

Unintentional Gun Violence in the Home: A Survey of Pediatric Advanced Practice Nurses' Preventive Measures



Agnes N. Cho, BSN, RN, & Elizabeth B. Dowdell, PhD, RN, FAAN

ABSTRACT

Introduction: Across the United States, unintentional shootings involving toddlers are on the rise. Pediatric nurses and nurse practitioners encounter families with toddlers regularly, allowing them the opportunity to make assessments and implement safety measures. The purpose of this study was to assess gun safety knowledge levels, health promotion strategies, and preventive interventions of advanced practice registered nurses (APRNs)

Methods: This quantitative study used an anonymous, online survey e-mailed to pediatric-focused APRNs using the National Association of Pediatric Nurse Practitioners e-mail list.

Results: The sample included 54 APRNs. The majority, 70.3%, reported asking parents about guns in the home; this was most often done with a new patient (62.3%, $p = .05$). APRNs were more likely (88.7%, $p = .05$) to believe that well-child practice standards should include questions about gun safety, but 56.4% ($p = .033$)

responded that their workplace does not have a teaching plan or policy about gun safety. In addition, APRNs who are gun owners were more likely to screen for guns (62.5%, $p = .05$) and teach about safe gun storage (75.0%, $p = .02$).

Discussion: Overall, APRNs feel knowledgeable enough to assess and inform patients about safe gun storage, as well as interventions. One obstacle to effective promotion of gun safety may exist at the broader systemic level, as most of the practice settings do not have pertinent policies and resources for families of toddlers. Findings suggest that most APRNs are including gun safety teaching without an identified policy. *J Pediatr Health Care.* (2020) 34, 23–29

KEY WORDS

Home safety, gun safety, toddlers, family education

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INTRODUCTION

In the United States, gun violence and injury are complex and polarizing public health issues among individuals, families, communities, and providers. A recent survey of adults found that 42% reported the presence of a gun in their household, with 31% personally owning a gun and 11% stating that they do not own a gun, but someone else in their household does (Parker, Horowitz, Igielnik, Oliphant, & Brown, 2017). Almost five million children live in homes where at least one firearm is stored loaded and unlocked (Azrael, Cohen, Salhi, & Miller, 2018). Children, especially young ones, and guns, can be a dangerous, often fatal combination. It is estimated that nearly 1,300 children die and 5,790 are treated for gunshot wounds each year (Fowler, Dahlberg, Haileyesus, Gutierrez, & Bacon, 2017). Unintentional gun shootings by a toddler appear to be on the rise; in 2015, there were 58 reported cases, and in 2016, there were 62 cases (Centers for Disease Control and Prevention [CDC], 2017). Many of these cases involved a toddler who picked up an unlocked gun and then shot themselves or someone else; many were fatal, and 65% occurred in the home or family vehicle (CDC, 2017; Fowler et al., 2017).

Nearly all gun owners (95%) believe that talking to children about gun safety is essential, 66% said all guns should be kept in a locked place when there are children living in the home, and 59% said gun-owning parents should take a gun safety course (Parker et al., 2017). Research shows that half of all U.S. handgun owners keep their guns loaded at least some of the time and that 40% of gun owners store guns in a bedroom or closet, not in a locked case, cabinet, or vault (Parker et al., 2017). These factors compound to put younger children at high risk of accessing a gun. Furthermore, 75% of 5- to 14-year-olds report knowing where the gun is kept in the home, even if the parent thinks they do not (Parker et al., 2017).

Gun and firearm safety discussions are not widely or routinely integrated into health care encounters. Though standard well-child practice includes early prevention, screening, and treatment of illnesses, as well as home safety assessments for children under the age of 5 years, it does not routinely include gun safety inquiry guidelines. Combine this with a concern about when and where such conversations are appropriate, and providers can have a sense of confusion or uncertainty. The American Academy of Pediatrics (AAP) affirms that the absence of guns in the home is the most reliable and effective measure to prevent firearm-related injuries in children. The AAP firearm safety policy states that safe gun storage (guns loaded and locked, ammunition locked separately) reduces children's risk of injury (Dowd, M. D., Sege, R. D., Council on Injury, Violence, and Poison Prevention Executive Committee, & American Academy of Pediatrics, 2012). The American Nurses Association (2018) has posted recommendations along with legislative requests to ensure that health care professionals are "unencumbered and fully permitted to fulfill their role in preventing firearm injuries by health screening, patient counseling, and referral to mental health services for those with high risk danger behaviors." Moreover, the National Association of Pediatric Nurse Practitioners (NAPNAP) Health Policy Agenda advocates for "injury prevention and harm reduction activities focusing on the leading causes of childhood illness, injury and death" without a formal policy (National Association of Pediatric Nurse Practitioners [NAPNAP], 2019).

There are several studies that discuss providers' feelings and actions about talking or screening for guns. In some circumstances, such as in emergency department or mental-health settings with suicidal patients and their family members (Frattaroli, Webster, & Wintemute, 2013; Laine et al., 2013), gun safety is often discussed as part of the intent to harm self. Regarding pediatric settings, there are gaps in the literature specific to pediatric-focused advanced practice registered nurses' (APRNs) understanding of how to make gun and firearm safety conversations as effective and acceptable as possible. Gun shootings by young children are primarily an issue of home safety and parental knowledge of safety measures, which means pediatric nurses and pediatric-focused APRNs can play a significant role in prevention of such shootings for these families (Faulkenberry & Schaechter, 2015; Schaechter, 2018). Despite misperceptions, it is not against the law for

health care providers to ask about guns in the home or to provide guidance about gun safety and safe storage of guns and ammunition.

To gain a better understanding of pediatric-focused APRNs' current practices for screening and teaching about gun safety, we undertook a descriptive study to identify knowledge levels, prevention measures, and teaching strategies of APRNs regarding unintentional gun violence by toddlers. Our research questions were as follows: What are the knowledge levels of pediatric-focused APRNs about unintentional gun violence by young children? Are pediatric-focused APRNs routinely screening for or teaching about gun safety?

METHODS

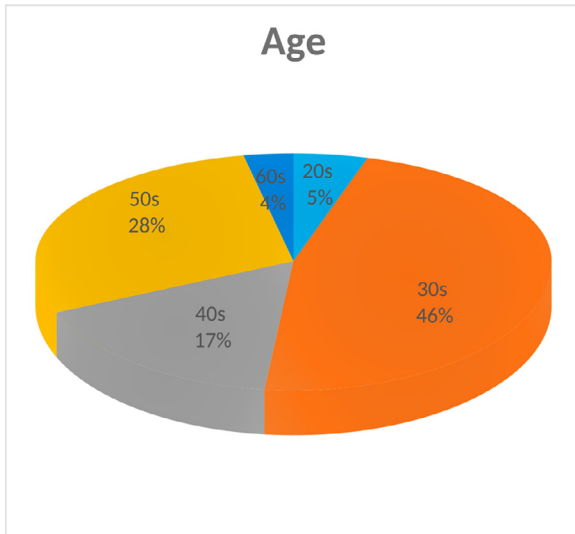
This descriptive, correlational study was conducted during the summer of 2017. After receiving approval by the authors' institutional review board and research review committee at NAPNAP, the authors were provided access to a modified NAPNAP membership e-mail database. The NAPNAP organization serves over 7,600 members nationally, 70% of whom are pediatric nurse practitioners (PNPs) and pediatric-focused APRNs, with 48 chapters throughout the United States (NAPNAP, 2013). The anonymous 36-question survey was administered to NAPNAP members practicing in the Northeast region of the United States using the Web-based survey format of Qualtrics (Provo, UT). This software package is specifically designed for collecting and analyzing data as well as concept testing, evaluations, and Web site feedback. The survey used collected demographic questions (age, gender, work experience, and type of workplace) and asked questions about knowledge levels regarding unintentional gun violence by toddlers, health promotion strategies, home safety teaching, and preventive interventions. The survey was distributed via e-mail as an online link. Those who agreed to participate in the anonymous survey, after reading the consent form, clicked on a link that opened the Qualtrics survey.

The data obtained through the Qualtrics survey were stored in a private account and then entered into the IBM SPSS version 24 for Windows. Frequencies were run on all selected variables, and a series of Pearson correlations were used to determine a relationship or interaction between variables. If there was an interaction between variables, then a cross-tabulation was used to determine significance. When determining the level of significance for results, a *p* value of .05 was considered the minimum. Chi-square (χ^2) analysis was also conducted on all dichotomous variables.

RESULTS

The all-female sample consisted of 54 pediatric-focused APRNs, who ranged in age from 25 to 62 years (Figure 1) and reported being Caucasian (90.7%), Asian (3.7%), or "other" (5.6%). Most (83.3%) were highly educated, having an MSN, a BSN (11.1%), PhD (3.7%), or "other" degree (1.9%). This group of pediatric-focused APRNs was also very experienced, with over half of them working for more than 10 years (Figure 2). Over half of the sample (55.6%)

FIGURE 1. APRN Age.



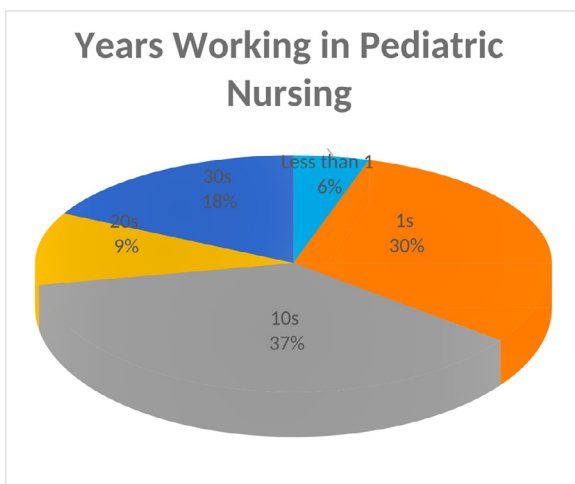
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worked as a PNP, 20.4% as a family nurse practitioner, 3.7% as a clinical nurse specialist, 3.7% as nursing faculty, and 16.7% in a position categorized as “other.” Approximately 75% ($n = 40$) of APRNs in this study reported working in an outpatient setting; 24.5% ($n = 13$) reported working in a hospital or inpatient setting, and over 70% reported being a certified in pediatrics (Table 1).

Home Safety Screenings

Most of APRNs reported that they always (61.1%, $n = 32$) or often (33.3%, $n = 17$) follow the well-child practice standards (marking growth charts, documenting milestones, nutrition, and daily exercise) for each patient. Over 57% ($n = 30$) of APRNs assessed childproofing practices in the home by asking the parent(s) about home safety at each visit. For

FIGURE 2. APRN Years Working in Pediatric Nursing.



(This figure appears in color online at www.jpedhc.org.)

TABLE 1. Sample demographics

Demographic data	Response analysis ($N = 54$)
Gender (%)	
Female	100
Male	0
Other	0
Parent (%)	
Yes	68.5
No	31.5
Age, years	
Minimum	25
Maximum	62
Mean	42.04
SD	10.47
Race (%)	
White	90.7
Asian	3.7
Other	5.6
Native American or Alaskan	0
Black or African American	0
Gun owner (%)	
Yes	14.8
No	85.2
Do not wish to specify	0
Years practicing as RN	
Minimum	2
Maximum	39
Mean	17.42
SD	10.72
Years in pediatric nursing	
Minimum	0.0
Maximum	39.0
Mean	14.82
SD	11.07
Level of education (%)	
BSN	11.1
MSN	83.3
PhD	3.7
Other	1.9
Certification in pediatrics (%)	
Yes	70.4
No	27.8
Work position (%)	
PNP	55.6
FNP	20.4
CNS	3.7
Faculty/education	3.7
Other	16.7
Work setting (%)	
Outpatient	75.5
Inpatient	24.5

Note. BSN, Bachelor of Science in Nursing; CNS, Clinical Nurse Specialist; FNP, Family Nurse Practitioner; MSN, Master of Science in Nursing; PhD, Doctor of Philosophy; PNP, Pediatric Nurse Practitioner; RN, registered nurse.

each new patient aged between 0 and 3 years, 62.3% ($n = 33$) of APRNs reported screening for guns in the home. Overall, 67% ($n = 36$) of APRNs reported asking parents about weapons, and approximately 70% ($n = 37$) asked about guns in the home regardless of setting (inpatient, 84.6% [$n = 11$] or outpatient, 97.5% [$n = 39$]; $\chi^2 = 10.985$, $df = 3$, $p = .01$).

Pediatric-focused APRNs with an MSN degree (46.5%, $n = 20$) or PhD (50%, $n = 1$) were more likely to teach the parent(s) of a toddler about the safety risk of leaving guns loaded in the home compared with 16.7% ($n = 1$) of APRNs with a BSN degree ($\chi^2 = 27.738$, $df = 6$, $p = .000$; Figure 3). Nearly 60% ($n = 32$) of APRNs reported having taught the parent(s) of a toddler about safe gun storage, and 42.3% ($n = 22$) specifically taught parents of toddlers about the risks of having loaded guns in the home. Almost all the APRNs surveyed, 88.7%, believed that well-child practice standards should include questions about gun safety.

Gun Ownership

Pediatric-focused APRNs in this study were asked if they are gun owners, and 14.8% ($n = 8$) responded, “yes.” Gun ownership showed a relationship with reports of higher knowledge levels and self-efficacy, as well as greater likelihood to screen and teach about gun safety than with those who do not own a gun (85.2%, $n = 45$). Most of APRNs who owned a gun, 75% ($n = 6$), were more likely to report being familiar with the gun laws and regulations of their state than those (23.9%; $n = 11$) who did not own a gun ($\chi^2 = 8.521$, $df = 2$, $p = .01$). One hundred percent of gun owners ($n = 8$) compared with 44.4% ($n = 16$) of nongun owners were more likely to report feeling that their knowledge of safe gun practices in the home (storage and gun locks) was adequate to provide patient teaching to parents of a toddler ($\chi^2 = 8.413$, $df = 2$, $p = .01$). Most of the APRNs who owned a gun (62.5%, $n = 5$) were more likely to report screening for guns in the home with new families of a child aged between 0 to 3 years in the past 6 months ($\chi^2 = 5.934$, $df = 2$, $p = .05$). In addition, they were more likely to teach parent(s) of toddlers (75%, $n = 6$) about safe gun storage over the past 6 months, than APRNs who are not gun owners ($\chi^2 = 7.824$, $df = 2$, $p = .02$; Figure 4).

Availability and Accessibility of Resources

The survey asked, “Does your practice have a teaching plan or policy about gun safety?” Over half, 56% ($n = 30$) of pediatric-focused APRNs working outpatient and

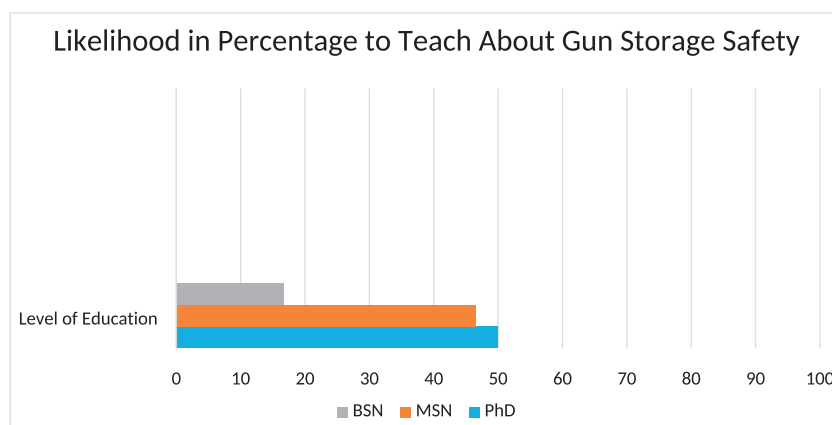
23.1% ($n = 12$) of APRNs working inpatient responded “no” ($\chi^2 = 6.809$, $df = 2$, $p = .03$). Over a third, 38.5% ($n = 5$), of inpatient APRNs and 10.3% ($n = 4$) of outpatient APRNs responded that they did not know if their work setting had teaching plans or policies about gun safety. When asked about the availability of resources for families assessed to be engaging in unsafe gun practices, 11.5% ($n = 6$) of APRNs in the study responded that there are no resources available at their workplace, and 51.9% ($n = 28$) said they did not know if such resources exist to be offered.

DISCUSSION

Pediatric nurses, APRNs, and other providers who practice in clinical settings that deliver care to families with young children have opportunities to influence the level of home safety of their patients. It is important that APRNs assess and screen for risk, actual or potential, including those associated with young children living with access to guns and firearms. Key findings from this study were as follows: (1) pediatric-focused APRNs are including gun injury prevention into their well-child practice assessments, screenings, and teachings specific to child or home safety; (2) pediatric-focused APRNs who are gun owners reported higher knowledge levels of state gun laws and regulations and were more consistent about teaching parents about gun safety with gun locks in addition to screening for guns in the home; and (3) most of the pediatric-focused APRNs are working in a setting where there are no specific teaching plans, policies, or resources in place about gun safety or prevention.

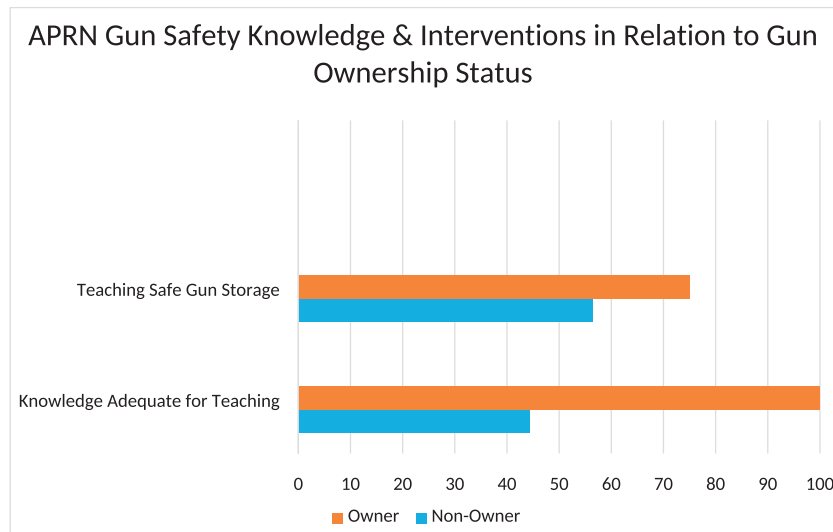
That most of the pediatric-focused APRNs in this study are independently doing gun safety assessments, screenings, and teachings on their own is not a surprising finding. APRNs and other health care providers often use well-child and sick visits as opportunities to reinforce teaching strategies, evaluate treatment outcomes, and provide education. Using age-related points during childhood when contact with families and children are more frequent, APRNs and

FIGURE 3. Safety Teaching and Type of Degree.



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FIGURE 4. APRN Gun Safety Knowledge & Interventions.



(This figure appears in color online at www.jpmedhc.org.)

providers can use developmental milestone visits as opportunities to screen and assess for guns in the home. For example, a child’s first 24 months of life will include scheduled well-child and sick visits as well as a family that is evolving because of their infant’s development and growth. The rapid changes in their child, for example, child’s growth as well as mobility with curiosity, may make parents open to changes that would increase the safety of the home after a provider asked about guns in the home.

Talking with parents about gun safety, asking parents to keep guns in a locked place, and encouraging parents who own a gun to take a gun safety course can be a good starting point and are topics on which both gun owners and nongun owners agree (Parker et al., 2017; Schaechter, 2018). However, in terms of discussions about keeping guns unloaded and in a separate place from the ammunition, there is disagreement among gun owners with children living in the home and nongun owners (Parker et al., 2017). The risk of a young child with a gun that is loaded is significantly higher than that of a young child with access to an unloaded gun. APRNs must ask parents and keep to this teaching point. It is imperative that health care professionals who interact with families regularly counsel parents about preventing their child from accessing guns that are not safely stored or are loaded. APRNs can begin a dialogue with parents by including the topic of guns and firearms into their home safety assessments.

In our study, APRNs who are also a gun owner were more likely to report teaching about safe gun storage, perhaps because they are more knowledgeable and comfortable talking about guns. These APRNs were also more knowledgeable and confident in their knowledge about guns, state legislation, and regulation. For many adults who own guns, exposure to guns happened at an early age. About two thirds of current gun owners (67%) say there were guns in their household growing up, and 76% report that they first fired a

gun before they were 18 years old (Parker et al., 2017). Many families that own guns do well in teaching their children about gun safety, but additional teaching in a health care setting can serve to reinforce safe gun storage education to increase knowledge, thereby influencing gun safety in the home. APRNs, regardless of gun ownership, must work together to achieve the goal of preventing unintentional gun violence by toddlers. Further research should be conducted to determine the most practical way to promote safe gun storage to parents.

Nurses are known for providing holistic care with a primary focus on the needs of a specific patient or family. Of concern from our study is that most of the APRNs are screening without official policies, guidelines, or standards where they are currently working. Not having a policy or statement may be perceived as a barrier to effective health promotion and prevention of unintentional gun injuries, especially for families that are assessed as being at risk or unsafe. Some APRNs may be informally following the guiding principles of NAPNAP’s 2019 Health Policy Agenda Goal 1, which states “injury prevention and harm reduction activities focusing on the leading causes of childhood illness, injury and death, including gun safety” (NAPNAP, 2019). Others may be working with providers using the AAP Policy Statement, *Preventing Firearm-Related Injuries in the Pediatric Population*. The broader implications for the nursing profession come from the need for official policies and standards, which will call APRNs to action in their practice settings. Developing or adopting gun injury prevention policies along with identification of resources available to families can be done by APRNs and providers who are in ideal roles to implement change. The CDC has created and endorsed its *National Action Plan for Child Injury Prevention*, which supports child access prevention laws. The Action Plan aligns with legislative priority in 28 states that have child access

TABLE 2. Resources

Resource	Link
2012 Policy Statement on Firearm-Related Injuries Affecting the Pediatric Population—AAP	https://pediatrics.aappublications.org/content/130/5/e1416.full
2018 Guns in the Home—Healthy Children from the AAP	https://www.healthychildren.org/English/safety-prevention/at-home/Pages/Handguns-in-the-Home.aspx
2018 Official Petition Letter Addressed to National Commission on Mass Shootings—AAN	https://higherlogicdownload.s3.amazonaws.com/AANNET/c8a8da9e-918c-4dae-b0c6-6d630c46007f/UploadedImages/docs/Policy%20Resources/Cosigned%20Letters/2018/Letter_to_Congress-2018_Commission_on_Mass_Shootings_with_cosigns-FINAL4.pdf
2019 Health Policy Agenda—NAPNAP	https://www.napnap.org/health-policy-agenda
2017 Call for Action—NAPNAP	https://www.napnap.org/gun-violence-and-working-together
2017 Gun Safety and Children—CS Mott Children's Hospital, Michigan Medicine	https://www.mottchildren.org/posts/your-child/gun-safety-and-children#store.htm

Note. AAN, American Academy of Nursing; AAP, American Academy of Pediatrics; NAPNAP, National Association of Nurse Practitioners.

prevention laws, which is designed to limit children's access to and use of firearms in homes and enforce safe firearm storage (CDC, 2016; see Table 2 for policy resources).

The present study has demonstrated that there is a need for resources, teaching plans, and policies to help inform APRNs' practice and families who are engaging in unsafe gun practices. APRNs must tactfully open the lines of communication with parents, remaining apolitical and nonaccusatory. Use of a standardized assessment tool can help destigmatize the conversation and be a way to measure as well as quantify home safety for children, which might help determine at-risk children. All nurses, especially APRNs, can explore health promotion strategies, focusing on the development of useful guidelines, assessment tools, and teaching resources. One consideration may be a need to create a gun safety assessment tool, such as the Braden Scale for Skin Integrity or the Glasgow Coma Scale for Neuro Status. Future research is recommended to standardize valid and reliable assessment tools and teaching instruments. Until such a tool is developed or policy put into place, individual APRNs must remain apolitical in approach and keep safety as the primary focus with all family members.

Our findings offer empirical support for the association between APRNs doing gun injury prevention screening and teaching. On the study's survey, multiple APRNs responded to the 1 open-ended question asking if there was anything further they would like to share. Most of these responses were about having time constraints: "I don't feel like I have enough time during well child checks to assess and discuss gun safety"; others cited parents as being a factor in not screening: "Fathers are often angry about this line of questioning stating it is really none of our business." One APRN had a different perspective on her work setting and incorporated her own experience as a parent:

[I] did not think about gun safety as being part of the well child assessment as I practice in the suburbs and don't consider this area to be a dangerous location. Also, as a parent of 4 year-old, I have

not been asked by our pediatrician or the PNP about gun safety—very interesting to consider.

Further qualitative inquiry of screening and teaching can facilitate the understanding of this behavior from the APRNs' perspective and inform the strategies to increase the inclusion of gun injury prevention and safety.

Limitations

The findings of this study should be viewed in light of the study's limitations. One limitation of the present study is the reliance of responses from APRNs in the Northeast, which may not be reflective of behaviors in other regions of the United States. APRNs were also asked to recall their actions of screening and teaching, which can be reliable as objective measures, but a chart review would provide documentation of actual activities. In addition, the survey relied on APRNs' self-reported responses.

Conclusions

Gun injury prevention and safety is increasingly recognized as important to health across the life span. Pediatric nursing supports actions and practices that promote the health and well-being in the homes of families with toddlers. As the number of cases of unintentional gun violence by young children increases (CDC, 2017), there is compelling logic that nurses can use their assessment skills and unique position of influence to promote safer homes. Pediatric-focused APRNs have frequent contact with young children who have regular well-child visits for immunizations, growth checks, and developmental evaluations. APRNs are in an opportune position to promote home safety specific to guns by asking about the presence of guns, providing practical counsel on safe use, and offering resources in addition to follow-up at the next meeting.

In our study, APRNs were screening for and teaching about gun safety. APRNs who had pediatric certification, obtained higher education, and owned guns were all more likely to carry out interventions, including screening and teaching, despite their workplace lacking policies, guidelines, and resources. The

significance of this study lies in the clarity that nursing is informally promoting safety and should be encouraged to formally join the conversation about gun safety. The profession of nursing can and will bring a unique and effective perspective on this issue to help create safer homes not only for toddlers but also for individuals of all ages.

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