ORIGINAL RESEARCH

Social pediatrics in a baccalaureate nursing curriculum

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ABSTRACT

This paper describes the use of social pediatrics in one baccalaureate nursing curriculum. Social pediatrics is a conceptual model that considers health as physical health and the social determinants of health. Social pediatrics focuses on community-based primary healthcare services for at-risk children and their families. The social pediatrics model is used by community early childhood education StrongStart sites in one Canadian province; these sites are collaborations between early childhood educators and public health nursing teams for children from infancy through five years of age. Acute care clinical placements are becoming too complex and limited in number to accommodate large undergraduate nursing cohorts. Our undergraduate nursing program recently shifted acute care pediatric placements to StrongStart sites, combining community pediatric and public health nursing learning objectives and learning activities that foreground social pediatrics. The acute care component of pediatric nursing includes classroom theory, clinical laboratory and virtual simulations. This paper describes social pediatrics integration within our undergraduate curriculum between 2018-2019; and a qualitative evaluation of our social pediatrics approach in 2019-2020. We used content analysis to identify common themes from interviews with key actors, including students' clinical instructors, StrongStart sites' early childhood educators and managers, and public health nurse managers affiliated with StrongStart sites. Common themes were related to social pediatrics learning opportunities and drawbacks; social pediatrics knowledge, skills and attitudes; and recommendations for curriculum enhancement.

Key Words: Social pediatrics, Community, Clinical education

1. INTRODUCTION

Social Pediatrics is an interdisciplinary community-based approach that builds supportive relationships between healthcare providers and community services for children and their families.[1] Health encompasses physical health and the social determinants of health. Health and community services are integrated to accommodate natural transitions across the developmental lifespan from early childhood to young adulthood. Social pediatrics offers a family-centered alternative to medicalized treatment of children and shifts the focus from disease treatment to therapeutic family and community relationships. This model of care began in the province of Quebec in Canada by Dr. Gilles Julien.[2] The model is based on the UN Convention "rights of the child." The model is designed to complement existing primary healthcare services and to provide holistic care to those children who are most vulnerable: children "experiencing extreme difficulty on the physical, social and psychological levels as well as families experiencing an alarming level of stress."[2] A central premise of social pediatrics is to acknowledge and reinforce existing competencies in children and their families. This model attempts to divert children from dangerous life course

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trajectories through sustained involvement with the child and their family in collaboration with existing services.[3,4]

In Canada, this model of care is championed by the Canadian Pediatric Society,[5] comprised predominantly of pediatricians. Uptake of the model by schools of nursing is relatively new, although the model is intended for collaborative practice. In Canada, our university-based baccalaureate nursing (BSN) program is the only program in the country to utilize the social pediatrics model within its undergraduate nursing curriculum.

The purpose of this paper is to describe integration of the social pediatrics model within the BSN pediatric-public health nursing curriculum of one university-based school of nursing. This paper also provides a preliminary qualitative evaluation with key actors involved in curriculum development and implementation over a 2-year period (2018-2020).

2. Overview of social pediatrics in a baccalaureate nursing program

2.1 Introducing the RICHER model

In 2005 the social pediatrics model was introduced to our school of nursing (SoN), and a year later, a collaborative initiative was launched between our SoN public health and pediatric nursing faculty and an inner-city primary care clinic servicing at-risk children and their families. The first of its kind in Canada, this social pediatric nursing initiative was known as Responsive Intersectoral Children's Health Education, and Research (RICHER).[1] The RICHER initiative expanded to community centers, daycares and non-profit family support sites within our province. A key feature of RICHER is the use of nurse practitioners to provide clinical services and make necessary referrals for further assessment and care (e.g., dental, nutrition, audiology). Families may drop in for healthcare needs—special bookings and appointments are not needed—to decrease the barrier for care. Evaluation of RICHER has shown that these community-based clinical services reach children with higher rates of complex health conditions and developmental needs than our typical population. Parents report having trusting relationships with clinical staff and positively rate their capacity to access supportive services for themselves and their children.[6]

Given the successful uptake of the RICHER social pediatrics model in our province, the model has been adopted by our provincial early childhood development program, StrongStart.[7] StrongStart Canada, akin to the US Headstart program, focuses on early learning development (e.g., language, cognitive, social-emotional, physical) for infants and children birth to five years of age. The StrongStart program is designed for children and their parents and caregivers in disadvantaged neighborhoods. StrongStart is an enrichment program facilitated by early childhood educators that prepares children for Kindergarten success. Interaction with children and adults is encouraged to build socialization skills. Attendance is no-cost, and parents and caregivers are invited to attend and network with other families.[7] On-site nurse practitioners have been replaced by public health nursing teams who make regular weekly visits to StrongStart sites. Public health nursing teams are based in community health centers located near StrongStart sites. Early childhood educators and public health nurses work collaboratively to assess and to refer children and their families for needed health services (i.e., physical, social determinants of health). Prior to 2017, our SoN faculty were using these sites as shadow experiences for undergraduate nursing students as part of ther public health nursing clinical component.

2.2 Shifting pediatric acute care to community care

With the increasing complexity of pediatric patients in acute care settings, our pediatric nursing faculty have had significant challenges finding suitable clinical placements for our undergraduate students. One US survey of pediatric nurse educators documented similar challenges with pediatric acute care placements and recommended a shift towards community-based clinical placements.[8] Common non-traditional settings for pediatric placements are public schools where students work with school nurses to address children's acute and chronic complaints. Students also develop and deliver health promotion events, such as health fairs and nutrition and dental hygiene sessions.[9,10] A concern is students' capacity to meet pediatric clinical objectives. One quantitative study randomly assigned students to either a hospital-based clnical placement, a half hospital and half non-traditional placement or a non-traditional placement. There were no significant differences in students' pediatric nursing test scores or clinical reasoning skills. The researchers concluded that a range of pediatric clinical sites are appropriate for education purposes.[11] Nontraditional clinical placements are often augmented with pediatric clinical simulations: Simulations aid successful completion of pediatric nursing clinical objectives with reports of high levels of student satisfaction.[12,13]

Given favorable findings in the literature, our SoN undergraduate pediatric faculty agreed to shift acute care clinical placements to community-based settings, beginning around 2018. This shift required the creation of a combined pediatric-public health nursing curriculum. Our BSN program is an accelerated 20-month program with five 12-week terms. The typical cohort size is 120 students. Public health and pediatric nursing are taught in the second term of the program.

Prior to our redesigned curriculum, students did six weeks of acute care pediatric clinical placements with an acute care theory component; and six-week public health nursing clinicals placements in primary care clinics and community health centers with associated public health nursing theory content.

The new, combined curriculum is six weeks of clinical placements in StrongStart sites with community pediatric and public health nursing theory. In addition to StrongStart experiences, students are assigned complementary community-based virtual simulations. This component of the curriculum is taught by public health nurses, preferably with community pediatric nursing experience. The other six weeks focus on acute care pediatric nursing theory with clnical laboratory and virtual simulations taught by acute care pediatric nurse clinical instructors. To accommodate student numbers, 60 students are at 18 inner-city StrongStart sites while the remaining 60 students are doing the acute care component: Students rotate mid-term,with the combined course covering one term or 12 weeks. For students who want to pursue pediatric nursing post-graduation, the final clinical practicum in the fifith senior term can be done in a community setting (e.g., community health center) or in an acute care setting.

The adopted conceptual model for the combined course is the RICHER social pediatrics model. Although the RICHER model focuses on community-based health services for at-risk children and their families, the model acknowledges the importance of integrated health care with primary care service links to secondary and tertiary care services. The model's unique aspect is its public health focus on upstream prevention and promotion—an important tenet of WHO international healthcare guidelines and initiatives.[14,15] Students' key social pediatrics learning objectives with sample clinical learning activities are in Table 1. The course includes other, generic learning activities such as individualized learning plans and reflection journals.

Table 1. Key social pediatrics learning objectives and sample learning activities

Key Learning Objective 1: Synthesize relevant history from patients, families and communities
Learning Activities: The Windshield survey, the Ages and Stages developmental screening tool The **Windshield suvey** is a public health nursing rapid observational assessment of the community. The survey can be conducted from a car (windshield) or community walk-about. The purpose of the survey is to give nurses an appreciation of community resources and potential/actual barriers to health and healthcare.[16] Each student observes and developmentally assesses an infant or child using the **Ages and Stages** developmental screening tool. This screening tool is for infants one-month-old to children five-six years old.[17,18] The student reviews their assessment with their clinical instructors.
Learning Objective 2: Determine the impact of factors such as age, sex/gender, disability, ethno-cultural background, social support and emotional influences on a child and family
Learning Activity: Virtual simulation, the Wheel of Intervention The course uses **Sentinel City®,** [19] a virtual community experience of four diverse neighborhoods. Students are given critical thinking questions related to key demographic factors for the child, family and community in the four cases. Students are asked to use the **Wheel of Intervention**[20] to propose potential public health nursing interventions for children, their families and their communities.
Learning Objective 3: Demonstrate an appreciation of the parent's perspective of and concerns for their child's health
Learning Activity: Health promotion teaching project Students are taught how to create a teaching lesson plan in collaboration with StrongStart early childhood educators based on family requests. During their 6 weeks at the sites, students organize and conduct a **health promotion project** with children (e.g., handwashing to eliminate germs) and with parents/caregivers (e.g., nutritional snack foods). Most recently, students at one StrongStart site conducted a session on stress management for community health workers and parents/caregivers.
Learning Objective 4: Collaborate with teachers, social workers, community leaders, child protection workers and other professionals to ensure child/family access to the social determinants of health. Learning Objective 5: Identify opportunities for advocacy, health promotion and disease prevention in the communities of children and their families.
Learning Activity for 4 and 5: The referral process Every student spends a day with the public health nursing team, **reviewing referrals** for StrongStart children and their families, to better understand the referral procress. The referrals are made by early childhood educators or public health nurses. For example, one new immigrant family required dental services and the public health nurses arranged a dental clinic visit with interpreter services.
Learning Objective 6: Describe how public health policy impacts on child health and access to health services, including the social determinants of health
Learning Activity: Online public health policy discussions An **online Discussion Board** is used to post current public health policy trends and issues related to accessibility of service for at-risk children and their families (e.g., COVID-19 vaccination planning). Students are asked to provide examples of how current policies are influencing the populations at their StrongStart sites. Clinical instructors and students post weekly to these policy Discussion threads--a different policy thread per week.

3. Methods: Evaluation of the social pediatrics curriculum and StrongStart clinical placements

Pediatric-public health nursing faculty conducted a qualitative descriptive study to answer the following question: "What are the barriers and facilitators associated with using StrongStart sites as combined pediatric-public health nursing clinical placements?" Internal funding was provided for the study and ethics permission was obtained through the university human ethics board (# H18-00873).

The study was conducted in 2018-2019 with interviews done via phone or in person with key actors involved in the curriculum redesign. Study participants were voluntarily recruited via email invitations sent out through the SoN researchers to three original StrongStart sites and their community health center affiliates; and to all SoN pediatric-public health nursing clinical instructors. Table 2 contains the interview questions.

Table 2. Interview questions

1	From your perspective, what type of learning opportunities are present for students in StrongStart settings?
2	What are drawbacks or concerns you have from having students present in StrongStart settings?
3	What pediatric-public health nursing knowledge-skills-attitudes (KSAs) are attainable at StrongStart settings?
4	What changes do you recommend to enhance the student learning experience in StrongStart settings?

Qualitative interviews were conducted by a research assistant, a practicing nurse with research background, and two SON nursing faculty with backgrounds in social pediatrics and qualitative research methods. Individual interviews were typically one hour long, and they were all audio-taped with permission, transcribed and de-identified. The research assistant and two faculty thematically coded the transcripts independently, meeting as a project team to discuss themes and reach consensus on themes and exemplar quotes. Common themes were identified across the interviewees.

4. Results

A total of 15 interviews were conducted: six SoN clinical instructors, three early childhood StrongStart educators, two StrongStart managers, and three public health nurse managers from community health centers affiliated with StrongStart sites. Table 3 summarizes common themes across the different interviewee groups per question.

Table 3. Common themes from interviews

Themes by Question	
Learning Opportunities	-Normal growth and development and developmental progression -Social determinants of health: impact on children and families -Expanded roles for nurses in multi-disciplinary teams in community settings -Family systems, family dynamics -The continuum of care, foregrounding health promotion and prevention
Drawbacks from this learning approach	-Combined course clinical instructors have either pediatric or public health backgrounds -Student concerns about learning in a community setting vs acute care setting -StrongStart staff do not know how to optimize students' engagement -StrongStart sites are based on a school year schedule -Children/families don't always attend consistently-lack of continuity for students
KSAs acquired through this learning approach	-Assessment, with a focus on growth and development and family systems -Communications with different age groups, adults -Teaching (systematic teaching plan development, implementation, evaluation) -Therapeutic relationships, including collaboration, relationship-building with children, families, educators and managers at sites -Professionalism, particularly autonomy and self-efficacy
Recommended Changes	-Shorten the time at StrongStart -Provide time in an acute care pediatric setting -Provide more orientation/training for instructors re: key learning objectives for pediatric nursing and public health nursing -Collaborate proactively with StrongStart sites to optimize use of students

4.1 Learning opportunities

All the interviewees identified multiple, similar learning opportunities in StrongStart settings. Instructors, educators, and managers appreciated having students on hand to provide more 1-on-1 quality time with children and their family members. Students introduced creative ways of teaching health education. For example, to teach handwashing and germs, students used special ink and ultraviolet light to show children the importance of good, sustained friction to eliminate germs on their skin. Another teaching area that students emphasized was the importance of updated vaccinations—the whats, hows, whys and whens.

"I think the opportunity is to really observe and understand normal growth and development of children, the various developmental stages, because there is a fairly wide range of children and ages and different cultural backgrounds. I think that is a very rich learning opportunity for students. I also think it's an opportunity to hear directly from parents what their challenges are in terms of supporting and nurturing their children's growth. I also think it's an opportunity to demonstrate collaboration between partners in the community and health and how we work together to support the health of families. So I think it's a very rich environment. Parents have an enormous number of questions about their children, about their children's growth and development, about the health care system. And we have an opportunity to really help increase their health literacy." (Public Health Manager A)

"I really see that the future of nursing is in the community and if we can connect with those families early, we can help support them" (Public Health Manager B)

"They [students] actually need to understand the fundamentally well child… that actually speaks to the higher critical thinking piece which they're not getting in the hospital setting [where] they're able to see goals and results, so they know something important is happening… in the community it's much more nuanced..so they really must understand the primary care setting and all the preventive steps before we get to a problem in the hospital."(Clinical instructor A)

"We get all the adults, all the caregivers from grandparents to nannies to moms, aunts, uncles, brothers, sisters come so you can tap into every single, you know, generation… " (StrongStart Manager A)

"I feel so honored that you are here, bringing up all the important topics and training them [students] on a practical level. It's really just the best teaching experience I think for them and for us to go through-it's wonderful." (Early Childhood Educator A)

4.2 Learning drawbacks

There were drawbacks to having students in the StrongStart setting, and most of these drawbacks were identified by the clinical instructors who had regular briefing and debriefing sessions with the students. The predominant concern was students' negative perceptions of learning pediatric nursing at these community sites. Students felt that they were being disadvantaged by doing all their pediatric clinical hours in a community setting. The StrongStart staff and familes in attendance were also confused by the students' presence over multiple weeks.

"The challenge is explaining to people, like [partners] and parents… what we do and why we are there. Similarly explaining exactly the same thing to the students because they don't understand. They are coming from an acute care background[first placements are medicine-surgery]. Now all of the sudden they're in the community playing with healthy children and they don't understand how that is public health nursing." (Clinical Instructor C)

"For nursing students the focus is skills-based. The reality is that it's a different set of skills in the community setting. They're not going to be practicing IVs." (Clinical Instructor D)

Many students and clinical instructors felt that six weeks in a StrongStart site was too long, particularly with logistic problems such as consistent attendance by the same children and their families. Some students were challenged learning how to build child/family relationships with irregular attendance. Students and clinical instructors also had to adapt to school year schedules; not always similar to typical clinical placement hours and schedules.

"The placements that we're able to utilize are sometimes morning or afternoon blocks of 2.5 hours and then they're closed during spring break. In order to supplement the hours there needs to be something for the students to do." (Clinical Instructor D)

Another drawback was using public health nursing and pediatric nursing clinical instructors for different components of a combined course; versus using the same instructors across the entire curriculum. Both types of instructors felt uncomfortable covering learning objectives typically taught in separate courses—not a combined curriculum.

"The very first and probably most problematic challenge is differentiation between the clinical instructors who are teaching the tertiary specialized component [of pediatrics]. Most peds instructors are from acute. … thus far we've had public health nurses teaching [in community], and no pediatric specialty nurses. …And while both offer a wide area of ex-

pertise. . . there needs to be a better collaborative approach." (Clinical Instructor E)

"So I would highly recommend that the clinical instructors be experienced public health clinicians. If you can find a public health nurse who has a pediatric background, I think that that's also a win win." (Clinical Instructor B)

Final drawbacks were insufficient orientation of clinical educators and students to the StrongStart sites; and StrongStart staff and early childhood educators to the SoN social pediatrics curriculum.

"So I think in terms of timing of the orientation, if you're going to start a course in September, I'd really recommend. late July, very early August, to have that clinical instructor come and spend time learning about the resources and learning who the staff are and just the community in general. I don't think it takes a lot of time, but I think having that familiarity early on helps to set the stage for thinking you're going to do it." (Early Childhood Educator B)

"I would kind of like to have even a little pro D session, if you will, have someone come in and talk to the facilitators for an hour or two hours and say, here's how to best use nursing students and this is what we want you to do. And we'd be very open to that. We enjoy having nurses in the program any way, shape or form. Parents enjoy it. We enjoy it." (StrongStart Manager B)

4.3 Knowledge, skills and attitudes

Based on a comparison of course learning objectives and successful attainment of these learning objectives, the clinical instructors stated that they were able to measure successful attainment through the learning activities, such as reliable completion of the Ages & Stages screening tool, students' teaching plans and health promotion education, and student responses to online critical thinking questions (e.g., public health policy questions). They agreed that parent-child health promotion education and relational practice were highlights of this clinical placement for students.

"Towards the end of the placement the students went with the public health nursing team to a drop-in program where they were able to effectively engage with children and the families. . . to create a safe therapeutic relationship. Their engagement was different than at the beginning of the course. . . more confidence and awareness." (Clinical Instructor E)

"One student wrote quite strongly how she was starting to understand the degree of inter-relationship needed in nursing. . . and drilling down with questions. The students indicate that in their journals. It means to me as the clinical instructor that they're starting to get that piece of relational practice-starting to pull it all together." (Clinical Instructor A)

"In our post-conference discussion, from the semester start to the end, the complexity of their answers and their perspectives. . . I could see a huge shift in their thinking about community health and healthy families." (Clinical Instructor B)

"Maybe relational practice should be the foundational component to go throughout the program-and to help tie together acute and community, since we can effectively teach this well in the community." (Clinical Instructor C)

4.4 Recommendations

Important recommendations emerged from the interviews. Instructors, in particular, felt key KSAs acquired in community-based settings needed to be clearly foregrounded in orientations with students, new clinical instructors and StrongStart sites. Students need to know that the goal for community-based placements with children and families is to acquire KSAs, such as relationship-building, which are foundational to nursing: They are not going to meet acute care pediatric learning objectives in StrongStart settings.

"Instructors should highlight and reinforce the learning objectives and content that's community-based. This may change or shift the perception that care of children and families is only acute. We need to reinforce the importance of community. Even though the faculty probably see something as community content, the students aren't." (Clinical Instructor A)

"Students believe that pediatrics is a specialty area, acute. They feel like they're not learning peds without acute care. We need to show them what they are learning through community." (Clinical Instructor E)

"In an ideal world all the students would get some acute Peds and some community Peds, but I know because of acute care issues, I don't know how realistic it is." (Public Health Manager B)

The nursing instructors agreed that acute care pediatric clinical simulations, taught by pediatric specialty nurses, are the best means to introduce students to generalist acute care pediatric nursing. There are insufficient acute care pediatric clinical placements for all students, especially with educational conisderations of multiple SoNs in our geographic region. Instead, acute care pediatric sites should be reserved for senior students' clinical preceptorships. Instructors also mentioned the importance of using more community-based virtual simulations and online case-based learning to make up sporadic hours in community ("during down-times"); and to further emphasize key KSAs associated with social

pediatrics and community-based care of children and their families, particularly marginalized and vulnerable populations.

5. DISCUSSION

Creative solutions must be found to meet the learning objectives for clinical rotations in pediatric nursing. The literature has many excellent examples of using non-traditional sites such as elementary and secondary schools[9,10] and clinical simulations.[13] These changes address shortages of acute care pediatric placements, but they also signal opportunities for ideological shifts in nursing eduation that emphasize current transitions in healthcare delivery from acute care to community and integrated care across health systems,[15] and greater emphasis on reaching populations in greatest need—where they live.[1,2,4] Global population studies have identified links between poor health over the life course due to early childhood and family health inequities, physical health and the social determinants of health.[21]

There are excellent examples of other models for community-engaged education, such as service learning models.[22] These models also illustrate the nursing education benefits of forging strong academic-practice-community partnerships.[23] Social pediatrics, the RICHER model, is an effective conceptual model for guiding nursing students' theoretical and clinical education that melds components of two nursing domains, pediatrics and public health and emphasizes foundational KSAs associated with relational practice and core values of equity, diversity and inclusivity.[1,6] We believe this shift in thinking will take time and require considerable curriculum planning, implementation and evaluation between our pediatric and public health nursing faculty. Feedback from our interviewees and student feedback on their course evaluation surveys indicate that we have not sufficiently threaded together the theory or clinical components of public health and pediatric nursing in community contexts; nor have we satisfied students' concerns about acute care pediatric nursing preparation. Future research is needed to compare the completion of learning objectives across acute care pediatrics, StrongStart and hybrid clinical placements. Another curricular limitation is the model's focus on early childhood development and family systems: We will need to address the entire developmental continuum from infancy to young adulthood.

These are preliminary findings: Evaluation is ongoing, as are further curricular changes based on feedback from faculty, students and community partners. We only sent email invitations to three original StrongStart sites, and we had a small convenience sample of interviewees. We did not interview students, although we had evaluation survey feedback from course surveys that are conducted at the end of each term. No public health nurses responded to our invitations, although we were able to interview two public health managers.

During the pandemic, StrongStart sites have had to scale back on in-person services, although students and faculty are still allowed on-site and they are involved in public health nursing team health service referrals. A 'silver lining' has been opportunities to further explore the use of virtual education offerings for the community and acute care components of our combined course. In a recent paper by Hudson et al.[24] faculty created a Simulation Hub to centralize simulation learning activities and systematically map them to course learning objectives—to ensure appropriate leveling of simulation content within and across courses. Our faculty similarly need to develop a systematic approach for integrating clinical laboratory and virtual simulations for acute/community pediatric nursing and public heath nursing within our undergraduate nursing curriculum.

In Canada and globally, nurses must know how to provide care in diverse community settings and to those who most need it.[16,22] Nursing career opportunities will expand in the community, and it is foresightful to expose students now to community-engaged healthcare delivery during sensitive periods of early childhood development—when nursing interventions with children and families can initiate a positive life course. Particularly during pandemic, nurses and nursing students, in partnership with communities, are well-placed to address community resilience through a social pediatrics lens.

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CONFLICTS OF INTEREST DISCLOSURE

The authors declare that there is no conflict of interest.

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