WEEK 2 LECTURE - STUDY GUIDE

STUDY GUIDE TOOLS

Print Study Guide Save Study Guide Return to Main Page

EXECUTIVE SUMMARY

This study guide provides a comprehensive overview of key concepts in community and public health nursing, focusing on health equity, vulnerable populations, rural and migrant health, substance use disorders, and school nursing. It delves into the definitions, historical contexts, ethical considerations, and practical strategies for nurses to address health disparities and promote well-being across diverse communities. Additionally, it includes essential information on immunization schedules, highlighting the nurse's role in preventive health.

1. POVERTY

Poverty is a significant public health issue with consequences at individual, family, and community levels. Nurses play a crucial role as advocates, educators, and connectors to public resources.

KEY DEFINITIONS AND CONCEPTS

Term	Definition
Federal Poverty Guidelines (FPG) HHS Poverty Guidelines	Set annually by the U.S. Department of Health and Human Services, these guidelines determine eligibility for federal assistance programs like Medicaid, SNAP, and Head Start. They are based on income and family size.
SNAP (Supplemental Nutrition Assistance Program) USDA SNAP	A federal program (formerly food stamps) offering nutrition assistance to low-income individuals and families. Eligibility is based on income, assets, and expenses.

Term	Definition
TANF (Temporary Assistance for Needy Families) HHS ACF TANF	A program providing time-limited financial assistance and job preparation for low-income families, often including work requirements and time limits.
Persistent Poverty	Long-term poverty lasting for multiple years, where individuals or communities remain below the poverty threshold across generations.
Neighborhood Poverty	A geographic area characterized by concentrated poverty, often associated with a lack of services, under-resourced schools, and higher crime rates.
Multigenerational Poverty	Poverty that persists for two or more generations within a family, frequently leading to limited educational and economic opportunities.
Non-Custodial Parent Funds	Programs designed to encourage non-custodial parents to financially support their children. Some states may redirect child support funds to custodial parents receiving public assistance.

HOW POVERTY AFFECTS HEALTH

Poverty profoundly impacts health across multiple domains.

Health Domain	Impact of Poverty
Physical Health	Higher risk of chronic illnesses (e.g., asthma, diabetes, heart disease), poor nutrition, delayed medical care, and higher infant mortality rates.
Mental Health	Increased rates of depression, anxiety, toxic stress, and substance use. Access to mental health services is often limited.
Access to Care	Barriers include fewer healthcare providers, lack of insurance, transportation difficulties, long wait times, and underfunded facilities.
Environmental Exposure	Substandard housing, exposure to violence, lead, mold, and poor air and water quality are common.

TOXIC STRESS AND POVERTY

Toxic Stress is defined as the prolonged activation of stress response systems without the presence of protective relationships.

Examples in poverty: Chronic food insecurity, exposure to violence, parental substance use, and homelessness or housing instability.

Health Effects: Impaired brain development, poor emotional regulation, and increased risk of chronic conditions like heart disease, stroke, and autoimmune disorders.

NURSE'S ROLE IN ADDRESSING POVERTY: THE ADPIE PROCESS

The nursing process (Assessment, Diagnosis, Planning, Intervention, Evaluation) provides a framework for addressing poverty.

1. **A -- Assessment**

   Screen for Social Determinants of Health (SDOH): Including housing, income, food security, education, employment, transportation, and childcare.

   Ask about: Insurance status, ability to afford prescriptions, and history of unmet health needs.

   Tools: Utilize tools like PRAPARE or AHC-HRSN.

2. **D -- Diagnosis**

   NANDA-I Diagnoses Related to Poverty: Ineffective health maintenance, imbalanced nutrition: less body requirements, risk for delayed development, ineffective coping, and readiness for enhanced community coping.

3. **P -- Planning**

   Goals: Identify SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals tailored to the patient's needs and resources.

   Collaboration: Work with interdisciplinary teams, such as case managers, social workers, and dietitians.

   Prioritization: Prioritize safety, access to care, and patient engagement.

4. **I -- Interventions**

5. **E -- Evaluation**

   Follow-up: Reassess social needs and determine if referrals were accessed.

   Outcomes: Evaluate health outcomes such as improved medication adherence, nutrition, and housing stability.

PUBLIC ASSISTANCE PROGRAMS

These programs provide vital support to low-income individuals and families.

Program	Description
Medicaid/CHIP Medicaid.gov	Health coverage for low-income children, pregnant women, and disabled individuals.
SNAP (Supplemental Nutrition Assistance Program) USDA SNAP	Nutrition support.

Program	Description
WIC (Women, Infants, and Children) USDA WIC	Nutritional assistance for women, infants, and children up to age 5.
Head Start HHS ACF Head Start	Early childhood education for low-income families.
TANF (Temporary Assistance for Needy Families) HHS ACF TANF	Temporary financial aid with work requirements.
Housing Choice Voucher (Section 8) HUD Section 8	Rental assistance for low-income families.

PREVENTION STRATEGIES

Prevention efforts are categorized into primary, secondary, and tertiary levels.

Level	Examples
Primary Prevention	Advocate for living wages, universal pre-kindergarten (pre-K), and access to healthcare and nutritious food.
Secondary Prevention	Early screening for developmental delays, mental health concerns, or unmet needs.
Tertiary Prevention	Long-term care management for chronic illnesses, mental health conditions, and substance use within vulnerable populations.

KEY TAKEAWAYS FOR NURSING PRACTICE

Trauma-informed care is essential when working with patients experiencing poverty.

Poverty is a public health issue with individual, family, and community consequences.

Nurses are advocates, educators, and connectors between patients and public resources.

Holistic care must include assessment of social, emotional, and physical needs.

2. HOMELESSNESS

KEY DEFINITIONS AND TYPES OF HOMELESSNESS

Homelessness is a critical social determinant of health.

Term	Definition
Homelessness	The lack of a fixed, regular, and adequate nighttime residence. This includes living in shelters, cars, public places, or temporary accommodations.
Chronic Homelessness	Long-term or repeated episodes of homelessness, often associated with physical or mental disabilities, substance use, or chronic health conditions. It is defined as being homeless for at least 12 months or repeatedly over 3 years.
Crisis Poverty (Situational Homelessness)	Temporary homelessness resulting from a sudden event such as job loss, eviction, domestic violence, or natural disaster. It frequently affects individuals who were previously housed and employed.

EFFECTS OF HOMELESSNESS ON HEALTH

Homelessness significantly impacts multiple health domains.

Health Domain	Impact
Physical Health	Increased prevalence of exposure-related illnesses, respiratory infections, wounds, chronic diseases (e.g., diabetes, hypertension), and untreated pain.
Mental Health	High rates of depression, anxiety, PTSD, schizophrenia, and increased suicide risk. These conditions are often worsened by a lack of access to consistent care.
Substance Use	High prevalence of alcohol and drug use disorders, often used as a coping mechanism for trauma and the challenging environment.
Access to Care	Barriers include lack of transportation, insufficient documentation, lack of insurance, distrust in providers, and lack of continuity of care.
Nutrition and Hygiene	Malnutrition, dehydration, dental disease, skin infections, and infestations (e.g., lice, scabies) are common.

POPULATIONS AT HIGHER RISK FOR HOMELESSNESS

Several populations face elevated risks for homelessness.

Population	Risk Factors
Veterans	PTSD, disabilities, limited support post-discharge, substance use.

Population	Risk Factors
Individuals with Mental Illness	May lack insight, support systems, or access to treatment.
Victims of Intimate Partner Violence (IPV)	Fleeing abuse without secure housing or resources.
Youth and LGBTQ+ Youth	Family rejection, aging out of foster care, trafficking.
Older Adults	Fixed incomes, eviction, cognitive decline, physical disability.
Formerly Incarcerated Individuals	Barriers to employment, stigma, limited housing options.

THE NURSE'S ROLE IN ADDRESSING HOMELESSNESS: ADPIE FRAMEWORK

Nurses must practice with cultural humility, compassion, and nonjudgment.

1. **A -- Assessment**

   Ask: Use open-ended, nonjudgmental questions such as "Where do you sleep most nights?" or "Do you have a safe place to stay?".

   Assess for: Basic needs (food, shelter, hygiene), physical and mental health issues, medication adherence barriers, substance use, and safety risks (IPV, weather exposure).

   Tools: Utilize the Homeless Management Information System (HMIS), Social Determinants of Health Screeners, or the Vulnerability Index -- Service Prioritization Decision Assistance Tool (VI-SPDAT).

2. **D -- Diagnosis**

   Common NANDA-I Diagnoses: Ineffective health maintenance, risk for infection, imbalanced nutrition: less body requirements, impaired skin integrity, disturbed thought processes, chronic low self-esteem, and risk for injury.

3. **P -- Planning**

   Collaboration: Work with case managers, social workers, mental health professionals, and community shelters.

   Goals: Set realistic, patient-centered goals (e.g., "Client will be connected with shelter services within 48 hours" or "Client will receive first dose of prescribed antibiotic before discharge").

4. **I -- Interventions**

5. **E -- Evaluation**

   Client Outcomes: Determine if the client connected to housing/shelter, began medical treatment, returned for follow-up, or reported improved safety/nutrition.

   Adjustments: Adjust the plan based on changing circumstances, including relocation or increased risk.

PUBLIC PROGRAMS AND RESOURCES

Various programs exist to support individuals experiencing homelessness.

Program	Description
HUD (Housing and Urban Development) HUD.gov	Funds emergency shelters, transitional, and permanent housing.
HCH (Healthcare for the Homeless) HRSA HCH	Federally funded programs offering primary care, dental, mental health, and substance use services.
SSVF (Supportive Services for Veteran Families) VA SSVF	Provides rapid rehousing and financial support for homeless veterans.
PATH (Projects for Assistance in Transition from Homelessness) SAMHSA PATH	Supports individuals with serious mental illness.
Local Continuum of Care (CoC) HUD Exchange CoC	Networks that coordinate community efforts to end homelessness.
211 Hotline 211.org	A free, confidential helpline connecting people to local resources.

PREVENTION STRATEGIES

Nurses are involved in prevention at all levels.

Level	Nursing Role
Primary Prevention	Advocate for affordable housing, universal healthcare, minimum wage increases, and accessible education. Promote trauma-informed community resources.
Secondary Prevention	Early identification of housing insecurity during hospital or clinic visits. Partner with outreach programs to reach people before they lose housing.
Tertiary Prevention	Prevent rehospitalization or return to homelessness through follow-up care, case management, and housing stabilization services. Work with discharge planners.

KEY POINTS FOR NURSES

Homelessness is both a cause and consequence of poor health.

Nurses must practice with cultural humility, compassion, and nonjudgment.

Trauma-informed care is essential.

Partnerships with public health, mental health, and housing programs are critical for successful interventions.

Nurses can reduce stigma and empower patients through advocacy and access to services.

3. TEEN PREGNANCY

TRENDS IN TEEN PREGNANCY

While overall U.S. rates have declined, disparities and repeat pregnancies remain concerns.

Factor	Trend
Overall U.S. Rate	Declined significantly over the past two decades but remains higher than in most developed nations.
High-Risk Populations	Higher rates among Black, Hispanic, rural, and socioeconomically disadvantaged teens.
Repeat Teen Pregnancy	About 17% of births to teens are repeat pregnancies.

KEY CONCEPTS

Understanding these concepts is vital for addressing teen pregnancy.

Term	Definition
Sexual Debut	The age at which a person first has sexual intercourse. Earlier debut correlates with a higher risk of unprotected sex and pregnancy.
Sexual Victimization	Includes unwanted sexual contact, coercion, assault, or rape. Increases risk for unplanned pregnancy, PTSD, and poor maternal outcomes.
Coercive Sex	Pressure or manipulation into sexual activity without consent. It may not involve force but undermines autonomy.
Statutory Rape	Sexual activity with a minor below the legal age of consent (which varies by state), even if consensual. Impacts legal rights related to paternity.

CONTRACEPTION AND PREVENTION

Effective contraception and access are crucial for prevention.

Method	Notes
Long-Acting Reversible Contraception (LARC)	Includes IUDs and implants. Highly effective, recommended as first-line for teens by ACOG and CDC.
Dual Contraception	Use of a condom plus a hormonal/LARC method to prevent both pregnancy and STIs.
Emergency Contraception	Should be offered after unprotected sex or sexual assault. Most effective within 72 hours.
Access and Barriers	Teens may face barriers such as parental consent laws, stigma, lack of education, or provider bias.

TEEN PREGNANCY RISKS AND EFFECTS

Teen pregnancy carries significant risks for both the mother and the infant.

Risk Area	Common Outcomes
Birth Outcomes	Higher rates of low birth weight, prematurity, and neonatal complications.
Maternal Health	Inadequate weight gain, poor nutrition, anemia, hypertension, and depression.
Mental Health	Teens are at higher risk of postpartum depression, isolation, and anxiety.
Education	Only about 50% of teen mothers earn a high school diploma by age 22, and there is an increased dropout risk.
Violence	Pregnant teens have an elevated risk of intimate partner violence (IPV), especially from controlling or coercive partners. 1 in 3 pregnant teens report physical violence by a partner.
Bonding	Risk of poor maternal-infant bonding due to developmental immaturity or lack of support.

NURSING ROLE IN TEEN PREGNANCY: ADPIE FRAMEWORK

Nurses provide nonjudgmental, holistic care, and early intervention.

1. **A -- Assessment**

   Ask about: Age of sexual debut and partners, willingness and consent, use of birth control and STI protection, current pregnancy symptoms and prenatal care, support system (family, partner, school), nutrition, mental health, education, and safety/IPV risk.

   Screeners: Use validated screeners like PHQ-9 for depression, IPV screening tools, and nutritional risk screens.

2. **D -- Diagnosis**

NANDA-I Examples: Risk for impaired parenting, risk for low self-esteem, imbalanced nutrition: less body requirements, risk for intimate partner violence, risk for ineffective coping, and readiness for enhanced childbearing process.

3. **P -- Planning**

   Prioritize: Safety, engagement in prenatal care, educational continuity, nutrition and fetal growth, and psychosocial support/parenting preparation.

   Collaborate: Work with social workers, school counselors, nutritionists, WIC, home health, OB/GYN, and mental health providers.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Assess if the teen is attending prenatal care, if safety/IPV risks are reduced, if she is gaining appropriate weight, if mental health is improving, if there is preparation for parenting/adoption, if postpartum contraception has been initiated, and if mother-infant bonding is observed.

PUBLIC PROGRAMS AND RESOURCES

These programs support pregnant teens and new mothers.

Program	Description
WIC USDA WIC	Provides food, nutrition education, and referrals for pregnant teens and children under 5.
Medicaid/CHIP Medicaid.gov	Covers prenatal care and delivery for low-income teens.
Teen Parent Programs (TPPs) HHS FYSB APP	School-based or community-based programs offering parenting education, childcare, and tutoring.
Healthy Start HRSA Healthy Start	Offers case management and home visiting for high-risk mothers.
Title X Clinics HHS OPA Title X	Provide confidential reproductive health care to teens, including contraception.
Safe Haven Laws National Safe Haven Alliance	Allow newborns to be surrendered safely without legal penalty (varies by state).

PREVENTION STRATEGIES

Nurses are key in promoting healthy relationships and access to care.

Level	Nursing Actions
Primary Prevention	Teach comprehensive sex education. Promote access to birth control without shame or barriers. Address social norms around consent and healthy relationships.
Secondary Prevention	Screen for pregnancy and sexual risk early in adolescence. Offer pregnancy testing and contraception at school clinics.
Tertiary Prevention	Provide wraparound services for pregnant teens. Address repeat pregnancy risk. Support educational and parenting goals. Help prevent child neglect and abuse.

KEY NURSING TAKEAWAYS

Teen pregnancy is a complex public health issue requiring nonjudgmental, holistic care.

Early intervention can improve maternal and infant outcomes.

Nurses are crucial in promoting autonomy, education, and support.

Teen mothers can thrive with the right resources, respect, and empowerment.

4. RURAL HEALTH & OCCUPATIONAL HEALTH IN AGRICULTURE

RURAL VS. URBAN HEALTH

Significant disparities exist between rural and urban healthcare.

Factor	Rural Areas	Urban Areas
Population Density	Low.	High.
Access to Care	Limited providers, long travel distances, fewer specialists.	Greater availability of hospitals and specialty care.
Health Outcomes	Higher rates of chronic illness, injury, and mortality.	Better outcomes with earlier diagnosis and intervention.
Transportation	Often unavailable or unreliable.	Public transport more accessible.
Healthcare Infrastructure	Underserved; reliance on Critical Access Hospitals (CAHs) and clinics.	Diverse hospital systems and urgent care facilities.

LIFE IN A RURAL AREA

Close-knit communities valuing self-reliance and privacy. Limited internet and health education. Economic reliance on agriculture, mining, manufacturing. Weather and isolation affect care access.

DISPARITIES IN RURAL HEALTH

Rural communities face unique health challenges.

Category	Disparities
Chronic Illness	Higher rates of diabetes, hypertension, and heart disease.
Mental Health	Limited access to mental health professionals, higher suicide rates.
Maternal Health	Fewer OB/GYNs, higher maternal and infant mortality.
Child Health	Fewer pediatricians, lower vaccination rates.
COVID-19 Impact	Fewer ICU beds, late testing availability, lower vaccination uptake.

VULNERABLE GROUPS IN RURAL COMMUNITIES

These groups often experience heightened health risks.

Older adults

Women and children

Racial and ethnic minorities (especially Native American and Hispanic populations)

Low-income families

Uninsured individuals

Migrant farm workers

People with disabilities

Veterans

RURAL MENTAL HEALTH CHALLENGES

Specific issues impede mental health care in rural settings.

Fewer psychiatrists and therapists

Stigma around seeking help

High rates of substance use

Long wait times and travel distances

NURSE'S ROLE IN RURAL HEALTH: ADPIE FRAMEWORK

Nurses often serve as lifelines in isolated areas.

1. **A -- Assessment**

   Identify: Transportation, insurance, and provider access.

   Screen for: Depression, domestic violence, chronic disease.

   Assess: Occupational risks (farming, chemicals).

   Identify: Barriers to prenatal and pediatric care.

2. **D -- Diagnosis**

   Examples: Ineffective health maintenance, risk for social isolation, risk for delayed development, risk for occupational injury, and ineffective community coping.

3. **P -- Planning**

   Strategies: Use telehealth for education and follow-up. Coordinate mobile clinics and faith-based outreach.

   Focus: Prioritize trust, accessibility, and cultural values.

4. **I -- Interventions**

5. **E -- Evaluation**

   Measures: Measure improved screening and vaccination rates. Monitor ER visits and preventable hospitalizations.

   Reassess: Reassess transportation and access needs.

PUBLIC PROGRAMS SUPPORTING RURAL HEALTH

These programs aim to improve healthcare access and quality in rural areas.

Program	Description
HRSA (Health Resources and Services Administration) HRSA.gov	Funds rural clinics and workforce programs.
Rural Health Clinics (RHCs) HRSA RHC	Provide primary care in underserved rural areas.
Critical Access Hospitals (CAHs) RHIhub CAH	Small hospitals with emergency services in isolated areas.
State Offices of Rural Health NOSORH	Develop rural health policies and training.
Telehealth and Broadband Expansion Grants	Improve virtual care delivery.

Program	Description
HRSA Telehealth	

PREVENTION & PROGRAM MANAGEMENT

Nurses engage in various prevention strategies.

Level	Strategy
Primary Prevention	Mobile wellness clinics, health fairs, vaccines, prenatal education.
Secondary Prevention	Depression and chronic disease screening, child developmental screening.
Tertiary Prevention	Home visits for chronic illness, rehab referrals, stroke follow-up care.

5. OCCUPATIONAL ACCIDENTS & MIGRANT WORKER HEALTH

COMMON AGRICULTURAL HEALTH HAZARDS

Agriculture poses unique health risks due to specific exposures and physical demands.

Hazard	Effects
Pesticide Exposure	Neurologic symptoms, cancer, respiratory illness, birth defects.
Farming Accidents	Machinery trauma, amputations, crush injuries.
Heat Stroke/Dehydration	Prolonged outdoor exposure, lack of breaks, limited water.
Musculoskeletal Injuries	From repetitive bending, lifting, and improper equipment use.

MIGRANT AND SEASONAL FARM WORKERS

These populations face unique challenges regarding health access and continuity of care.

Type	Description
Migrant Farmworker	Travels to different locations for temporary agricultural work. Often lacks permanent housing and continuity of care.
Seasonal Farmworker	Works seasonally in agriculture but has a permanent residence. May have more consistent access to care.

DOCUMENTED VS. UNDOCUMENTED STATUS

Immigration status significantly impacts access to healthcare.

Status	Impact on Health
Documented	May qualify for Medicaid, WIC, or employer-sponsored care.
Undocumented	Often ineligible for benefits, fears deportation, avoids care even in emergencies.

MIGRANT HEALTH ACT (PUBLIC HEALTH SERVICE ACT, SECTION 329) HRSA MIGRANT HEALTH PROGRAM

Funds community health centers that serve migrant and seasonal farm workers.

Provides comprehensive care, including dental, mental health, and case management.

Focuses on culturally and linguistically appropriate services.

NURSING ROLE IN AGRICULTURAL HEALTH: ADPIE FRAMEWORK

Trust and cultural competence are key in reaching these populations.

1. **A -- Assessment**

   Ask about: Work hours, exposure to chemicals, heat illness symptoms, housing and sanitation access, immigration status (confidentially), vaccination history, and prenatal/pediatric needs.

   Strategies: Use mobile clinics, interpreters, and community health workers.

2. **D -- Diagnosis**

   Examples: Risk for injury, risk for infection, imbalanced nutrition, ineffective coping, and impaired parenting (due to work stress, absence).

3. **P -- Planning**

   Collaboration: Collaborate with agricultural employers and school nurses.

   Timing: Schedule seasonal outreach before harvest and planting.

   Approach: Provide culturally competent care and translated materials.

4. **I -- Interventions**

5. **E -- Evaluation**

   Monitor: Reduction in ER visits from heat or trauma. Follow-up on child growth and vaccination rates.

   Track: Access to preventive services over the season.

PUBLIC HEALTH PROGRAMS

These programs are vital for farmworker health.

Program	Description
Migrant Health Centers (MHCs) HRSA Migrant Health Program	HRSA-funded sites offering bilingual, low-cost health services.
Farmworker Justice & Local Coalitions Farmworker Justice.org	Advocacy and community education for farmworker rights.
WIC for Migrants USDA WIC	Nutritional support for pregnant women and children.
Occupational Safety and Health Administration (OSHA) OSHA.gov	Regulates field sanitation, pesticide safety, and equipment use.
NIOSH Ag Center Grants CDC NIOSH Agriculture	Promote injury prevention and research in agricultural settings.

PREVENTION STRATEGIES

Nurses are central to prevention efforts.

Level	Examples
Primary Prevention	Distribute water stations, PPE, vaccines, bilingual signs.
Secondary Prevention	Skin exams, lung screening, pregnancy testing, TB testing.
Tertiary Prevention	Rehab referrals after farm accidents, home visits, chronic care management.

NURSING TAKEAWAYS

Trust and cultural competence are key in rural and migrant health.

Nurses often serve as lifelines to care in isolated areas.

Public health nurses must use creativity and persistence to reach mobile and underserved populations.

Advocacy for safe work environments, immigration protections, and health equity is central to nursing leadership.

6. COMMUNITY VIOLENCE

WHAT IS COMMUNITY VIOLENCE?

Community violence refers to intentional acts of interpersonal violence that occur in public spaces and are often committed by individuals who are not intimately related to the victim.

EXAMPLES OF COMMUNITY VIOLENCE

Community violence manifests in various forms.

Type of Violence	Description
Gang Violence	Includes turf wars, drug-related shootings, and initiation assaults; increases risk for youth recruitment, retaliation cycles, and school disruption.
Drive-by Shootings	Sudden, unexpected firearm attacks in neighborhoods; can injure or kill bystanders.
School Shootings	Armed assaults on students and staff in schools; a major public health concern with long-term psychological trauma.
Assaults in Public Spaces	Fights or attacks in parks, buses, streets; may involve weapons or physical aggression.
Armed Robbery and Carjackings	Heightened during times of economic distress or drug activity.
Hate Crimes	Violence based on race, religion, sexual orientation, or gender identity.
Police Brutality or Excessive Force	Community trauma associated with perceived injustice or racial profiling.

HEALTH EFFECTS OF COMMUNITY VIOLENCE

Community violence has widespread negative health impacts.

Area	Impact
Physical	Injuries, disability, death, long-term complications.
Mental Health	PTSD, depression, anxiety, toxic stress, substance use.
Developmental	Learning delays, poor academic performance in children.
Social	Community fear, distrust in authorities, reduced mobility, social withdrawal.

VULNERABLE POPULATIONS

Certain populations are at higher risk for experiencing community violence.

Children and adolescents

LGBTQ+ individuals

People of color

Homeless individuals

Residents of high-crime neighborhoods

People with disabilities or mental illness

Incarcerated individuals

NURSE'S ROLE IN COMMUNITY VIOLENCE PREVENTION AND RESPONSE

Nurses are essential in promoting healing, safety, and prevention.

Assessment and screening for exposure to violence and trauma

Crisis intervention and trauma-informed care

Community education about violence prevention

Referral to counseling, social work, and shelters

Advocacy for safer neighborhoods and policies to reduce gun violence

Partnerships with schools, law enforcement, and public health agencies

ADPIE: NURSING PROCESS FOR COMMUNITY VIOLENCE

Nurses play a critical role in intervention and prevention.

1. **A -- Assessment**

   Ask: "Have you ever felt unsafe in your neighborhood?" or "Have you witnessed or experienced violence?".

   Observe for: Signs of trauma (anxiety, hypervigilance, withdrawal, sleep disturbances, poor school performance).

   Tools: Use screening tools like ACES, Child Trauma Screen, or PTSD Checklists.

2. **D -- Diagnosis**

   Sample Nursing Diagnoses: Risk for injury, post-trauma syndrome, ineffective coping, risk for violence, impaired social interaction, and risk for delayed development (in children).

3. **P -- Planning**

   Prioritize: Safety and mental health.

Collaborate: Work with school nurses, social workers, police, and outreach programs.

Goals: Establish short-term goals (e.g., referral to therapy) and long-term goals (e.g., community involvement in violence prevention).

4. **I -- Interventions**
5. **E -- Evaluation**

   Outcomes: Has the client received mental health support? Are they attending school or work? Are there reduced re-hospitalizations, injuries, or behavioral problems? Is the community reporting fewer violent incidents or increased engagement?.

PUBLIC PROGRAMS AND RESOURCES

These programs aim to reduce and respond to community violence.

Program	Description
Safe Start OJJDP Safe Start	Promotes healing for children exposed to violence through community-based care.
Cure Violence Cure Violence Global	A public health model treating violence like a contagious disease, using credible messengers and outreach workers.
Trauma Recovery Centers (TRCs) OVC TRC	Offer mental health care and case management to victims of violence.
Youth Violence Prevention Programs (CDC) CDC Violence Prevention	Supports school- and community-based programs.
Violence Interruption Initiatives Cure Violence Interruption	Use community health workers or former gang members to mediate conflict.
School-Based Health Centers (SBHCs) School-Based Health Alliance	Provide trauma-informed care and mental health support to students exposed to violence.

PREVENTION STRATEGIES

Prevention is a collaborative effort across sectors.

Level	Examples
Primary Prevention	Community engagement, gun safety education, after-school programs, gang diversion, youth mentorship.
Secondary Prevention	Screening for trauma, home visits, school interventions, early therapy referral.

Level	Examples
Tertiary Prevention	Support for victims of violence, long-term counseling, legal advocacy, chronic disease prevention in trauma survivors.

KEY TAKEAWAYS FOR NURSES

Community violence is a public health emergency with multigenerational impacts.

Nurses must use trauma-informed care, especially in ERs, schools, and community clinics.

Prevention requires collaborative work across sectors.

Trust-building and cultural humility are essential to effective violence intervention.

Nurses are essential in promoting healing, safety, and prevention.

7. INTIMATE PARTNER VIOLENCE (IPV)

DEFINITION OF IPV

IPV refers to physical, sexual, emotional, psychological abuse, stalking, or coercive behaviors by a current or former intimate partner. It affects people of all genders, sexual orientations, and cultural backgrounds.

TYPES OF IPV

IPV encompasses various forms of abuse.

Type	Description
Physical	Hitting, slapping, choking, using weapons.
Sexual	Coercion, forced sex, reproductive control.
Emotional/Psychological	Gaslighting, threats, intimidation, isolation.
Financial	Controlling money, preventing employment.
Technological	Monitoring, stalking, revenge porn, control through digital means.

THE NURSE'S ROLE IN IPV

Nurses are critical in identifying and responding to IPV.

Screen all patients in a safe, private setting.

Recognize signs of abuse (physical and behavioral).

Respond using trauma-informed and nonjudgmental care.

Document clearly, using patient quotes and objective findings.

Refer to community services and legal support.

Advocate for policies that support survivor safety and health equity.

Collaborate with SANE/IPVNE (Intimate Partner Violence Nurse Examiner), social workers, shelters, and law enforcement.

ADPIE: NURSING PROCESS FOR IPV CARE

Leaving an abusive relationship is often the most dangerous time for a victim.

1. **A -- Assessment**

   Tools: Use validated tools like HITS (Hurt, Insult, Threaten, Scream), WAST (Woman Abuse Screening Tool), or Danger Assessment (for lethality risk).

   Ask: Direct, private, and supportive questions like "Do you feel safe at home?" or "Has anyone hurt or threatened you?".

   Observe for: Unexplained injuries, inconsistent stories, fearful behavior, frequent ER visits, or delays in seeking care (especially during pregnancy).

   Crucial: NEVER assess IPV in front of the partner.

2. **D -- Diagnosis**

   Sample NANDA Diagnoses: Risk for violence, post-trauma syndrome, ineffective coping, risk for injury, powerlessness, and anxiety.

3. **P -- Planning**

   Prioritize: Immediate safety and confidentiality.

   Safety Plan: Develop a safety plan with the patient.

   Focus: Prioritize physical injuries, emotional trauma, and child safety (if present).

   Goals: Identify short-term goals (e.g., contact IPV advocate) and long-term goals (e.g., secure housing, counseling).

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Has the patient connected with resources? Do they have a working safety plan? Are physical and psychological needs being addressed? Is follow-up care scheduled and accessible?.

PUBLIC PROGRAMS AND RESOURCES

These resources provide vital support to IPV survivors.

Program	Description
National Domestic Violence Hotline TheHotline.org	24/7 support, resources, safety planning (1-800-799-SAFE).
Local IPV Shelters NCADV Find Help	Emergency housing, legal advocacy, counseling.
Family Justice Centers National Family Justice Center Alliance	Multidisciplinary services in one location.
Title IX (for students) Department of Education Title IX	Protection from IPV and sexual violence in educational settings.
WIC & TANF USDA WIC / HHS ACF TANF	Offer support for women escaping IPV with children.
Child Protective Services (CPS) Child Welfare Info Gateway	May be involved if children are at risk of harm.

PREVENTION STRATEGIES

Nurses are involved in all levels of prevention.

Level	Example Actions
Primary Prevention	Teach healthy relationships, consent, and conflict resolution in schools. Promote gender equity.
Secondary Prevention	Screen for IPV during healthcare visits. Train providers to recognize and intervene.
Tertiary Prevention	Trauma counseling, safety planning, legal protection, housing stabilization for survivors.

INTIMATE PARTNER VIOLENCE NURSE EXAMINER (IPVNE)

An IPVNE is a nurse trained to provide specialized care to survivors of intimate partner violence.

Role Description	Details
Assessment & Forensics	Conduct injury documentation, collect evidence when appropriate.

Role Description	Details
Support & Safety	Provide trauma-informed emotional care, develop safety plans.
Referral & Advocacy	Connect patients to IPV resources and shelter.
Court Involvement	May provide expert witness testimony.
Training IAFN	Often receives training in IPV, strangulation assessment, and trauma-informed interviewing. Note: Some IPVNEs are cross-trained as SANEs, but IPVNE focuses more broadly on abuse beyond sexual assault.

RED FLAGS FOR IPV

These are critical signs for nurses to recognize.

Partner insists on staying during appointments.

Frequent “accidents” or delayed care.

Hesitation to speak, avoids eye contact.

Pregnancy complications or forced abortion.

Overly controlling partner behavior.

KEY TAKEAWAYS FOR NURSES

IPV is common, underreported, and highly dangerous.

Nurses must create a safe space for disclosure.

Documentation should be factual, objective, and detailed.

Never advise the patient to leave without proper planning; leaving is the most dangerous time.

IPV is not just a medical issue--it's a public health and human rights issue.

8. SEXUAL VIOLENCE

DEFINITIONS: SEXUAL ASSAULT VS. RAPE

Understanding the precise definitions is crucial for documentation and care.

Term	Definition
Sexual Assault	A broad term encompassing any non-consensual sexual contact, including groping, fondling, coercion, and attempted rape. It does not require penetration.
Rape	A type of sexual assault that includes non-consensual penetration of the vagina, anus, or mouth with a body part or object, by force, coercion, or without consent.

CONSENT MUST BE:

Freely given

Informed

Reversible

Enthusiastic

Specific

TRAUMA-INFORMED CARE PRINCIPLES

These principles guide all interactions with survivors.

Principle	Practice
Safety	Provide a private, calm, non-threatening environment.
Trustworthiness	Explain every step, ask for permission, maintain confidentiality.
Empowerment	Let the patient control the exam and reporting choices.
Collaboration	Include the patient in all decisions, validate their experiences.
Cultural Sensitivity	Be aware of language, spiritual, gender, and cultural preferences.

Avoid Victim-Blaming Language: Never say “Why didn’t you fight back?” or “What were you wearing?” Instead, use phrases like: “I’m so sorry this happened. You’re not alone, and this wasn’t your fault.”.

FORENSIC EXAMS (SANE-A VS. SANE-P)

Sexual Assault Nurse Examiners (SANEs) are specialized nurses.

Type	Description
SANE-A (Adult/Adolescent) IAFN SANE	For individuals ≥13 years; trained to collect forensic evidence, document injuries, and provide emotional support and STI/pregnancy prevention.

Type	Description
SANE-P (Pediatric) IAFN SANE	For children <13; includes developmentally appropriate care, parental involvement (unless the parent is the abuser), and a multidisciplinary team.

Key Points for Exams:

- Must obtain informed consent for each part of the exam.
- Evidence should ideally be collected within 72--120 hours.
- Includes: Full history, head-to-toe physical exam, genital exam, evidence collection (clothing, swabs, photographs), STI and pregnancy prophylaxis, crisis counseling, and safety planning.

DRUG-FACILITATED SEXUAL ASSAULT (DFSA)

Specific substances are used to incapacitate victims.

Substance	Effects
Rohypnol ("roofies")	Benzodiazepine causing sedation, confusion, amnesia, muscle relaxation to the point of paralysis. May not show up in standard toxicology screens.
Ketamine	Dissociative anesthetic; causes paralysis, hallucinations, confusion, and memory loss.
Scopolamine ("Devil's Breath")	Anticholinergic; causes sedation, amnesia, confusion, disinhibition; often used with intent to rob or assault.

Red Flags for DFSA: Gaps in memory, confusion/disorientation, sudden intoxication after one drink, vomiting, dizziness, or loss of consciousness.

WHAT VICTIMS SHOULD AND SHOULD NOT DO (IF RECENT ASSAULT OCCURRED)

Immediate actions can preserve evidence and well-being.

DO	DO NOT
Go to a safe place.	Bathe, shower, or douche.
Seek medical care as soon as possible.	Change clothes (if possible, bring them in a paper bag).
Save all evidence (clothing, texts, photos).	Eat, drink, smoke, or brush teeth (if oral assault suspected).

DO	DO NOT
Consider contacting police or advocate.	Wait too long to seek support; evidence may degrade.
Write down memories.	Self-blame or question your memory under pressure.

DISSOCIATION IN SEXUAL VIOLENCE SURVIVORS

Dissociation is a common protective psychological response to trauma.

Survivors may feel: Numb or detached, as if they are outside their body, foggy, confused, or as if it “was’t real”.

Nurses should not push for linear narratives and should validate these feelings: “That’s a normal response to trauma. You’re not broken.”.

THE NURSE'S ROLE: ADPIE FRAMEWORK

Nurses are first responders in healing and justice.

1. **A -- Assessment**

   Ensure: Immediate physical safety.

   Assess: Physical injuries, emotional state (fear, shock, dissociation), time of assault and possible exposure to STIs or pregnancy, and suicidal ideation/self-harm.

   Ask: Open, nonjudgmental questions: “Can you tell me what brought you in today?” or “Would you like to speak to someone trained in this type of care?”.

2. **D -- Diagnosis**

   NANDA Diagnoses: Rape trauma syndrome, risk for infection, risk for self-harm, post-trauma syndrome, anxiety, and ineffective coping.

3. **P -- Planning**

   Prioritize: Consent, safety, and stabilization.

   Short-term plan: Forensic exam (if within time window), STI and pregnancy prevention, and crisis counseling.

   Long-term goals: Link with therapy, legal advocacy (if desired), and follow-up for STI testing and emotional support.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Was a safety plan created? Did the patient receive medical and emotional care? Have follow-up appointments or resources been secured? Does the patient have access to a support person or advocate?.

VICARIOUS TRAUMA IN NURSES

Nurses are susceptible to vicarious trauma from repeated exposure to trauma stories.

Signs: Emotional exhaustion, secondary traumatic stress, compassion fatigue, nightmares, emotional numbing, irritability, detachment.

Prevention: Debriefing, clinical supervision, healthy boundaries, peer support, self-care, and mindfulness practices.

PUBLIC PROGRAMS AND RESOURCES

These resources offer vital support for sexual violence survivors.

Resource	Description
RAINN (Rape, Abuse & Incest National Network) RAINN.org	24/7 hotline and online chat for survivors: 1-800-656-HOPE.
Sexual Assault Response Teams (SARTs) NSVRC SART	Multidisciplinary response: nurse, advocate, law enforcement, legal.
SANE Programs IAFN SANE	Provide forensic exams and emotional care for adult, adolescent, or pediatric survivors.
Crime Victim Compensation Programs OVC Compensation	Help cover medical and counseling costs.
Planned Parenthood PlannedParenthood.org	Offers sexual assault care, EC, STI testing, counseling.
Child Advocacy Centers (CACs) National Children's Alliance	Child-focused, trauma-informed environments for pediatric forensic interviews and exams.

PREVENTION STRATEGIES

Nurses play a role in all levels of sexual violence prevention.

Level	Action
Primary Prevention	Teach consent, respect, and healthy relationships; challenge rape myths and gender-based violence in schools.
Secondary Prevention	Screen for IPV, provide early intervention, support survivors before escalation.
Tertiary Prevention	Offer long-term mental health care, legal advocacy, housing/shelter resources, and support group referrals.

KEY NURSING TAKEAWAYS

Believe survivors. Support their choices. Protect their dignity.

Trauma-informed care is not optional--it is essential.

Survivors need control, compassion, and confidentiality.

Nurses are first responders in healing and justice.

9. STRANGULATION

WHAT IS STRANGULATION?

Strangulation is the external compression of the neck that interferes with airflow and/or blood flow to the brain. It is a lethal form of assault frequently associated with IPV and sexual assault.

Key fact: Victims may have no visible external injuries but still suffer life-threatening internal damage.

WHY STRANGULATION IS SO DANGEROUS

Strangulation can cause severe and immediate or delayed physiological harm.

Physiological Effect	Outcome
Compression of carotid arteries	Stroke, unconsciousness in seconds.
Jugular vein obstruction	Increased intracranial pressure, hemorrhage.
Trachea/larynx injury	Swelling, hoarseness, airway obstruction.
Vagal stimulation	Cardiac arrest.
Anoxia/hypoxia	Brain injury or death within 4--5 minutes.

SIGNS AND SYMPTOMS OF STRANGULATION

Symptoms can be delayed for hours or days, making thorough assessment critical.

External Signs	Internal & Delayed Symptoms
Redness or bruising on neck.	Voice changes (hoarseness, loss of voice).

External Signs	Internal & Delayed Symptoms
Scratches, fingernail marks.	Swallowing difficulty (dysphagia).
Petechiae on face, eyes, gums.	Shortness of breath, coughing.
Bloodshot eyes (subconjunctival hemorrhage).	Memory loss, confusion, dizziness.
Ligature marks.	Loss of consciousness or incontinence.
Defensive wounds.	Headache, seizures, stroke symptoms.

Important: Always assess risk of airway swelling and neurological compromise.

THE NURSE'S ROLE IN STRANGULATION CARE

Nurses must recognize strangulation as a medical emergency.

Recognize strangulation as a medical emergency, even if the patient appears stable.

Screen for history of IPV, especially if the patient reports choking or "pressure on the neck".

Document findings with objective, detailed language, photographs, and direct quotes.

Ensure safety by involving social work, law enforcement, or an advocate if IPV is suspected.

Refer to forensic nursing services (e.g., SANE/strangulation-trained nurses) and imaging when indicated.

Educate on delayed symptoms and emergency warning signs.

ADPIE: NURSING PROCESS FOR STRANGULATION CARE

Accurate documentation and early recognition save lives.

1. **A -- Assessment**

   Ask: Direct, trauma-informed questions: “Has anyone ever placed their hands or anything else around your neck?” or “Did you lose consciousness, feel dizzy, or lose your voice?”.

   Perform: A head-to-toe exam with special focus on the neck, face, oral cavity, neurological status, respiratory effort, and vocal quality.

   Monitor: Vital signs, O2 saturation, and mental status.

2. **D -- Diagnosis**

   NANDA Examples: Risk for ineffective airway clearance, acute pain, risk for impaired tissue perfusion, post-trauma syndrome, risk for violence, and impaired gas exchange.

3. **P -- Planning**

   Immediate goals: Stabilize airway and circulation, prevent complications (e.g., delayed swelling, stroke), and ensure safety from further violence.

Long-term goals: Referral for forensic evaluation and follow-up, trauma-informed counseling, and legal advocacy if needed.

4. **I -- Interventions**
5. **E -- Evaluation**

   Outcomes: Has the patient remained stable? Were signs of airway obstruction or stroke addressed? Did the patient receive trauma-informed care and referrals? Was the patient connected to IPV support and follow-up services?.

PUBLIC PROGRAMS & RESOURCES

These resources support strangulation victims.

Program	Description
Strangulation Training Institute (Alliance for HOPE) Alliance for HOPE	National training for healthcare and law enforcement professionals.
SANE Programs IAFN SANE	Forensic exams, documentation, emotional support, and legal preparation.
Family Justice Centers (FJC) National Family Justice Center Alliance	One-stop service for IPV survivors including legal and medical support.
National Domestic Violence Hotline TheHotline.org	24/7 support: 1-800-799-SAFE (7233).
Crime Victim Compensation Funds OVC Compensation	Financial support for forensic exams, counseling, medical care.

PREVENTION STRATEGIES

Prevention targets healthy relationships and early intervention.

Level	Action
Primary Prevention	IPV education, healthy relationship promotion, anti-violence school programs.
Secondary Prevention	Universal screening in EDs, OB/GYN, and primary care; danger assessments; early intervention.
Tertiary Prevention	Trauma therapy, long-term safety planning, rehabilitation for neurological or airway injury.

VICARIOUS TRAUMA FOR NURSES

Caring for strangulation victims can lead to vicarious trauma.

Signs	Self-Care
Emotional fatigue, numbness, avoidance.	Clinical supervision, counseling, peer debriefing.
Intrusive thoughts, guilt, irritability.	Healthy boundaries, journaling, mindfulness.
Detachment, nightmares, burnout.	Scheduled rest, emotional support, mental health days.

Vicarious trauma is common in forensic nurses, ER staff, and IPV advocates. Recognize it early, and seek support to maintain professional well-being.

NURSING TAKEAWAYS

Strangulation is a strong predictor of future homicide in IPV survivors.

Even without external injuries, the internal risk is high.

Nurses must combine clinical skill, forensic awareness, and trauma-informed compassion.

Accurate documentation and early recognition save lives.

Protect yourself emotionally while helping others.

10. SUICIDE

WHY IT MATTERS

Suicide is a major public health concern.

Suicide is the 10th leading cause of death in the U.S., and 2nd among people aged 10--34.

It is preventable with early identification, compassionate care, and timely intervention.

THE NURSE'S ROLE IN SUICIDE PREVENTION

Nurses are often a critical point of contact for individuals at risk.

Recognize warning signs and risk factors.

Provide nonjudgmental, trauma-informed care.

Perform risk assessments.

Ensure patient safety.

Facilitate referrals to mental health and crisis services.

Advocate for follow-up care and community support.

ADPIE FRAMEWORK

Nurses must always take suicidal ideation seriously.

1. **A -- Assessment**

RISK FACTORS

Category	Examples
Mental Health	Depression, bipolar disorder, schizophrenia, PTSD.
Substance Use	Alcohol or drug misuse increases impulsivity.
Medical Illness	Chronic pain, terminal illness, recent diagnosis.
Situational	Divorce, job loss, financial stress, bullying.
History	Previous suicide attempt, family history of suicide.
Access to Means	Firearms, medications, sharp objects.

WARNING SIGNS

Behavioral	Verbal	Emotional
Giving away possessions.	“I wish I were dead”.	Hopelessness.
Withdrawing from others.	“You’d be better off without me”.	Rage or agitation.
Sudden calmness after depression.	“I can’t take it anymore”.	Feeling trapped.
Risk-taking, substance use.	“No one cares if I’m gone”.	Shame or despair.

Screening Tools: Columbia Suicide Severity Rating Scale (C-SSRS), SAFE-T (Suicide Assessment Five-Step Evaluation and Triage), PHQ-9 (especially question 9) [83].

Ask Directly: “Are you thinking about hurting yourself?” or “Do you have a plan?” [83].

2. **D -- Diagnosis**

   NANDA Diagnoses: Risk for suicide, risk for self-directed violence, hopelessness, ineffective coping, chronic low self-esteem, and anxiety.

3. **P -- Planning**

   Prioritize: Immediate safety.

Determine: Level of risk (low, moderate, or high).

Decide: Inpatient vs. outpatient care.

Involve: Family or support system with permission.

Ensure: Continuity of care post-discharge.

4. **I -- Interventions**

   Safety Planning Includes: Identifying warning signs, listing internal coping strategies, contacting trusted people, crisis line numbers, and securing environment (remove firearms, pills).

   Therapeutic Phrases: “You’re not alone. I’m glad you told me.” “There is help, and I want to keep you safe.”.

5. **E -- Evaluation**

   Outcomes: Is the client safe and receiving care? Are supports in place (therapy, family, medication)? Has suicidal ideation reduced? Has a follow-up plan been implemented?.

   Reassess: Frequently, especially after discharge or new stressors.

PUBLIC PROGRAMS AND RESOURCES

These resources offer immediate and ongoing support.

Program	Description
988 Suicide & Crisis Lifeline 988Lifeline.org	Call or text 988 for free 24/7 support.
National Alliance on Mental Illness (NAMI) NAMI.org	Education and peer support for individuals and families.
Veterans Crisis Line VeteransCrisisLine.net	Call 988 then press 1; or text 838255.
Mobile Crisis Units SAMHSA Mobile Crisis	Community-based mental health crisis response teams.
The Trevor Project TheTrevorProject.org	LGBTQ+ youth crisis support: 1-866-488-7386.
School Counselors & College Resources NASP School Mental Health	School-based screening, therapy, and safety planning.
Zero Suicide Initiative ZeroSuicide.edc.org	Health system framework for suicide prevention in clinical care.

PREVENTION STRATEGIES

Suicide is preventable through multi-level strategies.

Level	Strategies
Primary Prevention	Mental health education, anti-bullying programs, access to care, destigmatizing conversations.
Secondary Prevention	Depression/suicide screenings in schools, primary care, EDs.
Tertiary Prevention	Follow-up after an attempt, suicide survivor support groups, therapy, medication management, safety planning.

VICARIOUS TRAUMA IN SUICIDE CARE

Nurses involved in suicide care can experience vicarious trauma.

Signs	Self-Care Strategies
Helplessness, guilt, emotional fatigue.	Peer debriefing and clinical supervision.
Nightmares, flashbacks.	Personal therapy and journaling.
Detachment from patients.	Mindfulness and boundaries.
Fear of saying the wrong thing.	Suicide prevention training and simulation.

Remember: You can support someone without carrying their pain.

NURSING TAKEAWAYS

Suicide is preventable--screen, act, and follow up.

Always take suicidal ideation seriously, even if the patient “seems okay”.

Never promise to keep suicidal thoughts a secret.

Use compassionate language and avoid judgment.

Protect your own mental health while caring for others.

11. SELF-DIRECTED VIOLENCE (SELF-HARM)

DEFINITION

Self-directed violence refers to behaviors in which a person deliberately harms their own body. It may or may not involve suicidal intent.

Type	Description
Non-Suicidal Self-Injury (NSSI)	Deliberate self-harm without intent to die (e.g., cutting, burning, scratching, head banging).
Suicidal Behavior	Includes suicidal ideation, planning, and attempts to end one's life.
Self-Neglect	Failure to provide adequate care for one’s own health and safety (e.g., refusing medication, food, or shelter).

People who engage in self-harm are often trying to cope with intense emotional pain, not seeking attention.

COMMON REASONS FOR SELF-HARM

Self-harm serves as a coping mechanism for intense emotional distress.

Emotional regulation (to reduce anger, sadness, or numbness)

Feeling of control

Expression of internal pain

Punishment for perceived failures or guilt

Relief from dissociation

THE NURSE'S ROLE

Nurses play a critical role in providing sensitive, trauma-informed care.

Identify and assess self-directed violence sensitively.

Provide trauma-informed care.

Ensure safety and stabilization.

Offer emotional support without judgment.

Refer to mental health services.

Educate and involve family or caregivers (with consent).

Document objectively and accurately.

ADPIE FRAMEWORK FOR SELF-DIRECTED VIOLENCE

Respond with empathy, not judgment.

1. **A -- Assessment**

   What to Ask:

   - “Have you ever hurt yourself on purpose?”

- “What do you do when you're feeling overwhelmed?”
- “Do you have thoughts of harming yourself or ending your life?”
- “Do you have a safety plan or support system?”

What to Observe:

- Scars, fresh wounds, hidden injuries
- Frequent ER visits for unexplained injuries
- Emotional distress, withdrawal, shame
- Use of bandages or clothing to hide marks

Screening Tools: Columbia Suicide Severity Rating Scale (C-SSRS), Self-Harm Inventory (SHI), PHQ-9 (for depression and suicidal ideation).

2. **D -- Diagnosis**

   NANDA Examples: Risk for self-directed violence, ineffective coping, disturbed body image, hopelessness, anxiety, and chronic low self-esteem.

3. **P -- Planning**

   Immediate: Safety.

   Emotional: Stabilization.

   Identify: Coping strategies.

   Connect: To mental health providers.

   Create: A safety plan if there is risk for escalation.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Has the frequency/severity of self-harm decreased? Has the patient engaged in therapy or mental health services? Are healthier coping strategies being used? Does the patient report improved emotional regulation? Are safety and support systems in place?.

WARNING SIGNS OF SELF-HARM

These indicators alert nurses to potential self-harm.

Behavioral	Physical	Emotional
Wearing long sleeves in hot weather.	Scars, bruises, burns, cuts.	Emotional numbness or intense mood swings.
Isolation or social withdrawal.	Frequent “accidents”.	Feelings of shame, self-loathing.

Behavioral	Physical	Emotional
Hiding objects (razors, lighters).	Unexplained bandages.	Talking about feeling worthless or empty.
Drawing or writing about violence.	Frequent ER visits.	Irritability, impulsivity.

PUBLIC PROGRAMS AND RESOURCES

Support systems are available for those struggling with self-harm.

Program	Description
988 Suicide & Crisis Lifeline 988Lifeline.org	Call or text 988 for free, confidential help 24/7.
National Alliance on Mental Illness (NAMI) NAMI.org	Support groups, education, and advocacy.
To Write Love on Her Arms (TWLOHA) TWLOHA.com	Mental health resources and community outreach focused on self-harm, depression, and suicide.
The Trevor Project TheTrevorProject.org	Support for LGBTQ+ youth in crisis.
School-Based Mental Health Services NASP School Mental Health	On-site therapy, peer counseling, and crisis referrals.
Partial Hospitalization and Intensive Outpatient Programs (PHP/IOP) SAMHSA Treatment Types	Structured mental health care without full admission.

PREVENTION STRATEGIES

Prevention involves promoting mental health and early intervention.

Level	Actions
Primary Prevention	Mental health promotion in schools, healthy coping education, stigma reduction.
Secondary Prevention	Early identification, school screenings, trauma support after crisis.
Tertiary Prevention	Individualized treatment plans, family therapy, psychiatric follow-up, relapse prevention.

VICARIOUS TRAUMA IN NURSES

Caring for individuals who self-harm can be emotionally draining.

Signs	Coping Strategies
Emotional fatigue, intrusive thoughts.	Peer support, clinical supervision, mental health days.
Feeling helpless, avoidant, or over-involved.	Boundaries, mindfulness, journaling.
Nightmares or anxiety after patient care.	Debriefing, de-escalation training, therapy access.

Support for nurses is essential to maintain professional well-being.

NURSING TAKEAWAYS

Don’t dismiss self-harm as “attention seeking.” It is a sign of serious emotional pain.

Respond with empathy, not judgment.

Document thoroughly and objectively.

Ensure safety, dignity, and continuity of care.

Collaborate with the patient to build healthy coping and support systems.

12. ANOREXIA NERVOSA & BULIMIA NERVOSA

OVERVIEW

Eating disorders are severe mental health conditions with physical complications.

Disorder	Description
Anorexia Nervosa	Restriction of energy intake leading to significantly low body weight, intense fear of gaining weight, and distorted body image.
Bulimia Nervosa	Recurrent episodes of binge eating followed by compensatory behaviors (vomiting, laxatives, excessive exercise, fasting). Usually maintain normal weight.

Both disorders can result in severe medical complications and are often accompanied by co-occurring anxiety, depression, or trauma.

NURSING PRIORITIES

Early identification and a holistic approach are crucial.

Early identification and intervention.

Nonjudgmental, trauma-informed care.

Monitor for complications (cardiac, electrolyte, GI).

Support emotional safety and body image healing.

Facilitate referrals to eating disorder specialists.

Educate patient and family on nutrition, risks, and recovery.

ADPIE: NURSING PROCESS FOR EATING DISORDERS

Treatment involves addressing both mental and physical aspects.

1. **A -- Assessment**

KEY AREAS TO ASSESS

Category	Examples
Physical	Low BMI (anorexia), dehydration, lanugo, amenorrhea, dental erosion (bulimia), callused knuckles (Russell's sign), bradycardia, hypotension.
Behavioral	Rituals around food, hiding food, excessive exercise, bathroom use after meals, purging behaviors.
Psychological	Fear of weight gain, perfectionism, distorted body image, guilt/shame, anxiety or depression.
Labs	Electrolytes (low K+, low Na+), CBC, ECG for arrhythmias, renal function, albumin, amylase (elevated in bulimia).

Screening Tools: SCOFF Questionnaire, Eating Disorder Inventory (EDI), PHQ-9 (for depression screening) [100].

2. **D -- Diagnosis**

   NANDA Nursing Diagnoses: Imbalanced nutrition: less body requirements, disturbed body image, risk for electrolyte imbalance, risk for cardiac dysrhythmia, anxiety, chronic low self-esteem, ineffective coping, and risk for self-harm (if comorbid depression or suicidal ideation is present).

3. **P -- Planning**

   Short-term goals: Stabilize vitals and lab values, establish trust and therapeutic rapport, and begin nutrition education and meal support.

Long-term goals: Normalize eating patterns, improve body image and self-esteem, and prevent relapse through coping strategies and therapy.

4. **I -- Interventions**
5. **E -- Evaluation**

   Outcomes: Is the patient gaining or maintaining a safe weight? Are eating behaviors becoming more normalized? Is there improved self-esteem or body image? Is the patient engaging in therapy and coping skills? Has medical stability been achieved?.

PUBLIC PROGRAMS & RESOURCES

These resources provide support and treatment for eating disorders.

Program	Description
National Eating Disorders Association (NEDA) NEDA.org	Education, helpline (1-800-931-2237), screening tools, support resources.
Project HEAL TheProjectHEAL.org	Access to care for underinsured and low-income patients.
Eating Recovery Center EatingRecoveryCenter.com	Inpatient and outpatient treatment options.
The Renfrew Center RenfrewCenter.com	Nationwide eating disorder treatment programs for women and teens.
School Counselors & College Services NASP School Mental Health	On-site support, screening, accommodations, meal planning.
WIC (if pregnant) USDA WIC	Nutritional support for women with disordered eating during pregnancy.

PREVENTION STRATEGIES

Prevention involves promoting positive body image and healthy eating.

Level	Strategies
Primary Prevention	Media literacy education, promoting body positivity, school-based self-esteem programs, early conversations about healthy eating.
Secondary Prevention	Early screening in schools, pediatric and OB/GYN offices, use of eating behavior questionnaires.
Tertiary Prevention	Relapse prevention planning, long-term therapy, support groups, psychiatric and nutritional follow-up.

NURSING TAKEAWAYS

Eating disorders have high mortality and require early, sustained intervention.

Avoid focusing on weight; instead, prioritize function, feelings, and recovery goals.

Use consistent, supportive, and nonjudgmental communication.

Monitor for medical instability even in patients who appear "high functioning".

Treat the mind and body together through interdisciplinary care.

13. HOMICIDE

DEFINITION OF HOMICIDE

Homicide is the intentional killing of one human being by another. It includes criminal homicide (murder, manslaughter) and justifiable homicide (e.g., self-defense, law enforcement).

Often associated with community violence, intimate partner violence, gang activity, or mental health crises.

Homicide is a leading cause of death among adolescents and young adults, especially in marginalized and underserved populations.

NURSE'S ROLE IN HOMICIDE PREVENTION AND RESPONSE

Nurses play a key public health role in preventing homicide.

Screen for violence risk in healthcare and community settings.

Recognize red flags (especially in IPV and gang-involved patients).

Provide trauma-informed care to victims, families, and communities.

Support survivors of homicide victims (grief counseling, referrals).

Collaborate with law enforcement, social services, and violence prevention programs.

Engage in public health education and advocacy.

ADPIE: NURSING PROCESS FOR HOMICIDE PREVENTION

Homicide is preventable when nurses identify risk early and take action.

1. **A -- Assessment**

WHAT TO ASSESS

Category	Examples
Risk of Perpetrating or Becoming a Victim	History of violence, substance use, access to weapons, IPV, community violence exposure.
Mental Health	Depression, PTSD, psychosis, hopelessness, prior aggression.
Social Determinants	Poverty, unemployment, homelessness, school failure, gang involvement.
Family Dynamics	Domestic abuse, child maltreatment, caregiver neglect, family history of violence.
Environmental	Unsafe neighborhoods, recent threats, lack of police or community support.

2. **D -- Diagnosis**

   NANDA Examples: Risk for violence directed at others, risk for trauma, risk for self-directed violence (homicide-suicide situations), ineffective coping, post-trauma syndrome, and risk for complicated grieving (in survivors of homicide victims).

3. **P -- Planning**

   Identify: Patients or communities at risk.

   Prioritize: Safety, early intervention, and community referral.

   Short-term goals: Removing weapons from home, providing emotional support, engaging with outreach programs.

   Long-term goals: Promoting resilience, reducing violence exposure, and establishing safe housing or schooling.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Is the individual or family engaged in support services? Have violence risk behaviors decreased? Has safety planning been implemented? Have referrals to mental health, shelter, or youth programs been successful? Are grief or trauma symptoms improving (for survivors)?.

RED FLAGS FOR POTENTIAL HOMICIDE RISK

These indicators are critical for nurses to recognize.

Victim/Survivor Clues	Perpetrator Clues
Repeated threats from a partner or family member.	Obsession with partner or ex-partner.

Victim/Survivor Clues	Perpetrator Clues
Fear of a specific person.	Stalking, controlling behavior.
History of IPV with escalating violence.	Access to firearms, making threats.
Physical injuries without explanation.	Prior violence, criminal history.
Suicidal ideation with mention of "taking others with me".	Paranoia, untreated psychosis, extreme agitation.

80% of intimate partner homicides are preceded by warning signs, especially strangulation and threats to kill.

PUBLIC PROGRAMS AND RESOURCES

Various programs work to prevent homicide and support survivors.

Program	Description
National Domestic Violence Hotline TheHotline.org	1-800-799-SAFE -- crisis support and referral for IPV victims.
Cure Violence Cure Violence Global	Public health approach to interrupting community violence using trained “violence interrupters”.
Safe Streets / CeaseFire Safe Streets Baltimore	Local anti-gun violence programs focused on mediation and prevention.
Family Justice Centers National Family Justice Center Alliance	One-stop support for IPV victims including legal, medical, and housing aid.
Trauma Recovery Centers (TRCs) OVC TRC	Mental health care and case management for survivors of violence.
Victim Compensation Programs OVC Compensation	Financial aid for funeral costs, counseling, and relocation.
Youth Mentorship & Violence Prevention Initiatives CDC Youth Violence Prevention	School and community-based interventions for at-risk youth.

PREVENTION STRATEGIES

Homicide prevention requires a multi-faceted approach.

Level	Strategies
Primary Prevention	Anti-violence education, conflict resolution training, safe gun storage, media literacy, community policing.
Secondary Prevention	Screening for IPV and threats, early mental health referral, gang outreach, school-based interventions.
Tertiary Prevention	Long-term support for victims and survivors, trauma recovery, home visits, re-entry support for formerly incarcerated individuals.

NURSING TAKEAWAYS

Homicide is preventable when nurses identify risk early and take action.

Screening for IPV, suicide, mental illness, and social stressors is critical.

Nurses play a key public health role in connecting individuals to support services.

Survivors of homicide victims need grief counseling and trauma-informed care.

Advocacy, education, and violence prevention save lives.

14. ASSAULT VS. BATTERY

KEY DEFINITIONS

These legal definitions distinguish between the threat and the act of violence.

Term	Legal Definition
Assault	The threat or attempt to make physical contact with another person without their consent, causing fear or apprehension. No physical contact is necessary.
Battery	The actual physical contact or touching of another person without their consent or lawful justification. Can involve hitting, slapping, restraining, or invasive procedures without consent.

THE NURSE'S ROLE

Nurses have a crucial role in preventing and responding to assault and battery, and must also ensure their own actions do not constitute battery.

Identify signs of assault or battery in patients (especially children, elderly, and IPV victims).

Report suspected abuse as mandated by state law (especially for minors, elders, or vulnerable adults).

Prevent battery in practice by always obtaining informed consent.

Provide trauma-informed care to patients reporting or recovering from violence.

Document objectively: record what the patient says, observed injuries, and behavior.

Collaborate with law enforcement, social services, and advocacy groups as needed.

Nurses can also commit assault or battery if they threaten or perform procedures without consent, including: Administering medication without consent, forcibly restraining a patient without proper justification or order, or ignoring a patient's right to refuse care.

ADPIE: NURSING PROCESS FOR ASSAULT AND BATTERY

Nurses must respect patient autonomy and legal rights.

1. **A -- Assessment**

   What to Ask:

   - "Has someone tried to hurt or scare you?"
   - "Do you feel safe at home?"
   - "Has anyone touched you against your will?"
   - "Can you tell me what happened?"

   What to Observe:

   - Bruises, lacerations, defensive wounds
   - Inconsistent explanations of injuries
   - Fearful behavior, flinching, anxiety around certain individuals
   - Repeated ER visits for injuries

   Physical Clues: Bilateral injuries (suggesting restraint), injuries in various stages of healing, neck injuries (possible strangulation), burns, welts, or patterned marks.

   Psychological Clues: Withdrawal, dissociation, hypervigilance, panic attacks.

2. **D -- Diagnosis**

   NANDA Examples: Risk for violence, acute pain, post-trauma syndrome, risk for impaired skin integrity, ineffective coping, and fear.

3. **P -- Planning**

   Prioritize: Immediate safety, physical treatment, pain management, and trauma care.

   Referrals: Make referrals for legal, social, and psychological support.

   Plan: Establish a care plan that respects patient autonomy and promotes recovery.

4. **I -- Interventions**

5. **E -- Evaluation**

Outcomes: Has the patient been physically stabilized? Have safety and legal concerns been addressed? Is the patient linked with needed support (housing, counseling, legal)? Has a protection plan or referral to law enforcement been made (if requested)? Is documentation complete and properly stored?.

WARNING SIGNS OF ASSAULT AND BATTERY

These signs can indicate a patient is experiencing assault or battery.

Physical	Behavioral	Environmental
Bruises, cuts, broken bones.	Fearful or evasive answers.	Partner or family member speaks for patient.
Injuries inconsistent with explanation.	Avoids eye contact.	Delays in seeking care.
Unexplained genital or anal injuries.	Extreme startle response.	Frequent ER visits or missed appointments.

PUBLIC PROGRAMS AND RESOURCES

Resources are available to support survivors.

Program	Description
National Domestic Violence Hotline TheHotline.org	1-800-799-SAFE -- 24/7 confidential support.
Adult Protective Services (APS) NAPSA.org	Investigates abuse or neglect of vulnerable adults.
Child Protective Services (CPS) Child Welfare Info Gateway	Investigates abuse or neglect of children.
Sexual Assault Nurse Examiner (SANE) IAFN SANE	Forensic exams and trauma-informed care following sexual assault.
Family Justice Centers National Family Justice Center Alliance	One-stop centers for survivors needing legal, medical, or housing assistance.
Crime Victim Compensation Programs OVC Compensation	Helps cover medical and legal expenses for survivors of violent crimes.
Title IX Coordinators Department of Education Title IX	College-based protections for students reporting violence or assault.

PREVENTION STRATEGIES

Nurses are vital in preventing violence at various levels.

Level	Strategies
Primary Prevention	Public education on consent and respectful communication; anti-violence school programs.
Secondary Prevention	IPV screening in primary care, ERs, OB/GYN, and mental health settings.
Tertiary Prevention	Long-term support for survivors, rehabilitation, advocacy, and mental health care.

NURSING TAKEAWAYS

Assault = threat or attempt to cause harm.

Battery = actual, intentional, non-consensual touching.

Nurses must respect patient autonomy and legal rights.

Always screen for violence, even if injuries appear minor.

Use trauma-informed care, especially when dealing with vulnerable populations.

Documentation and consent protect both the patient and the nurse.

15. HUMAN TRAFFICKING

DEFINITION

Human trafficking is the use of force, fraud, or coercion to exploit people for labor or commercial sex acts. It is a form of modern-day slavery and a severe violation of human rights.

Type	Description
Sex Trafficking	Exploiting individuals (often women and children) through forced prostitution, pornography, or sexual servitude.
Labor Trafficking	Forced labor in agriculture, construction, domestic work, or factories through manipulation, threats, or abuse.
Child Trafficking	Any exploitation of a minor for labor or sex--even without force or coercion.

Key Law: The Trafficking Victims Protection Act (TVPA) defines trafficking as a federal crime. Victims may be U.S. citizens or undocumented individuals.

THE NURSE'S ROLE

Nurses must trust their instincts and prioritize patient safety.

Recognize signs of trafficking in clinical settings.

Screen sensitively and privately.

Provide trauma-informed, culturally competent care.

Ensure safety without alerting traffickers.

Report to appropriate authorities as required by law.

Collaborate with social workers, case managers, and legal advocates.

Educate peers and advocate for systems change.

ADPIE: NURSING PROCESS FOR HUMAN TRAFFICKING

The goal is to ensure safety, medical care, and connection to services--not rescue.

1. **A -- Assessment**

   Ask (in private):

   - "Do you feel safe where you live or work?"
   - "Are you free to come and go as you wish?"
   - "Has anyone hurt or threatened you?"
   - "Are you being forced to do anything you don't want to?"

   Look For:

   - Patient is anxious, avoids eye contact, appears rehearsed.
   - Someone speaks for them or refuses to leave the room.
   - Bruises, burns, malnutrition, untreated infections.
   - No ID, signs of branding/tattoos, poor hygiene, sleep deprivation.

   Physical Signs: Injuries in different stages of healing, STI, pregnancy, or multiple abortions, malnutrition or dehydration, signs of physical or sexual abuse.

   Psychological Signs: Fear, hypervigilance, dissociation, substance use, shame, suicidal thoughts.

   Environmental/Behavioral Signs: Patient has no control over money, phone, or documents; accompanied by controlling "friend," "boss," or "partner"; avoids details about home or work.

2. **D -- Diagnosis**

NANDA Examples: Risk for post-trauma syndrome, risk for injury, impaired social interaction, anxiety, powerlessness, and risk for ineffective coping.

3. **P -- Planning**

   Immediate: Ensure immediate safety and stabilization.

   Trust: Establish trust using trauma-informed, nonjudgmental communication.

   Short-term goals: Contact social worker, initiate medical treatment.

   Long-term goals: Recovery, referral, and safety planning.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Has the patient been connected to safety and shelter? Have urgent medical and mental health needs been addressed? Has trust been established and support engaged? Is the patient receiving ongoing case management? Are safety and legal protections in place?.

WARNING SIGNS OF TRAFFICKING

Nurses should be vigilant for these red flags.

Category	Red Flags
Physical	Injuries, untreated infections, repeated ER visits, malnourishment.
Behavioral	Fearful, avoids eye contact, anxious if separated from companion.
Control	Cannot speak freely, lacks ID, no control of money or schedule.
Work Conditions	Claims of long hours, no breaks, abuse, unusual work descriptions.
Branding	Tattoos of barcodes, names, symbols, or “property of” phrases.

PUBLIC PROGRAMS AND RESOURCES

These organizations offer support and resources for trafficking victims.

Program	Description
National Human Trafficking Hotline HumanTraffickingHotline.org	1-888-373-7888 -- 24/7 support for victims and providers.
Polaris Project PolarisProject.org	Leading anti-trafficking organization with survivor-led initiatives.
HEAL Trafficking HEALTrafficking.org	Provides education and advocacy for health professionals.

Program	Description
Safe Harbor Laws HHS OTIP Safe Harbor	Protect minors from being criminalized for sex work.
Family Justice Centers National Family Justice Center Alliance	Provide wraparound services for IPV and trafficking survivors.
State & Local Task Forces DOJ Human Trafficking Task Forces	Collaborations between law enforcement, healthcare, and nonprofits.

PREVENTION STRATEGIES

Prevention involves public awareness and early intervention.

Level	Example Actions
Primary Prevention	Public awareness campaigns, school-based prevention, safe job recruitment education.
Secondary Prevention	Screening in ERs, clinics, prenatal care, and community outreach programs.
Tertiary Prevention	Housing, therapy, legal aid, reintegration, and long-term trauma recovery services.

NURSING TAKEAWAYS

Trust your instincts--if something feels wrong, it might be.

Use nonjudgmental, trauma-informed language.

Never confront the trafficker or insist the patient disclose.

Your job is to ensure safety, medical care, and connection to services--not rescue.

Understand your state's mandatory reporting requirements.

16. CHILD ABUSE

TYPES OF CHILD ABUSE

Child abuse can take many forms, affecting any child regardless of setting or background.

Type	Description	Examples
Physical Abuse	Non-accidental physical injury.	Bruising, burns, fractures, shaking.
Emotional Abuse	Verbal or psychological harm that damages self-esteem.	Constant criticism, humiliation, threats.
Sexual Abuse	Exploitation or sexual acts imposed on a child.	Fondling, incest, rape, exploitation.
Neglect	Failure to meet basic physical, emotional, medical, or educational needs.	Malnutrition, missed appointments, unsafe living conditions.
Medical Neglect / Munchausen by Proxy	Caregiver fabricates or induces illness in a child.	Repeated hospitalizations, conflicting reports.

Note: Abuse can occur in any setting--home, school, foster care--and affect any age or demographic.

THE NURSE'S ROLE

Nurses are legally mandated reporters of suspected child abuse.

Mandated reporter: Legally required to report suspected child abuse or neglect.

Provide trauma-informed care.

Assess, document, and refer appropriately.

Ensure the child's physical and emotional safety.

Work closely with social workers, CPS, pediatricians, and mental health providers.

Educate caregivers on safe parenting practices and resources.

ADPIE: NURSING PROCESS FOR CHILD ABUSE

Reasonable suspicion is enough to report abuse; proof is not required.

1. **A -- Assessment**

   Observe the Child: Bruises, burns, fractures in various stages of healing; poor hygiene, malnutrition, medical neglect; fearful, withdrawn, overly compliant behavior; sexual knowledge inappropriate for age.

   Observe the Caregiver: Aggressive, controlling, or indifferent behavior toward child; delays seeking care or gives inconsistent explanations; reluctant to leave child alone with providers; belittles child or views child as "bad" or "evil".

   Assessment Tools: Body map to document injuries, Pediatric Abuse Head Trauma Tool (PAHT), Developmental screenings to detect delays.

Ask the Child: Open-ended, age-appropriate questions in private: “Can you tell me how that happened?” “Has anyone hurt or scared you?”.

2. **D -- Diagnosis**

   NANDA Examples: Risk for trauma, impaired parenting, delayed growth and development, risk for injury, post-trauma syndrome, fear, and imbalanced nutrition: less body requirements.

3. **P -- Planning**

   Prioritize: Safety and medical stabilization.

   Engage: Child protective services (CPS) and social services.

   Provide: Access to mental health and family support.

   Create: A long-term plan for healing and protective placement if needed.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Has the child been safely placed or protected? Have injuries or medical conditions improved? Is there follow-up with social services and mental health care? Is the family receiving parenting support or therapy? Has the child’s developmental trajectory stabilized or improved?.

WARNING SIGNS OF CHILD ABUSE

These warning signs should prompt suspicion and reporting.

Child Behaviors	Physical Signs	Environmental Clues
Sudden withdrawal or aggression.	Bruises in patterns or on soft tissue.	Unsafe, chaotic, or unsanitary home.
Regression (bedwetting, thumb sucking).	Burns, bite marks, head injuries.	Lack of food, heat, clothing.
Clinginess or fear of going home.	Frequent or untreated illnesses/injuries.	Multiple caregivers or unknown adults present.
Sexualized behaviors.	STIs, genital pain, blood-stained underwear.	Inconsistent or delayed care.

HOW TO IDENTIFY POTENTIALLY ABUSIVE PARENTS/CAREGIVERS

Behavioral indicators can signal abuse.

Uses harsh or degrading language toward the child.

Shows little concern or empathy for the child’s well-being.

Blames the child for problems or injuries.

Has a history of substance use, IPV, or being abused themselves.

Avoids speaking to providers or answering questions about the child's condition.

Appears controlling, overly defensive, or indifferent.

Delays medical care or gives conflicting accounts.

Isolates the elder from family or community services.

Trust your intuition: If something feels wrong, document, assess, and report.

PUBLIC PROGRAMS & RESOURCES

These programs support child protection and family well-being.

Program	Description
Child Protective Services (CPS) Child Welfare Info Gateway	Investigates reports of abuse and coordinates protective care.
Children's Advocacy Centers (CACs) National Children's Alliance	Provide forensic interviews, medical exams, therapy, and legal support in child-friendly settings.
National Child Abuse Hotline Childhelp Hotline	1-800-4-A-CHILD (1-800-422-4453).
Safe Haven Laws National Safe Haven Alliance	Allow parents to surrender infants at designated locations without legal consequences.
Early Head Start & WIC HHS ACF Head Start / USDA WIC	Support low-income families with child development and nutrition.
Prevent Child Abuse America PreventChildAbuse.org	Advocacy, research, and local support programs.
Triple P Parenting Program TripleP.net	Evidence-based education for parents on positive discipline and stress management.

PREVENTION STRATEGIES

Prevention involves supporting families and early intervention.

Level	Example Actions
Primary Prevention	Parenting education, home visiting programs, stress and anger management, public awareness.

Level	Example Actions
Secondary Prevention	Early identification and intervention for at-risk families (e.g., postpartum depression, poverty).
Tertiary Prevention	Counseling for survivors, supervised visitation, reunification support, trauma therapy.

NURSING TAKEAWAYS

You do not need proof of abuse to report--reasonable suspicion is enough.

Always separate child and caregiver to assess safely and privately.

Use developmentally appropriate communication.

Your report may be the child's only chance at protection.

Document carefully, using objective descriptions and direct quotes.

17. TRAUMA & ADVERSE CHILDHOOD EXPERIENCES (ACES)

WHAT IS TRAUMA?

Trauma is an emotional, psychological, or physical response to a deeply distressing or disturbing experience that overwhelms an individual's ability to cope.

In children, trauma interferes with development, learning, trust, attachment, and safety.

ADVERSE CHILDHOOD EXPERIENCES (ACES)

ACEs are potentially traumatic events that occur before age 18. They are a framework for understanding how childhood trauma affects long-term health, identified in a CDC--Kaiser Permanente study (1998).

A higher ACE score correlates with greater risk for poor physical and mental health outcomes.

ACE CATEGORIES (ORIGINAL 10)

These categories cover various forms of abuse, neglect, and household dysfunction.

Type	Examples
Abuse	Physical abuse, sexual abuse, emotional/verbal abuse.

Type	Examples
Neglect	Physical neglect or emotional neglect.
Household Dysfunction	Mental illness in the home, substance abuse, incarcerated relative, domestic violence, divorce/separation.

IMPACT OF ACES ON HEALTH

ACEs have profound, long-lasting consequences on health and well-being.

Area	Consequences
Brain Development	Impaired memory, learning, attention, emotion regulation.
Mental Health	Depression, PTSD, anxiety, substance use.
Behavior	Aggression, withdrawal, risk-taking, academic failure.
Physical Health	Heart disease, cancer, diabetes, obesity, autoimmune diseases.
Social Function	Difficulty trusting others, unstable relationships, legal problems.

THE NURSE'S ROLE IN ADDRESSING TRAUMA & ACES

All nurses must practice trauma-informed care.

Recognize trauma symptoms even when not disclosed.

Use trauma-informed care: Sadness, anger, regression, nightmares, fear, risky behavior.

Developmental delays: Language, motor, social skills.

Physical health: Chronic complaints (headaches, stomachaches), missed growth milestones.

Environmental stressors: Food insecurity, IPV, neglect, parental substance use.

ADPIE: NURSING PROCESS FOR TRAUMA & ACES

Nurses are crucial in identifying and mitigating the effects of trauma.

1. **A -- Assessment**

   What to Ask:

   - "Have you ever experienced anything really scary or upsetting?"
   - "Do you feel safe at home/school?"
   - "How do you cope when you're stressed or upset?"

   What to Observe:

   - Hypervigilance, exaggerated startle response, difficulty sleeping.

- Emotional dysregulation (sudden outbursts, extreme withdrawal).
- Physical symptoms without medical explanation (headaches, stomachaches).
- Difficulty forming relationships or trusting adults.

Screening Tools: ACE Questionnaire (child and adult versions), PEARLS (Pediatric ACEs and Related Life Events Screener), PSC-17 (Pediatric Symptom Checklist).

2. **D -- Diagnosis**

   NANDA Examples: Post-trauma syndrome, anxiety, risk for delayed development, chronic sorrow, risk for self-directed violence, impaired attachment, and risk for injury.

3. **P -- Planning**

   Environment: Create a safe, predictable environment.

   Goals: Use age-appropriate, strength-based goals.

   Collaboration: Work with mental health providers, schools, and caregivers.

   Integration: Integrate developmental, emotional, and physical needs.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Is the child emotionally and physically safe? Are symptoms improving with support? Has the child engaged in therapy or school support? Are caregivers demonstrating understanding and support? Has developmental progress resumed?.

WARNING SIGNS OF CHILDHOOD TRAUMA

These signs can indicate a child has experienced trauma.

Behavioral	Emotional	Physical
Aggression or withdrawal.	Fearfulness, depression, excessive crying.	Enuresis (bedwetting), somatic complaints.
Self-harm or suicidal ideation.	Low self-worth.	Eating/sleep disturbances.
Regressive behavior.	Hypervigilance or startle response.	Failure to thrive.
Risk-taking or “zoning out”.	Nightmares or flashbacks.	Headaches, GI issues.

PUBLIC PROGRAMS & RESOURCES

These programs provide support for trauma and ACEs.

Program	Description
SAMHSA Trauma & Resilience Programs SAMHSA Trauma & Violence	Grants and tools for trauma-informed systems.
ACES Aware ACESAware.org	Screening and training initiative for providers.
Child Advocacy Centers (CACs) National Children's Alliance	Provide forensic interviews, therapy, and case coordination.
National Child Traumatic Stress Network (NCTSN) NCTSN.org	Offers screening tools, protocols, and family resources.
Early Head Start & Home Visiting HHS ACF Head Start / HRSA Home Visiting	Early intervention and parent coaching for high-risk families.
Wraparound Services National Wraparound Initiative	Holistic family and community support programs.

PREVENTION STRATEGIES

Prevention focuses on promoting healthy development and resilience.

Level	Strategies
Primary Prevention	Promote positive parenting, early childhood education, social support for families.
Secondary Prevention	Early screening and intervention for children exposed to trauma or stress.
Tertiary Prevention	Access to mental health care, school-based trauma support, therapy for survivors.

NURSING TAKEAWAYS

Trauma rewires the brain--but resilience can rewire it again.

ACEs are not destiny: early intervention and loving relationships can heal.

All nurses must practice trauma-informed care, especially in pediatric, school, and community health settings.

Trust, safety, and connection are the foundation of healing.

18. ELDER ABUSE

DEFINITION

Elder abuse is a single or repeated act--or lack of appropriate action--that causes harm or distress to an older adult. It typically occurs in relationships of trust (e.g., family, caregivers, healthcare providers).

TYPES OF ELDER ABUSE

Elder abuse can manifest in various ways.

Type	Examples
Physical Abuse	Hitting, slapping, pushing, restraining, inappropriate use of drugs.
Sexual Abuse	Non-consensual sexual contact of any kind.
Emotional/Psychological Abuse	Verbal assaults, threats, intimidation, humiliation, isolation.
Financial Exploitation	Misuse of an elder’s money or assets, fraud, theft.
Neglect	Withholding food, medications, hygiene, or medical care.
Abandonment	Deserting an older adult who requires care.
Self-Neglect	Inability of the elder to care for themselves (not always considered abuse, but still reportable).

NURSE’S ROLE IN ELDER ABUSE RESPONSE

Nurses are in a prime position to identify and report suspected abuse.

Identify and screen for abuse during routine care.

Provide trauma-informed care and emotional support.

Ensure physical safety and stabilize medical needs.

Document thoroughly and objectively.

Report suspected abuse to Adult Protective Services (APS) or ombudsman.

Educate families, caregivers, and colleagues on recognizing and preventing abuse.

Advocate for vulnerable adults and their rights.

ADPIE: NURSING PROCESS FOR ELDER ABUSE

Nurses must combine clinical skill with advocacy.

1. **A -- Assessment**

   What to Ask:

   - “Do you feel safe where you live?”
   - “Has anyone hurt or taken advantage of you?”
   - “Are you getting help with meals, medication, and bills?”
   - “Has anyone touched you in a way you didn’t like?”

   What to Observe:

   - Unexplained injuries (bruises, burns, fractures)
   - Fearfulness around caregivers, flinching
   - Poor hygiene, malnutrition, pressure injuries
   - Torn clothing, STI symptoms, withdrawal

   Tools: Elder Abuse Suspicion Index (EASI), Hwalek-Sengstock Elder Abuse Screening Test, Cognitive and functional assessments.

2. **D -- Diagnosis**

   NANDA Examples: Risk for injury, powerlessness, chronic confusion, risk for impaired skin integrity, fear, and self-care deficit.

3. **P -- Planning**

   Prioritize: Safety, medical stabilization, and emotional well-being.

   Collaborate with: Social workers, APS, mental health professionals, and legal services.

   Ensure: Short-term protection and long-term care planning.

4. **I -- Interventions**

5. **E -- Evaluation**

   Outcomes: Has the elder been safely removed or protected? Are medical needs addressed? Is the elder connected to support services (counseling, legal aid)? Is the caregiver receiving support or intervention? Has the elder's quality of life improved?.

WARNING SIGNS OF ELDER ABUSE

These signs should prompt suspicion and reporting.

Physical	Behavioral	Financial
Bruises, burns, fractures.	Depression, withdrawal, fear of caregiver.	Unpaid bills, missing money, forged checks.

Physical	Behavioral	Financial
Pressure injuries, malnutrition.	Sudden change in behavior.	Utilities shut off, clutter or filth.
Frequent hospital visits or injuries.	Appears confused or scared.	Caregiver speaks for the elder or won't leave the room.

HOW TO IDENTIFY ABUSIVE ADULT CHILDREN OR CAREGIVERS

Recognizing red flags in caregiver behavior is crucial.

Controls elder's communication or money.

Speaks for the elder or won't leave them alone.

Appears angry, resentful, or burdened by caregiving.

Has a history of substance abuse, mental illness, or past violence.

Depends financially on the elder.

Lives with the elder but does not contribute to their care.

Delays or avoids medical treatment for the elder.

Isolates the elder from family or community services.

PUBLIC PROGRAMS & RESOURCES

These resources offer protection and support for older adults.

Program	Description
Adult Protective Services (APS) NAPSA.org	Investigates reports of abuse, neglect, or exploitation of vulnerable adults.
National Center on Elder Abuse (NCEA) NCEA.acl.gov	Provides information and resources on elder abuse prevention.
Long-Term Care Ombudsman Programs NORC	Advocates for residents of nursing homes and assisted living facilities.
Elder Abuse Multidisciplinary Teams (MDTs) NCEA MDTs	Bring together social, legal, medical, and financial experts for case management.
Meals on Wheels, home health, and respite care Meals on Wheels America	Reduce caregiver stress and risk of neglect.

PREVENTION STRATEGIES

Nurses are involved in preventing elder abuse at all levels.

Level	Examples
Primary Prevention	Education on aging, positive caregiving, financial planning for older adults.
Secondary Prevention	Screening in ERs, clinics, home health visits.
Tertiary Prevention	Crisis intervention, case management, caregiver training, legal protections.

MANDATED REPORTING

Nurses have a legal obligation to report suspected elder abuse.

All nurses are mandated reporters in all 50 U.S. states.

You must report any suspected abuse, neglect, or exploitation of: Older adults, individuals with disabilities, and long-term care residents.

Reports should be made immediately or within 24 hours, depending on state law.

You do not need proof--reasonable suspicion is enough.

NURSING TAKEAWAYS

Elder abuse is common, underreported, and preventable.

Nurses are in a prime position to identify and report suspected abuse.

Use trauma-informed care and avoid blaming language.

Document carefully and follow legal protocols.

Your report could save a life.

IMMUNIZATIONS: CHILD AND ADOLESCENT IMMUNIZATION SCHEDULE

This section provides guidance on using the immunization schedule and lists common vaccines for children and adolescents.

IMPORTANCE OF IMMUNIZATION

Immunizations are critical for preventing communicable diseases and protecting public health, especially in school settings.

The immunization schedule serves as a guideline for healthcare providers to ensure timely vaccinations for children and adolescents.

Understanding the schedule helps in determining catch-up vaccinations and additional vaccines based on medical conditions.

HOW TO USE THE IMMUNIZATION SCHEDULE FOR HEALTHCARE PROVIDERS

The immunization schedule is a critical tool for healthcare providers to ensure appropriate vaccination.

1. Determine Recommended Vaccine by Age: Refer to "Table 1 - By Age".
2. Determine Recommended Interval for Catch-up Vaccination: Use "Table 2 - Catch-up" if a child is behind on vaccinations.
3. Assess Need for Additional Recommended Vaccines by Medical Condition or Other Indication: Consult "Table 3 - By Medical Indication" for specific health circumstances.
4. Review Vaccine Types, Frequencies, Intervals, and Considerations for Special Situations (Notes section).
5. Review Contraindications and Precautions for Vaccine Types (Appendix section).
6. Review New or Updated ACIP (Advisory Committee on Immunization Practices) Guidance (Addendum).

COMMON VACCINES AND THEIR ADMINISTRATION

The following table lists commonly administered vaccines, their abbreviations, and trade names. This is not an exhaustive list but highlights key examples.

Vaccine	Abbreviation(s)	Trade Name(s)
COVID-19 vaccine	b-CoV-mRNA, u-CoV-mRNA	Comirnaty/Pfizer-BioNtech, Spikevax/Moderna
Dengue vaccine	DENGUE	Dengvaxia
Diphtheria, tetanus, and acellular pertussis	DTaP	Daptacel, Infanrix
Haemophilus influenzae type b	Hib	ActHib, Hiberix
Hepatitis A	HepA	Havrix, Vaqta
Hepatitis B	HepB	Engerix-B, Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9

Vaccine	Abbreviation(s)	Trade Name(s)
Influenza vaccine (inactivated)	IIV	Afluria Quadrivalent, Fluarix Quadrivalent, Fluzone Quadrivalent, Flucelvax Quadrivalent, FluLaval Quadrivalent
Influenza vaccine (live, attenuated)	LAIV	FluMist Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II, Priorix
Meningococcal serogroup A, C, W, Y vaccine	MenACWY-CRM, MenACWY-TT	Menveo, MenQuadfi
Meningococcal serogroup B vaccine	MenB	Bexsero, Trumenba
Mpox vaccine	MPOX	Jynneos
Pneumococcal conjugate vaccine	PCV13, PCV15	Prevnar 13, Vaxneuvance
Pneumococcal polysaccharide vaccine	PPSV23	Pneumovax 23
Polio vaccine (inactivated)	IPV	Ipol
Rotavirus vaccine	RV1, RV5	Rotarix, RotaTeq
Tetanus, diphtheria	Td	Tenivac, Tdavax
Tetanus, diphtheria, and acellular pertussis	Tdap	Adacel, Boostrix
Varicella vaccine	VAR	Varivax

COMBINATION VACCINES

Vaccine	Abbreviation(s)	Trade Name(s)
DTaP, HepB, and inactivated poliovirus	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus, Haemophilus influenzae type b	DTaP-IPV/Hib	Pentacel
DTaP, inactivated poliovirus, Haemophilus influenzae type b, HepB	DTaP-IPV-Hib-HepB	Vaxelis

Vaccine	Abbreviation(s)	Trade Name(s)
MMR and Varicella	MMRV	ProQuad

Important Notes for Administration:

- If a vaccine is not administered at the recommended age, it should be administered at a subsequent visit.
- Trade names are provided for identification only and do not imply endorsement by the CDC.
- Content is sourced from the National Center for Immunization and Respiratory Diseases.

THE ROLE OF SCHOOL NURSING

I. INTRODUCTION TO SCHOOL NURSING

Definition: A specialized practice supporting students' health, development, and academic success, recognized by the National Association of School Nurses (NASN).

Focus: Health promotion, illness prevention, chronic condition management, and early intervention to enhance student well-being.

School nurses play a critical role in bridging health and education, ensuring that students are healthy and ready to learn.

II. HISTORICAL PERSPECTIVE

First U.S. School Nurse: Lina Rogers, New York City, 1902.

Origin: Arose to reduce absenteeism and address communicable diseases in crowded urban schools.

Evolution: Grew into a key role within education and community health systems. Historical developments highlight the increasing recognition of health as a vital component of educational success.

III. SCOPE OF SCHOOL NURSING PRACTICE

School nurses fulfill diverse roles within the school environment.

Direct Care Provider: Treats injuries, manages chronic conditions (e.g., asthma, diabetes, seizures).

Case Manager: Coordinates care with families, healthcare providers, and school staff.

Health Educator: Teaches students about hygiene, nutrition, mental health, sexual health, and substance use prevention.

Advocate and Liaison: Promotes equity and access for students with health needs or disabilities.

Emergency Preparedness Leader: Creates and implements crisis response plans (e.g., for anaphylaxis, natural disasters, school shootings).

Health Screener: Conducts vision, hearing, BMI, scoliosis, and dental assessments.

IV. LEGAL AND ETHICAL FRAMEWORK

School nursing practice is governed by specific laws and ethical principles.

FERPA (Family Educational Rights and Privacy Act) and HIPAA: Guide the management of student health records.

State laws and school district policies: Dictate medication administration and immunization requirements, ensuring compliance with health regulations.

Reporting Requirements: For communicable diseases and suspected child abuse.

Confidentiality and Informed Consent: Nurses must maintain confidentiality, ensure informed consent, and practice within their licensure scope. Ethical principles guide confidentiality, informed consent, and the scope of practice for school nurses.

V. COMMON HEALTH ISSUES IN SCHOOL POPULATIONS

Overview of Health Concerns

School nurses manage a variety of health issues, including chronic conditions (asthma, diabetes, epilepsy, food allergies, ADHD), acute concerns (injuries, infections, medication side effects), and mental health issues (anxiety, depression, bullying, suicidal ideation).

Nutrition and physical activity are critical areas of focus, addressing obesity and promoting healthy lifestyles among students.

Substance use and risky behaviors are particularly prevalent among middle and high school students, necessitating targeted interventions.

Sexual and Reproductive Health: Depending on state/school policy.

VI. INDIVIDUALIZED HEALTH PLANNING AND DOCUMENTATION

Tailored plans are essential for students with specific health needs.

Individualized Healthcare Plans (IHPs): Tailored to meet student-specific medical needs.

Emergency Care Plans (ECPs): Step-by-step actions for urgent situations (e.g., anaphylaxis, seizures).

504 Plans and IEPs (Individualized Education Programs): Provide legal support for students with chronic health conditions or disabilities impacting learning.

VII. PROMOTING A HEALTHY SCHOOL ENVIRONMENT

School nurses contribute to a holistic approach to student well-being.

Ensuring a safe and clean physical environment, essential for student health and learning.

Advocating for school wellness policies (e.g., healthy meals, physical education).

Addressing social determinants: Poverty, trauma, housing instability, is crucial for fostering a supportive school environment.

Participating in school-wide health promotion initiatives: Anti-bullying campaigns, immunization drives, hand hygiene education.

VIII. SCHOOL NURSING DURING EMERGENCIES AND PUBLIC HEALTH CRISES

Crisis Management and Leadership

Crisis Management: Nurses play a key role in managing COVID-19 protocols, outbreaks of communicable diseases, and vaccination compliance.

Leadership: Lead efforts in contact tracing, infection control, and public health communication, ensuring student safety during emergencies. Effective crisis management requires strong leadership and collaboration with local health departments and school administrators.

IX. COLLABORATION AND COMMUNICATION

Effective school nursing relies on strong partnerships.

Collaboration with: Local health departments, school administrators, and parents.

Close Work With: Teachers and administrators, parents and guardians, primary care providers and specialists, social workers, psychologists, and counselors.

Interdisciplinary Team Meetings: Especially important for students with IEPs or behavioral concerns, ensuring comprehensive support.

X. SKILLS AND COMPETENCIES FOR SCHOOL NURSES

Clinical Skills: Assessment, medication administration, first aid.

Communication: Effective communication with students of all ages, families, and staff.

Cultural Competence: Ability to address diverse student backgrounds and beliefs.

Autonomy and Critical Thinking: Often the only healthcare professional on site.

Public Health Perspective: Monitoring trends, preventing illness, promoting wellness.

XI. SUMMARY AND KEY TAKEAWAYS

School nurses bridge health and education to support student well-being and readiness to learn.

The role is diverse, autonomous, and essential for early intervention and chronic disease management.

Strong communication, legal knowledge, and clinical expertise are required.

School nurses are leaders in emergency response, public health promotion, and equity advocacy in schools.

KEY CONCEPTS AND SUMMARIES

KEY TERMS/CONCEPTS

Health Equity: Achieving the highest level of health for all people by addressing avoidable inequalities.

Vulnerability: Increased susceptibility to poor health outcomes due to risk exposure, limited resources, or systemic barriers.

Health Disparities: Differences in health outcomes among groups that may or may not be avoidable.

Health Inequities: Systemic, unjust differences in opportunities and resources that lead to disparities, considered ethically unacceptable.

KEY POPULATIONS

Vulnerable Populations: Groups commonly affected by vulnerability, including:

- Homeless Individuals
- Migrant and Seasonal Farmworkers
- Low-income families
- Racial and ethnic minorities
- Immigrants and refugees
- People with disabilities
- Elderly and very young
- LGBTQ+ Individuals
- Incarcerated populations
- People living with chronic disease, mental illness, or substance use disorders.

KEY STRATEGIES FOR PUBLIC HEALTH NURSING

Strategy	Description
Advocate	For access to care, social services, and policy change.
Educator	Enhance health literacy and implement prevention strategies.
Care Coordinator	Provide wraparound services, addressing comprehensive needs.
Community Partner	Build trust and mobilize community resources.
Upstream Thinking	Focus on the root causes of health issues and prevention.
Trauma-Informed Care	Recognize the impact of trauma on health behavior and outcomes.
Culturally Competent Care	Respect diverse cultural beliefs and values; practice reflective self-awareness to minimize bias.
Community Empowerment	Strengthen social support and leadership from within vulnerable groups.

KEY BARRIERS TO HEALTH CARE

Rural Populations: Geographic distance, provider shortages, hospital closures, and cultural norms of self-reliance.

Migrant and Seasonal Farmworkers: Language barriers, documentation concerns, lack of insurance, and irregular work schedules.

KEY NURSING ROLES

Direct Care Provider: Delivers care across the lifespan in various settings.

Educator and Advocate: Teaches health promotion and advocates for policy change.

Case Manager and Care Coordinator: Assists clients in navigating fragmented systems of care.

Community Collaborator: Partners with local agencies and organizations to improve health outcomes.

FACTS TO MEMORIZE

Definition of Health Equity: Achieving the highest level of health for all people by addressing avoidable inequalities.

Key Social Determinants of Health (SDOH): Economic stability, education access and quality, health care access and quality, neighborhood and built environment, social and community context.

Commonly Used Vaccines: COVID-19, DTaP, MMR, HPV, Influenza, and others listed in the immunization schedule.

CONCEPT COMPARISONS

Concept	Definition	Implications
Health Disparities	Differences in health outcomes among groups.	May or may not be avoidable; simply observed differences.
Health Inequities	Systemic, unjust differences in opportunities and resources that lead to disparities.	Are avoidable and rooted in social, economic, and environmental factors; considered ethically unacceptable.

CONCLUSION

This study guide has explored the multifaceted roles of community and public health nurses in addressing complex health challenges. From promoting health equity and caring for vulnerable populations to tackling substance use disorders and ensuring student well-being through school nursing and immunizations, the content underscores the critical importance of a holistic, culturally competent, and prevention-focused approach. Nurses are pivotal in advocating for systemic change, implementing evidence-based interventions, and fostering community partnerships to achieve optimal population health outcomes.

QUIZ: PUBLIC HEALTH NURSING FUNDAMENTALS

Instructions: Answer each question in 2-3 sentences.

1. What is the primary role of federal public health agencies in the United States, and how do they support state and local efforts?
2. Describe the key responsibilities of state public health agencies, including their financial role regarding local agencies.
3. How do local public health agencies primarily serve their communities, and what is their overarching goal?
4. Identify two significant historical trends that have shaped the scope of public health beyond its initial focus on communicable diseases.
5. What is Winslow's classic definition of public health, and how does it relate to the focus of public health nursing?

6. Explain how the shift to Medicaid managed care influenced the activities of many public health agencies.
7. List three emerging public health issues that nurses in the 21st century are currently facing.
8. According to ACHNE, what is the recommended minimum educational preparation for public health nurses, and why is this emphasized?
9. Name three distinct functions or roles of public health nurses as discussed in the text.
10. How do public health nurses contribute to addressing racial and ethnic disparities in health outcomes?

QUIZ ANSWER KEY

1. Federal public health agencies primarily develop regulations to implement policies from Congress and provide significant funding to state and territorial health agencies. This support enables states to provide public health activities, survey health status, set standards, and coordinate cross-state public health efforts.
2. State public health agencies are responsible for monitoring health status and enforcing laws that protect and improve public health. They distribute federal and state funds to local public health agencies to implement community-level programs and provide essential oversight and consultation.
3. Local public health agencies are responsible for implementing and enforcing public health codes and providing essential health programs directly to a community. Their overarching goal is to safeguard the public's health and improve the community's overall health status.
4. Historically, public health expanded significantly beyond its initial focus on communicable disease prevention, occupational health, and environmental health to include reproductive health and chronic disease prevention. Another trend is the shift under Medicaid managed care, emphasizing core public health activities over direct personal health care services.
5. Winslow defined public health as "the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort." Public health nursing synthesizes nursing and public health theory to apply this definition to the health of populations.
6. The shift to Medicaid managed care resulted in many public health agencies no longer primarily providing personal health care services. Instead, their emphasis moved towards core public health activities like investigating and controlling diseases, assessing population health, and planning community health initiatives.
7. Three emerging public health issues include increasing rates of drug resistance to community-acquired pathogens, preventing bioterrorism and violence, and handling and disposing of hazardous waste. The text also highlights newly emerging communicable diseases as a major challenge.
8. The Association of Community Health Nursing Educators (ACHNE) recommends at least a baccalaureate degree for public health nurses. This is emphasized due to the increasing complexity of healthcare delivery in public health and the need for a strong public health system.

9. Public health nurses function in many roles, including advocate, case manager, and educator. They also serve as referral resources, direct primary caregivers in certain situations, and disaster responders.
10. Public health nurses contribute by working as case managers and at the policy level to promote equal access to healthcare. They ensure that health literature and spoken services reflect the community, partner with agencies for culturally appropriate services, and identify/alert the community to service gaps.

ESSAY FORMAT QUESTIONS (NO ANSWERS)

1. Analyze the interdependent relationships between local, state, and federal public health agencies. Provide specific examples of how their roles intersect and collaborate to achieve national health objectives, and discuss potential challenges in this partnership.
2. Discuss the evolution of public health from the early 20th century to the present day, highlighting how historical events and policy changes (e.g., Medicaid managed care, post-9/11) have reshaped its scope and priorities.
3. Evaluate the critical role of public health nurses in addressing health disparities and promoting health equity within communities. How do their diverse functions, such as case management and advocacy, specifically contribute to improving access and outcomes for vulnerable populations?
4. Examine the significance of "partnerships" in public health, as defined by the Community-Campus Partnerships for Health (CCPH). Discuss why collaboration is essential for effective public health programs and illustrate with examples from the text.
5. Describe the essential competencies and educational preparation required for public health nurses in the 21st century. How do these requirements equip nurses to respond to emerging public health challenges, including infectious disease outbreaks and disaster preparedness?

GLOSSARY OF KEY TERMS

Advocate:
A public health nurse function where the nurse collects and analyzes data, discusses services needed with clients (individuals, families, or groups), develops effective plans, and helps implement them to foster client independence in decision-making and service acquisition.

Assessor (of literacy):
A public health nurse function that involves recognizing and addressing clients' limitations in reading, writing, and clear communication, while being culturally sensitive to ensure understanding of health information.

Case Manager:
A major role for public health nurses involving the use of the nursing process (assessing, planning, implementing, evaluating) to meet client needs, often through complex

communications and by linking individuals to needed health and social services at the least cost.

Core Public Health Competencies:
A set of skills, knowledge, and attitudes identified by the Council on Linkages Between Academia and Public Health Practice, deemed necessary for the broad practice of public health across all providers, including nurses.

Disaster Responders:
A role of public health nurses during emergencies, involving assessment, planning, implementing, and evaluating needs and resources for affected populations, regardless of the disaster's scale or cause.

Educator:
A public health nurse function focused on teaching clients at their comprehension level, identifying community needs, and developing/implementing educational activities to promote behavior change over time.

Emergency Preparedness Activities:
Planning for and responding to natural and human-made disasters and emergencies, a key function of local, state, and federal public health agencies, with nurses playing a crucial role.

Evidence-Based Practice:
The use of current, high-quality research evidence in conjunction with clinical expertise and patient values to make healthcare decisions; emphasized as a priority for public health in the 21st century.

Federal Public Health Agencies:
National-level government bodies (e.g., USDHHS, EPA) that develop regulations, implement policies, provide funding, set standards, and coordinate public health activities that cross state lines.

Healthy People 2030:
A set of national health objectives that guide the work of public health professionals, including nurses, over a decade, often leading to new partnerships and community coalitions to address specific goals.

Incident Commander:
A leadership role, often filled by public health nurses during a widespread public health emergency or disaster, involving functions like providing education, establishing mass-dispensing clinics, and conducting enhanced surveillance.

Local Public Health Agencies:
Community-level government entities responsible for implementing and enforcing public health codes and ordinances, and providing essential public health programs directly to the population served.

Multidisciplinary Teams:
Groups of professionals from different fields (e.g., nurses, physicians, epidemiologists, health educators) who collaborate on public health initiatives and programs.

Outreach Workers:
Staff in public health agencies or community organizations who engage with populations to identify needs, provide information, and connect individuals to services, often reaching those with limited access to care.

Partnerships/Coalitions:
Formal or informal agreements and collaborations between various providers, agencies, and groups (e.g., social services, mental health, education, businesses) to implement public health programs and improve population health.

Population Health:
An approach to health that aims to improve the health outcomes of a group of individuals, often focusing on broad determinants of health and disease prevention for the entire community.

Primary Caregivers (Direct Primary Caregivers):
A function of public health nurses, particularly in situations where the private sector cannot respond, providing direct health services to fill identified gaps (e.g., prenatal care for uninsured, immunizations).

Public Health:
Defined as "the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort," focusing on the health of populations.

Public Health Nurses (PHN):
Nurses whose practice synthesizes nursing theory and public health theory to promote, preserve, and maintain the health of populations through the delivery of personal health services to individuals, families, and groups.

Public Health Programs:
Organized community efforts designed with the goal of improving a population's health status, extending beyond direct healthcare administration to include assessment, education, and disease surveillance.

Referral Resource:
A public health nurse function involving maintaining current information about available health and social services in the community and educating clients on how to utilize these resources effectively for self-care or other needs.

Role Model:
A public health nurse function where the nurse exemplifies healthy behaviors and professional conduct, inspiring others in the community.

Scope and Standards of Public Health Nursing Practice:
A publication by the American Nurses Association (ANA) that outlines the specialized competencies and framework for nursing practice in public health.

State Public Health Agency:
Official government body at the state or territorial level responsible for monitoring health status, enforcing laws, distributing funds, and providing oversight for local public health agencies.

Vital Statistics:
Data collected and analyzed by public health agencies, including births, deaths, marriages, and divorces, used to understand population health trends and needs.