of pre & post-operative care of infants & children. • Child health nursing procedures.	**T 10 hrs.** **P 05 hrs** 1 1 1 1 1 1 1 1 1 1 5

Unit	Learning Objectives	Content	Hrs : allocation.
II	*Describe the normal growth & development of children at different ages *Identify the needs of children at different ages & provide parental guidance *Identify the nutritional needs of children at different ages & ways of meeting the needs. *Appreciate the role of play for normal & sick children. *Appreciate the preventive measures & strategies for children.	**The healthy child** • Principles of growth & development. • Factors affecting growth & development. • Growth & development from birth to adolescence • The needs of normal children through the stages of developmental & parental guidance • Nutritional needs of children & infants: Breast feeding, supplementary & artificial Feeding & weaning. • Baby friendly hospital concept. • Accidents: causes & prevention. • Value of play & selection of play material. • Preventive immunization, immunization programme & cold chain. • Preventive pediatrics • Care of under five & under five clinics/ well baby clinic.	**T 18 hrs.** **P 02 hrs** 1 1 6 2 1 2 2 2 1 2
III	*Provide care to normal & high risk neonates. *Perform neonatal resuscitation. *Recognize & manage common neonatal problems.	**Nursing care of a neonate.** • Nursing care of a normal newborn / Essential newborn care. • Neonatal resuscitation. • Nursing management of a low birth weight baby & high risk babies. • Kangaroo mother care. • Organization of neonatal unit. • Identification & nursing management of common neonatal problems. • Nursing management of babies with common congenital malformations. • Control & prevention of infection in N.I.C.U.	**T 12 hrs.** **P 03 hrs.** 4 1 4 1 1 1 2 1
IV	*Explain the concept of IMNCI & other health strategies initiated by National population policy 2000.	**Integrated management of neonatal & childhood illnesses (IMNCI).** Health strategies: National population policy- • RCH camps & RCH outreach schemes. • Operationalization of district newborn care, home based neonatal care. • Border district cluster strategy. • Integrated management of infants & children with illnesses like diarrhea, A.R.I., malaria, measles & Malnutrition. • * Nurses' role: IMNCI.	**10 hrs.** 2 2 1 3 2

U nit	Learning Objectives	Content	Hrs : allocation.
V	*Provide nursing care in common childhood diseases. *Identify measures to prevent common childhood diseases including immunization.	**Nursing management in common childhood diseases-** • Nutritional deficiency disorders. • Respiratory disorders & infections. • Gastro-intestinal infections, infestations, & congenital disorders. • Cardio-vascular problems: congenital defects & rheumatic fever, rheumatic heart disease. • Genito-urinary disorders: acute glomerulo nephritis, nephritic syndrome, Wilm's tumour, infections, calculi, & congenital disorders. • Neurological infections & disorders : convulsions, meningitis, hydrocephalus, head injury. • Hematological disorders : anemias, thalassemia, ITP, leukemia, hemophilia. • Endocrine disorders: juvenile diabetes mellitus & other diseases. • Orthopaedic disorders : club feet, hip dislocation & fracture. • Disorders of skin, eye & ears. • Common communicable diseases in children, their identification, nursing care in hospital & home & prevention. • Child health emergencies : poisoning, haemmorrhage, burns & drowning. • Nursingcareof infant and children with HIV / AIDS	**20 hrs.** 1 2 2 3 2 3 2 1 1 1 1 1
VI	*Manage the child with behavioral & social problems	**Management of behavioural & social Problems in children.** • Management of common behavioral disorders. • Management of common psychiatric problems. • Management of challenged children: • Mentally, physically, & socially challenged. • Welfare services for challenged children in India. • Child guidance clinics.	**10 hrs.** 4 2 2 1 1

References-

1. Ghai O.p. et al. (2000) Ghai's Essentials of Paediatrics. 1st edn. Mehta offset works. New Delhi.

2. Marlow Dorothy & Redding. (2001) Textbook of Paed. Nsg. 6th edn. Harbarcourt India ltd. New Delhi

3. Parthsarathy et al. (2000) IAP Textbook of Paediatric Nsg. Jaypee bros., 2 nd ed. New Delhi.

4. Vishwanathan & Desai. (1999) Achar's Textbook of Paediatrics 3rd ed. Orient Longman. Chennai.

5. Wong Dona et al. Whaley & Wong's Nursing care of infants & children.6th edn. Mosby co., Philadelphia.

6. Dr. C.S. Waghale, Principles and Practice of Clinical Pediatrics, Vora publication 1996

PRACTICAL

Time: 270 hrs (9 weeks)

Areas	Duration (in weeks)	Objectives	Skills	Assignments	Assessment methods
Pediatric medicine ward	3	• Provide nursing care to children with various medical disorders • Counsel and educate parents	• Taking pediatric history • Physical examination and assessment of children • Administer of oral, IM/IV medicine and fluids. • Calculation fluid requirements • Prepare different strengths of IV fluids • Apply restraints • Administer O2inhalation by different methods • Give baby bath • Feed children by katori spoon etc • Collect specimens for common investigations • Assist with common diagnostic procedures • Teach mothers/parents ➢ Malnutrition ➢ Oral rehydration therapy ➢ Feeding and weaning ➢ Immunization schedule ➢ Play therapy ➢ Specific disease conditions	• Give care to three assigned pediatric patients • Nursing care plan- 1 • Case study /Presentation - 1	• Assess clinical performance with rating scale. • Assess each skill with checklist OSCE/OSPE • Evaluation of case study / presentation and health education session. • Completion of activity record

Pediatric surgery ward	3	• Recognize different pediatric conditions / malformations • Provide pre and post operative care to children with common pediatric surgical conditions/ malformation • Counsel and educate parents	• Calculate,prepare and administer IV fluids • Do bowel wash • Care for ostomies: ➢ Colostomy irrigation ➢ Ureterostomy ➢ Gastrostomy ➢ Enterostomy • Urinary catheterisation and drainage • Feeding ➢ Nasogastric ➢ Gastrostomy ➢ Jejunostomy • Care of surgical wounds • Dressing • Suture removal	Give care to three assigned pediatric surgical patients Nursing care plan- 1 Case study / presentation - 1	• Assess clinical performance with rating scale. • Assess each skill with checklist OSCE/OSPE • Evaluation of case study / presentation and health education session. • Completion of activity record
Pediatric OPD/ Immunization room	1	• Perform assessment of children: Health, developmental and anthropometric • Perform immunization • Give health education/ nutritional education	• Assessment of children ➢ Health assessment ➢ Developmental assessment ➢ Anthropometric assessment • Immunization • Health / Nutritional education	Developmental study -1	• Assess clinical performance with rating scale • Completion of activity record.
Pediatric medicine and surgery ICU	1+1	• Provide Nursing care to critically ill children	• Care of a baby in incubator / warmer • Care of child on ventilator. • Endotracheal suction • Chest physiotherapy • Administer fluids with infusion pump. • Total parenteral nutrition • Phototherapy • Monitoring of babies • Cardio pulmonary resuscitation	Nursing care plan 1 Observation report 1.	• Assess clinical performance with rating scale • Completion of activity record • Evaluation of observation report.

EVALUATION

I. Internal assessment :

Maximum marks 25

Theory :	**Marks**
Midterm	50
Prefinal	75
Total marks	125

Practicum : Maximum marks 50

1. Case presentation - (Paed Medical / Surgical 01)		50
2. Case study - (Paed. medical. / surgical. 01)		50
3. Nursing care plan 03	3 x 25	75
4. Clinical evaluation of comprehensive. (paed. Medical / surgical / P.I.C.U./ N.I.C.U.)	3 X 100	300
5. Health teaching - 01		25
6. Assessment of growth & development reports. (20 marks each) (Neonate, infant, toddler, preschooler, & School age)	5 X 20	100
Observation report of NICU surgery/ Medical	1 x 25	25

Practical exam :

1. Midterm exam	50
2. Preterm exam	50
	725

II External assessment : University exam :

Theory	**75**
Practical	**50**

FORMAT FOR CASE PRESENTATION

Patients Biodata: Name, address, age, sex, religion, occupation of parent, source of health care, date of admission, provisional diagnosis, date of surgery if any

Presenting complaints: Describe the complaints with which the patient has come to hospital

History of illness

History of present illness – onset, symptoms, duration, precipitating / alleviating factors

History of past illness – illnesses, surgeries, allergies, immunizations, medications

Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems.

Childs personal data

Obstetric history of - prenatal & natal history of mother, growth an development (compare with normal), immunization status, dietary pattern including weaning, play habits, toilet training, sleep pattern, schooling.

Economic status of the family: Monthly income & expenditure on health, food and education material assets (own pacca house car, two wheeler, phone, TV etc…)

Psychological status: ethnic background, (geographical information, cultural information) support system available.

Physical examination with date and time

Investigations

Date	Investigations done	Normal value	Patient value	Inference

Treatment

Sr. No.	Drug (Pharmacological name)	Dose	Frequency / Time	Action	Side effects & drug interaction	Nursing responsibi--lity

Description of disease

Definition, related anatomy physiology, etiology, risk factors, clinical features, management and nursing care

Clinical features of the disease condition

Clinical features present in the book	Description of clinical features of patient	Pathophysiology

Nursing process:

Patients name Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementation	Rationale	Evaluation

Discharge planning:
It should include health education and discharge planning given to patient

Evaluation of care
Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Evaluation format for case presentation

SN	Content		Marks
1	Assessment / Introduction		05
2	Knowledge and understanding of disease		10
3	Nursing care plan		15
4	Presentation skill		10
5	A.V. aids		05
6	Overall		
	Time		01
	Summary& conclusion		02
	Bibliography		02
		Total	50

Format for case study

Format is similar to case presentation but should be in detail
The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

SN	Content		Marks
1	Assessment / Introduction		05
2	Knowledge and understanding of disease		15
3	Nursing care plan		20
4	Discharge plan		05
5	Summary & evaluation		02
6	Bibliography		03
		Total	50

Nursing care plan

1. **Patients Biodata:** Name, address, age, sex, religion, occupation of parents, source of health care, date of admission, provisional diagnosis, date of surgery if any
2. **Presenting complaints:** Describe the complaints with which the patient has come to hospital
3. **History of illness**

   History of present illness – onset, symptoms, duration, precipitating / alleviating factors
   History of past illness – illnesses, surgeries, allergies, immunizations, medications
   Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems

4. Childs personal data

Obstetric history of - prenatal & natal history of mother, growth an development (compare with normal),immunization status, dietary pattern including weaning, play habits, toilet training, sleep pattern, schooling.

5 **Economic status:** Monthly income & expenditure on health, food and education, material assets (own pacca house car, two wheeler, phone, TV etc…)

6 **Psychological status:** ethnic background,(geographical information, cultural information) support system available.

7 **Personal habits:** consumption of alcohol, smoking, tobacco chewing, sleep, exercise, work elimination, nutrition.

8 **Physical examination with date and time**

9 **Investigations**

Date	Investigations done	Normal value	Patient value	Inference

10. Treatment

SN	Drug (pharmacological name)	Dose	Frequency/time	Action	Side effects & drug interaction	Nursing responsibility

11. Nursing process:

Patients name Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementa –tion	Rationale	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient

12.Evalaution of care

Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Care plan evaluation

1. History taking	03
2. Assessment and nursing diagnosis	05
3. Planning of care	05
4. Implementation and evaluation	08
5. Follow up care	02
6. Bibliography	02
	25

EVALUATION FORMAT FOR HEALTH TALK

NAME OF THE STUDENT: ----------

AREA OF EXPERIENCE: _____

PERIOD OF EXPERIENCE: _____

SUPERVISOR: _____

Total 100 Marks

Scores: 5 = Excellent, 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

SN	Particular	1	2	3	4	5	Score
1	**I) Planning and organization** a) Formulation of attainable objectives b) Adequacy of content c) Organization of subject matter d) Current knowledge related to subject Matter e) Suitable A.V.Aids **II) Presentation:** a) Interesting b) Clear Audible c) Adequate explanation d) Effective use of A.V. Aids e) Group Involvement f) Time Limit **III) Personal qualities**: a) Self confidence b) Personal appearance c) Language d) Mannerism e) Self awareness of strong & weak points **IV) Feed back:** a) Recapitulation b) Effectiveness c) Group response **V) Submits assignment on time**						

* 100 marks will be converted into 25

CLINICAL EVALUATION PROFORMA

Name of the student : _____

Year : _____

Area of clinical experience : _____

Duration of posting in weeks : _____

Name of the supervisor : _____

Total Marks: - 100

Scores:- 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

SN	EVALUATION CRITERIA	Grades			
		4	3	2	1
1	**Personal & Professional behavior**				
1	Wears clean & neat uniform and well groomed.				
2	Arrives and leaves punctually				
3	Demonstrates understanding of the need for quietness in speech & manner & protects the patient from undue notice.				
4	Is notably poised and effective even in situations of stress				
5	Influential & displaced persuasive assertive leadership behaviour				
II	**Attitude to Co-workers and patients**				
6	Works well as member of nursing team				
7	Gives assistance to other in clinical situations				
8	Understands the child as an individual				
9	Shows skills in gaining the confidence & co-operation of child and relatives, tactful and considerate.				
IV	**Application of knowledge**				
10	Possess sound knowledge of pediatric conditions.				
11	Has sound knowledge of scientific principles				
12	Has knowledge of normal growth and development of children				
13	Has knowledge of current treatment modalities inclusive of medicine, surgery, pharmacology and dietetics.				
14	Takes interest in new learning from current literature & seeks help from resourceful people.				

SR NO	EVALUATION CRITERIA	Grades			
		4	3	2	1
V	**Quality of clinical skill**				
15	Able to elicit health history of child and family accurately.				
16	Skillful in carrying out physical examination, developmental screening and detecting deviations from normal				
	Identifies problems & sets priorities and grasps essentials while performing duties				
17	Able to plan and implement care both preoperatively and post operatively.				
18	Applies principles in carrying out procedures & carries out duties promptly.				
19	Has technical competence in performing nursing procedures. Able to calculate and administer medicines accurately				
20	Resourceful and practices economy of time material and energy.				
21	Recognizes the role of play in children and facilitates play therapy in hospitalized children				
22	Observes carefully, reports & records signs & symptoms & other relevant information				
23	Uses opportunities to give health education to patients & relatives				
24					
25					
	TOTAL				

Grade

Very good	=	70 % and above
Good	=	60 – 69 %
Satisfactory	=	50- 59 %
Poor	=	Below 50 %

Remarks for improvement:

Student's Remark:

Signature of the student Signature of the teacher

Assessment of growth & development reports

(Neonate, infant, toddler, preschooler, & School age)

PROFORMA FOR ASSESSMENT OF GROWTH & DEVELOPMENT

(Age group: birth to 5 yrs.)

I] Identification Data :

Name of the child	:	
Age	:	
Sex	:	
Date of admission	:	
Diagnosis	:	
Type of delivery	:	Normal/ Instrumental/ LSCS
Place of delivery	:	Hospital/ Home
Any problem during birth	:	Yes/ No
If yes, give details	:	
Order of birth	:	

II] Growth & development of child & comparison with normal:

Anthropometry	**In the child**	**Normal**
Weight		
Height		
Chest circumference		
Head circumference		
Mid arm circumference		
Dentition		

III] Milestones of development:

Development milestones	In Child	Comparison with the normal
1. Responsive smile 2. Responds to Sound 3. Head control 4. Grasps object 5. Rolls over 6. Sits alone 7. Crawls or creeps 8. Thumb-finger co-ordination (Prehension) 9. Stands with support 10. Stands alone 11. Walks with support 12. Walks alone 13. Climbs steps 14. Runs		

IV] Social, Emotional & Language Development:

Social & emotional development	In Child	Comparison with the normal
Responds to closeness when held Smiles in recognition recognized mother coos and gurgles seated before a mirror, regards image Discriminates strangers wants more than one to play says Mamma, Papa responds to name, no or give it to me. Increasingly demanding offers cheek to be kissed can speak single word use pronouns like I, Me, You asks for food, drinks, toilet, plays with doll gives full name can help put thinks away understands differences between boy & girl washes hands feeds himself/ herself repeats with number understands under, behind, inside, outside Dresses and undresses		

V] Play habits

Child favorite toy and play:
Does he play alone or with other children?

VI] Toilet training

Is the child trained for bowel movement & if yes, at what age:
Has the child attained bladder control & if yes, at what age:
Does the child use the toilet?

VII] Nutrition

- Breast feeding (as relevant to age)
- Weaning has weaning started for the child: Yes/No If yes, at what age & specify the weaning diet. Any problems observed during weaning:

Meal pattern at home

Sample of a day's meal: Daily requirements of chief nutrients:
Breakfast: Lunch: Dinner Snacks:
VIII] Immunization status & schedule of completion of immunization.

IX] Sleep pattern

How many hours does the child sleep during day and night?
Any sleep problems observed & how it is handled:

X] Schooling

Does the child attend school?
If yes, which grade and report of school performance:

XI] Parent child relationship

How much time do the parents spend with the child?
Observation of parent-child interaction

XII] Explain parental reaction to illness and hospitalization

XIII] Child's reaction to the illness & hospital team

XIV] Identification of needs on priority

XV] Conclusion

XVI] Bibliography

Evaluation Criteria: Assessment of Growth & Development (birth to 5 year)

(Maximum Marks: 50)

S.No.	Item	Marks
1.	Adherence to format	02
2.	Skill in Physical examination & assessment	10
3.	Relevance and accuracy of data recorded	05
4.	Interpretation Identification of Needs	05
5.	Bibliography	03
	Total	25

Note: - Same format to be used for assessment of infant, Toddler & Preschooler child.

PROFORMA FOR EXAMINATION AND ASSESSMENT OF NEW BORN

I] Biodata of baby and mother :

Name of the baby (if any) : Age

Birth weight : Present weight:

Mother's name : Period of gestation:

Date of delivery :

Identification band applied

Type of delivery : Normal/ Instruments/ Operation

Place of delivery : Hospital/ Home

Any problems during birth : Yes/ No

If yes explain :

Antenatal history :

Mother's age : Height: Weight:

Nutritional status of mother :

Socio-economic background :

II] Examination of the baby :

Characteristics	In the Baby	Comparison with the normal
1. Weight 2. Length 3. Head circumference 4. Chest circumference 5. Mid-arm circumference 6. Temperature 7. heart rate 8. Respiration		

III] General behavior and observations

Color :
Skin/ Lanugo :
Vernix caseosa :
Jaundiec :
Cyanosis :
Rashes :
Mongolian spot :
Birth marks :
Head :

- Anterior fontanel:

- Posterior fontanel:
- Any cephalhematoma / caput succedaneum
- Forceps marks (if any) :

Face:

Eyes:
Cleft lip / palate
Ear Cartilage :
Trunk:

- Breast nodule
- Umbilical cord
- Hands :

Feet / Sole creases :
Legs
Genitalia :
Muscle tone :
Reflexes :

- Clinging
- Laughing / sneezing :
- Sucking :
- Rooting :
- Gagging :
- Grasp :
- Moro :
- Tonic neck reflex :

Cry: Good / week
APGAR scoring at birth :
First feed given :
Type of feed given :
Total requirement of fluid & calories :
Amount of feed accepted :
Special observations made during feed:
Care of skin
Care of eyes, nose, ear, mouth :
Care of umbilicus and genitalia :
Meconium passed / not passed :
Urine passed / not passed :

IV] Identification of Health Needs in Baby & Mother.
V] Health education to mother about Breast feeding

Care of skin, eye and umbilicus etc.
V] Bibliography

Evaluation Criteria: Examination & Assessment of Newborn

(Maximum Marks: 50)

S.No.	Item	Marks
1	Adherence to format	02
2	Skill in Physical examination & assessment	10
3	Relevance and accuracy of data recorded	05
4	Interpretation of Priority Needs Identification of baby & mother	06
5	Bibliography	02
	Total	25

Maharashtra University of Health Sciences
External Practical Evaluation Guidelines
III Basic B.Sc Nursing
Subject : Child Health Nursing

50 Marks

Internal Examiner **25 Marks**

Nursing Procedure (15 marks)

Planning and Organizing	**5 marks**
• Preparation of tray	3
• Environment	1
• Preparation of patient	1
Execution of Procedure	**7 marks**
• Applies scientific principles	3
• Proficiency in skill	3
• Ensures sequential order	1
Termination of procedure	**3marks**
• Makes patient comfortable	1
• Reports & Records	1
• After care of articles	1

Viva (10 Marks)	**10 marks**
• Knowledge about common pediatric medical surgical conditions	3
• Preparation of various diagnostic procedures	2
• Instruments and articles	2
• Growth and Development	3

External Examiner **25 Marks**

Nursing Process (15 Marks)	**15 marks**
• Assessment	3
• Nursing Diagnosis	2
• Goal	1
• Outcome criteria	1
• Nursing intervention	3
• Rationale	2
• Evaluation	1
• Nurses notes	2

Viva (10 Marks)	**10 marks**
• National Health Programs for child care including IMNSI	2
• Behavioral and social problem in children	3
• Drugs	3
• Nursing care of neonates	2

CHILD HEALTH NURSING PRACTICAL EXAMINATION
PRACTICAL / ORAL MARK LIST

NAME OF THE EXAMINATION : CHILD HEALTH NURSING PRACTICALS

MONTH : **YEAR :**

THIRD YEAR Basic B. Sc NURSING : **MARKS : 50**

SUBJECT : CHILD HEALTH NURSING

CENTRE :

Roll No	Internal Examiner		External Examiner		Total	Total
	Procedure	Viva voce	Nursing process	Viva voce		
	15	10	15	10	50	25

Signature of the Internal Examiner **Signature of the External Examiner**

Date : **Date :**