SECTION 9: PLAY, RECREATION AND EDUCATION

SUMMARY OF CONCEPTS

Play is recognised as essential for children's ability to make sense of and to cope with the world. Since the 1940s play has consistently been cited as a means of preventing anxiety, depression and feelings of helplessness and loss of control associated with the experience of being hospitalised (Bolig, 1990; Burstein & Meichenbaum, 1979; Thompson & Stanford, 1981).

Play activities effectively provide opportunities to rehearse and express feelings directly related to health care experiences (Cassell, 1965; Erikson, 1963; Goldberger, 1988; Oremland, 1988l Schwartz, Albino & Tedesco, 1983; Visintainer & Wolfer, 1975; Wolfer & Visintainer, 1975). Play is also a form of communication and facilitates learning (Bergen, 1987; Sutton-Smith, 1979).

Another simple yet very important function of play in the hospital setting is to provide a 'normal' everyday activity which is a diversion from health care issues (Thompson & Stanford, 1981).

However, the hospitalised child's mobility is frequently restricted, the environment is often unstimulating and the natural motivation to play and learn is generally reduced (Burstein & Meichenbaum, 1979; Thompson & Stanford, 1981; Tisza, Hurwitz & Angoff, 1970).

Separate play rooms and outdoor play areas, which provide a variety of age-appropriate toys and activities, will help to stimulate children to play. Within the hospital, play areas represent a normal and neutral place where no medical treatments are performed. Play areas also promote social interaction and communication with other children (Piserchia, Bragg & Alvarez, 1982).

The presence of a non-threatening and responsive play facilitator, who gives psychological permission to play, and who actively initiates and maintains constructive play, is essential. (Ispa, Barret & Kim, 1988; Pearson, Cataldo, Tureman, Bessman & Rogers, 1980). It is insufficient to simply provide some toys. Cross & Swift (1990) observed that children were happy, involved, stimulated, engrossed and content when activities were provided by experienced non-medical staff. Without the support of a play leader, children were often unhappy, bored, aimless and sometimes placed themselves in dangerous situations.

Even when parents are physically present, their own fear, grief, guilt, financial concerns and other stresses may leave them emotionally unavailable to promote or participate fully in their children's play (Goldberger, 1988).

Medical and nursing staff are often not educated to acknowledge the role of play in the successful management of illness, and generally do not have time to spend periods of uninterrupted play with a child (Oremland, 1988).

A number of play activities are particularly relevant for the child in hospital and require a trained play leader. **Expressive play** enables children to express the complex feelings associated with illness, injury and hospitalisation and can provide forms of expression that have a calming, soothing effect. This is important for young children who are developmentally unable to express their feelings verbally. Other children may have the required verbal skills, but are emotionally unable to convey their feelings related to their healthcare experiences, consciously or appropriately (Erikson, 1963; Gaynard et al., 1990).

Medical play gives children the opportunity to become familiar with health care objects through manipulation and exploration activities. It is often part of the preparation process and incorporated in **dramatic play**, which refers to guided or spontaneous role-play focused on medical issues (Gaynard et al., 1990). It helps to provide understandable, developmentally appropriate information, to correct misconceptions and to make procedures more predicable. Medical play is also useful following procedures, as children can explore and express what has been happening to them, as well as providing an opportunity to regain a sense of control. (Bolig, 1985; DelPo & Frick, 1988; McCue, 1988; Rae, Worchel, Upchurch, Sanner & Daniel, 1989).

Domestic play links the child back with the home environment, providing a familiar setting within which the child may express their fears and concerns. Playing house, dolls corner and cooking are all familiar settings in which children may also find relief from the institutional setting of the hospital.

'Indifference to the provision of play is reflective of adult attitudes towards illness…' (Prugh, 1983 ; Bolig, 1985, p.47). The passive, withdrawn child who does not respond to play or social stimulation is perceived as a child experiencing emotional distress (Bolig, 1985). In the home, parents traditionally have a tendency to tell their children that if they are well enough to play, then they are not sick enough to stay home from school. However, in the hospital setting, we hope that the child will be encouraged to play in spite of illness or injuries.

Scarcity of funds for play is of particular concern during this period of financial restraint. Lack of uniform standards in the provision of play staff and facilities, leaves this important aspect vulnerable to cost cutting.

SURVEY RESULTS

Play Areas and Toys

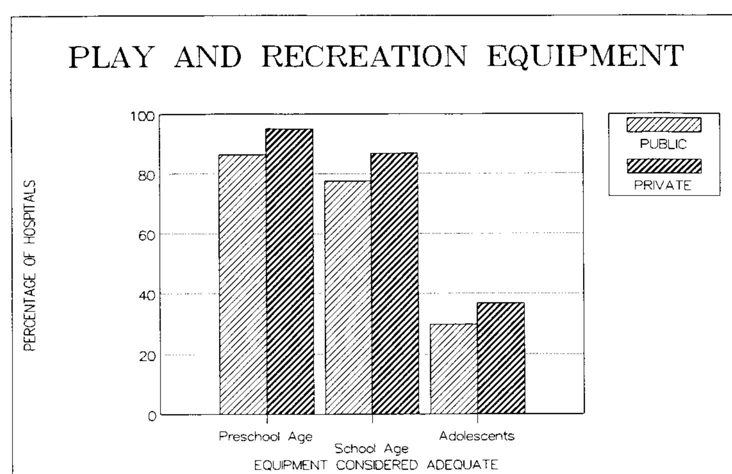
- As seen in **Table 5** just over half of the surveyed hospitals provide a separate playroom (58.1%) and 43.5% have outdoor facilities. 21.3% of hospitals have both options as well as floor space for play within the ward.

TABLE 5: Indoor and Outdoor Play Areas

	%	Number of Hospitals	Average Number of Paediatric Beds
Separate Play Room	58.1	147	28.9
Outdoor Play Area	43.5	10	32.3
Play Room and Outdoor Area	28.1	71	41.1
Floor Space, Play Room and Outdoor Area	21.3	54	49.0
Floor Space only	22.9	58	8.8
No Play Space	2.4	6	11.3

- ✦ The provision of play areas increases as the average number of paediatric beds increases. All paediatric hospitals have play rooms and outdoor play areas.
- ✦ Compared with public hospitals, private hospitals have less play facilities.
- ✦ 22.9% of hospitals do not have any separate play areas, but can use some floor space for play within the ward. This applies to 44.7% of all private hospitals (N=17) and to 19.1% of public hospitals (N=41).
- ✦ 6 public hospitals, ranging from 5 – 24 paediatric beds, reported not to have any space for play available.
- ✦ Toys, play materials and recreation equipment were considered adequate to varying degrees depending on age groups, as seen in **Graph 12**.

Graph 12



30.7% of participants reported that they have adequate play materials for all age groups. These represent 29.3% of all public hospitals and 36.8% of all private hospitals.

Play Staff

- Play staff are available in 21.3% of all surveyed hospitals (N=54), including one private hospital.

- Arrangements for the provision of play staff varied greatly between hospitals. Information was not sufficient to establish a number of children per play staff ratio.

- Increases in the number of paediatric beds appear to directly affect:
  - employment of qualified play staff
  - the likelihood of qualified staff working with volunteers
  - the hours of duty play staff are employed at the hospital

TABLE 6: Distribution of Play Staff

	Play Volunteers only	Qualified Play Staff only	Both
Number of hospitals	12	22	20
Average number of paediatric beds	25.5	53.1	82.9
Range of paediatric beds	6 – 50	8 – 445	18 – 300
Average number of days Play Staff are available	4.4	4.5	5.1
Range of days	1 – 7	1 – 5	2 – 7
Average number of hours per day	5.0	5.6	6.4
Range of hours	2 – 8	1 – 8	2 – 9 3

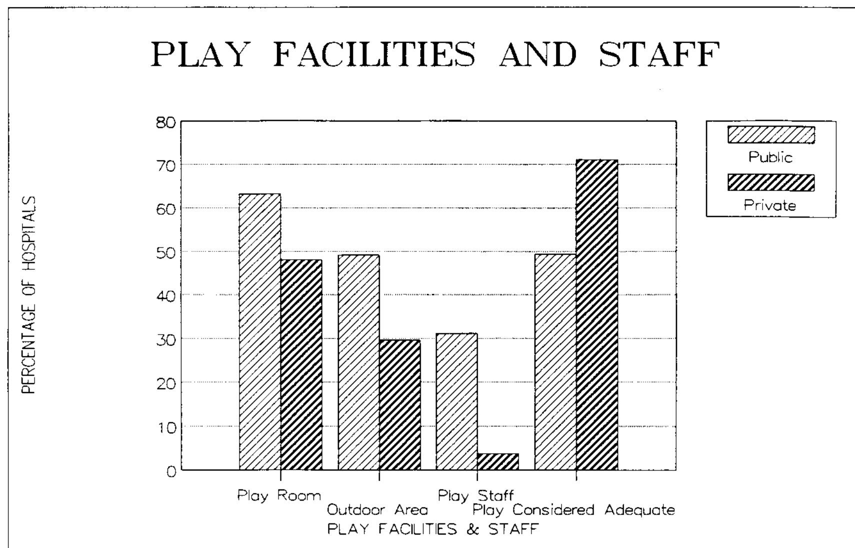
- Over one third of the hospitals with play staff do not consider the arrangements for play adequate. 18 out of 20 hospitals indicated they required additional play staff.

- 133 survey participants (52.6%) considered the arrangements for play adequate. 99 of these hospitals (74.4%) do not have any play staff, 48 (36.1%) also do not have a playroom.

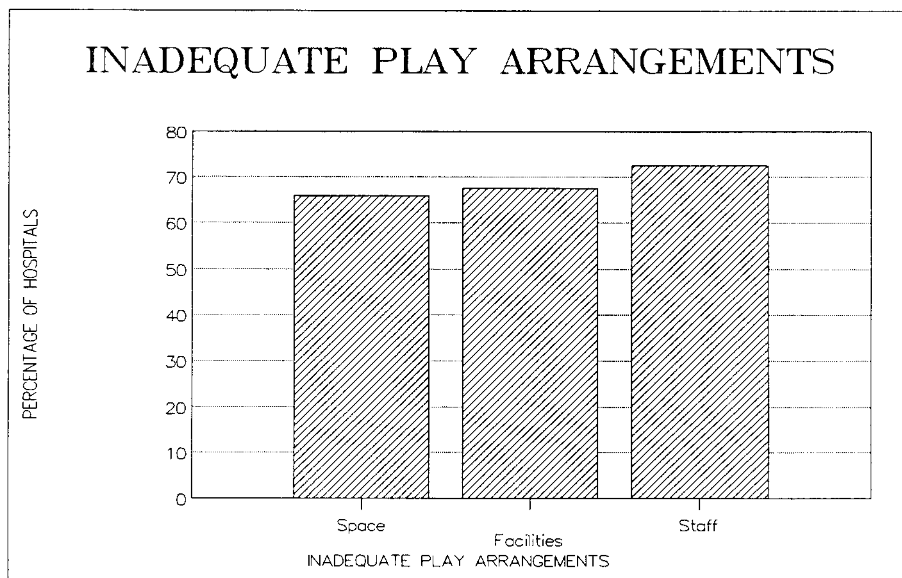
- Perceptions about adequacy of play provision appear to vary greatly between public and private hospitals. Only 49.3% of public hospitals (N=106) compared to 71.1% of private hospitals (N=27) considered play arrangements to be adequate, even though 44.4% of these private hospitals do not have separate play spaces nor play staff (**Graph 13**).

- 120 of all participants (47.4%) considered play arrangements inadequate. The highest priority expressed by the majority of hospitals (N=87) was for play staff. Over one third of respondents felt that all three areas – space, facilities and staff arrangements – were insufficient (**Graph 14**).

Graph 13



Graph 14



Educational Arrangements

- ✦ Established Hospital Schools or a Visiting Teachers Scheme were reported to operate in 71 hospitals (28.1%).

This applies to 20.2% (N=43) of the 213 hospitals with less than 26 Paediatric beds; 57.1% (N=16) of the 28 hospitals with 26 to 50 paediatric beds; and to all hospitals with more than 50 paediatric beds.

- ✦ Correspondence lessons are arranged by 43 hospitals, of which 32 are country hospitals. This represents 19.2% of all country hospitals.

- ✦ 149 hospitals (58.9%) have no formal arrangements for education. 115 respondents (77.2%) however indicated that individual arrangements may be made with parents, at times involving the child's school.