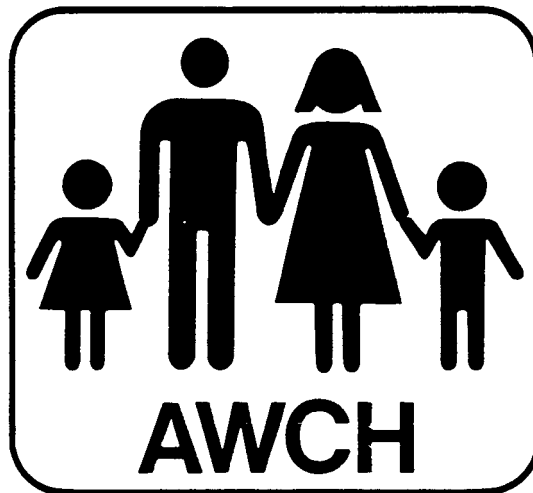


A Recommended

**HEALTH CARE POLICY
RELATING TO CHILDREN
AND THEIR FAMILIES**



**Prepared by
The Australian Association
For the Welfare
Of Children in Hospital**

October, 1974

PREFACE

There is a growing awareness of the sensitivity of young children in psychological aspects of their environment. The influence that it exerts can sometimes be quite harmful, and we should all be distressed to learn that abnormal personality development has occurred in young children as a direct result of their care in hospital.

Not only can such effects be avoided, but – should hospitalisation be essential - arrangements can be made to protect and even benefit the emotional well-being of children and their families. This document lists a number of policies that should be adopted in connection with the hospitalisation of children. Sensible and practical recommendations are made for the implementation of each policy.

The Association for the Welfare of Children in Hospital is to be commended for its initiative in developing and publishing this very important work.

Canberra, January 3, 1975.
Sidney Sax,
Chairman,
Hospitals and Health Services Commission.

PREAMBLE

In recent years attention has been drawn increasingly to the psychological aspects of the professional care of the hospitalised child. It is now generally realized that the provision of a clinical, sterile, medically orientated environment has overshadowed the emotional needs of the child, sometimes, in the case of very young children, at the high cost of aberrated personality development.

An impersonal detached attitude which fails to recognize the emotional needs of the child has no place in a hospital or similar environment which, to a child, is threatening, alien, without familiar figures, and distorted by fears of unknown possibilities of pain and loneliness.

Many world-wide studies of the interaction of hospital and child have led to the formulation of principles and practices recognised and proven as indispensable to child care in hospital.

A.W.C.H. hereunder presents these principles in a concise form for consideration of their adoption into a National Health Care Policy for Australia.

POLICY STATEMENTS

1. A child should only be hospitalised if there are clear and unavoidable indications for this.
2. The duration of a hospital stay, particularly for a young child, should be as brief as possible.
3. When health care for the child is necessary within an institution or any health care programme, a close and continuous relationship between the child and the family (or surrogate care-givers) should be encouraged and maintained wherever possible.

Provision should be made for a range of facilities and programmes to allow for this continuing relationship.
4. Every effort should be made to minimize the physical and emotional distress to children and their families whether inpatients, outpatients, or in other community health care.
5. Those involved in child care should be chosen with consideration for their special personal attributes such as perception, sensitivity and compassion for young children which will render them more suited to this role.
6. Professionals involved in child care should have special training in the unique psychological needs of young children in sickness and in health. This should logically include knowledge of family dynamics and child development.
7. The provision of paediatric care, recognizing the physical, emotional and intellectual needs of the child during sickness, provides a special opportunity to help create an informed public opinion about the care of children generally and the relevance of the family.
8. On-going evaluation of policies (including this one) and programmes of care is essential. This should involve staff at all levels, of all disciplines, the recipients of care, and the community generally.

Recommendations relating to POLICY (1):

- A child should only be hospitalised if there are clear and unavoidable indications for this.
- a) That improved educational programmes for both lay and professional members of the community as to the psychological implications of hospitalising young children be instituted.
 - b) That domiciliary health care services be made generally available to children. The implementation of recommendations 1(a) and 1(b) could be expected to reduce the frequency of hospitalisation.

Recommendations relating to POLICY (2):

- The duration of a hospital stay, particularly for a young child, should be as brief as possible.
- a) That educational programmes emphasize that when the emotional needs of the child and family are fulfilled then he will do better medically as well as psychologically, and his hospital stay will be shorter.
 - b) The availability of domiciliary health care services (see Recommendation Policy 1(b)) should enable earlier discharge from hospital.

Recommendations relating to POLICY (3):

- When health care for the child is necessary within an institution or any health care programme, a close and continuous relationship between the child and the family (or surrogate care-givers) should be encouraged and maintained wherever possible. Provision should be made for a range of facilities and programmes to allow for this continuing relationship.
- a) That parents should have right of access to their children at any time.
 - In the absence of the parents this right should be the prerogative of the usual parent substitute.
 - The system of restricted visiting should be replaced by a system of 'free' access or 'open' visiting.
 - This would reduce the tension which prevails amongst children, parents and ward staff during the time when only limited access is allowed.

- b) That in the rare case where separation is in the best medical interests of the child or even the parents, then this should be a carefully weighed decision and fully explored with the child and parents: such a decision should be recorded in the files relating to the child and his parents.
 - c) That in the planning of new hospitals and in existing hospitals provision should be made for the routine admission of parents (usually the mother) with their infants or young children whenever possible.
- This will necessitate
- i) Care-by-parent units specially designed so that parents can, in suitable cases, care for their sick child with or without other young children.
 - ii) Rooms in which parents can help care for an infant or young child in the hospital ward.
 - iii) Proper design to allow adults of both sexes in a child and family ward. E.g. single toilets allowing use by either sex.
 - iv) Doorways and other appropriate facilities to allow wheelchair access.
 - d) That when distance and financial implications restrict parent access to their hospitalised child a generous fare subsidy should be available if their concurrent admission is not possible.
 - e) That parents are never made to feel guilty or be subject to coercion to live in with their children in hospital. Domestic or economic pressures may prohibit them from utilizing live in facilities. When this is so it is appropriate to encourage discussions of this dilemma with informed professionals, who may arrange for domiciliary assessment visits.
 - f) It should also be recognised that when hospitalisation of a mother (in some cases a father) is essential, then hospitalisation with her should be considered for other family members. The members of the family require various degrees of access to the mother, restricted by her state of health at different times. This implies that children have right of access to their hospitalised parents, relatives, and other significant persons in their lives.

Recommendations relating to POLICY (4):

Every effort should be made to minimize the physical and emotional distress to children and their families whether inpatients, outpatients or in other community health care.

A) The child as an Individual:

- i) In decisions relating to the care of children, the child should be treated with respect and sensitivity.
- ii) Wherever possible adequate explanation must be offered at the child's own level of understanding for any intended procedures or plans.

This is doubly important for those children who are handicapped in their capacity to understand by virtue of serious illness, those who are emotionally or socially deprived, migrant children, adolescents, and particularly the under five year old because of his vulnerability to the effects of maternal deprivation.

B) Preparation for Admission:

- i) That preadmission visits to hospital by children should be considered where appropriate.

Children should be given every opportunity to ask questions about things they have witnessed.

- ii) That preadmission visits by members of hospital staff to the child's home should be encouraged to help prepare the child and the parents for their roles in the hospital experience.
- iii) That parents be encouraged to give information to their young children and so prepare them in an honest and informed manner for a hospital admission.

As there is no way of preparing a very young child, this is further reason for the mother to be admitted with them.

This can prevent much needless distress for the child: nursing may be made considerably easier for the ward staff.

- iv) That it be mandatory for brochures to be available in large numbers and widely distributed on the preparation of the child for hospital: these should be multilingual.

Such material would be essential during preadmission visits by staff and for parents in preparing their children for hospital.

C) Reception Procedure:

- i) *That for an elective admission,* - the child should be greeted by the ward sister or his own 'special' nurse in pleasant surroundings.

One nurse only should handle him, at least until he has had a chance to 'settle in'.

With second or subsequent admissions, as far as possible he should be admitted to a familiar ward.

Technical and possibly painful procedures should be left whenever possible till he has gained confidence.

It is highly desirable that the young child is not separated from the accompanying parent – certainly at this settling-in stage.

If the child has to be bathed, then the mother should be encouraged to do this.

Nappies should be avoided for toilet-trained children.

If possible, their own preference for clothes or pyjamas should be respected; such practices assist the child to maintain his own identity.

Idiosyncrasies should be assessed at this early stage, e.g. special language problems, special foods which may upset the child, allergies, special words for toileting, etc., an appropriate history sheet for the admitting doctor could well be used here.

The child should be encouraged to bring his own favourite toy or blanket marked with his name.

He should be encouraged to explore his surroundings within reason and not be confined to bed or cot unless this is medically necessary.

- ii) *That for an urgent admission,* - Where it is likely that the child will be frightened and in pain, it be considered even more imperative to maintain a close and continuous relationship with the parents.
- iii) *That for treatment in a casualty or outpatients section,* - There should be a separate reception room or waiting room for children and their family members.

It is important to 'spare' children distressing sights such as mutilated victims of accidents, drunken or severely disturbed behaviour.

Where such events occur the child and family should be offered the opportunity to discuss the matter with an informed, sensitive person.

Frightening looking medical equipment should be concealed from children where possible.

Consideration should be given to providing a separate reception desk to deal with the admission of children through casualty, and an appropriate nurse allocated to deal specifically with children.

Outpatients for children should have a supervised play area with ample toys.

Further efforts should be made to decrease the time spent in waiting in outpatients and casualty.

Interpreters should be readily available, either on site or contactable by phone when migrant children are involved.

D) Communication:

- i) That communication channels should be fully explained as early as possible to the child and family.

Hopefully this will begin before admission through discussion with the referring practitioner.

Appropriate brochures should be available at doctors' surgeries, health centres, local councils, etc., and mandatory at hospital admitting offices.

- ii) That parents should be fully informed and have access to enquiry.

The mother, father or parent substitute who offers practical help in the ward should be told where and when this could be of use – depending on the condition and age of the child, and the ward set-up.

Brochures produced by the hospital could inform about hospital lay-out, phone location, kiosks, etc., and at the ward level, the name of the sister in charge, best times for routine questions of doctors and ward sisters and a diagram of the ward, etc.

If unusual medical requirements permit only limited access to the child, then visiting opportunities should be clarified.

Large and easily readable badges should be worn by those who work in the hospital giving their name and function.

Specific opportunities should be made for interviews with R.M.Os Registrars or Consultants.

No child should be discharged without the parents being fully informed about the diagnosis (where appropriate), medication and future management of the child. The special needs of migrants in this area must be met.

Relatives should also be made aware that their nominated local general practitioner (and nurse) has been informed as well.

- iii) That hospital staff should recognize their responsibility to relay information accurately to parents about the child in hospital.

They should be careful not to relay more information than is consistent with their knowledge of the child's sickness.

A helpful attitude should be displayed by all medical staff to enquiring parents at all times. Because of stress, parents often need to have answers repeated several times before they fully understand the implications of what is being said to them.

- iv) That if there should be discord between parents and a member of the medical or nursing staff, this should be resolved in private.

Children, particularly young children, should never witness staff being reprimanded: similarly children should observe their parents being treated with respect by the medical or nursing staff at all times.

- v) That children of all ages should have access to a telephone. Young children may need assistance.

Such access to a telephone is more important for instance in isolation wards: these children should also have access to an intercom and be encouraged to use it appropriately.

- vi) That medical and nursing staff be prepared for the adjustments which will be necessary when parents increasingly exercise their option to be involved in the ward routine, and be encouraged to understand the vital need for parental involvement.

Care may need to be exercised to prevent parents from being exposed to confusing medical discussions about the differential diagnosis of their child's illness.

However, medical students should be able to learn much by observing their seniors interviewing and advising parents.

Parents informed by 'appropriate' authorities will have less need to ask questions of those less well equipped to answer.

That communication between hospital and local community services (including local doctor) be mandatory at times when significant events occur throughout the hospital stay and at discharge.

The local doctor (and nurse) should be given right of access to the child in hospital even if not directly under his care there.

E) Daily Routine:

- i) That this should enable necessary and routine medical care to proceed while permitting all those activities, both structured and spontaneous, which help alleviate the destructive psychological impact which the hospital as an institution tends to create.

- ii) That children should be nursed broadly within their own age group, but with access to other age groups.

Children alone, or without other family members accompanying them should not be admitted to adult wards or be exposed to unnecessarily extreme experiences for which they are unprepared, especially where no opportunity is offered for the child to 'work through' the impact with an understanding, knowledgeable person in a trusting situation.

- iii) That the mother of a young child who is willing to assist in the ward should be allowed to carry out as much of the nursing care of her child as is possible.

This could familiarize her with special nursing techniques and even permit earlier discharge of the child.

On occasions this might remove a load from the nursing staff as well as relieving them of the care of a fretful child.

However, this practice should not be instituted for this purpose alone.

When a parent or familiar figure is available to 'support' the young child in hospital, nursing care should always complement rather than supplant.

- iv) That as a child recovers from an anaesthetic he should be able to have the comfort of a familiar figure – preferably a parent.

This assumes particular importance if the child is in pain and is under five and so especially vulnerable to the effects of maternal deprivation.

It is also important where communication may be hindered, e.g., for the migrant child, the child who wakes blindfolded, the handicapped child, and so on.

- v) That, except in an emergency, children should never be moved from one hospital to another or from one ward to another without prior knowledge of the parents.

If transfer is necessary, the parents should be notified and encouraged to accompany the child. It is absolutely essential that the child understands that his parents know where he is.

Young children admitted to hospital frequently have the conviction that they have been abandoned. Transfer to another hospital can further reinforce this conviction, especially if they are not certain that their parents know of their whereabouts.

- vi) That the system of 'case assignment' nursing be encouraged as the system which best fulfils the psychological needs of the child.

Here one nurse, regardless of seniority, may be allocated say six beds or cots. She can be the 'special' nurse for these children. Such a system can do much to avoid multiple handling which is a potent cause of distress.

This may also lessen the risk of the difficult or unattractive child being denied extra comfort and attention which characterizes the nursing of other children.

It also provides the maximum opportunity for continuity of care. Children need someone who 'knows what happened yesterday'.

Case assignment nursing must never be regarded as an alternative to parental involvement. The young child still needs his mother or substitute mother.

- vii) That a full range of child health facilities, including regional hospitals, be developed, enabling children to be treated within their own areas.

F. Play:

That play facilities must always be available in and out of the ward, at the same level and adjoining it, and opportunities provided for occupational therapists and play leaders to help exploit the profound therapeutic potential of play.

The importance of play and appropriate helpers should be understood by all those who work in children's wards. Toys should be regarded as 'instruments of healing' and funds made available for the setting up and maintenance of play programmes.

Nurses and parents themselves should learn some of the essential features of play.

This could help some who harbour unrealistic expectations about a child's maturity and dexterity. Thus young children who might otherwise be left prematurely to feed or toilet themselves may attract appropriate and timely care consistent with the needs of their age group.

This provides a significant opportunity for the staff to assess the potential of a child.

Inability of a child to play should be a matter of concern. Such children urgently need skilled help.

The child's choice of play should be a matter of concern. Such children urgently need skilled help.

The child's choice of play should never be ridiculed: e.g., boys playing with dolls, etc.

Play facilities should particularly be available for the non-ambulant child.

G) Design and Environment:

- i) That the ward design and set up should be consistent with modern trends.

The ward should be so planned that the sister in charge can see all children from where she sits.

It is equally important that the sick child can always see an adult. The child's sense of security is at stake.

The ward should be at ground level and include a playroom and outdoor play area for ambulant children.

Many facilities are now recognised as being necessary to help fulfill the total needs of the child.

Bright colours, ample light, play areas, appropriate furniture, etc., are all highly desirable.

An 'identity board' placed above each bed, for appropriate age groups, represents an ideal display area for special pictures of family or home features. This can help the child retain his identity, and provide a talking point for members of the health team.

- ii) That when it is proposed to build new hospitals, the plans should be open to public scrutiny.

This must be done before tenders are let.

With public opinion that is becoming increasingly more informed, this practice will prevent much needless community discontent as well as doing much to ensure that enlightened and up to date features are incorporated.

- iii) That those involved in child care be made aware that current research into colour and music increasingly confirms the profound effect that these influences may have on the child's mood, his state of health and even his developing personality.

H) Special Care:

That when a child requires special nursing, parents should be encouraged to be closely involved wherever possible in the direct care of the child with any necessary supervision, even if this involves extra staff and effort.

Children in 'isolation' in a 'burns' unit and infants in humid cribs are representatives of a group with special needs.

This involvement with the parents is significant in the personality development of family members and family relationships.

In particular, the mother of the premature infant needs this access to her child, to whatever level is possible, in order to develop a sense of attachment and commitment from the beginning of its life.

I) Death:

That the special needs of the dying child and his parents be specially provided for. The setting in which such matters are discussed should be private and soundproof.

i) *Needs of the child:*

He needs to be treated as any other child.

Consultation regarding the parents' wishes is important before talking with the child who has asked if he is going to die.

Child therapists such as child psychiatrists could play a vital role here.

ii) *Needs of the parents:*

They are to be allowed full involvement in the management of their dying child.

There should be frank and informed discussion encouraged with any member of the health team.

After the death of the child members of the pathology department should likewise be available to answer parents' questions.

iii) *Needs of the staff:*

Insight and understanding is required by professionals in child as to their own response to patient death, which many feel symbolizes a threat to their self esteem. This often causes them to avoid the dying patient and even the relatives at a time when support is most urgently needed.

Recommendations relating to POLICY (5):

Those involved in child care should be chosen with consideration for their special personal attributes such as perception, sensitivity and compassion for young children which will render them more suited to this role.

That staff should only be allocated for duty on paediatric wards if they are orientated to this sphere of work and have appropriate personality characteristics.

This may be assessed from attitudes, personal recommendations, interviews, questionnaires and psychological testing.

Parents will be less inclined to press for unjustified 'panic' readmission of their child if during a previous admission they encountered ward staff who were not only warm and accepting but who discussed fully the implications of the child's sickness and management.

Recommendations relating to POLICY (6):

Professionals involved in child care should have special training in the unique psychological needs of young children in sickness and in health. This should logically include knowledge of family dynamics and child development.

- a) That there should be opportunities for professional staff to assimilate appropriate attitudes and an understanding of normal family dynamics as displayed both in sickness and in health.
The involvement of parents at ward level in the care of children will provide just such an opportunity.

- b) That professional staff training should become more 'patient' orientated rather than 'task' orientated.

Doctors and nurses need to learn to do things with people rather than just for people or to people.

Training of nurses and other professional staff should include at every stage the vital importance of playing and talking with the infant and young child during the normal course of daily care.

- c) That professional training be broadened to prepare staff to cope with a new range of situations which will arise as parents are increasingly encouraged to exercise their options at a number of stages in paediatric care.

- d) That periodically paid study leave or 'days off' be provided for professional ward staff.

This will facilitate further moves towards in-service training with opportunities for broadening liaison and consequently upgraded standards of patient care.

Recommendations relating to POLICY (7):

The provision of paediatric care, recognizing the physical, emotional and intellectual needs of the child during sickness, provides a special opportunity to help create an informed public opinion about the care of children generally and the relevance of the family.

- a) That all professional staff be made aware of the special responsibility they have in displaying their attitudes and skills. These are assimilated by professional colleagues, parents, siblings and patients.
- b) That a close liaison between play leaders, parents and the child should be encouraged.

Play leaders can assist in communicating with the 'inner' world of the child so that parent and

play leader interaction which arises through play with the child could well improve the parent-child relationship.

- c) That parents be tactfully prepared for the likely but largely unavoidable behaviour disturbance which so often arises when the child returns home.

Regression and aggression are likely to be displayed by the under five year old for some time after leaving hospital, particularly when the child has had an unsatisfactory hospital experience.

This is normal; it is not spoilt behaviour, and should not be met with undue discipline.

Recommendations relating to POLICY (8):

On-going evaluation of policies (including this one) and programmes of care is essential. This should involve staff at all levels, of all disciplines, the recipients of care, and the community generally.

That regular meeting of staff is required in all health programmes.

This involves an aspect of evaluation and policy formation.

Any policies affecting children and their families should not be contrary to the principles of care outlined in this policy document.