

**NATIONAL SURVEY REPORT  
ON PSYCHO-SOCIAL CARE OF CHILDREN  
(AND FAMILIES) IN HOSPITAL**

**AUSTRALIAN ASSOCIATION FOR THE WELFARE  
OF CHILDREN IN HOSPITAL**



# **AUSTRALIAN ASSOCIATION FOR THE WELFARE OF CHILDREN IN HOSPITAL**

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## **Enquiries should be directed to:**

AWCH National Office  
PO Box 113  
WESTMEAD NSW 2145

Phone: (02) 9631 9208  
Fax: (02) 9631 9390  
Email: [awch@awch.com.au](mailto:awch@awch.com.au)  
Web: [www.awch.org.au](http://www.awch.org.au)

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## FOREWORD

As a signatory to the *United Nations Convention on the Rights of the Child* Australia is committed to the value of a holistic service approach to ensure each child ‘... *such protection and care as is necessary for his or her well-being*’ (*Article 3*). With specific reference to health we guarantee to ‘*recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.*’ (*Article 24*)

The health care environment of the late 20th Century is a changing one, in which high technology produces its own environmental and psychological pressures. Health care practices that evolve as a product of such change need constant review when providing for the special developmental, social and emotional needs of children.

In this context, *The National Survey Report on Psychosocial Care of Children (and Families) in Hospital* conducted by the Australian Association for the Welfare of Children in Hospital (AWCH) in 1991, has brought the quality of hospital care for children to the national consciousness.

The New South Wales Health Department supports the national activities of the Australian Association for the Welfare of Children in Hospital. I congratulate the Association for presenting a well documented *National Survey Report on Psychosocial Care of Children (and families) in Hospital*, and commend its outcomes to the attention of the Australian community.



R.A.PHILLIPS, M.P.,  
Minister for Health Services Management.

## **PREFACE**

Australia is an aging community but while the proportion of children is falling the absolute number of children in Australia is rising. Their needs and the health services required for them must match this increase in numbers.

People concerned about children must ensure that children get their rightful share of funds from governments at both Commonwealth and State levels. Children do not have a vote, but we do and we need to be advocates for kids and to protect their interests.

It is very timely that AWCH should carry out a National Survey Report on Psychosocial care for Children and issue recommendations relevant to the 1990s. The ageing of Australia and the recession have meant lesser funds for children and paediatric services in hospitals. At such times, the value of providing for the psychosocial needs of children tends to be undervalued and such areas are often the first to suffer when budgets are cut.

This report confirms that much has been achieved in our hospitals but existing deficiencies and further financial constraints in the future demand that we remain vigilant in protecting the gains already made and ensure continuing progress.

It is now twenty years since AWCH commenced its operations in response to a need to humanise our treatment of children in hospital, it remains an important watchdog in our community. In some ways, it is an indictment on our society that AWCH is still needed, but it is and we must be grateful, for AWCH and its continuing work.

**John YU**  
**Chief Executive**  
**Royal Alexandra Hospital for Children**  
**and**  
**President, Australian Association of**  
**Paediatric Teaching Centres**

10 April 1992

This report follows a nation-wide survey of hospitals offering paediatric facilities, conducted by the Association for the Welfare of Children in Hospital between October 1990 and March 1991. The focus of the survey was the various aspects of psychosocial care of hospitalised children.

The findings outlined in the body of this report include information on key policies, facilities and services currently operating in Australian paediatric wards that are of significance to the quality of psychosocial care for child patients and their families. It is envisaged that this information will:

1. provide health care personnel, hospital administrators and all those concerned with the care of children in hospitals with a comprehensive analysis of services offered in hospitals Australia-wide;
2. highlight areas of concern and shortcomings of services in terms of specific Health Care Policies recommended by the Association;
3. assist health care educators to develop relevant (comprehensive) training programmes for students on psychosocial aspects of paediatric care;
4. assist in the planning and further development of psychosocial aspects of paediatric care;
5. provide valuable statistical data for State Health Departments throughout Australia.

I would like to acknowledge the tireless efforts of the AWCH National Headquarters staff and the AWCH Librarian in the compilation of this document.

**IRENE HANCOCK**  
NATIONAL PRESIDENT  
AUSTRALIAN ASSOCIATION FOR THE WELFARE  
OF CHILDREN IN HOSPITAL



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## BACKGROUND

The Australian Association for the Welfare of Children in Hospital (AWCH) is a voluntary organisation established in 1973. Nationally, members include parents, health professionals and concerned members of the public. AWCH aims to promote public and professional awareness of the non-medical needs of children and their families in hospital and health care settings.

In 1969, a Sydney mother, Joy Chester, spent four days in a large paediatric hospital with her six-year-old son. Whilst the television proudly showed man taking his first step on the moon, below it lonely babies and children cried, rocked or were quietly withdrawn. The contrast between advanced scientific technology and the neglect of the emotional needs of those children spurred Joy Chester into action (Langley, 1986).

Mounting public pressure, together with committees of enquiry, led to the formation of AWCH, which has resulted in momentous changes in policies and practices affecting the psychosocial needs of children and their families within the health care system.

The formation of AWCH followed an international movement towards new concepts of children's health care based on the work of John Bowlby and James Robertson, who recognised the traumatic effects of separation of young children from their parents, and focused attention on the neglect of non-medical needs of hospitalised children (Bowlby, 1953, 1969; Robertson, 1953 & 1958).

In 1956, a British committee had been appointed to investigate '... the arrangements made in hospitals for the welfare of ill children – as distinct from their medical and nursing treatment – and to make suggestions which could be passed on to hospital authorities' (Great Britain, Ministry of Health, 1959, p.1). The resulting report, was – and still is – highly influential in shaping the concepts of a new philosophy in paediatric nursing and health care.

The Association advocates a holistic family-orientated approach to the care of children. This is reflected in the *Recommended Health Care Policy for Children and their families* (refer Appendix A), which was declared the official policy of the NSW Department of Health in 1975 and endorsed by the National Health & Medical Research Council in 1977. This policy has been supplemented with a series of additional recommendations from AWCH on specific topics (Maternity Services, Disabilities and Play).

Since 1975, AWCH has maintained a specialist information and resource library which now functions within the framework of the University of Western Sydney, Nepean. This unique collection includes printed and audio-visual materials on all aspects of psychosocial care.

As part of the Association's commitment to provide information and education to professionals, parents and the community at large, AWCH organises conferences and seminars, provides speakers for professional or community groups, disseminates health education resources through the AWCH Library, conducts a telephone advisory service, and publishes a quarterly journal *Children in Hospital*. Recent AWCH National Headquarters and State Branch projects include the establishment and

support of a Visiting Granny Scheme; the development of a National Paediatric Support Groups Database; the production of a video on the psychosocial needs of children in hospital and a hospital familiarisation programme.

## **SURVEY QUESTIONNAIRE**

A trial questionnaire was designed and completed by 21 randomly selected hospitals, representing all states including both public and private hospitals from rural and metropolitan areas. After a number of adjustments the final version of the questionnaire was produced consisting of 14 sections with a total of 252 items. Questions are in forced choice form with some open-ended items, including a section for general comments (*refer* Appendix B).

Survey questionnaires were sent to all Australian public and private hospitals with five or more paediatric beds, as listed in the Hospitals & Health Services Yearbook, 1990.

It was requested that forms be completed by either the Director of Nursing, Nursing Unit Manger (Paediatric) or Clinical Nurse Consultant (Paediatric).

Not all items have been answered by every participant as some questions may not have been relevant to all hospitals. A number of questionnaire items were not included in the report because results indicated that the questions were ambiguous. There are a number of important issues that were either addressed briefly or not at all. Separate studies are needed to fully examine the standard of psychosocial care in other areas such as:

- ✦ Intensive Care Units
- ✦ Accident and Emergency
- ✦ Outpatients
- ✦ Day Surgery
- ✦ Admission and Discharge Procedures
- ✦ Disabled children
- ✦ The needs of other cultural groups
- ✦ Care by Parent Units
- ✦ Respite care

### **Respondents to the survey**

AWCH greatly appreciates the responses of all the hospitals that participated in the survey.

310 hospitals (92.3%) responded and only 26 (7.7%) did not reply or declined involvement.

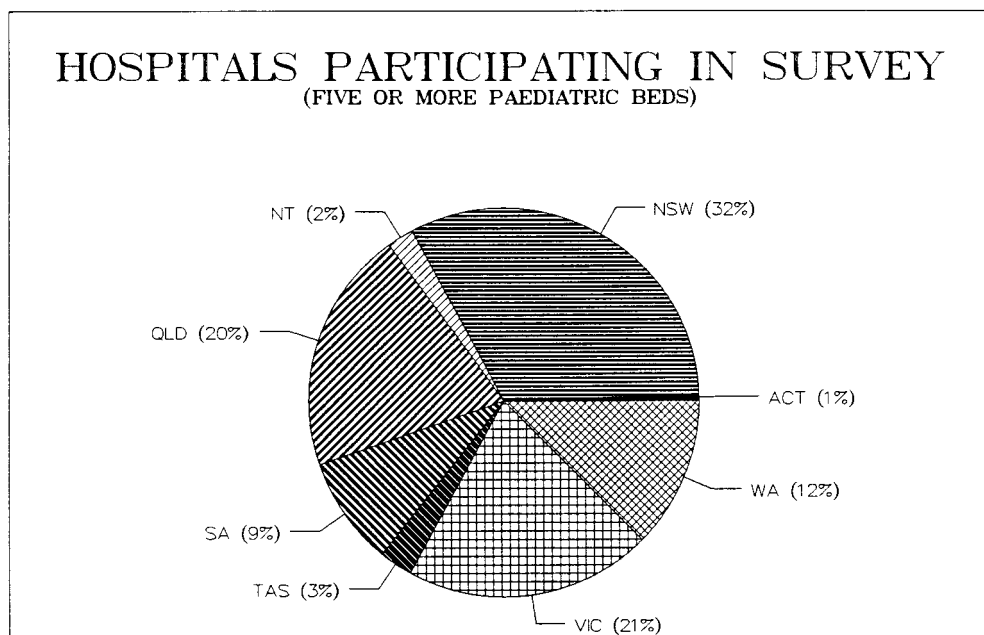
51 of the targeted hospitals (15.2%) were not included in the survey results as they reported less than 5 paediatric beds, the majority having 4. This possibly reflects the trend towards reducing the number of hospital beds since data for the 1990 Hospital Yearbook was compiled.

A further 6 respondents (1.8%) were Mothercraft Homes and their responses were not included in the analysis as many questionnaire items were not applicable to their situation.

The following report therefore represents an analysis of 253 hospitals, 75.3% of all hospitals contacted. The high response rate to the questionnaire may in itself point to the perceived importance of the issues addressed.

The distribution of the 253 respondents per state and territories as shown in **Graph 1** closely corresponds to the distribution of the Australian population (Australian Bureau of Statistics, 1989).

### **Graph 1**



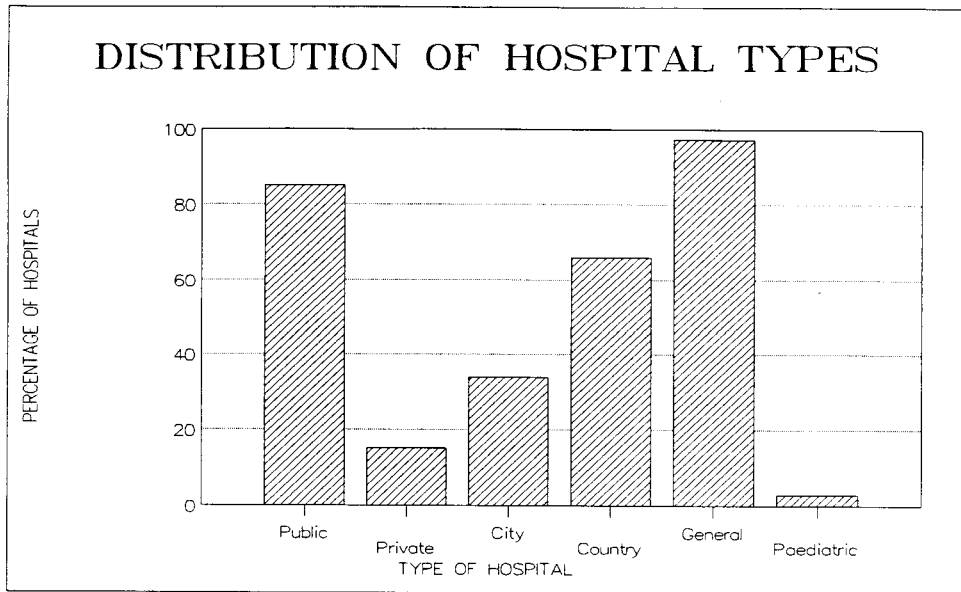
As shown in **Graph 2**, 85% of surveyed hospitals (N=215)\* are public, 15% are private (N=38). The majority (N=167=66%) are located in country areas, whereas 34% (N=86) service city/metropolitan areas. There are 7 (2.8%) large specialized paediatric hospitals.

All private hospitals are general hospitals, with relatively small paediatric wards averaging 11 beds.

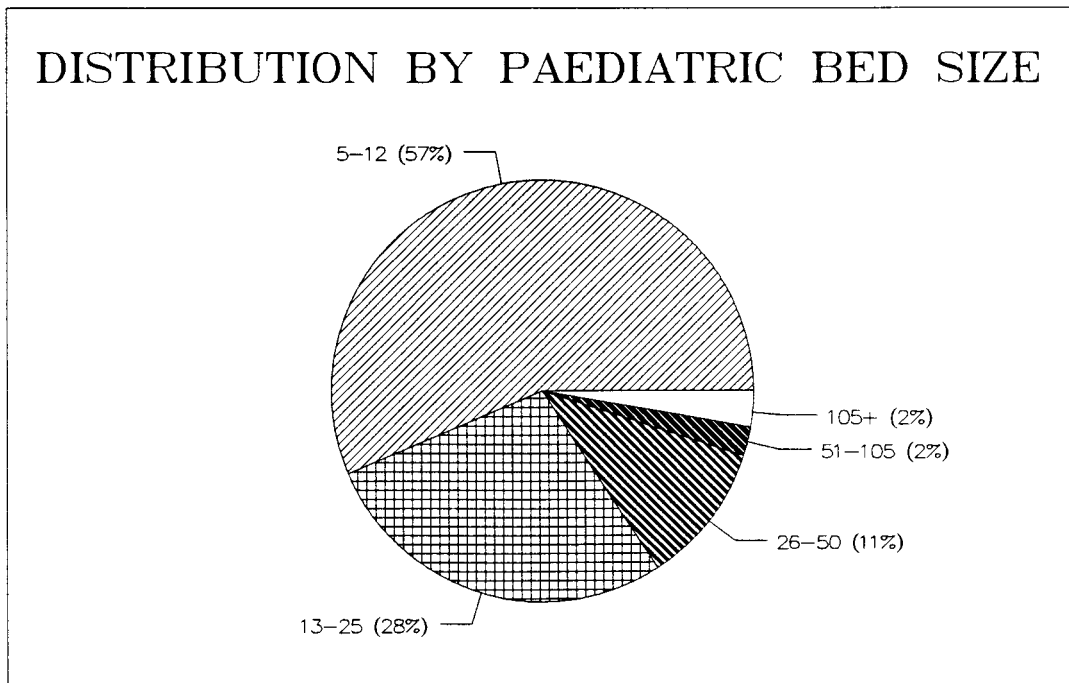
The distribution of hospitals according to number of paediatric beds is shown in **Graph 3**.

(\* ) N = Number of respondents.

**Graph 2**



**Graph 3**



## **SUMMARY AND RECOMMENDATIONS**

### **SEPARATE PAEDIATRIC AND ADOLESCENT FACILITIES (Section 1)**

The care of children in hospital has changed dramatically over the past twenty years.

The majority of children are nursed in separate paediatric wards. However, there are many situations in which children and adults are still placed together in some wards, recovery and casualty departments.

AWCH is concerned about a recent increase in enquiries to National Headquarters from Nurse Unit Managers requesting research articles to support the case for nursing children in separate paediatric wards. During this current period of economic restraint, it would appear that the closure of paediatric wards is increasing, thus undoing the progress achieved over the last twenty years.

Adolescent patients are generally nursed with either adults or younger children. Adolescent wards established to meet the specific needs of this age group are few in number.

#### **Recommendation 1**

- 1.1 AWCH recommends that wherever possible, children should be cared for in paediatric areas and not with adults.
- 1.2 The unique needs of adolescent patients are generally served best by the provision of adolescent wards in large hospitals or by grouping adolescents in a room together in small hospitals.

### **PREPARATION FOR ADMISSION (Section 2)**

While over 70% of hospitals offer some form of preparation for admission, this is generally restricted to familiarisation visits to the ward. There appears to be a need for more comprehensive preparation programmes.

The need for multi-lingual pre-admission pamphlets and signs was highlighted by the survey results.

#### **Recommendation 2**

- 2.1 Hospitals should allocate staff specifically responsible for the co-ordination of preparation materials and activities for all children and parents:
  - prior to admission
  - or on admission

2.2 All parents should receive written information prior to admission of their child (or on admission in emergency cases) explaining the following:

- effects of hospitalisation on children
- pre-admission preparation offered by the hospital
- visiting policies
- overnight facilities
- role of parents in the ward
- aspects of care in which parents may be invited to participate

2.3 This information should be available in all relevant community languages.

2.4 A hospital staff member should be available to answer questions from parents on any aspects of the above.

### **ACCOMODATION FACILITIES FOR FAMILIES, CHILDCARE AND VISITING HOURS (Sections 3, 4 & 5)**

It is now generally accepted that parents have the right to stay with their child in hospital. Provisions have been made in most cases to offer overnight accommodation either next to or near the child. However, only a small proportion of hospitals advise parents routinely in writing about the availability of overnight facilities.

Costs for overnight accommodation and meals for parents vary greatly between hospitals.

Most hospitals appear to offer adequate ablution facilities for parents.

Over 90% of hospitals have adopted a 24-hour visiting policy for parents.

Visiting arrangements for siblings of paediatric patients are usually flexible, but some restrictions apply in over 60% of hospitals.

Less than 5% of hospitals offer child care facilities for well siblings.

### **Recommendation 3**

3.1 Costs incurred by parents, who are required to stay overnight with their child, should be refunded through Medicare.

3.2 A list of local child care resources, as well as hospital policies on siblings' access to the playroom, or hospital child care facilities, should be made available to parents on admission.

## **OTHER PAEDIATRIC FACILITIES (Section 6)**

### **Alternative Care Givers**

13% of hospitals replying to the survey indicated that they have an alternative care giver scheme, for children whose parents are not able to visit sufficiently, to provide adequate support for their hospitalised child.

### **Recommendation 4**

A visiting 'Granny Scheme' should be established for children who require a consistent care giver to complement parental support. Carefully selected volunteers work in conjunction with nursing or social work personnel and become the companion of one child over the duration of his or her stay in hospital, or as required.

### **Individual Patient Needs**

Often simple ways of normalising the ward environment can help to make children feel less threatened and more at ease.

Efforts to acknowledge each child's individuality will also help the child to maintain a sense of self and to feel more secure in the hospital environment.

### **Recommendation 5**

The following arrangements can help to normalize the hospital environment:

Access to a phone on the ward for children to maintain contact with family and friends.

Permitting children to dress in their own clothes or pyjamas.

Encouraging children to personalise their bed with photographs or drawings.

Serving meals in a separate dining area helps to make mealtimes enjoyable, social occasions.

## **PARENT PARTICIPATION IN PATIENT CARE (Section 7)**

### **Basic and Nursing Care**

Incorporating parents as part of the health care team, often enables parents to feel more co-operative, less anxious and more trusting of hospital staff.

## **Recommendation 6**

Parents should be encouraged and supported to participate in the care of their child in hospital. Clear information and guidelines to define their role, within the hospital setting, should be available to parents.

**Caution** – Hospital personnel, however, should take care not to abdicate their role to the parent, who will also be under external stress whilst their child is hospitalised.

## **Medical Procedures**

In the majority of cases parents are present to support their child through general procedures and tests. 51.9% of hospitals indicated that parental presence in recovery was allowed and 26.6% of hospitals allow parents to stay with their child during the induction of anaesthesia.

## **Recommendation 7**

AWCH recommends that hospitals modify theatre and recovery facilities so that parents are able to be present, if they wish, during the anaesthetisation and recovery process.

The Association also encourages the education of medical and theatre staff re parental presence in these areas.

## **EDUCATION/PREPARATION FOR SPECIFIC MEDICAL TEST PROCEDURES (Section 8)**

Preparation for medical procedures and tests is in the majority of cases limited to descriptive information. There appears to be a need for more specific preparation activities, including the use of videos and medical play, and teaching coping strategies to complement current programmes.

## **Recommendation 8**

Prior to all medical tests/procedures children and parents should receive information about the events that occur before and during tests/procedures, including sensory information, specific to their individual needs.

## **PLAY, RECREATION AND EDUCATION (Section 9)**

The involvement of children in play activities enhances recovery.

47.4% of hospitals considered play arrangements as inadequate. The highest priority need expressed by the majority of hospitals was for the employment of specific play staff.

### **Recommendation 9**

9.1 Hospital play policies should be formulated according to a sound philosophy on play which gives recognition to the developmental, therapeutic and social effects of play on children of all ages.

9.2 Hospitals which accept child patients should provide an adequate budget for the salaries of an appropriate number of play staff and the purchase and maintenance of play equipment and materials. The minimum number of children to justify the employment of a play specialist being 10, using average daily bed occupancy statistics. A ratio of one play specialist to 25 children, with appropriate assistance, is recommended to ensure adequate individualised attention to meet the needs of particular children and the ward system in each hospital.

9.3 Child patients should have access to both indoor and outdoor play facilities.

9.4 Opportunities for play should be made available in other areas, as well as paediatric wards, such as outpatient departments, accident and emergency and day surgery areas.

## **STAFFING (Section 10)**

It is important that all staff working with children and families in the hospital setting have an understanding of child development and the importance of the family to the child.

### **Recommendation 10**

Medical officers, nurses, support staff and volunteers should have access to in-service training programmes on the psychosocial and emotional needs of children in hospital.

## **ACCIDENT/EMERGENCY AND OUTPATIENT SERVICES (Section 11)**

Families in accident and emergency departments often feel anxious and distressed. Waiting times can be long and trying for parents and children.

### **Recommendation 11**

- 11.1 Separate Paediatric Accident and Emergency areas should be established wherever possible, including the provision of play equipment and play staff.
- 11.2 Where separate Paediatric Accident and Emergency areas are not possible, provision of play equipment and play staff for children should still be available.

## **EVALUATION AND PLANNING (Sections 12)**

The concept of the health care consumer, within the health care system, has empowered 'health consumers' to develop greater knowledge of their rights.

### **Recommendation 12**

The process of collaboration between the health care consumer and the hospital should be facilitated through the involvement of parents and community groups, on quality assurance and parent or community advisory committees.

## **HOSPITAL/COMMUNITY LIAISON AND GENERAL DATA (Sections 13 & 14)**

Insufficient data resulted in the inability to comment on these sections.



## INTRODUCTION

General awareness of the non-medical needs of children in hospital and the health care system has developed greatly over the last twenty years.

However, during this period of financial constraint, gains in the quality of psychosocial care of children need to be carefully monitored, as they are often the areas which are vulnerable to cost-saving programmes.

Dr. Lionel Lubitz, Consultant Paediatrician at the Royal Children's Hospital, Melbourne, spoke recently at a public meeting organised by the Victorian Branch of AWCH. Dr. Lubitz's words express the spirit in which this survey report has been created.

'There are so many noxious influences in the process of hospitalisation that we must go out of our way to reduce the trauma. What do we do? Here follow the Ten Commandments:

- 1 We prepare the child and parents by careful explanation of what they should expect.
- 2 We minimise pain, by our expertise or by using medication or other techniques.
- 3 We work with the child within their family, as a team.
- 4 We involve parents in caring for their child, and very importantly, in all major decision-making processes. We never separate child and family.
- 5 We humanise the environment by making the ward less sterile and frightening.
- 6 We humanise ourselves, by appearing more like normal people.
- 7 We learn skills (and look at our own responses to stress) to deal with people in a crisis.
- 8 We try to communicate clearly, avoiding jargon and long medical words.
- 9 We develop both words and body language that are less threatening.
- 10 We address the CHILD, not simply regard the child as an appendage with no feelings or fears of their own.

Sometimes we do it well. We also fail at other times, not because we are uncaring and callous. We fail because we are working in a complex, fragile environment where it is easy to make mistakes. But we are always trying to do it better – and we do succeed in our efforts. We are getting better at looking after the whole child within their family, and not merely focusing on the disease or the organ involved. Our greatest teachers are our parents and their families. We learn our technical and knowledge-based skills from our universities, colleges and peers. We learn our human skills from our own

parents, our own children, and our patients and their families. These groups form the nucleus of organisations like AWCH. We have a very important mission, and we, the medical profession, are dependent on groups like AWCH to re-focus us on important human issues, to keep us open to new ideas on caring for children and constantly doing it better.'

## **SECTION 1: SEPARATE PAEDIATRIC AND ADOLESCENT FACILITIES**

### **SUMMARY OF CONCEPTS**

The needs of children in hospital are different from those of adult patients and they should be nursed in separate wards (Lindquist, 1985; Ministry of Health, 1959).

When surroundings are welcoming, comforting and supportive they may actually assist in treatment and recovery (Olds, 1988). The ward environment and treatment rooms can be designed and decorated to help children and parents feel more comfortable and relaxed, to gain a sense of control and status.

Children need the stimulus of other children. Adequate play and educational facilities are necessary to give children the opportunity to carry on with as normal a life as possible. They may require parents and possibly siblings to be accommodated with them. A children's ward can be designed and organised to fulfill these needs.

Children require different patterns of nursing from adult patients (Laurent, 1990). Paediatric-trained and experienced nurses are an essential component of any children's ward.

A significant percentage of children who are hospitalised, especially between 6 months and 6 years of age, face repeated hospital stays. A children's ward provides for re-admissions to a familiar environment.

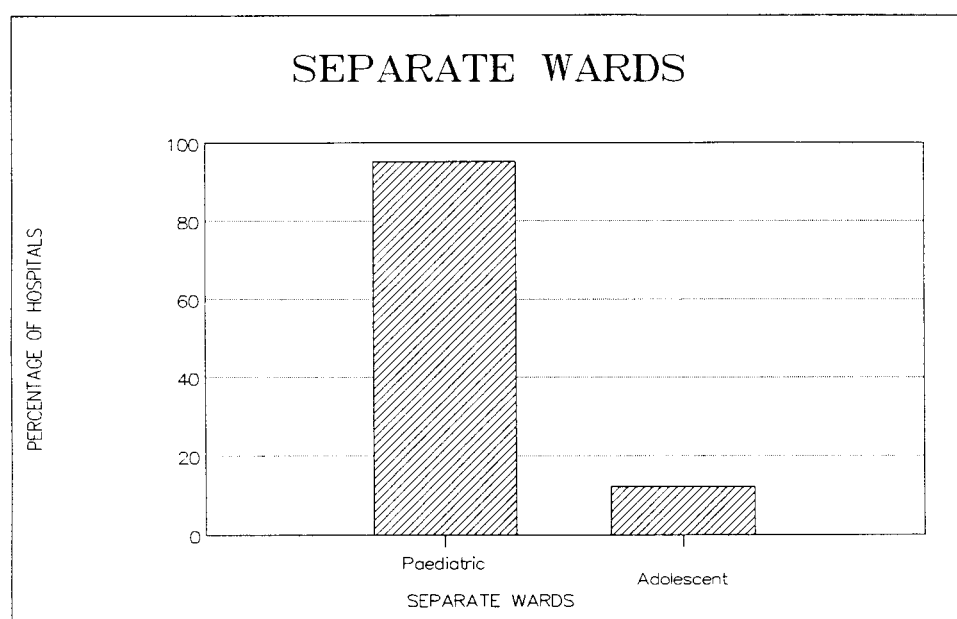
Children's wards are not only essential to cater for the specific needs of children, they are also a necessary alternative to nursing adults and children together. Children can be noisy and demanding, their behaviour may intrude on adult patients' privacy.

NSW private hospitals define a child as a person who is under the age of ten years (NSW Government Gazette, 1990).

### **SURVEY RESULTS**

- ❖ As shown in Graph 4, 95.1% (N=234) of the 246 general hospitals surveyed provide separate wards for children.
- ❖ However, at least 14.6% (N=34) of these hospitals also place children among other patients in a number of situations, e.g. on weekends or public holidays, depending on staff numbers. Other hospitals reported that they place adults within the children's ward when beds are vacant. While it was frequently indicated that attempts are made in many of the above circumstances to place children together but separate from adults, this cannot always be achieved. Thus a number of facilities and services which are part of a paediatric ward may not be available to these children and their families.
- ❖ 13 hospitals (4.9%) indicated that they do not have separate paediatric wards.

**Graph 4**



- ❖ Policies regarding minimum and maximum ages of children being admitted to paediatric wards vary significantly.
- ❖ Some hospitals indicated that their age brackets are flexible depending on a child's development, usually allowing boys to be older than girls before they are separated. A frequent criterion for admission to a children's ward is whether or not a child has reached puberty.
- ❖ Overall, the average maximum age of children nursed on paediatric wards is 14 years. However, the amount of variation between individual hospitals is extremely high, ranging from 8 to 21 years.
- ❖ The issue of ward decoration was addressed very briefly. Among respondents 9.9% (N=25) felt that the décor as inadequate, 41.1% (N=104) indicated that it could be better and 49% (N=24) felt that it was adequate. Private hospitals rated higher than public hospitals on this parameter.

Due to the increasing financial constraints experienced by hospitals, a large number of paediatric wards are currently under threat of being reduced in size or being closed. Reduction in staff and facilities may affect the quality of care and creative solutions are required to meet the needs of children and their families adequately.

### **Adolescent Needs**

Caring for adolescents requires a different approach to that of nursing children or adults. Adolescents have distinct needs for privacy, autonomy, confidentiality, independence and peer support. When adolescents come into hospital, these needs may be intensified by anxieties related to illness, together with fears of death and

concerns about body image and function (Thompson, 1985). A major cause of hospitalisation in this age group is injury (NSW Health Department, 1990), which may result in long-term physical and emotional consequences.

Adolescent patients have expressed dissatisfaction with the psychological atmosphere and ward rules when placed into a paediatric ward with much younger children or in a ward with adults. They prefer to be nursed in separate adolescent units (Louis & Lovejoy, 1975; Rigg & Fisher, 1971).

The establishment of adolescent units, either as a special part of or separate from the paediatric ward, has been advocated for many years (Hofman, Becker & Gabriel, 1976; Lindheim, Glaser & Coffin, 1972; Great Britain, Ministry of Health, 1959).

Guidelines recently prepared in England (NAWCH, 1990) for requirements of adolescent units suggest the provision of single, 2- or 4-bed units with bathrooms and toilets, designed to provide adequate privacy for adolescents. Other facilities recommended include parent accommodation, school and reading rooms, areas for noisy social activities, as well as kitchen facilities for preparing snacks and drinks.

It is preferable that medical and nursing staffs in the unit have a special interest in adolescents and have appropriate skills to respond with sensitivity to this unique patient group. It is recommended that staff consist of both male and female nurses, and support personnel also be aware of the emotional and social needs of this age group. Social workers and counsellors, as well as education and recreation staff, should be part of the adolescent unit.

Adolescent patients should be informed about their condition and adequately prepared for treatments, as well as being supplied with clear information regarding the adolescent unit's guidelines and rules. They should be encouraged to develop independence and to participate in treatment decisions whenever possible.

In an environment where their emotional, social and educational needs are understood and met, adolescent patients can adjust more effectively to their illness or injury, and are more likely to co-operate with hospital routines and treatments. This may not only affect their current recovery but also attitudes towards health care in the future.

Even though the present survey did not specifically address adolescent issues, there are indications that this client group is not generally catered for in separate adolescent units.

- ✦ Only 31 hospitals (12.3%) provide separate adolescent units. Some respondents indicated that they attempt to place similarly aged patients together, or to bed them in rooms separate from young children or adults, if possible.
- ✦ Play and recreation materials for adolescents were reported to be adequate by only 30.8% of participants, compared to 87.7% for pre-school aged children and 79% for school-aged children.

## SECTION 2: PREPARATION FOR ADMISSION

### Pre-admission Preparation

#### SUMMARY OF CONCEPTS

Both parents and children need information that helps them to prepare for their roles in the hospital experience (NAWCH, 1980; Gross, 1986; Meng & Zastowny, 1982; Petrillo & Azaroff, 1985).

It has been well documented that advance preparation for hospitalisation, health care procedures or impending surgery, provides children with a sense of mastery over the hospital environment and helps them to cope more effectively with this potentially highly stressful situation. Reducing fears of the unknown and therefore anxiety, fosters better adjustment and co-operation of children during their hospital stay (Adams, Gill & McDonald, 1991; Ellerton, Caty & Ritchie 1985; Price, 1991; Thompson, 1985).

Effective preparation programmes must be specifically designed taking children's ages and developmental stages into account (Beckmeyer & Bahr, 1980; Skipper & Leonard, 1968).

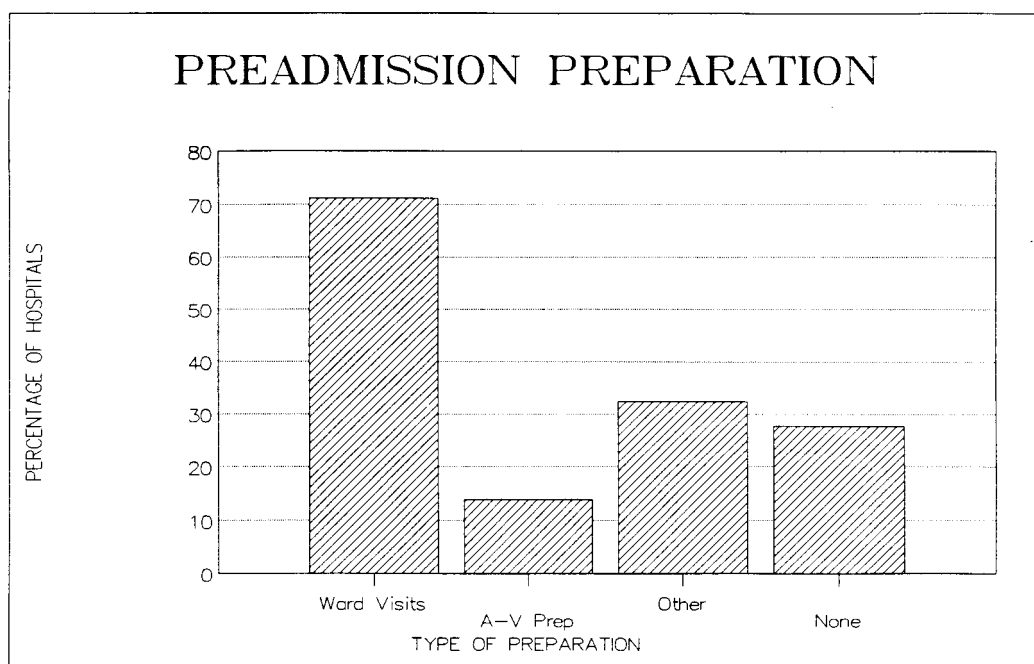
Story books and pictorial information or audio-visual materials are beneficial to facilitate understanding of the events and are recommended for preparing both parents and children (Melamed & Siegel, 1975). In addition, particularly for pre-school and school-aged children and their parents, pre-admission hospital tours or ward visits have been found to be very effective preparation tools, as they allow children the opportunity to ask questions and to have hands-on experience (Adams et al., 1991; Gross, 1896; Pass & Pass, 1987; Gaynard et al., 1990).

Preparation activities should not be viewed as a substitute for open discussions with the doctor about purposes and details of medical procedures and hospitalisation. Rather, they are an additional source of information and an important part of the psychological care for patients and their families.

#### SURVEY RESULTS

- ✦ In total 183 hospitals (72.3%) organise some pre-admission preparation activities (**Graph 5**).

**Graph 5**



- ✦ Of the 183 hospitals offering preparation, 80.9% (N=148) offer ward visits only and 3 (2.0%) offer audio-visual preparation only.

Only 32 hospitals (17.5%) offer both ward visits and audio-visual preparation. This includes 3 paediatric hospitals.

- ✦ Of the 183 hospitals offering pre-admission preparation, only 25.1% (N=46) advise parents about these activities in writing, in their admission letter. The remaining 74.9% (N=137) of hospitals, including one specialised paediatric hospital, rely on medical staff, schools and community groups or family and friends to inform parents that these activities are available. This may be a major reason for the relatively low attendance rates of these activities in many hospitals.
- ✦ Responses to 'other' preparation activities (**Graph 5**) were collated into three main areas: written or pictorial information, medical/role play activities or school/kindergarten visits.
- ✦ 34 hospitals (13.4%) mentioned that they distribute books, colouring-in books or pamphlets to children prior to or on admission. In one hospital this was the only form of preparation offered.
- ✦ A total of 10 hospitals (4%) reported regular, formally organised preparation activities such as play with medical instruments, role play or operating theatre visits prior to admission.

- ✦ 32 hospitals (12.6%) were also involved in organised school and kindergarten tours with varying degrees of regularity. For 8 hospitals this is the only preparation activity provided.
- ✦ 27.7% (N=70) of hospitals (with an average of 16 paediatric beds) do not offer any pre-admission preparation activities at all (Graph 5). 66% (N=46) of these would like to do so, 33% would not. Apart from time and financial restraints, a major reason for not providing this service was the small number of planned admissions.
- ✦ 84.2% of private hospitals (N=32) offer some form of preparation and 15.8% (N=6) offer no preparation at all, even though 78% of admissions to private hospitals are planned.

## **Written information for parents**

### **SUMMARY OF CONCEPTS**

It has been well established that young children will be affected by their parent's emotional state, often influencing the child's behaviour (Glasper & Stradling, 1989; Heffernan & Azarnoff, 1971; Mahaffy, 1965; Skipper & Leonard, 1968).

If parents are prepared for their child's hospitalisation and know what to expect, anxieties and fears are reduced. Parents can in turn provide effective preparation for their child. (Wolfer & Visintainer, 1975; Price, 1991).

Comprehensive written information should help parents to prepare themselves and their children for the hospital experience. Much information can be covered in well designed and easily written (multilingual) brochures (Jackson, Bradham & Burwell, 1978). It is often difficult for many parents to recall details given during the admission process, hence the importance of the provision of comprehensive written material.

Written information should include:

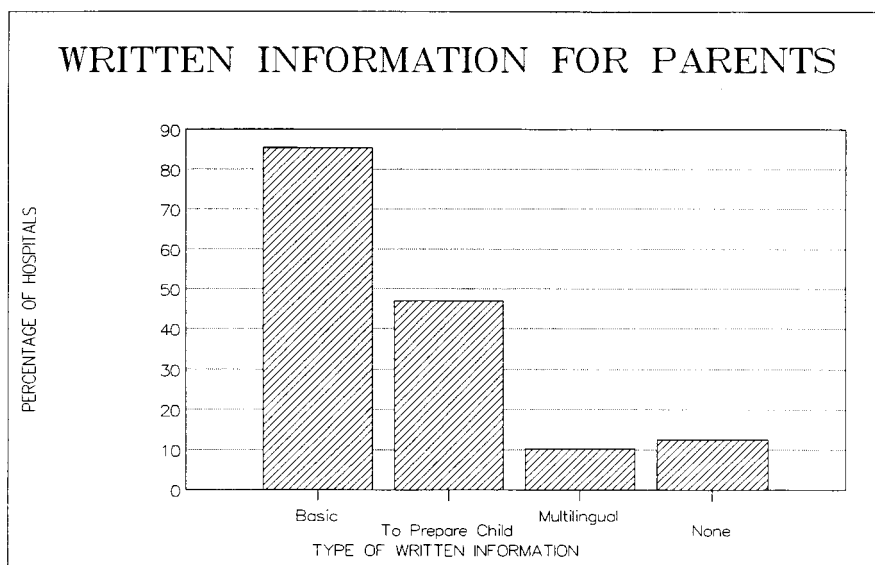
- hospital routines and their times
- the child's need for simple truthful explanations of the reason for hospitalisation
- encouragement for the child to bring a favourite toy or rug to hospital
- a reminder to tell ward staff of family names for toilet, eating habits and so on
- whether children can bring day clothes and their own pyjamas, and other requirements
- the need for frequent visiting by all family members and the importance of saying goodbye 'in spite of tears'
- clearly stated visiting hours and policies, e.g. for siblings
- the value of using live-in facilities for parents, particularly of young children, including details of accommodation, meals and other facilities, and costs
- whether meal tickets are provided, cafeteria or kiosk opening hours, etc.

- which aspects of basic care or nursing, in which parents are encouraged to participate
- information about any play programmes or suggested activities
- an explanation of possible behaviour changes in the child during and after hospitalisation
- encouragement to seek information or assistance

## SURVEY RESULTS

- ✦ Basic written information about the hospital is provided by 84.4% (N=216) of participants. No written information at all is given by 12.3% (N=31) (**Graph 6**).
- ✦ 119 hospitals (47%) including all paediatric hospitals, provide specific reading material for parents to help them to prepare their child for hospitalisation.
- ✦ Of the 224 hospitals that provide written information, 11.1% (N=25) have this available in other languages, among them one paediatric hospital, and none of the private hospitals. However, over 50% of respondents indicated elsewhere in the questionnaire that families with limited English language skills attend their hospital.
- ✦ Even though in country areas it is often more difficult for patients to attend ward visits prior to admission, only 40.1% (N=67) of all country hospitals include preparation information for parents.
- ✦ 33 hospitals (13.0%), including 4 out of the 7 paediatric hospitals, provide access to a resource library for families covering medical, developmental and psychosocial topics.

**Graph 6**



## **SECTIONS 3, 4 & 5: ACCOMMODATION FACILITIES FOR FAMILIES, CHILDCARE AND VISITING HOURS**

### **SUMMARY OF CONCEPTS**

Parents are generally the best source of emotional support and comfort for their children. The continuous presence of a parent (at least for the first four days) has been recognised as one of the most important factors in preventing damaging emotional stress from hospitalisation, especially in young children (Bowlby, 1953, 1973; Robertson, 1958; Robertson & Robertson, 1989).

Even a very well adjusted and independent child may need more support than expected during a hospital stay. For the very young, the greatest distress is caused by separation from their caregiver. For the slightly older child, the fear of medical procedures and bodily harm is paramount and can be reduced by the reassurance and support of a parent. Even for adolescents, the parent can provide comfort, stability and support that assist them to cope (Thornes, 1988).

Usually the child's need for a parent's presence will be even greater at night. Many children have never slept away from home before hospitalisation. The presence of a parent is extremely reassuring and can provide an element of normality.

Siblings and other family members are often of great significance to hospitalised children and should have liberal opportunities to visit frequently. Unrestricted visiting hours for parents and siblings means less separation from normal family life and provides a sense of continuity. It also gives increased and more accurate understanding about the hospitalised sibling's condition to other children in the family, who often are themselves emotionally affected by the event (Consolvo, 1986).

However, it is often not appropriate to keep siblings on the ward for extended periods of times. They too need to be supported at times when the hospitalised child is particularly unwell or is undergoing tests or procedures. This has been found to be a major concern for many parents and an additional source of stress and anxiety, which in turn affects the child patient. Therefore, adequate childcare facilities should be available for siblings at the hospital (Flint & Walsh, 1988). Paediatric care ideally involves family care.

After meeting medical requirements, policies should enhance family ties and promote the philosophy that children 'belong' to their parents. Parents are more and more considered as important members of the health care team rather than 'visitors'. It is therefore seen as the hospital's responsibility to inform parents clearly in writing about hospital policies and parent facilities, and to make parents feel welcome and accepted and as comfortable as possible (Consolvo, 1986).

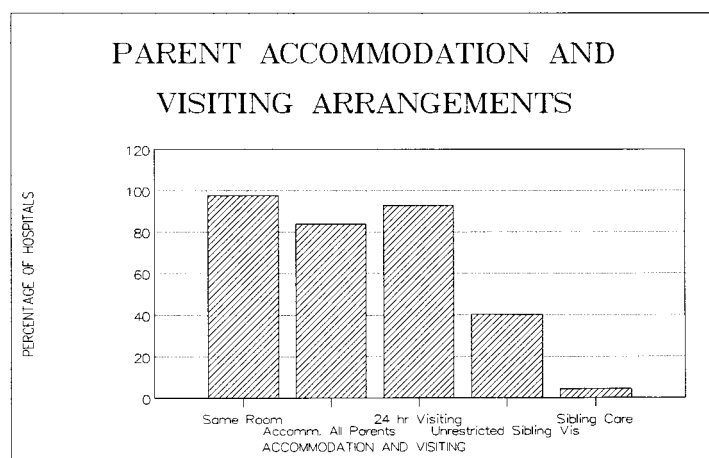
It has been found that relying simply on verbal communication in regard to visiting is often not effective (Flint & Walsh, 1988). Visiting policies and overnight arrangements should be clearly explained in the admission letter or hospital brochure. Ideally, there should be a well-positioned sign on the ward with this information.

Additionally, parents should be invited by the nurse in charge to discuss any special needs, visiting preferences or the necessity for special arrangements over the duration of the child's hospital stay. Individualised arrangements can significantly reduce parents' stress and anxiety (Proctor, 1987; Terry, 1987).

## SURVEY RESULTS

- ✦ All surveyed hospitals offer accommodation for at least one parent and in 248 hospitals (98.0%) parents can sleep in the same room as the child (**Graph 7**). In the remaining 6 hospitals (2.3%) parent accommodation is off-ward including in separate rooms or in nurses' quarters.

**Graph 7**



- ✦ The majority of hospitals (N=194=76.7%) offer a fixed or folding bed beside the child. In 6 hospitals (2.3%) parents can spend the night next to their child accommodated in a chair, 3 of these hospitals offering off-ward accommodation.
- ✦ Other options available in a number of hospitals are recliner chairs beside the child, a bed in an area near the ward (e.g. in the play-room), flats, nurses' quarters, Red Cross rooms, mattress on the floor etc.
- ✦ 212 hospitals (83.8%), including all paediatric hospitals, reported that they are able to accommodate all parents who ask to stay with their child.
- ✦ 29 of the 167 country hospitals (17.4%) are unable to accommodate all parents who wish to stay with their child, while this applies to only 5 of the 86 city hospitals (5.8%). This situation for country families is of concern.
- ✦ 215 of all surveyed hospitals (84.9%) maintain that they routinely advise all parents of their overnight facilities. This applies to 184 public and 31 private hospitals.
- ✦ However, of those 215 hospitals, only 28.4% (N=61) inform parents about their overnight facilities in writing.

- ✦ Policies regarding charges for parents staying overnight seem to vary significantly, from state to state, and between individual hospitals. A number of public and private hospitals provide this service entirely free of charge including meals. Others apply various charges ranging from \$2 to \$43 per night in public hospitals and from \$15 to \$50 per night in private hospitals.

Parent accommodation charges are presently not covered by Medicare. Some private health funds cover this item, however, generally that is only in the top hospital plans.

**Table 1: Meal Arrangements for Live-in Parents**

	Number of Hospitals	%
Kiosk	133	52.6
Meal Tickets	108	42.7
Food Preparation Areas	49	19.4
Ward Food	126	49.8
Staff Cafeteria	109	43.1

- ✦ Meal arrangements for parents differ greatly between individual hospitals. While some hospitals offer a number of options, others have very limited facilities (**Table 1**).
- ✦ As shown in **Table 2**, different conveniences for parents on or near the children's ward are offered to varying degrees, with private hospitals generally providing more facilities than public hospitals.

**Table 2: Facilities available for parents on or near the children's ward**

	Number of Hospitals	%
Access to toilet or hand basin	241	95.3
Lounge area	411	55.7
Private space for parents to grieve or talk with staff	155	61.3
Showering facilities	209	82.6
Public telephone	238	94.1
Facilities for making tea or coffee	211	83.4
Facilities to wash/dry personal laundry	81	32.0

- ✦ The majority of hospitals (N=235=92.9%) have a 24-hour visiting policy for parents of paediatric patients. 35.7% (N=84) advise parents about this in writing, and only 29.4% (N=69) of hospitals actually have a relevant sign in the ward area. 112 hospitals (47.7%) rely on verbal communication only, which in an emergency admission can easily be overlooked.
- ✦ Those 18 hospitals (7.1%) that do not have a 24-hour visiting policy generally allow parents to visit until about 8 pm, however a number of respondents have indicated a fair amount of flexibility.
- ✦ Unrestricted visiting for siblings of patients is policy in 102 hospitals (40.3%), including 5 paediatric hospitals.

## **SECTION 6: OTHER PAEDIATRIC FACILITIES**

### **SUMMARY OF CONCEPTS**

The majority of families seem to be able to take advantage of live-in arrangements and unrestricted visiting. A family's ability to utilise unrestricted visiting will be affected by: single parent family structures; siblings with special needs; inadequate child care; work and financial commitments; long distances from hospitals and the health of the parents.

A major source of stress for children is the absence of a trusting personal relationship with at least one care-giver who is frequently and regularly available (Robertson & Robertson, 1989; Wolfer & Visintainer, 1975). This is particularly true when parents cannot be with their children and when children come in contact with a large number of different hospital staff.

If a consistent care-giver is available to a child, and a supportive relationship develops, the stress of separation will be greatly reduced. Support from a consistent care-giver may be expressed in a number of ways:

- assurance, empathy and support before and after or during health care events
- expression of natural warmth and sensitivity, similar to a parent, which differs from the prescribed roles of hospital staff
- providing accurate, understandable information in developmentally appropriate ways
- communicating interest in the child's welfare
- engaging the child in play activities
- providing support and more personal, non-medical information to the parents and other family members (Gaynard et al., 1990)

Often another family member or friend can fill in for a parent, but if this is not possible, alternative arrangements should be offered by the hospital. Robertson (1985) suggests that a lay foster mother should be available to every unaccompanied child so that contact with one consistent person, taking the mother's role, can be maintained.

Based on this concept, some Australian and overseas hospitals operate highly successful volunteer programmes, sometimes known as the 'Granny Scheme' (Dunbar, 1990; Tedeschi, 1988; Lodge, 1988). Carefully selected volunteers work in conjunction with the Social Work Department and become the companion of one child over the duration of their hospital stay, or as required.

A compromise to this highly committed and organised programme is to designate a particular staff member as the special 'guardian', who spends extra time with an unaccompanied child and attempts to build a supportive relationship. Play Leaders or Diversional Therapists are well suited for this task.

Ideally, such arrangements for times when parents cannot be with their children should be made prior to admission or as soon as the situation arises. Some parents

may need to be made aware of the importance and value of such a 'parent substitute'. The volunteer should always be introduced to the parents first and then to the child. The final decision to have a substitute support person should rest with the parents not the hospital (Lodge, 1988).

Selection of volunteers requires careful consideration. It was found that well selected 'grannies' did not require a great deal of 'training' apart from orientation to the ward environment and the hospital. It is important that the volunteers feel accepted and supported in their role by hospital staff. The social work department may provide structured opportunities for support and debriefing for volunteers (Lodge, 1988).

Often simple ways of normalising the ward environment can help to make children feel less threatened and more at ease.

Access to a telephone and being able to receive phone calls reduces feelings of isolation from friends and family members, especially for older children and teens.

Being able to dress in their own pyjamas and day clothes can make a big difference to children of all ages and may help to avoid distress upon admission. If for certain medical conditions hospital clothes must be worn, these clothes should be attractive, age appropriate and well-fitting.

When children are allowed to personalise their own bed with photographs or drawings and can bring a favourite toy, it helps to make them feel more 'at home' and secure. It also provides a focus for interacting with the child.

Serving meals in a separate dining area, rather than in bed, can make mealtimes an enjoyable social occasion. Food should be presented in an appealing form and in appropriately-sized portions for each child.

Personalised information sheets especially for young or disabled children or for children with limited understanding of the English language, should be compiled on admission. Information such as food likes and dislikes, sleeping patterns and habits, or special family vocabulary may help to prevent distress when parents are absent.

## **SURVEY RESULTS**

- ✦ 30.4 % ( N=77) of hospitals indicated that they make special arrangements for children whose parents cannot visit them regularly or at all. Few of these arrangements seem to be following a specific policy or formally organised procedure. It seems that generally, efforts are made to encourage other family members to visit the child, or various community resources are sought for assistance. Often nursing and other staff or hospital volunteers seem to pay special attention to these children. In some cases the social worker becomes involved.
- ✦ A number of hospitals indicated that the need for special arrangements has never or rarely arisen. This may be a good indication that most children have a parent or family member with them for most of the time.

It is also possible that the need for such arrangements is under-estimated. It may be perceived as acceptable that working parents only visit for a few hours in the evening. However, some children would benefit from visits from a consistent care-giver during the day to complement parents visits at night.

- ✦ 6 hospitals (4%) run a fully organised Granny Scheme with a volunteer taking the role of the parent on a continuous basis for as long as required. This includes 2 paediatric hospitals.
- ✦ 33 hospitals (13.0%) have indicated that they arrange an alternative care scheme for unaccompanied children. However, from a number of comments it became apparent that this does not in all cases mean that consistent regular contact with the child is assigned to one person, but that it may involve whoever is available to spend extra time with the child.
- ✦ Special arrangements which help to normalise the hospital environment and care for children are summarized in Table 3.
- ✦ The majority of hospitals surveyed permit children to use the phone. However, a number of respondents commented that only the ward phone is available and that permission was given in ‘certain cases’, or if a child is upset. 19 (7.5%) hospitals indicated that as a rule phone contact was not available.
- ✦ 43.1% of hospitals indicated that they did not have the facilities to provide a separate meals area for children.

**Table 3: Special Arrangements**

	<b>Number of Hospitals</b>	<b>%</b>
Receive phone calls	226	89.0
Make phone calls	204	80.6
Personal information sheets	243	96.0
Children can wear their own pyjamas or clothes	240	94.9
Children can personalise their beds	241	95.3
Separate meal areas	144	56.9

### **Special Needs of Disabled Children**

Children with long term physical and /or mental disabilities are particularly vulnerable to the stresses of hospitalisation. Special skills, facilities and resources are required to meet the specific individual needs of these children, and to facilitate and continue their development.

A separate policy relating to the care of the child with a long term disability in hospital was developed by AWCH in 1986.

As mentioned earlier, due to its complexity this topic was not addressed in detail in the present survey. However, it was asked whether difficulties were encountered in caring for disabled children.

- ✦ 62 hospitals (24.5%), including 1 paediatric hospital, reported difficulties in caring for children with special needs.
- ✦ Of these 62 hospitals:
  - 70.9% (N=44) experienced difficulties due to staffing
  - 58.1% (N=36) due to facilities
  - 37.9% (N=23) due to both staffing and facilities
- ✦ Other concerns expressed related to staff expertise, lack of special equipment and lack of play facilities.

## **SECTION 7: PARENT PARTICIPATION IN PATIENT CARE**

### **Basic and Nursing Care**

#### **SUMMARY OF CONCEPTS**

Just as children want and need their parents' presence and support, most parents feel the need to continue to take an active role in their child's care in hospital. The value of parental presence during procedures, tests and on the hospital ward has long been recognised (e.g. Brain & Maclay, 1968; Mason, 1978; Peterson, Mori & Carter, 1985; Wessel & LaCamera, 1969).

Incorporating parents as part of the health care team has been found to have many important advantages. Both children and parents are more co-operative and less anxious. Parents express greater trust and confidence in the hospital staff and greater satisfaction with the hospital experience when they are involved in caring for their child in hospital (Wolfer & Visintainer, 1975).

Parents at home assume a primary role in the health care of their children, they are usually the first to recognise or identify a problem and basically know their child and their needs best. During the hospital stay most parents would like to continue to provide basic care for their child, and many also learn to assist with nursing care. Involved parents can provide a positive coping model, as well as being in a position to give reassurance and relevant information to their child, in preparation for medical procedures.

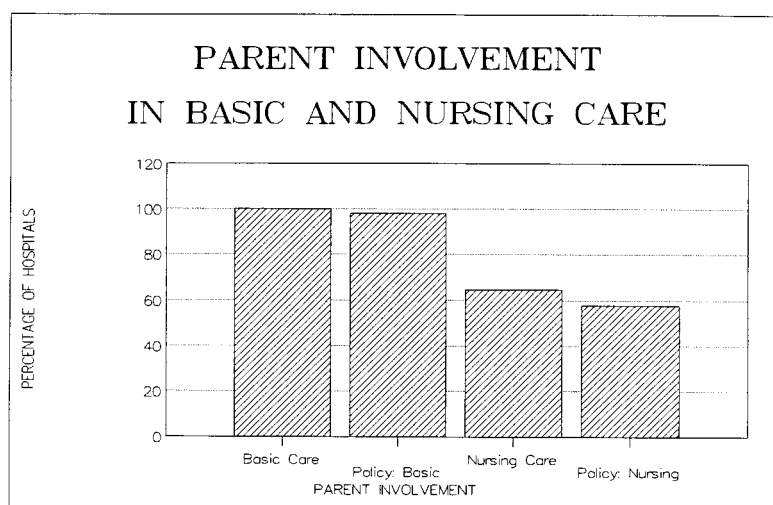
For successful collaboration between hospital and family, parents need clear information and guidelines to define their role in the hospital setting – tangible indications that they are welcome and have a legitimate place as part of the health care team. Without assistance and emotional support some parents may feel out of place or disoriented, and consequently will be of less support for their child (Terry, 1987).

Parents' involvement in general and nursing care of their child may reduce the length of stay in hospital, and result in parents feeling more confident and relaxed to take responsibility for the care of their child at home.

It is essential that hospital staff are convinced of the value of working with the parent-child unit in the healing process. A vital component for a successful parent-staff partnership is communication, encompassing the family, hospital staff and community services (Ayer, 1978).

## SURVEY RESULTS

**Graph 8**



- ✦ All 253 surveyed hospitals (100%) indicated that parents are able to participate in the basic care of their children.
- ✦ Parent involvement in nursing care, such as taking temperatures etc., is practiced in 163 hospitals (64.4%). This applies to 65.6% (N=141) of public and 57.9% (N=22) of private hospitals.
- ✦ Some discrepancies between policies and actual practice were found in both public and private hospitals, e.g. 29 respondents indicated that parents are involved in nursing care but that this is not part of the policy, whereas 12 hospitals do not allow parent participation even though it was reported to be hospital policy.

### **Medical Procedures, Induction of Anaesthesia & Recovery**

#### **SUMMARY OF CONCEPTS**

The right of parents to be able to comfort and support their children should extend to all situations, including medical procedures and operations. Often the day of an operation can be unnecessarily traumatic. The benefits of parents being able to accompany their child into the operating theatre, to be present while the child is being anaesthetised and to be in the recovery room, have been demonstrated in many instances (Bush, 1990; Diniaco & Ingoldsby, 1983; Donnelly, 1990; Glover, 1990; Schulman, Foley, Vernon & Allan, 1967). Hospitals that allow parental presence provide a model of successful teamwork between surgeons, anaesthetists, theatre and nursing staff, orderlies, management and families.

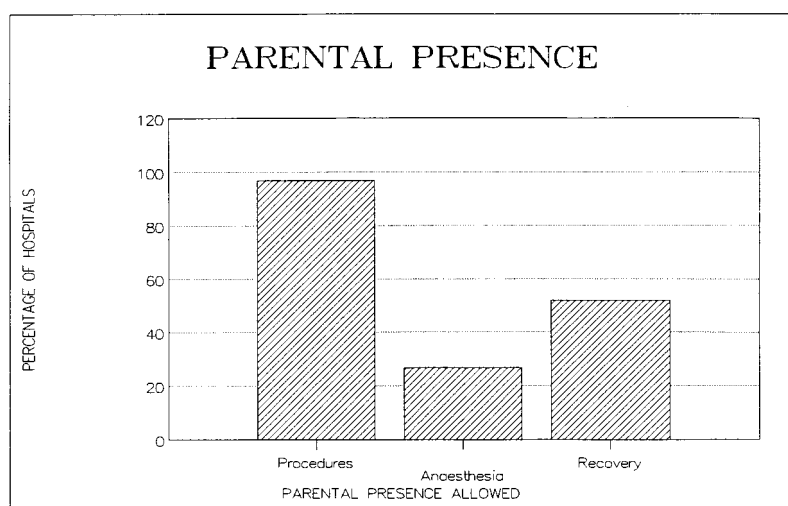
It is important however, that parents are sufficiently prepared for their role and the visit to the theatre, so that they can give maximum support to their children. Parents should never feel pressured to go beyond what they wish to do, as this is likely to increase anxiety in both parent and child. Parents should have the right to be involved as much as they wish, at an appropriate level (Bush, 1990; Glasper, 1990).

## SURVEY RESULTS

### Medical Procedures

- ✦ In most hospitals (N=244=96.4%) parents are able to stay with their children during actual treatments and medical procedures when the child is conscious (**Graph 9**). However, a number of qualifying statements such as ‘depends on procedure’, ‘up to a point’ or ‘if doctor agrees’, indicate that it is likely that the high percentage of positive responses could be misleading and highly conditional in some cases.
- ✦ Both inadequate facilities and lack of staff support seem to be the main reasons for not allowing parents to be present during procedures (N=9=3.6%).

**Graph 9**



### Induction of Anaesthesia

- ✦ During induction of anesthesia parents are permitted to stay with their child in 63 hospitals (26.6%); this section was not applicable to 16 hospitals. No significant difference between public and private hospitals was found.
- ✦ 2 paediatric hospitals out of 7 (28.6%) reported that parents could accompany their child during induction. One of these does so only ‘in certain cases’ and does not permit parents into the recovery ward after the operation or procedure.

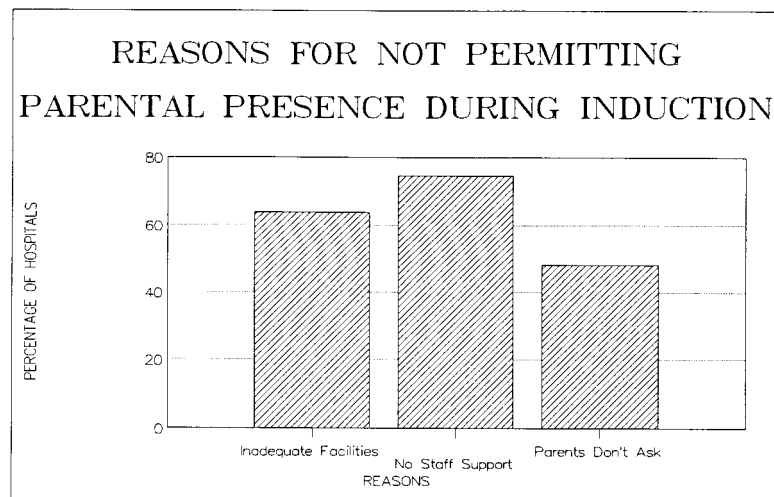
- ✦ Comments made it clear that parental presence is often not uniform hospital policy, but is dependent on the attitude of individual staff members, e.g. ‘2 of 4 anaesthetists allow’, ‘depends on doctor’ etc.

Other comments indicate that even though respondents answered the question affirmatively, in reality parental presence seems not to be a common occurrence at the hospital; rather it is possible ‘in some cases’, e.g. if the child has special needs.

- ✦ Reasons given for not permitting parental presence during induction include: ‘inappropriate reaction from families’, ‘not thought of’ or ‘parents would rather not be present’. One hospital commented that children are asleep by the time they get taken to the theatre due to pre-med.

Some hospitals however, indicated that changes are planned.

**Graph 10**



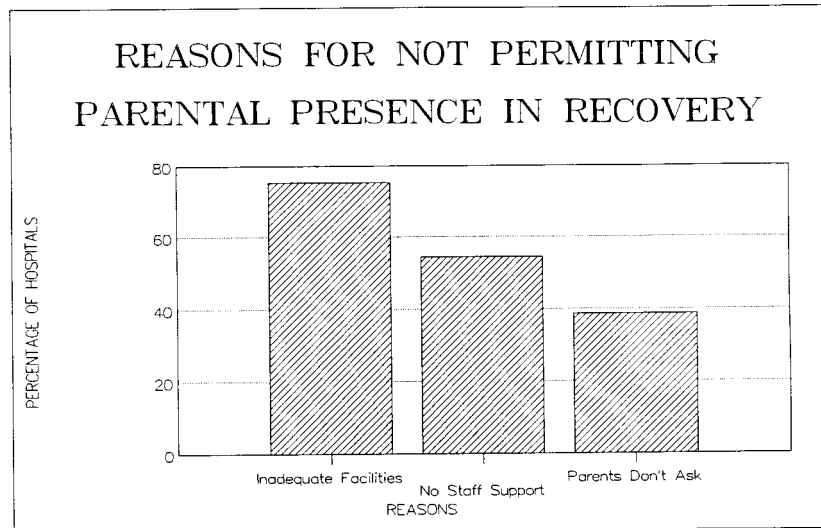
- ✦ 174 hospitals do not permit parental presence during induction of anaesthesia. As seen in Graph 10, lack of staff support (N=130=74.7%) was found to be the major reason, followed by inadequacy of facilities (N=111=63.8%).
- ✦ 84 respondents (48.3%) indicated that ‘parents don’t ask’, which may be due to the fact that the possibility has not been mentioned by parents or preparation has not been offered to them.

### Recovery

- ✦ 123 respondents (51.9%) of the 237 hospitals with operating theatres indicated that parental presence in the recovery room was permitted. This applies to 54.8% of public hospitals (including 4 paediatric hospitals) compared to 36.8% (N=14) of private hospitals.

- ✦ Comments like ‘if no adults in recovery’, ‘if child is distressed’ or ‘rarely happens’, indicate that this often seems to depend on certain conditions and may not necessarily be everyday practice.

**Graph 11**



- ✦ 75.4 % (N=86) of the 114 hospitals not permitting parental presence in the recovery room reported inadequate facilities as the main reason (**Graph 11**).

It appears that often children are not kept in separate areas from adults and it was frequently mentioned that parents could invade the privacy of other patient in the recovery ward.

- ✦ Lack of staff support is given as a major factor in preventing parents from being present in the recovery ward (54.4% = N= 62).
- ✦ 44 respondents (38.6%) indicated that parents don't ask to be there, while other respondents commented that ‘parents often ask’, especially if they are able to be present during induction. Possibly many more parents would ask if they knew they had the option and were prepared for the situation.
- ✦ In total, only 24 of all surveyed hospitals (9.1%) seem to have adopted a comprehensive practice of parental involvement, which is reflected in a policy encouraging parents to participate in the basic and nursing care of their child, including presence during treatment, induction of anaesthesia and in the recovery room.

## **SECTION 8: EDUCATION/PREPARATION FOR SPECIFIC MEDICAL TEST PROCEDURES**

### **SUMMARY OF CONCEPTS**

Apart from often being painful, medical and surgical procedures can be extremely frightening. Children's cognitive development is not sufficient to enable them to comprehend fully the meaning of and need for medical procedures. They have fewer coping strategies at their disposal and common fears of helplessness, pain, bodily mutilation or death are often experienced by children in the process of interpreting what is happening to them in the hospital environment. Young children often view these experiences as punishment for real or imaginary transgressions. All these factors can lead to heightened emotional reactions and fear (Brewster, 1982; Burstein & Meichenbaum, 1979; Bush, 1990; Gellert, 1978; Freud, 1952; Lindquist, 1985; MacCarthy, 1979; Prugh, 1983).

When these issues are addressed by way of preparation activities, many misconceptions can be corrected. A variety of preparation strategies have been found to be effective in helping children cope with surgical, and other intervention procedures.

Ideally, children are provided with information about their medical condition, about the events that occur before and during medical procedures or surgery, or sensory information, describing sights, sounds, smells and sensations associated with the procedure (e.g. Johnson, Kirchoff & Endress, 1975).

Information processing can be further enhanced through play and the systematic use of play techniques, including rehearsal or dramatic play using medical equipment (Ellerton et al., 1985; Goldberger, 1988; Gaynard et al., 1990; Thompson, 1985). Other preparation methods include modelling (Elkins & Roberts, 1985; Melamed & Siegel, 1975) or coping skills and relaxation techniques (Peterson & Shegetomi, 1981).

Generally, patients who received appropriate preparation were found to be less anxious, required less pain-reducing medication, exhibited fewer maladaptive behaviours and coped more effectively with procedures. They also tend to have fewer complications and to leave hospital earlier. Benefits have also been reported for parents (Peterson & Shigetomi, 1981; Peterson, Ridley-Johnson, Tracey & Mullins, 1984; Pass & Pass, 1987; Visintainer & Wolfer, 1975).

However, a number of factors, such as the procedure in question, age and developmental stage, previous hospital experiences and the extent of parental involvement should be considered when choosing a method of preparation for an individual child (Melamed, Robbins & Fernandez, 1982; Peterson & Mori, 1988; Thompson, 1985).

Thus, ideally hospital preparation programmes should be individualised and involve staff specifically trained for this purpose.

## SURVEY RESULTS

The use of various preparation methods is shown in **Table 4**.

- ✦ These results indicate that procedural and sensory information is supplied to children by almost all hospitals.

**Table 4: Preparation Methods**

	<b>Number of Hospitals (Total = 253)</b>	<b>%</b>
Explanations of the sequence, nature and reasons for procedure	244	96.4
Description of physical sensations	240	94.9
Special teaching materials (e.g. dolls, body outlines or photos)	78	30.8
Opportunities to see and play with medical equipment	97	38.3
Teaching relaxation techniques or coping strategies	57	22.5

- ✦ All of the above methods of preparation are used by only 11.9% of hospitals (N=30), ranging in size from 6 to 241 paediatric beds. 4 of the 7 paediatric hospitals (57.1%) and none of the private hospitals make the full range of preparation methods available to their patients.
- ✦ In nearly half of all surveyed hospitals (N= 120=47.4%) no particular department or discipline was indicated as being specifically responsible for the co-ordination of preparation education. Where play staffs are employed, preparation of patients is often their responsibility. Nursing staff appear to be solely responsible for preparation activities in 82.7% of the remaining 133 hospitals.

## **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, 1988; 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 predictable. 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**

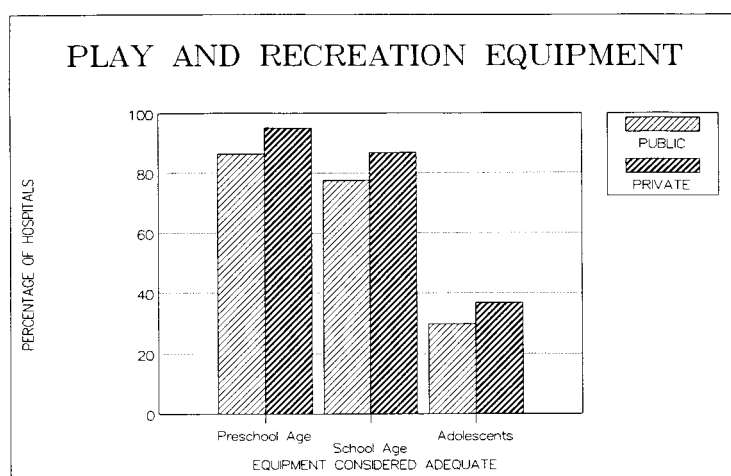
### **Play Areas and Toys**

- 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

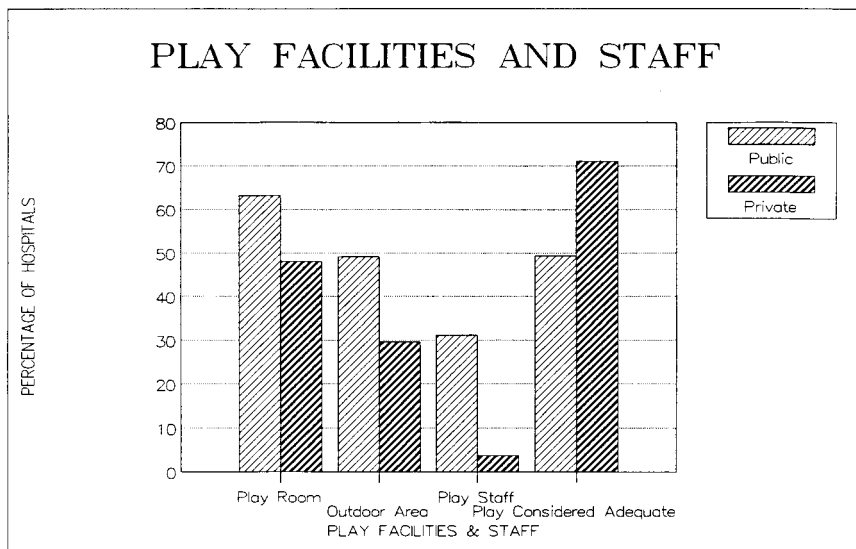
**TABLE 6: Distribution of Play Staff**

	<b>Play Volunteers only</b>	<b>Qualified Play Staff only</b>	<b>Both</b>
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	3 – 9 4

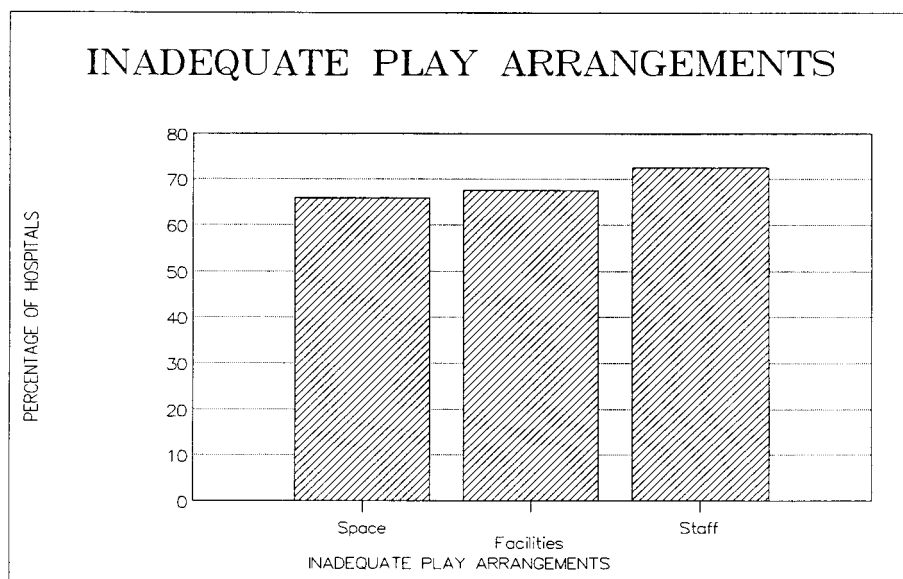
- ✦ Over one third of the hospitals with play staff do not consider the arrangements for play adequate. 18 out of 20 hospitals indicated they required additional play staff.
- ✦ 133 survey participants (52.6%) considered the arrangements for play adequate. 99 of these hospitals (74.4%) do not have any 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.

## **SECTION 10: STAFFING**

### **SUMMARY OF CONCEPTS**

Changes in the philosophy of caring for children in hospital since the Platt Report (Great Britain, Ministry of Health, 1959) together with alterations in the pattern of hospital admissions, require a whole range of new skills from nurses working in paediatrics. Not only are nurses involved in increasingly more complex and technologically advanced procedures, they are also required to understand normal child development and how to respond to the varied special needs of hospitalised children based on their age and development. They need specific skills in play, preparation and communication. They need to understand the importance of the family to the child, especially at the time of hospitalisation, and be able to co-ordinate and support parents in their role. Often they may have to respond to the needs of healthy siblings who form part of ward life.

Personal interactions between staff and patients in the hospital environment are typically brief, goal orientated, and revolve around tasks related to patient care (Grant, 1983). Even when nurses make a special effort, shortage of staff and busy ward routines often prevent them from spending enough uninterrupted time with the child to form a supportive personal relationship.

Systems of personalised and individualised nursing care may reduce some of the barriers preventing nurses from building more consistent and mutually satisfying relationships with their patients.

Primary Nursing Care provides the needed consistency of one nurse who is responsible for planning and implementing most aspects of care throughout the child's stay. This type of nursing provides an ideal situation for nurses 'to get close to' their patients and 'to work in partnership with them and their families' (McMahon, 1990, p.66). However, in practice it is often virtually impossible to fit a clear definition of nursing care to a particular ward, as many combine features of several methods of nursing (Mead, 1991).

During their stay in hospital children frequently come in contact with non-paediatric staff. These members of different departments are often involved in procedures and tests that can cause considerable distress to children, such as taking blood, X-rays, removing plaster casts etc.

All staff dealing with children should be aware of their special needs and have the skills required to respond appropriately to their child patients. Not only will this help the child to cope better, but it also will make working with children less problematic, much more effective and pleasant for the personnel involved.

Hospital in-service programmes encompassing relevant aspects of the social and emotional needs of children should be available to all staff working with children. These programmes should be made available to a range of services such as accident and emergency, outpatient staff, pathology, radiology, admission clerks etc., as well as being part of orientation for new employees.

Volunteers and support staff should also be included in any training programmes covering the psychosocial needs of children in hospital. A handbook on the social and emotional needs of children and their families in hospital may be used to complement their training programme (e.g. Schneider Children's Hospital, New York).

Regular inter-disciplinary meetings, with a holistic approach to health care, will help to raise staff awareness of the psychosocial needs of children and families.

An internal member of the interdisciplinary team is the paediatric social worker, whose role may encompass a variety of tasks, ranging from family counselling to assisting with transport or accommodation, or organising substitute care.

Another important feature affecting the quality of care in a multi-cultural society, is the availability of interpreters and the necessity of providing hospital staff with knowledge of cultural norms related to health care issues, so that serious misunderstandings or potential conflicts due to language problems can be avoided.

## **SURVEY RESULTS**

Whilst team nursing was found to be the most common model of nursing care provided for paediatric patients (61.3%), survey results suggest that there is some confusion about definitions of nursing systems and that often aspects of several methods are combined.

- ✦ The proportion of registered nurses, with postgraduate paediatric training working permanently in children's wards, varies greatly between individual hospitals.

### **In-service Education**

- ✦ 52.2% (N=132) of the surveyed hospitals reported that topics on psychosocial aspects of the hospitalised child and/or family are included in their in-service staff education programme.

- ✦ These programmes are mainly provided for medical and paramedical staff:

19 of the above 132 hospitals (14.4%) also support non-medical personnel, e.g. housekeeping staff, in these training programmes.

17 hospitals (12.9%) provide the above training for volunteers who are directly involved with paediatric patients.

In total 6 hospitals (4.5%), including 2 paediatric hospitals, provide in-service training on psychosocial topics for all relevant staff members who are involved with paediatric patients – professional, support personnel and volunteers.

- ✦ Regular inter-disciplinary team meetings, in addition to ward rounds and ward team meetings, were reported to be held in 113 hospitals (44.7%) including all paediatric hospitals.

- ✦ 41.6% of the 113 above hospitals hold these inter-disciplinary team meetings on a weekly basis, 34.5% on a monthly basis and 23.9% at various intervals, including daily, fortnightly, quarterly or as required.

### **Social Worker**

- ✦ 68.4% of the surveyed hospitals (N=173) reported that a social worker is available to families of paediatric patients. This applies to 77.2% of all public hospitals (including all paediatric hospitals) and to 18.4% of all private hospitals surveyed.

### **Families with limited English language skills**

- ✦ 136 participants (53.8%) indicated that families with limited command of the English language attend the hospital.
- ✦ In 77 of these hospitals (56.6%) interpreter facilities, other than a telephone interpreter service, were reported to be available.
- ✦ Three main areas in need of improvement were identified by 50 respondents who did not consider ethnic services adequate:
  - access to interpreters of community languages
  - more appropriate staff to provide information regarding various cultural norms and practices relevant to health and child care issues, e.g. cultural advisers
  - availability of written material for family members, including signs within the hospital

## **SECTION 11: ACCIDENT/EMERGENCY AND OUTPATIENT SERVICES**

### **SUMMARY OF CONCEPTS**

Children admitted to the accident and emergency department are often frightened on experiencing pain or discomfort. Circumstances surrounding an emergency admission also tend to leave parents feeling anxious and distressed.

Extra care is often required to reduce trauma and unco-operative behaviour. A separate treatment room for children is preferable. It is desirable that staff in this area be experienced in working with children. Parents should be allowed to remain with their child whenever possible.

Waiting times for less urgent cases in accident and emergency, as well as in hospital outpatient clinics, can be long and trying for children and parents. Boredom may be alleviated by toys and books in an area with child-sized furniture and a blackboard.

The presence of a play leader has been demonstrated to be particularly beneficial to both children and the adults accompanying them (Alcock et al., 1985; Ispa et al., 1988; Williams & Powell, 1980). Children also displayed less anxious and aggressive behaviour when going to the treatment room.

Supervised play programmes can be provided by trained volunteers or students thus incurring minimal cost to the hospital with great benefits to patients and staff.

### **SURVEY RESULTS**

- ✦ 215 of the 253 surveyed hospitals (85.0%) have an Accident and Emergency Unit.
- ✦ 73 of these hospitals (34.0%) indicated that appropriate play materials for all age groups are available in the waiting area.
- ✦ 3 hospitals (1.4%) offer a supervised play programme, which in 2 cases is run by qualified staff.
- ✦ Outpatient clinics operate in 152 hospitals (60.1%).
- ✦ 62 (40.8%) of these have appropriate play materials for all age groups in their waiting areas.
- ✦ Supervised play activities are provided in outpatient departments of 7 hospitals (11.3%), 5 of which are paediatric hospitals. Qualified play staff are leading these programmes in 6 hospitals, one of which also involves Early Childhood students. The play programme in the remaining hospital is operated by trained volunteers.

## **SECTION 12: EVALUATION AND PLANNING**

### **SUMMARY OF CONCEPTS**

With the emergence of the concept of ‘consumerism’ in the health care system, patients – or ‘health consumers’ – have gained greater knowledge of their rights and greater equality and power.

In order to address the social determinants of health, government bodies and health officials have started to acknowledge and promote the need for involvement of individuals and community groups in decision-making about health care policies. Since 1985, a large number of significant organisations and publications addressing various areas of health care and the consumer, have emerged (Consumers’ Health Forum of Australia, 1990) including the development of systems of quality assurance.

In the foreword of a publication entitled ‘A Consumer Focus in the Department of Community Services and Health’ (Department of Community Services and Health, 1990, cited in Consumers’ Health Forum of Australia Inc., 1990) it is stated:

*‘A consumer focus recognizes that consumers’ rights are part of our society and that as a government department we must strive to give consumers the best we can and to facilitate their participation in decisions and activities which affect them.’ (p. 22).*

This process of collaboration can be directly facilitated by individual hospitals (Popper, 1990). Consumer representatives (e.g. Parent Advisory Groups) should be appointed to hospital quality assurance committees and administration boards. Promoting communication and information exchange will result in greater co-operation and better mutual understanding between parents and care providers. Such collaboration cannot only increase the standard of health care and of patient satisfaction, but also result in greater professional and personal satisfaction for health care providers.

### **SURVEY RESULTS**

- ✦ 7 hospitals (2.8%) indicated that they have a Parent Committee or similar mechanism, to obtain parent input for hospital administration.
- ✦ 3 of these hospitals also reported that they obtain suggestions on how to improve their care from a Paediatric Patient Committee.

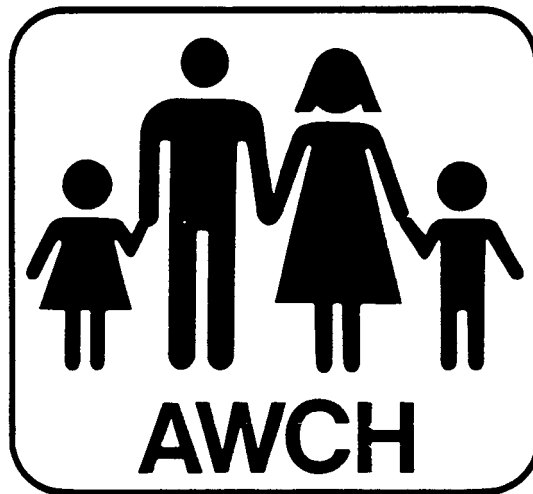
Feedback and evaluation of hospital services is obtained from patient satisfaction questionnaires by 80 hospitals (31.6%). Private hospitals appear to take advantage of this method of quality assurance and client satisfaction to a greater extent (47.4%) than public hospitals (26%).

**SECTIONS 13 & 14: HOSPITAL/COMMUNITY LIAISON & GENERAL DATA**

Insufficient data resulted in the inability to comment on these sections.

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

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## **PREFACE**

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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.

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## **PREAMBLE**

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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.

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## POLICY STATEMENTS

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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.

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### Recommendations relating to POLICY (1):

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- 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.

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### Recommendations relating to POLICY (2):

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- 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.

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### Recommendations relating to POLICY (3):

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- 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.

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#### **Recommendations relating to POLICY (4):**

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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.

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## Recommendations relating to POLICY (5):

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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):

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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.



**APPENDIX B**

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**AUSTRALIAN ASSOCIATION FOR THE WELFARE OF  
CHILDREN IN HOSPITAL**

**QUESTIONNAIRE ON PSYCHOSOCIAL CARE OF CHILD  
PATIENTS (AND FAMILIES) IN HOSPITAL**

**To be completed by the Director of Nursing, Nursing Unit Manager (Paediatric) or  
Clinical Nurse Consultant (Paediatric).**

- 1) When completing this questionnaire please:
- 2) Place a tick in a square alongside the appropriate answer.
- 3) If there is insufficient space to make comments please use the reverse side of the form.
- 4) Space has been provided at the end of the questionnaire for general comments.

**All of your responses will be treated in the strictest of confidence and it will not be possible for any person to identify individual responses in the final report.**

After you have completed the questionnaire please place it in the pre-stamped envelope provided and post it to:

Sally O'Donohue  
Project Officer  
Association for the Welfare of Children in Hospital  
158-160 Hawkesbury Road  
Westmead, NSW 2145.

**If you have any queries please contact A.W.C.H. Headquarters  
on (02) 633-1988 or 008 244 -396**

Date completed: / /

Position of person completing the questionnaire.....

**We thank you for your time in completing this questionnaire.**

We understand that the smaller or general hospitals will possibly not have the same range of services and facilities as the larger paediatric hospitals.

**1. SEPARATE PAEDIATRIC & ADOLESCENT FACILITIES**

- 1.1 Please indicate the type and location of your hospital within the following three groups: **Yes No**
- a) Public..... 1
- Private..... 2
- b) City/Metro..... 3
- Country..... 4
- c) General Hospital admitting paediatric and adult patients..... 5
- Specialised Paediatric Hospital admitting only paediatric patients..... 6
- 1.2 Total number of hospital beds 7 \_\_\_\_\_
- 1.3 Total number of paediatric beds 8 \_\_\_\_\_
- 1.4 If general hospital: **Yes No**
- a) Are children in separate ward(s)? 9
- b) Are children placed amongst other patients? 10
- 1.5 Please indicate the allowed minimum and maximum age of admitted paediatric patients:
- a) Minimum 11 \_\_\_\_\_
- b) Maximum 12 \_\_\_\_\_
- 1.6 Does your hospital have a day surgery ward that is used by paediatric patients? **Yes No**
- 13
- 1.7 Please indicate where adolescent patients are placed: **Yes No**
- a) In a unit designated for adolescents only? 14
- b) Amongst other patients? 15
- 2. PREPARATION FOR ADMISSION**
- 2.1 Do you offer any of the following pre-admission preparation information or activities for elective child patients and their families: **Yes No**
- a) Familiarisation visits to the ward? 16
- b) Audio-visual presentation, eg. puppet, slide, video? 17
- c) Other?..... 18-20 \_\_\_\_\_
- If no, please proceed to 2.4.
- 2.2 How do families and children hear about activities such as these? **Yes No**
- a) Medical staff verbally?..... 21
- b) Admission letter?..... 22
- c) Schools/community groups?..... 23
- d) Other..... 24-6 \_\_\_\_\_
- 2.3 Approximately what percentage of children over the past 12 months do you consider attended a preparation activity prior to their admission? 27 \_\_\_\_\_ %
- Please proceed to 2.7

- 2.4 Would you like to offer preparation information or activities? **Yes No**
- 28
- If no, please proceed to 2.7
- If yes,
- 2.5 What factors currently prevent you from doing this? **Yes No**
- a) Lack of staff..... 29
- b) Lack of finance..... 30
- c) Other..... 31-3 \_\_\_\_\_
- 2.6 If you are already planning to offer such a program, please advise details, eg. a) expected date of commencement month/year, b) the kinds of activities you intend to include
- a) ..... 34 \_\_\_\_\_
- b) ..... 35-7 \_\_\_\_\_
- 2.7 Does your hospital provide written information for parents to: **Yes No**
- a) Help prepare their children for a hospital experience? 38
- b) Provide basic information about the hospital? 39
- If no to both, please proceed to 2.8
- If yes,
- c) When is the information distributed: **Yes No**
- prior to admission? 40
- on or after admission? 41
- d) Is this information available in languages other than English? 42
- 2.8 Are you aware that a pamphlet for parents titled *Your Child in Hospital* is available free of charge from A.W.C.H.? **Yes No**
- 43
- 3. ACCOMMODATION FACILITIES FOR FAMILIES**
- 3.1 Is it possible for a parent to sleep in the room with their hospitalised child? **Yes No**
- 44
- If yes,
- 3.2 What sort of sleeping accommodation is available: **Yes No**
- a) Fixed or folding bed beside the child? 45
- b) Fixed chair beside child? 46
- c) Recliner chair beside child? 47
- d) Bed in area near ward? 48
- e) Flat? 49

- f) Other?.....  
..... 50-2 \_\_\_\_\_
- 3.3 Are you able to accommodate all parents who ask to stay with or near their child overnight? 53 **Yes** **No**
- 3.4 Are **all** parents routinely advised of your overnight facilities? 54 **Yes** **No**
- 3.5 How are parents notified of these facilities: **Yes** **No**
- a) In writing? 55
- b) Verbally? 56
- 3.6 What costs are involved to parents staying with their child?.....  
.....  
..... 57-9 \_\_\_\_\_
- 3.7 What is available on, or conveniently near, wards for parents? **Yes** **No**
- a) Access to toilet or handbasin? 60
- b) Lounge area for parents? 61
- c) Private space(s) for parents to grieve or talk with staff? 62
- d) Showering facilities? 63
- e) Public telephone? 64
- f) Facilities for making tea/coffee? 65
- g) Facilities to wash/dry personal laundry? 66
- 3.8 Are there any special meal facilities or arrangements available to -
- a) live-in parents? **Yes** **No**
- i) Hospital kiosk 67
- ii) Meal tickets 68
- iii) Food preparation areas 69
- iv) Ward food 70
- v) Staff cafeteria 71
- vi) Other.....  
..... 72-4 \_\_\_\_\_
- b) visiting parents?
- i) Hospital kiosk 75
- ii) Meal tickets 76
- iii) Food preparation areas 77
- iv) Ward food 78
- v) Staff cafeteria 79
- vi) Other.....  
..... 80-2 \_\_\_\_\_

#### 4. CHILD MINDING PROVISIONS

- 4.1 Does your hospital provide child care for siblings of child patients and other children of visitors? **Yes** **No**  
83
- If no, please proceed to 5.1
- If yes, please indicate:
- a) The age range catered for? 84 \_\_\_\_\_
- b) Hours available? 85 \_\_\_\_\_
- c) Days available? 86 \_\_\_\_\_

- 4.2 Are severely disabled children catered for in the child minding facilities? **Yes** **No**  
87
- 4.3 Please tick the staffing arrangements in your child minding centre: **Yes** **No**
- a) Professionally trained Director/staff? 88
- b) Volunteers only? 89

#### 5. VISITING HOURS

- 5.1 Does your hospital have a 24 hour visiting policy for parents of paediatric patients? **Yes** **No**  
90
- If yes, how are the patients advised of this policy: **Yes** **No**
- a) In writing? 91
- b) Verbally? 92
- c) A sign in the ward area? 93

Please proceed to question 5.3

- 5.2 If you do not have a 24 hour visiting policy for parents, please outline the policy you do have.  
.....  
.....  
..... 94-6 \_\_\_\_\_
- 5.3 What are the visiting arrangements for the siblings of patients? **Yes** **No**
- a) Unrestricted 24 hours? 97
- b) Restricted, e.g. outside rest time or prior to 20:00 hours? 98

#### 6. OTHER PAEDIATRIC FACILITIES

- 6.1 Does your hospital make special arrangements for children whose parent/s cannot visit them regularly or at all? **Yes** **No**  
99
- If yes, do any of your arrangements include: **Yes** **No**
- a) A granny scheme? 100
- b) A parent surrogate scheme where parents nominate a substitute parent to the child or select a designated nurse, O.T., or another staff member? 101
- c) Other?.....  
.....  
..... 102-4 \_\_\_\_\_
- 6.2 Do child patients have access to any telephone (including ward phone) in the ward area to: **Yes** **No**
- a) Receive phone calls? 105
- b) Make phone calls? 106
- 6.3 On admission does your hospital compile a personal sheet on the child, eg. eating, sleeping, toileting etc? **Yes** **No**  
107
- 6.4 Can your paediatric patients: **Yes** **No**
- a) Choose their own food? 108
- b) Dress in their own pyjamas/clothes? 109

- c) Personalise their bed unit (with artwork, photos, bedspreads etc)? 110
- d) Eat in ward dining areas? 111
- 6.5 Do you encounter difficulties in caring for disabled children in your hospital? 112 **Yes**  **No**
- If yes, please indicate if these difficulties relate to: **Yes**  **No**
- a) Staffing? 113
- b) Facilities, e.g. appropriate toilets? 114
- c) Other?..... 115-7 \_\_\_\_\_

**7. PARENT PARTICIPATION IN PATIENT CARE**

- 7.1 Can parents participate in the care of their children in any of the following ways: **Yes**  **No**
- a) Basic care (feeding, bathing, dressing)? 118
- b) Nursing care (e.g. taking temperatures, treatments)? 119
- 7.2 Is it policy that parents are encouraged to be involved with their child's: **Yes**  **No**
- a) Basic care? 120
- b) Nursing care? 121
- 7.3 Are parents able, if they wish, to be with their children during induction of anaesthesia? 122 **Yes**  **No**
- If yes,
- a) Please indicate approximately what percentage of children undergoing surgery this would involve 123 \_\_\_\_\_ %
- If no,
- b) What do you see as the main reason/s that prevent this from happening? **Yes**  **No**
- i) Inadequacy of physical facilities? 124
- ii) Not supported by surgeons/anaesthetists? 125
- iii) Parents do not ask to be present? 126
- iv) Other..... 127-9 \_\_\_\_\_
- 7.4 Are parents able, if they wish, to be in the Recovery Ward following surgery and other procedures requiring an anaesthetic? 130 **Yes**  **No**
- If no,
- a) What do you see as the main reason/s that prevent this from happening? **Yes**  **No**
- i) Inadequacy of physical facilities? 131
- ii) Not supported by Staff involved? 132
- iii) Parents do not ask to be present? 133
- iv) Other..... 134-6 \_\_\_\_\_

- 7.5 Are parents able, if they wish, to be with their child during actual treatments and medical procedures when the child is conscious? 137 **Yes**  **No**
- If no,
- a) What do you see as the main reason/s that stops this from happening: **Yes**  **No**
- i) Inadequacy of physical facilities? 138
- ii) Not supported by staff involved? 139
- iii) Parents do not ask to be present? 140
- iv) Other..... 141-3 \_\_\_\_\_

**8. EDUCATIONAL/PREPARATION FOR SPECIFIC MEDICAL TEST PROCEDURES**

- The following question explores whether if a child in your hospital has to undergo any tests, procedures and operations that could be distressing, psychological preparation methods are available.
- Although often such teaching is informal or spontaneous, we are asking here about whether routine teaching is done on a **regular basis**, and is offered to **each** paediatric patient.
- 8.1 Are diagnostic tests and operations explained to children (in a manner appropriate for their age), and their families in: **Yes**  **No**
- a) All cases? 144
- b) Most cases? 145
- c) Few cases? 146
- 8.2 Does this preparation include: **Yes**  **No**
- a) Explanations of the sequence, nature and reasons for the procedure? 147
- b) Descriptions of physical sensations the child may experience? 148
- c) Special teaching materials (e.g. printed materials, dolls, body outlines or photographs)? 149
- d) Opportunities to see and play with medical equipment (e.g. plastering a doll's legs in plaster)? 150
- e) Teaching of relaxation techniques or other coping strategies? 151
- f) Other, please specify..... 152\*4 \_\_\_\_\_
- 8.3 Is there a department/discipline in your hospital responsible for co-ordinating this teaching? 155
- If yes, please identify those responsible: **Yes**  **No**
- a) Nursing 155
- c) Other.....

8.4 a) Do you consider that there is a need for individual teaching in your hospital about specific diagnostic tests to all children and families? 157 **Yes** **No**

If yes,

b) What has prevented your hospital from doing this? **Yes** **No**  
 i) Staff? 158    
 ii) Time? 159    
 iii) Finance? 160

8.5 Does your hospital provide a family resource library for parents and children regarding medical, developmental and psychosocial topics? 161 **Yes** **No**

### 9. PLAY, RECREATION AND EDUCATION

9.1 What space does your hospital provide for indoor play for your child patients: **Yes** **No**  
 a) Floorspace within the ward? 162    
 b) A separate playroom in or near the ward? 163    
 c) Outdoor play area? 164    
 d) Other..... 165-7 \_\_\_\_\_

9.2 Do you consider your ward has adequate toys, play materials and recreation equipment to cater for the age range of patients you usually cater for? **Yes** **No**  
 a) Pre-school age? 168    
 b) School age? 169    
 c) Adolescents? 170

9.3 Do you consider the decoration of your ward given the age range you usually cater for, is: **Yes** **No**  
 a) Inadequate? 171    
 b) Adequate? 172    
 c) Adequate but could be better? 173

9.4 a) Does your hospital provide the services of play or recreation staff? 174 **Yes** **No**

If no please proceed to 9.7

If yes, are staff: **Yes** **No**  
 b) Qualified in child care, early childhood education development/care or recreation? 175    
 c) Volunteers untrained in this area? 176    
 d) Both? 177

9.5 a) Please indicate the numbers of staff involved in each of the above areas:  
 i) ..... 178 \_\_\_\_\_  
 ii) ..... 179 \_\_\_\_\_  
 iii) ..... 180 \_\_\_\_\_

b) Please indicate when this service is available (e.g. 9am-9pm every day)  
 i) Days..... 181-2 \_\_\_\_\_

ii) Times..... 183-5 \_\_\_\_\_

9.6 Are recreation/play staff employed to organise programs, activities and other experiences for adolescent patients? 186 **Yes** **No**

9.7 a) Do you consider the arrangements for adolescent play on your ward to be adequate? 187 **Yes** **No**

If no,

b) How would you rectify this? **Yes** **No**  
 i) Space 188    
 ii) Facilities 189    
 iii) Staff 190    
 iv) Other..... 191-3 \_\_\_\_\_

9.8 If your hospital has school aged patients are the following arrangements made for continuing their education:  
 a) Attend a **school within the hospital** or have teachers **from this school unit** visit patients on the ward? 194 **Yes** **No**  
   
 b) Correspondence lessons arranged? 195    
 c) Informal arrangements made with parents? 196

### 10. STAFFING

10.1 Does your hospital use a system of:  
 a) Primary nursing where an individual nurse is responsible for identifying patient care needs, planning and co-ordinating care throughout a patient's stay? 197 **Yes** **No**  
   
 b) Team nursing? 198    
 c) Other.....  
 .....  
 ..... 199 201 \_\_\_\_\_

10.2 Please indicate approximately what percentage of registered nurses working permanently in each paediatric area have postgraduate paediatric training: 202 \_\_\_\_\_ %

10.3 a) Do psychosocial aspects of the hospitalised child and/or family feature in your ward in-service education program? 203 **Yes** **No**

b) Please indicate if this in-service education is provided for: **Yes** **No**  
 i) Professional personnel, e.g. nurses, doctors, technicians, administrators? 204    
 ii) Support personnel e.g. house-keeping staff, dietary aides, clerical? 205    
 iii) Volunteers working directly with paediatric patients and their families? 206

10.4 Aside from usual ward rounds and ward team meetings does your ward hold regular inter-disciplinary team meetings? 207 **Yes** **No**

If yes, approximately how often do these occur? **Yes** **No**  
 a) Weekly 208

- b) Monthly 209    
 c) Other..... 210 \_\_\_\_\_

10.5 Is there a social worker available to families in the paediatric area? 211 **Yes**  **No**

10.6 Do families with limited English skills attend your hospital? 212 **Yes**  **No**

If no, please proceed to 11.1

10.7 a) Are recognised interpreter facilities other than a telephone interpreter service available in your hospital? 213 **Yes**  **No**

10.8 a) Do you consider that the services your hospital provides for ethnic minority groups are adequate? 213 **Yes**  **No**

If no,

a) What do you consider would assist to rectify this?.....  
 .....  
 ..... 214-6 \_\_\_\_\_

**11. ACCIDENT/EMERGENCY AND OUTPATIENT SERVICES**

11.1 a) Does your hospital have an Accident and Emergency area? 217 **Yes**  **No**

If no, please proceed to 11.2

If yes,

b) When non-urgent paediatric patients are awaiting treatment in the accident/emergency area are appropriate play materials available for all age groups? 218 **Yes**  **No**

c) Is a supervised play program available in the accident/emergency area? 219

If yes, are the staff:

d) i) Qualified in child care, early childhood education or recreation? 220 **Yes**  **No**   
 ii) Other?.....  
 ..... 221-3 \_\_\_\_\_

11.2 Does your hospital have an Outpatient Department? 224 **Yes**  **No**

If no, please proceed to 12.1

If yes,

a) Are appropriate play materials available in the outpatient area/s for all age groups? 225 **Yes**  **No**

b) Is a supervised play program available in the outpatient area/s? 226 **Yes**  **No**

If yes, are the staff:

d) i) Qualified in child care, early childhood education or recreation? 227 **Yes**  **No**   
 ii) Other?.....

..... 228-9 \_\_\_\_\_

**12. EVALUTATION AND PLANNING**

12 Does your hospital have the following:  
 a) A Parent Committee or a similar mechanism to obtain parent input for hospital administration and governing boards? 230 **Yes**  **No**

b) A Paediatric Patient Committee comprised of children who make suggestions to improve patient care? 231 **Yes**  **No**

c) A comprehensive paediatric patient satisfaction questionnaire to provide direct evaluation of hospital services? 232 **Yes**  **No**

**13. HOSPITAL/COMMUNITY LIAISON**

13.1 a) Does your hospital provide a formal 'home care program' for children with special health needs? 233 **Yes**  **No**

If yes, do you provide -

b) Home-based physical, occupational, or respiratory therapy? 234 **Yes**  **No**

c) In-home nursing services? 235

d) Physician overview? 236

e) Social services? 237

f) Counselling? 238

g) Nutrition services? 239

13.2 Does your hospital provide care such as:  
 a) Emergency respite care for families with special health care needs? 240 **Yes**  **No**

b) Planned respite care for families with special health care needs? 241

c) Hospice care for paediatric patients? 242

d) Provide or have access to recreational/educational camps for children with special health care needs? 243

13.3 Does your hospital provide some mechanism for parent-to-parent support? 244 **Yes**  **No**

If yes, please specify.....  
 .....  
 ..... 245-7 \_\_\_\_\_

13.4 Does your hospital have: **Yes**  **No**   
 a) A paediatric patient support group? 248    
 b) A sibling support group? 249

**14. GENERAL DATA**

If you can easily obtain data for the following two questions your help in answering them would be appreciated.

14.1 What is the approximate length of stay for paediatric patients in your hospital? 250 \_\_\_\_\_

14.2 Approximately what percentage of your paediatric admissions are scheduled admissions? 251 \_\_\_\_\_ %



Hospital Name: (OPTIONAL) \_\_\_\_\_

**Thank you for your time in completing this survey.**

If you would be interested in receiving any of the following information or services please do not hesitate to contact us or indicate below:

- Access to the AWCH Library to gain printed information and/or view audio-visual materials. The library is a 'special collection' library within the University of Western Sydney library network. It collects in three main subject fields:
  - i) the non-medical needs of children and adolescents (and their families) in hospital and health care,
  - ii) handicapped children and adolescents and
  - iii) general child development
  
- Assistance in formulating psychosocial related policies or programs relating to children in hospital e.g. those relating to unaccompanied children, play programs, pre-admission programs, preparation for medical procedures.
  
- A guest speaker from AWCH to attend a staff in-service meeting to address a range of issues relating to psychosocial paediatric issues.
  
- Copies of the following AWCH publications
  - Film/video catalogue
  - Your child in hospital pamphlets for parents (available in 11 languages)
  - Health care policy information
  - Copy of survey report.
  - Bibliographies on specific subjects: e.g. Intensive care units, anaesthesia and anaesthetics, grief and bereavement, preparation for hospitalisation, play in hospital, child abuse. All items in the bibliographies are available photocopied.

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