

Sections 3, 4 and 5 Accommodation Facilities for Families, Childcare and Visiting Hours

Forty years ago, it was common for a child's stay in hospital to extend for periods of weeks to months, and for them to see their parents infrequently during this time. Due to their 'sanitarium' nature, such hospital facilities were often situated in the country, long distances from home. The child's contact with their family ranged from drop off and pick up contact only, to occasional short visits 'tolerated' by hospital staff. Parents were generally viewed as unwelcome visitors who upset their child and disrupted the hospital routine (Blair, 1995). Quiet and resigned children were thought to be happier and in less pain, and thus the ideal model for the care of children in hospital. Visitors were seen as a potential source of infection to already sick children, and were often actively discouraged (Connell & Bradley, 2000). Parents were not encouraged to participate in any aspect of their child's care, and information was limited to narrow facts about procedures and discharge.

Children are entitled to the care and support of their parents at all times, especially during periods of ill health or injury. Several government recommendations support the principles of unrestricted access, overnight accommodation and adequate facilities for parents; and research has indicated the harmful effects of parental separation (e.g. Great Britain Ministry of Health, Central Health Services Council, 1959). However, there is also some evidence of long-term effects in children who are subjected to repeated hospital admissions of more than one week's duration early in life, with the findings consistently showing that children should be visited frequently in hospital (Connell & Bradley, 2000).

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

Parents are generally the best source of emotional support and comfort for their children. The continuous presence of a parent (for at least the first four days of a child being in hospital) 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). Parental presence can promote continuity in a child's life, and minimise the trauma caused by hospital admission. Despite evidence supporting the beneficial nature of parental presence, there remains some ambiguity regarding the division of roles and responsibilities of parents and nurses, with parents wishing to do more and nurses unwilling to give up their duties to parents (Taylor, 1996). Further guidance on how to be a 'parent-in-the-ward' would be useful.

The presence of a parent is extremely reassuring for a child, and can provide an element of normality (Blair, 1995). A child's need for their parents may be even greater at night, as many children may never have slept away from home prior to hospitalisation. More recently, there has been a considerable increase in the numbers of parents staying overnight (Audit Commission, 1993; Connell & Bradley, 2000), and many parents are not only encouraged and supported to stay with their child throughout the entire hospital experience, but may also be viewed by themselves and staff as partners in their child's care. The admission of parents to the wards has reduced the traumatisation of hospital admission for children (Blair, 1995).

Despite this increase in encouragement and demand, there remain serious deficiencies in the provision of accommodation and facilities for parents who wish to stay on the ward for any length of time. Hospitals have a variety of ways of providing accommodation for families, both on and off the ward, with some families preferring a bed or chair next to the child, and others preferring accommodation away from the ward (Blair, 1995). Parents need to have facilities where they can wash, shower, prepare or heat food, grieve and have private space (Audit Commission, 1993). Further requisite amenities include access to a telephone/internet, storage for personal effects and access to laundry areas. Facilities should be provided at a minimum cost or free of charge (Blair, 1995). As parents and carers are essential to the child's well-being whilst in hospital, there should be no charge for their accommodation (Blair, 1995). Charges for other services can be subsidised. A parent liaison officer can assist with informing parents of the availability of facilities.

Hospitalisation affects not only the child but the entire family, and therefore the needs of all family members must be considered. Having an ill sibling is a potentially stressful event for healthy children. They face frequent separations from one or both parents as well as from the sick child, and disruption in their daily routines (Eiser, 1993). It is natural for parents to be emotionally preoccupied and physically busy with the sick child. When a child is admitted to hospital, parents are still responsible for providing care and support to that child's siblings (Kleiber, Montgomery & Craft-Rosenberg, 1995). Studies of the siblings of children with chronic illnesses have shown that providing information is a key component of support (Brett & Davies, 1988). It is important to intervene to ameliorate adverse responses in siblings, and to enhance positive responses such as increased maturity, compassion and sensitivity (Kleiber, Montgomery & Craft-Rosenberg, 1995).

As we have seen, sibling impact can include separation from parents, separation from the ill child and an upset in the healthy siblings' routine (Kleiber et al., 1995). Healthy family members may also show signs of stress, somatisation and negative behavioural responses (Kleiber et al., 1995). Siblings must not feel excluded. They will have to work hard to maintain their parent's attention (Eiser, 1993). Parents often need help with additional caretaking tasks, including the routine care of healthy siblings (Eiser, 1993).

Siblings and other family members are often of great significance to hospitalised children, and should have 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 are often themselves emotionally affected by the situation (Consolvo, 1986). Accommodation for siblings means that family life will be less disrupted. Providing childcare for siblings means that the siblings' needs can still be met while the parent is giving comfort and care to their hospitalised child.

Notwithstanding these considerations, it is often not appropriate to keep siblings on the ward for extended periods of time. They need to be taken care of 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, hospital policies should enhance family ties and promote the philosophy that children 'belong' with their parents. Parents are increasingly considered to be important members of the health care team rather than simply 'visitors'. Hospitals should, therefore, inform parents clearly in writing about hospital policies and parent facilities, and make them feel welcome, accepted and as comfortable as possible (Consolvo, 1986). Relying simply on verbal communication about visiting policies and overnight arrangements is often not effective (Flint & Walsh, 1988). These arrangements should be clearly explained in the admission letter or hospital brochure, as well as on a well-positioned sign on the ward.

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

Some of the hospitals' objections to open visiting are due to a fear of an increased workload for staff. However, unrestricted visiting can reduce nursing staff's workload slightly, rather than increasing it, by relieving them of some duties. Mothers prefer to be more involved in their child's care than nursing staff realise (Brown & Ritchie, 1990).

Survey results

Almost every hospital can accommodate at least one parent in the same room as their child (98.4%), with the majority offering a fixed or folding bed beside the child's bed (92.8%). Other options include a chair or recliner chair next to the child, or accommodation in the nurses' quarters or parent accommodation (flat) near the hospital.

Over three-quarters of hospitals can accommodate ALL parents who ask to stay with or near their child overnight, however 29.5% of city hospitals and 19.4% of country hospitals do not have the capacity to do so. In 94.9% of cases, parents are notified of the availability of overnight accommodation, with 32.3% being advised in writing and 91.3% being advised verbally.

Charges for parents staying overnight vary greatly, from \$nil to \$70 per night. The majority of surveyed hospitals reported no cost for an overnight stay at the hospital, although parents are frequently asked to pay for most or all of their meals, use of laundry facilities and other services.

Medicare still does not cover parent accommodation charges; however, some private health funds do cover this item, e.g. HCF will pay up to \$75 per day towards the charge for a hospital boarder who is a relative of the patient being treated in hospital. There is a maximum of 10 days per membership per year.

Comparison Table

Meal arrangements for live-in parents	1992	2004	Difference	% change
Kiosk	52.6	47	-5.6	-10.65
Meal tickets	42.7	28.2	-14.5	-33.96
Food prep areas	19.4	41	21.6	111.34
Ward food	49.8	66.5	16.7	33.53
Staff cafe	43.1	22.6	-20.5	-47.56

Availability of facilities for live-in parents

Almost all parents have access to a toilet and hand basin (96.4%), and 86.8% have access to showering facilities. Seventy one percent of hospitals have a lounge area for parents near the ward, 68.2% have a private space for parents to grieve or talk with staff, 86.7% have access to a public telephone, facilities for making tea or coffee (89.2%), and 34.4% have access to facilities to wash and dry personal laundry.

Meal arrangements for live-in parents differ between hospitals, with some offering ward food and others giving parents access to the staff cafe (see the comparison table above). Fewer facilities are available for visiting parents.

Child-minding for siblings

Only a very small proportion of hospitals offer child-minding facilities for siblings of patients.

The survey did not ask if this assistance was negotiable, and it may be that many hospitals have unofficial sibling-minding facilities. Of those facilities who do offer sibling child-minding, 57% are able to cater for children with disabilities, 33% employ trained, child-minding professionals and 33% use volunteers only.

No data was available from the 1992 survey on this topic.

Child-minding for siblings	Availability %
Sibling child-minding	4.2
Not available	93.8
Negotiable	2.1
Children with disabilities are catered for in available child minding facilities	57
Trained professionals employed in the facility	33
Volunteers work in the facility	33

Visiting hours

Most hospitals (95.3%) have a 24-hour visiting policy for parents of paediatric patients. This policy is communicated in writing in 40.9% of cases, verbally in 93.5% of cases and with a sign in the ward area in 20.4% of instances. Hospitals that do not have a 24-hour visiting policy (4.7%) generally have flexible visiting hours and/or may restrict visiting hours for security reasons.

Sibling visiting

An open, unrestricted visiting policy for siblings of patients applies in 43.5% of hospitals, and a restricted policy (e.g. outside of rest times) applies to 56.5%.

Comparison table

Visiting for parents	1992	2004	Difference	% change
24-hour policy	92.9	95.3	2.4	2.58
Advised in writing	35.7	40.9	5.2	14.57
Sign in ward area	29.4	20.4	-9	-30.61
Communicated verbally	47.7	93.5	45.8	96.02
Not 24-hour policy	7.1	4.7	-2.4	-33.80

Visiting for siblings	1992	2004	Difference	% change
Unrestricted visiting hours	40.3	41.1	0.8	1.99
Restricted visiting hours	59.7	57	-2.7	-4.52

Section 3, 4 and 5 Recommendations

- Adequate parent or family accommodation must be available at a minimal cost
- Medicare should provide a rebate on the cost of any accommodation charged by a hospital
- Parents should be provided with meals or meal tickets or low cost meals
- Better strategies should be developed for managing sibling care
- Visiting hours for siblings should be brought into line with parental visiting hours.



Accommodation should be offered to all parents and they should be helped and encouraged to stay. Parents should not need to incur additional costs or suffer loss of income. In order to share in the care of their child, parents should be kept informed about ward routine and their active participation encouraged.

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