A COLLECTION OF ESSAYS ON CHILDREN'S HEALTHCARE

student pack

Action for Sick Children

National Association for the Welfare of Children in Hospital Limited

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Action for Sick Children

Charity history

Action for Sick Children was founded in 1961 under the name of Mother Care for Children in Hospital, by Jane Thomas, a young London mother who had been impressed by the first television showing of James Robertson's films 'A Two Year Old Goes to Hospital' (1953) and 'Going to Hospital with Mother' (1958). Robertson, a psychotherapist, who had worked under psychoanalyst, John Bowlby, had produced the films to demonstrate the levels of distress and anxiety experienced by children in hospital when separated from their mother. At the time, parents were actively discouraged from staying with their child because it was felt their presence was disruptive. Even visiting hours were very restricted.

In 1959 the Platt Report, 'The Welfare of Children in Hospital', outlined recommendations on the non-medical aspects of care for hospitalised children. It recognised the emotional needs of children and the importance of parental involvement in preparation. Jane Thomas wrote to James Robertson seeking advice on persuading hospitals to implement the report's proposals. He suggested the formation of a parents group and advised her to become well informed on key issues. Regional groups were established and in 1963 the groups joined together to form one national organisation. In 1965 the group changed its name to the National Association for the Welfare of Children in Hospital (NAWCH). From its early days it was a multi-disciplinary organisation of parents and health professionals which sought to persuade hospitals to adopt the Platt Report proposals on unrestricted visiting and parental access. Although adopted as official Ministry of Health policy, hospitals were not legally obliged to implement the report.

Since the 1960s the organisation has campaigned , with considerable success, for child and family centred care. Using its own surveys, the first conducted in 1962, NAWCH was able to dispute government figures on unrestricted visiting to children's wards. The campaign for open visiting which began in the 1960s drew to a close in 1986 when the association considered the battle won. However, overnight accommodation and facilities for parents remains patchy and the organisation continues to campaign for improvements.

By 1963, NAWCH had become a national organisation with 31 member groups. It held its first national conference and was gaining public recognition as an organisation offering support and advice to parents. In 1967 it launched its leaflet 'Coming into Hospital' which gives parents guidance on preparing themselves and their children for hospital admission. By the 1970s, NAWCH members were being appointed to regional hospital boards, districts health authorities and community health councils. An increasing number of health professionals joined the association.

In 1984 NAWCH published its Charter for Children (Appendix 1) which received widespread approval. It was used as the basis for the European Charter for Children in Hospital and signalled the association's move into the area of standard setting. The principles of the Charter were expanded into NAWCH's first quality review 'Setting Standards for Children in Health Care'. This was updated in 1996 as 'Health Services for Children and Young People: A Guide for Commissioners and Providers', which has been used by many hospitals and health authorities as a benchmark of high quality children's health services. The Quality Review Series has established standards for surgery (1994), adolescents in hospital (1990), health care for ethnic minority children (1993), children's mental health services (1992) and, most recently, emergency health services (1997).

In 1991 NAWCH changed its name to Action for Sick Children to reflect the trend towards community health care and shorter hospital stays. In 1996 Action for Sick Children was invited to give evidence to the House of Commons select committee on children's health and was also involved in the consultation process for 'The Patient's Charter: Services for Children and Young People'. The charity continues to undertake research into the state of children's services and to provide parents with the information necessary to make informed choices.

Charity profile

Action for Sick Children is a registered charity. While its head office focuses on national issues, its nationwide branches work to improve local child health services. The charity is governed by a Board of Trustees and is funded by donations, publications sales and grants from the Department of Health and charitable trusts. The library and information service provides a unique resource on child health care for parents, health professionals and students. A range of information leaflets is available for parents. A national parent adviser provides information, support and advice to parents with a sick child.

Children are the most vulnerable members of our society and sick or injured children are in the greatest need of our help and protection. Every year over one million children receive treatment in Britain's hospitals. More than half of these children are under five years of age. A further three million attend hospitals for accident and emergency treatment. Separation from family and friends and the disruption of their lives only adds to their distress. Adults, however well prepared, are apprehensive at the thought of a stay in hospital - to a small child the prospect and reality can be terrifying.

The charity continues to influence key policy makers and government to make children's health a priority. Many calls are still received from parents seeking information and advice on best treatments and appropriate care or background information on their child's illness or disease. Services still exist where children are receiving inappropriate care and parents experience a lack of support and control in the most distressing situations.

As long as there are sick children, there will be problems for parents and professionals - both social and financial. Children's wards are closing due to insufficient staffing levels and parents are expected to nurse children at home without the necessary support and information. Children continue to be nursed on adult wards in some areas. We still have a long way to go before all children receive the care and attention they deserve.

Campaigning Milestones

1961	Mother Care of Children in Hospital established
1962	First visiting survey reveals widespread disparities and very limited access for parents Advice service to help families stay with a child in hospital is set up
1963	31 member groups formed into one national organisation. First national conference held.
1965	Changes name to National Association for the Welfare of Children in Hospital (NAWCH)
1967	Publishes 'Coming into Hospital' leaflet. The booklet continues to be in demand.
1973	NAWCH publishes its national 'Survey of Visiting Arrangements, Accommodation and Play Provision' and reports inadequacies to Regional Hospital Boards
1974	NAWCH members appointed to newly constituted Health Authorities and elected to more than fifty Community Health Councils
1983	NAWCH 'Survey of Hospital Facilities for Parents' highlights continued restriction on visiting, especially on operation day, and the lack of parental accommodation
1985	NAWCH Charter published and endorsed by many organisations concerned with the care of sick children. It is used as the basis for the European Charter for Children in Hospital.
1986	NAWCH visiting hours campaign considered to be effectively won, with most hospitals allowing open access to sick children by parents, carers and the wider family
1989	NAWCH publishes 'Setting Standards for Children in Health Care', the first in a series of Quality Reviews.
1990	NAWCH publishes 'Setting Standards for Adolescents in Hospital'
1991	NAWCH launches the Action for Sick Children campaign to promote quality health care for sick children at home and in hospital. The change of name to Action for Sick Children reflects the growing number of children being nursed at home.
1992	ASC publishes 'With Health in Mind' based on the work of a multi-disciplinary working group set up to review the range and quality of services required. 'Children and Pain' booklet also published.
1993	Launches the Too Dear to Visit campaign in conjunction with Contact a Family, to establish a fund for hospital visiting costs ASC publishes 'Health for all our Children', a guide to the provision of appropriate healthcare for black and ethnic minority children; 'When your Child is Sick' - an advice booklet about the NHS and hospital care; 'Teenagers in Hospital' - a booklet answering common queries and worries about hospital stays.
1994	ASC publishes 'Setting Standards for Children undergoing Surgery'and 'Needles - Helping to take away the fear'
1995	ASC is invited to comment on the Department of Health's proposed Children's Charter.
1996	ASC publishes 'Health Services for Children and Young People - A Guide for Commissioners and Providers'. This replaces 'Setting Standards for Children in Health Care'. ASC is invited to give evidence to the House of Commons Health Select Committee on the care of sick children in hospital and in the community.
1997	ASC publishes 'Emergency Health Services for Children and Young People', the most recent report in its highly acclaimed Quality Review series.

CHAPTER ONE

Care of Children in Hospital

In 1948 James Robertson, a young psychoanalyst, visited a short stay children's ward at the Central Middlesex Hospital to observe a group of young children separated from their mothers. Having been told that this was a happy children's ward, Robertson soon became aware of the deep distress displayed by the very young children on the ward. Although very evident to Robertson, the degree of unhappiness was apparently unnoticed by the busy medical staff. Behavioural patterns displayed by the children were considered normal in this situation. Emotional involvement between nursing staff and patients was discouraged. As a result of his experiences, James Robertson made two documentary films - 'A Two Year Old Goes to Hospital' and 'Going to Hospital with Mother' which did much to change the prevailing attitudes towards hospitalised children.

THE WELFARE OF CHILDREN IN HOSPITAL (THE PLATT REPORT) 1959

In 1956 the Department of Health set up a committee to examine arrangements made for the emotional welfare of sick children in hospital as distinct from their medical care. This was in response to growing concern about the care of children in hospital. The subsequent report, known as the Platt Report, acknowledged the emotional and psychological needs of children and the supportive role of parents in hospital. It made a total of 55 recommendations, the most important of which were:-

1. Children should only be admitted to hospital when absolutely necessary
2. Children and adolescents should not be nursed on adult wards
3. A paediatrician should have a general concern with the care of all children in hospital
4. Mothers should be admitted with children, especially with the under-fives
5. A child in hospital should be visited frequently to preserve the link with home and to provide continuity
6. Parents should be allowed open access and should be encouraged to help with the care of their child
7. Medical training should include greater awareness of the emotional and social needs of children and their families

ACTION FOR SICK CHILDREN - THE BEGINNINGS

(See Charity history for early beginnings)

This new pressure group realised it had to persuade the medical profession that the new approaches to child-centred care were worthwhile and that parents had an important role in the care of their child in hospital. In 1962, the group, now called the National Association for the Welfare of Children in Hospital (NAWCH), undertook a postal survey of parental visiting in hospitals in the south east of England. Its results showed that very few hospitals welcomed parents throughout the day, some only allowed a half hourly visit daily. Other hospitals claimed to have unrestricted visiting hours while failing to acknowledge the negative pressure put on parents not to visit at certain times of the day. In general, visiting on operation day was still strongly discouraged. Parent accommodation was very rare. Written information prior to admission was offered by only a few hospitals.

HOSPITAL VISITING

In 1966 Hospital Memorandum (66) 18 declared that fixed visiting hours were to be abandoned. A decision to advise a parent not to visit a child at any particular time could only be made by the consultant in charge. A NAWCH survey in the 1980s found that three quarters of wards could offer some accommodation for parents and almost half had restricted visiting 24 hours a day. However, the 1993 Audit Commission report, 'Children First', was still critical of provision made for parent accommodation and family centred care. In 1986 NAWCH launched a campaign focusing on visiting hours. Consequently, the majority of hospitals do now allow open access to sick children by parents and family members.

STANDARDS

In 1985 NAWCH launched its Charter for Children in Hospital which identified ten minimum standards for the care of children in hospital (see appendix 1). It was endorsed by the Department of Health, the British Medical Association, the British Paediatric Association, the National Association of Health Authorities and the Royal College of Nursing. Health Authorities have used the Charter as a basis for their children's services specifications. The Charter was later adopted as the basis for the European Charter for Children in Hospital. The quality review 'Setting Standards for Children in Health Care' , published in 1989, was based on the principles incorporated in the Charter and has been used widely in the planning and monitoring of children's services at health authority level. In 1996 it was updated as 'Health Services for Children and Young People: A guide for commissioners and providers'. The organisation has now published a range of quality reviews on hospital play, adolescent services, mental health care, services for ethnic minority children and accident and emergency services which list high quality standards by which health authorities can plan and monitor their contract specifications.

The Department of Health published its own guidelines in 1991, 'The Welfare of Children and Young People in Hospital'. These assimilate the good practice guidance on child welfare issued by government departments, professional bodies and voluntary organisations including Action for Sick Children. The guide covers hospital services contracting, service delivery, meeting children's special needs and staffing and training. Parental involvement in the care of the child is a consistent theme. Although none of the recommendations are legally binding, its seven main principles have provided a framework for the provision of children's hospital services.

They are as follows:-

1 Children are admitted to hospital only if the care they require cannot be as well provided at home, in a day clinic or on a day basis in hospital

2 Children requiring admission to hospital are provided with a high standard of medical, nursing and therapeutic care to facilitate a speedy recovery and minimise complications and mortality

3 Families with children have easy access to hospital facilities for children without having to travel significantly further than to other similar amenities

4 Children are discharged from hospital as soon as socially and clinically appropriate and full support is provided for subsequent home or day care

5 Good child health care is shared with parents/carers and they are closely involved in the care of their children at all times, unless, exceptionally, this is not in the best interests of the child; accommodation is provided for them to remain with their children overnight

6 Accommodation, facilities and staffing are appropriate to the needs of children and adolescents and separate from those provided for adults; where possible separate accommodation is provided for adolescents

7 Children have a right for their privacy to be respected and to be treated with tact and understanding . They have an equal right to information appropriate to their age, understanding and specific circumstances.

Following on from this publication, the Audit Commission published 'Children First: A study of hospital services' in 1993. The report identified six main principles for the future development of child welfare in hospital-

1 Child and family-centred care

2 Specially skilled staff

3 Separate facilities for children

4 Effective treatments

5 Appropriate hospitalisation

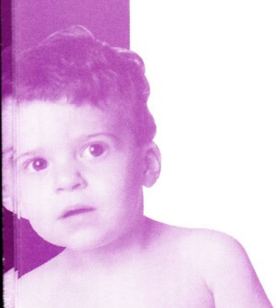
6 Strategic commissioning

THE CHILDREN'S CHARTER

The first Patient's Charter was published in 1991 and endorsed a growing trend towards consumerism within the health service. The Children's Charter, published in 1996, was the result of consultation with health care staff, professional bodies and consumer groups like Action for Sick Children. It makes a clear distinction between rights - which all patients will receive at all times - and expectations - levels of services which the NHS is aiming to achieve. Most recommendations are prefixed by 'you can expect'. Although children were involved in the consultation process, the booklet is aimed essentially at parents and carers of children and young people. In terms of hospital care, key recommendations are as follows:-

You can expect your child to

- be cared for in a children's ward under the supervision of a consultant paediatrician or paediatric specialist
- see the children's ward before being admitted
- be asked if they want to go to a children's or adult ward or any accommodation specially for adolescents
- be nursed by a named qualified children's nurse
- be offered full opportunities to play
- receive suitable education if in hospital for a long time



As a parent or carer you can expect to

- stay in the hospital and to be encouraged to take part in the care of your child
- accompany the child to the anaesthetic room and to be present until he goes to sleep
- be told what pain relief will be given
- be given appropriate information upon discharge

The charter also covers community health services.

FAMILY CENTRED CARE

The importance of care by parents was recognised as early as the 1940s when Sir James Spence admitted mothers with their babies to the Babies' Hospital, Newcastle-upon-Tyne, but hospitals have been slow to adopt the concept into everyday practice. The Court Report of 1976 asserted the need for a child and family centred service but acknowledged the lack of sufficient numbers of trained children's nurses as a barrier to further development. Although originating in the UK, the idea has been more eagerly implemented in North America. A parent has a unique understanding of his or her child and the strength of this contribution needs to be acknowledged by the nursing staff. However, it is important that nurses do not feel threatened by parents' relationships with their children and that parents do not feel intimidated by hospital staff. Many parents find the practical difficulties of parenting in public awkward. Failure to establish the appropriate atmosphere on a children's ward can lead to parents feeling uninvolved, disenfranchised and bored. Negotiating a care plan in conjunction with the family should make both parents and the child feel involved in his/her own care. It establishes the degree of involvement sought by parents. Not all families want to be fully involved in a treatment programme. Early discussion should lead to greater parental understanding of treatment and nursing staff familiarity with the wishes of both child and family.

Care by parents can cover a range of activities and degrees of involvement. At the simplest level, it means parental presence with the child but it is increasingly common for the parent to be actively involved in the daily care of the child and in the nursing process.

In 1987 the Association for the Care of Children's Health in the United States published 'Family-centred care for children with special health care needs' which identified the basic elements of family centred care as follows:-

1. Recognition that the family is the constant in the child's life
2. Parents and health professionals working together at all levels of health care
3. Recognition of family strengths and individuality and respect for different ways of coping
4. Continuous sharing of all information with parents about their child's care in an appropriate manner
5. Encouragement and facilitation of parent-to-parent support
6. Understanding and incorporating the developmental needs of patients and their families into health care delivery systems
7. Implementation of comprehensive and appropriate policies and provision of emotional and financial support to meet the needs of families
8. Health care delivery systems should be flexible, accessible and responsive to family needs

PARENTS IN THE ANAESTHETIC AND RECOVERY ROOM

The implementation of family centred care and parental involvement in this area has proved more problematic. In 1959 the Platt Report stated that :

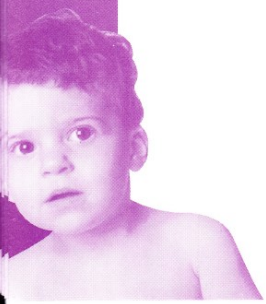
> "It may often be helpful if the mother is allowed to be present until the child goes to sleep"
>
> and
>
> "The mother may also be present when the child is coming round from the anaesthetic, provided that she is not present at to early a stage"

The Welfare of Children in Hospital (1959) (p.29)

Action for Sick Children recommends that a parent should be encouraged but not pressurised to stay with the child in the anaesthetic room. The Department of Health also states that parents should be able to be with their child at the 'most stressful times, e.g., during and after treatment, anaesthesia, investigations and X ray'. However, some anaesthetists remain concerned about parental presence in the anaesthetic room because of concerns about infection or the damaging effects of a highly stressed parent on the child. In most hospitals it is generally accepted that parents will be able to accompany their child to the anaesthetic room but it is less common for parents to be in the recovery room when their child awakes after surgery. Action for Sick Children recommends that parents are allowed in the recovery room where appropriate but acknowledges that space, safety and the presence of other critically ill patients may make this difficult.

RECENT DEVELOPMENTS

In March 1997 the House of Commons Select Committee on Health produced three reports arising from its enquiry into children's health. The committee endorsed the central principles of children's health care established in 'The Welfare of Children in Hospital' in 1991. However the report concluded that health services do not always consider the specific needs of children and are not sufficiently needs-led. It also stated that good practice guidance, while available, is not always fully implemented and that information necessary for the planning and provision of child-centred and cost-effective services is not always available. Service fragmentation has led to poorer services and, it is suggested, the Department of Health should establish a cost-effective mechanism for delivering co-ordinated care. Adolescent services, in particular, require much greater planning and priority.



BIBLIOGRAPHY

1. Action for Sick Children, Parents and Anaesthesia, NAWCH Update, No 27, Summer 1989, p2

2. Agnew T, Children First?, Nursing Times, vol 92, No 7, 14 February 1997, pp22-23

3. Audit Commission, Children First, HMSO, 1993

4. Baker S, Family Centred Care: A theory practice dilemma, Paediatric Nursing, Vol 7, No 6, July 1997, pp17-20

5. Belson P, And Mother Came Too, The Tablet, 23/30 December 1989, pp1492-1494

6. Belson P, Children in Hospital, Children in Society, 7:2, 1993, pp196-210

7. Blair K, Facilities for parents, Paediatric Nursing, Vol 7, No 4, May 1995, pp18-21

8. Brown V, Parents in Recovery: Parental and staff attitudes, Paediatric Nursing, Vol 7, No 7, September 1995, pp17-19

9. Campbell S et al, Keeping it in the Family, Child Health, June/July 1993, pp17-20

10. Campbell S et al, Putting the Family First, Child Health, August/September 1993, pp59-63

11. Darbyshire P, Living with a Sick Child in Hospital: The experiences of parents and nurses, Chapman & Hall, 1994

12. Date J, Glad Tidings for Lonely Children, The Health Service Journal, 18/25 December 1986, pp1636-1637

13. Dearmun A, Perceptions of parental participation, Paediatric Nursing, Vol 4, No 7, September 1992, pp6-9

14. Department of Health, The Patient's Charter: Services for Children and Young People London, 1996

15. Department of Health, The Welfare of Children and Young People in Hospital, 1991

16. DHSS, Fit for the Future. The Court Report, HMSO, 1976

17. DHSS, The Welfare of Children in Hospital: The Platt Report, 1959

18. Evans M, Extending the Parental Role: Involving parents in paediatric care, Professional Nurse, September 1992, pp774-776

19. Fradd E, It's Child's Play, Nursing Times, 8 October 1986, pp40-42

20. Fradd E, The Importance of Negotiating a Care Plan, Paediatric Nursing, Vol. 8, No. 6, July 1996, pp6-9

21. Glasper A, Parents in the Anaesthetic Room: A Blessing or a Curse?, Professional Nurse, Vol 3, No 4, January 1988, pp112-115

22. House of Commons Health Committee, Health Services for Children and Young People in the Community , Home and School, The Stationery Office, 1997

23. House of Commons Health Committee, Hospital Services for Children and Young People, The Stationery Office, 1997

24. Hogg C, Health Services for Children and Young People, Action for Sick Children, 1996

25. Johnson B, The Changing Role of Families in Health Care, Children's Health Care, Vol. 19, No 4, Fall 1990, pp234-241

26. Knight L, Negotiating Care Roles, Nursing Times, Vol 91, No 27, 5 July 1995, pp31-33

27. Lansdown R, Children in Hospital: A guide for family and carers, Oxford University Press, 1996

28. Leenders F, An Overview of Policies Guiding Health Care for Children, Nursing Standard, Vol 10, no 28, 3 April 1996, pp33-38

29. NAWCH, The NAWCH Charter, 1984

30. Shaw M, Paediatric Care: Then and now, Nursing Standard, Vol 3, No 47, 19 August 1997, pp35-37

31. Sherwood P, Why Can't Mummy Stay Until I'm Asleep?, Paediatric Nursing, April 1990, pp18-19

32. Spence J C, The Care of Children in Hospital, British Medical Journal, 25 January 1947, pp125-130

33. The Care of Young Children: Implications of Recent Research, University of London Institute of Education, 1986

CHAPTER TWO

The Effects of Hospitalisation

THEORIES OF ATTACHMENT AND SEPARATION

The need of infants to attach themselves to adults was initially thought to arise solely from their nutritional needs. Dr John Bowlby of the Tavistock Clinic in Hampstead, London, identified a more complex process by which the infant displayed a need for physical closeness and comfort beyond the basic search for food. By identifying attachment theory in terms of security, Bowlby greatly influenced the way in which parental bonding is regarded.

Attachment behaviours are apparent from birth in the form of crying, smiling and grasping but the attachment system must be developed. This developmental period has been divided into four phases:-

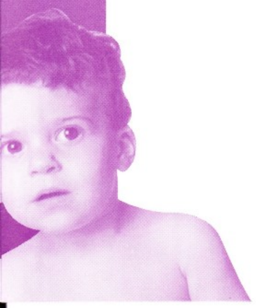
- up to three months, the baby appears indiscriminate in relationships with adults. Disturbances are based on alteration to routine, although a baby can recognise the mother at this stage.
- from three months, the baby will respond specifically to mother's voice and will probably cry when she leaves. Between 6-12 months the baby will develop some anxiety about strangers. The ability to crawl will allow him to move purposefully towards the mother.
- Interactions become more highly developed as language and social awareness develop.

Since Bowlby first developed his theories, certain aspects have been modified:-

- the critical first two year period as the key to attachment forming is now considered too narrow
- the idea that infants make one special relationship of prime importance is no longer considered valid. Infants are more likely to form a bond with a small group of adults although a hierarchy within will establish itself.
- while early relationships do affect social development they are not exclusively important. Later relationships will also have an impact.

MEASURING ATTACHMENT

The most widely used method of assessment is the 'strange situation' test devised by M Ainsworth and colleagues (1). Infant responses to separation from the mother are measured at the time of reunion according to three main classifications: security attached, insecure-avoidant and insecure-ambivalent/resistant. Although widely used, it focuses on one type of attachment only and fails to consider variant cultural and family rearing patterns.



JOHN BOWLBY AND JAMES ROBERTSON

The work of psychoanalyst, Dr John Bowlby, has been instrumental in the understanding of the emotional and psychological effects of hospitalisation on young children. In 1944 he conducted a study on juvenile delinquency entitled `Forty-four Juvenile Thieves' which concluded that separation from their mothers in childhood had been a key factor in the later delinquency of the children. As an extension of this work, Bowlby developed his theory of emotional attachment which stated that children needed to bond with a loving mother in early infancy and failure to do so resulted in unsatisfactory emotional development and an inability to form loving relationships in later life. He later revised his theory to allow for emotional attachment to another adult such as the father or a nanny.

The theory was hotly disputed and debated by other analysts. In order to support the theory with first-hand observations, Bowlby employed James Robertson, a young psychoanalyst, to observe the behaviour of young children during and after separation from their mothers. Robertson chose a short stay children's ward to undertake his initial observations.

Robertson became particularly shocked by the situation of the very youngest children, those under five years old. Although their distress was obvious to him, it seemed that the nurses were much more concerned with the children's physical and medical needs than with their emotional state. Nurses were discouraged from engaging children in any kind of emotional relationship, preferring a state of mute misery to any outward display of emotion, positive or negative.

The youngest children did not understand why they were in hospital nor why there parents had apparently abandoned them. It was considered normal for children to cry at first but to become used to the situation in time and then to 'settle down'. Visits by parents were thought to upset the child because the child was likely to begin crying again when the parent had to leave and so were actively discouraged. It was quite common for a child to see his mother for a couple of hours once a week. Distress was commonplace and was therefore considered to be no cause for concern.

BEHAVIOURAL STAGES

Following further observations in long-stay wards, Robertson identified three phases of response to parental separation in the under-threes in hospital. These were:-

Protest The initial stage of confusion, fear and upset

Despair While recognising a need for his mother, the child becomes less active and more withdrawn as he realises the hopelessness of his situation

Denial (later called detachment)
The child may appear outwardly contented with his surroundings because he has repressed his longing for his mother as a result of being unable to tolerate his feelings of distress. He also regards his mother as failing to meet his needs

To the nursing staff during the 1940s, the Denial stage was interpreted as evidence that the child had settled in and was no longer unhappy.

When Robertson tried to talk to nursing staff abut his observations and about the emotional problems experienced by children upon discharge from hospital, he was told that difficult behaviour at home indicated that mothers were less competent in behavioural management than nursing staff. After all, the child had appeared contented and submissive in hospital. Although supported by colleagues,

Robertson took it upon himself to humanise the face of paediatrics and to inform the paediatric profession of the extent of the problem. He decided the best way forward was to compile a filmed record of a young child throughout a short hospital stay, presenting the stages of behaviour in a way that paediatric staff would not normally notice amid the preoccupations of daily routine. The resulting film 'A Two Year Old Goes to Hospital' (1953) was a milestone in the understanding of the emotional effects of hospitalisation and led to changes in attitude in both the professional and public arena. A second film 'Going to Hospital with Mother' (1958) showed the benefits of the mother's presence in lessening both the child's and the parent's distress. It also showed that parental presence in the ward was manageable for the nursing staff.

EMOTIONAL EFFECTS

In general, a pre-school child is likely to be more adversely affected by a period of hospitalisation than a school-age child if a period of separation from the mother is inevitable. However, providing the parent is able to accompany the child throughout the hospital stay, any upset should be minimal. The older child is used to periods of separation from his parents and is able to analyse his situation and the reasons for it. A school-age child has greater communication skills and is able to verbalise his concerns to a much greater degree. The child under five is less capable of rationalising his experience and has less awareness of time. He is much more likely to be adversely affected by separation from his parents and home environment and to feel more threatened by unfamiliar faces and places. Levels of emotional disturbance will be influenced by immaturity, poor verbal skills, previous experience of separation and disturbance in the home background. This last factor can include not only aspects of social deprivation but less obviously disturbing aspects such as the arrival of a new sibling or moving house. Operations on certain parts of the body such as the eyes, mouth, genitals or anal region also tend to heighten anxiety.

COPING WITH STRESS

Being able to deal with the stress of hospitalisation can strengthen a child's emotional development if it is dealt with correctly. However, a very young child does not always have the coping mechanisms in place to deal with an unusual situation. A good outcome can be judged largely by the reaction of the child following discharge from hospital. Ideally, the child should not show any signs of regression such as loss of bladder control. Emotional development should continue as before. There should be no hypochondriacal symptoms or sleep disturbance. The child should be able to deal with common accidents without showing signs of undue anxiety or behavioural regression. Signs of a distressing hospital stay may manifest themselves in the following:- loss of bladder or bowel control, regressive behaviour, panic attacks, specific phobias, temper tantrums and a heightened fear of being separated from his mother.

EFFECTS ON THE FAMILY

Parents and carers may also experience stress or anxiety. Strong feelings of disempowerment as the decision-making process moves away from them can lead to feelings of guilt and loss of confidence. Such feelings may make parents less capable of giving their child the necessary support. Their anxieties may be picked up by the child, making the child more frightened. In addition to their concerns for the sick child, parents will often have to cope with the practicalities of caring for the rest of the family while spending a considerable amount of time away from home. There may also be additional worries about the impact of hospitalisation on the family's financial situation.

Some parents who stay with their children throughout the hospital stay find the intensity of the relationship overpowering. They are used to the care of the child being interrupted by daily chores, routine and other siblings' needs. They may also find living in hospital boring and may find caring for their child in this public environment difficult and uncomfortable. It is important for nursing staff to help parents define their role in the care of their child.

FAMILY CENTRED CARE AND PREPARATION

There is considerable evidence to show that the continued presence of the parent in hospital is a significant factor in the reduction of emotional stress.

'Hospitals that have tried admitting mothers with their children claim that the young child shows less emotional disturbance on his return home, that the experience is beneficial to nurses and mothers and creates a happy atmosphere in the ward....'

The Welfare of Children in Hospital (1959). p.17

The gradual move toward family centred care in which parental presence and an active parental role is encouraged, has made the hospital environment less intimidating. A positive approach by the child is made easier when the child experiences full support from parents. From the parents' perspective, it is easier to provide support when well-informed about procedure, treatment and outcome. An active coping role in which information is sought and fear is recognised, leads to greater co-operation with staff and reduced levels of disturbance following discharge.

BIBLIOGRAPHY

1. Anon, Effects of Hospitalisation, Pediatric Mental Health, Vol 13, No 4, July/Aug 1994, pp1-2
2. Barker P, Psychological Effects on Children of Admission to Hospital, Hospital Update, January 1975, pp27-31
3. Bossert E, Stress Appraisals of Hospitalised School-age Children, Children's Health Care, 23 (1), 1994, pp33-49
4. Bowlby J, A Secure Base: Clinical applications of attachment theory, Routledge, 1989
5. Darbyshire P, Living with a Sick Child in Hospital: The experiences of parents and nurses, Chapman Hall, 1994
6. Elfer P, Attachment Theory and day care for young children, Highlight No 155, National Children's Bureau, June 1997
7. Hall D and Stacey M, Beyond Separation, Routledge and Kegan Paul, 1979
8. Hart D et al, Self-reported fears of hospitalised school-age children, Journal of Pediatric Nursing, Vol 9, No 2, April 1994, pp83-90
9. Inglis R, Attached to an idea (Profile of John Bowlby), Nursery World, 10 October 1996, pp10
10. King J et al, The Effects of Hospitalisation on children's behaviour: a review of the literature, Children's Health Care, Summer 1981, 10 (1), pp20-28
11. Leverton T, Attachment Theory and its Implications for Pediatricians, Current Opinion in Pediatrics, 3, 1991, pp624-629
12. MacCarthy D, The Under Fives in Hospital, Action for Sick Children, 1979
13. Robertson J, Young Children in Hospital, Tavistock, 2nd ed , 1970
14. Robertson J and J, Separation and the Very Young, Free Association Books, 1989
15. Sheldon L, Hospitalising Children: a review of the effects, Nursing Standard, Vol 12, No 1, 24 September 1997, pp44-47
16. Strachan R, Emotional Responses to Paediatric Hospitalisation, Nursing Times, Vol 89, No 46, 17 November 1993, pp45-49
17. Sylva K et al, Commissioned Review: Effects of hospitalisation on young children, Association for Child Psychology and Psychiatry Newsletter, Vol 12, No 1, Jan 1990, pp3-8
18. Thompson M, Information-seeking, Coping and Anxiety in School-age Children Anticipating Surgery, Children's Health Care, 23, (2), 1994, pp87-97
19. Tizzard B, The Care of Young Children: Implications of recent research, University of London Institute of Education, 1986
20. Wallace M, Temperament and the Hospitalised Child, Journal of Pediatric Nursing, Vol 10, No 3, June 1995, pp173-180
21. Willcox E, Reactive Attachment Disorder in Children, Paediatric Nursing, Vol 7, No 6, July 1995, pp14-16
22. Woodward J, Has Your Child Been In Hospital?, NAWCH, 1978

REFERENCES

(1) Ainsworth MDU et al, Individual differences in strange situation behaviour of one year olds in Schaffer J R (ed), The Origins of Human Social Relations, Academic Press, 1971

CHAPTER THREE

Play

Play is recognised as an essential aspect of child development. It enables the child to explore his surroundings, to make sense of his environment and to practise his social, intellectual and emotional skills. Through play, the child can express emotions which he may otherwise find difficult to verbalise. Play offers the child and arena in which he can exercise control and a degree of freedom.

The right of the child to play is included in Article 31 of the UN Convention on the Rights of the Child:

'Every child has the right to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts'.

The Children Act 1989 also recognises the role of play:

'Children's need for good quality play opportunities changes as they grow up, but they need such opportunities throughout childhood in order to reach and maintain their optimum development and well-being'

The Children's Play Council defines play as:

'a generic term for a variety of activities which are satisfying to the child, creative for the child and freely chosen by the child. The activities may involve equipment or they may not, be boisterous and energetic or quiet and contemplative, be done with other people or on one's own, have an end product or not, be light-hearted or very serious.'

STAGES OF PLAY

BABIES

The new born baby cannot focus his eyes properly and so stimulation is best achieved by sound and touch. It helps visual development if something bright or shiny is positioned nearby. By one month old a baby will be trying to grab hold of toys and nearby objects. He or she will learn about shapes and touch by putting things in his mouth. Lips and tongue are sensitive parts of the body and are ideal for exploration. Musical toys and mobiles are appropriate toys at this stage but even at this level, toys should be changed regularly to avoid boredom and to stretch the baby's imagination. From about six months babies will deliberately set out to make things happen by banging things together or putting one item inside another. The child is now ready for early educational toys which aim to stimulate aspects of development, e.g. pop up toys, stacking toys and posting toys.

TODDLERS

If the toddler is not already walking he will be crawling and moving independently within a confined environment. Push and ride-on toys will be particularly popular as will toys that respond to the child's movements. Pretend play begins to have an impact at this stage.

3-5 YEARS

The development of logic and the ability to concentrate for longer periods mean children of this age range can begin to play simple board games. Activity play is also very important. Swings, slides and toy vehicles will build up the sort of motor skills required to ride a tricycle or bicycle. At this stage, children are usually ready for parallel play, i.e. playing alongside other children. Their ideas of sharing will begin to develop.

Toys and activities should be geared towards the individual child's level of physical and intellectual development. Babies and children do not require constant levels of high stimulation but like to relax and repeat familiar activities.

PLAY SKILLS

Play stimulates the development of a variety of skills:

Physical skills:

Agility
Balance
Hand/eye co-ordination
Physical co-ordination/dexterity
Strength

Cognitive skills:

Attention span
Creativity
Imagination
Intelligence
Language
Logical thinking
Numeracy
Memory
Planning
Problem solving
Reading

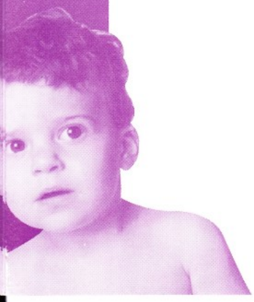
Social skills:

Communication
Co-operation
Sharing

Personal skills:

Adjustment
Emotional development
Popularity
Social development

(1) Goldstein, Professor J, A Question of Play, Under Five Contact, June 1995, pp8-9



THEORIES OF PLAY

The first systematic theories concerning the function of play appeared in the nineteenth century. In 1898 H Spencer developed his "Surplus Energy"theory which stated that play was not an essential part of man's survival but existed merely to use up excess energy. K Groos was the first to develop the idea of play as training for adult life. Groos's theory took no account of behavioural learning and asserted that play was purely instinctive. Darwin's evolutionary theory began to influence thoughts about play leading to the idea of play as a child's means of progressing through stages towards adult levels of maturity. Sigmund Freud's revolutionary psychoanalytical approach asserted that childhood experiences had an impact on subsequent development. His work was continued by his daughter, Anna, and Melanie Klein who were the first exponents of the technique known as play therapy. This type of psychotherapy should not be confused with free play undertaken in hospitals. J Piaget developed a theory of intellectual development in the 1940s and 1950s which consolidated Freud's work on emotional development. Both Piaget and Freud believed play was the modification of reality to understand real events. J Huizinga in the 1950s asserted that play was a means of acquiring cultural roles and behaviour and had a positive role in developing interpersonal relationships. In the 1960s E H Erickson saw play as a positive and constructive form of human behaviour but also as a way children could cope with anxiety. By the 1970s B Sutton-Smith was developing the concept of control and role reversal. Children are able to exercise control by reversing the usual positions of power. Playing doctors and nurses is an example.

HOSPITAL PLAY:

A SHORT HISTORY

Although St Bartholomew's Hospital in London has employed a 'play person' since 1961, it was not until 1963 that the first formal hospital playscheme was set up at the Brook Hospital in Greenwich as a result of informal discussions between Dr David Morris, consultant paediatrician, and Susan Harvey, an educationalist and advisor for Save the Children Fund playgroups. The charity, Save the Children, has a long history of providing play for children in deprived situations. In the past this provision had focused on children from slums and deprived inner city areas but observation of the subdued behaviour of children in hospital had led both Morris and Harvey to consider hospitalised children as deprived of opportunities to play. The Fund agreed to pay the salary of a part-time play worker and the first appointment was made in September 1963. Both Susan Harvey and David Morris favoured a psychodynamic approach to play although this was never officially stated. For the first time, a play scheme was established based on a clear philosophy of play with a play worker distinguished from other members of the ward team. In 1964 a similar scheme was established at the Hospital for Sick Children, Great Ormond Street, at the request of Dr Guy Michel, an experienced practitioner in psychoanalytical techniques. In 1965, Dr Hugh Jolly, consultant paediatrician at Charing Cross Hospital, opened a playscheme in conjunction with Save the Children Fund. Dr Jolly became a tireless promoter of play for children in hospital and did much to increase provision within the NHS. The therapeutic value of play in hospital was increasingly recognised not only in the UK but also in Sweden and the USA through the work of Ivonny Lindquist and Emma Plank respectively.

In 1966 the UK National Committee of OMEP (Organisation Mondiale pour L'Education Prescolaire) set up a working party and published their booklet, 'Play in Hospital'. A DHSS Expert Group Report in 1975 established guidelines for the provision of playschemes and trained staff but the DHSS failed to implement them. Action for Sick Children had been campaigning for hospital play for several years when in 1971 it established a small committee within the Hospital Liaison Committee in conjunction with the Preschool Playgroup Association to promote the concept of hospital play. Save the Children Fund, the British Association for Early Childhood Education and the National Association of Hospital Play Staff joined in 1972.

The first training course for Hospital Play Specialists was established at Chiswick College in 1972 by Susan Harvey with Dr Hugh Jolly as the first external examiner. In 1985 the National Association for Hospital Play Staff set up an independent charitable trust, the Hospital Play Staff Examination Board, to oversee training and qualifications. In 1992, the Certificate was recognised nationally as the appropriate qualification for Hospital Play Specialists.

THE VALUE OF PLAY IN HOSPITAL

Research has shown that hospitalisation can be stressful and distressing not only for children but also for their parents and families. A bad experience in hospital can be detrimental to the future emotional and psychological development of a child and can induce disturbed behaviour on discharge. Such effects are related to length of hospital stay, the continuous involvement of carers, play facilities on the ward and age and maturity of the individual child.

Children are frightened not only by alien environments and strange faces but also by the pain of their injury or condition, the prospect of painful treatment, separation from family and friends and the fear of death. The parents' feelings of disempowerment, isolation and fear should not be underestimated. These can be transferred to the child, increasing fear, insecurity and lack of co-operation.

Hospital play provides the following functions:

1. Creates a normal, home-like atmosphere within the hospital
2. Helps involve the parents in the care of their child in hospital, reducing their anxiety
3. Provides a valuable means of communication between professionals and young children
4. Provides an opportunity to prepare a child for hospital admission, procedures, treatment and surgery
5. Helps reduce stress and anxiety through the relief of boredom
6. Helps children meet specific developmental goals through structured programmes
7. Helps prevent developmental regression linked with childhood trauma

The basic needs of children within a hospital environment are the same as those of children in a normal environment but certain factors make it a unique setting for play provision. Children will be anxious, their normal routines have been disrupted. Play must be provided for children of all ages including adolescents. Some children may be confined to bed or may have other medical conditions which limit their ability to play. The opportunity to play can be provided in the ward or in other parts of the hospital such as outpatients and accident and emergency where the child will be in situ for a limited period.

PLAY PROGRAMMES

Specific programmes for all types of play should be implemented. These should include the following:

- Basic play for manipulative skills:- sand, water, clay, play-dough
- Constructive play for number and colour skills:- bricks and construction toys
- Imaginative play:- dressing up, home corner, make-believe, role-playing puppets
- Adventure play for gross and fine motor skills
- Creative play to build self-esteem and encourage emotional expression:- painting, gluing, cutting, drawing
- Quiet or solitary play to aid preparation skills, reassurance, teaching a child about his situation and hospital environment:- books, music, jig-saws

SPECIALISED PROGRAMMES

Play specialists may also be called upon to implement behaviour modification programmes if the child shows signs of psychological or physical impairment problems. This can also include behavioural problems following child sexual abuse. Preparation skills are used to familiarise the child with the process of going to theatre, specific procedures such as scans, ECG and blood tests, or hospital admission generally. Needle play, for example, can be implemented to alleviate a child's fears and concerns about injections. Needle phobia often arises as a result of a previous bad experience. Puppets are a useful tool in preparation play. They act as an intermediary between the child and play specialist. A child can act out the procedures of injection on the puppet and will gradually become less fearful and more confident in the presence of needles and syringes. It is important to be honest during preparation play and acknowledge the likelihood of some pain. Behavioural boundaries should be set. For example, the child is entitled to scream and cry but should try to keep still.

SELECTING PLAY MEDIA

A range of toys and activities should be provided to cater for all ages of children and their different developmental stages.

-Dolls can be used in role play to explain medical procedures and the best way for the child to respond to them. They are easy for the child to relate to and focus on visual and aural memory.
-The Playmobil range of medical toys are also good for role play and encourage a medium for discussion. They enable the play specialist to monitor the child's understanding and to provide further information.
-Books provide clear information and the opportunity to increase knowledge and understanding. The child can refer to books frequently, absorbing information at his own pace. Story reading is an easy way of encouraging adult participation. Books are also useful tools for providing parents with easily absorbed information.
-Leaflets can provide more specific information relating to particular procedures.
-Art work allows the child free expression. Children's pictures in hospital can provide a useful insight into the child's fears and misunderstandings.
-Photo diaries are useful for older children and adolescents. They are informative and can give rise to discussions. They also encourage active participation by child and family.
-Videos can provide both general and highly specific information. They are useful for a child who is reluctant to participate in other activities. Ideally, the subject of the video should be a child the patient can relate to. They are also a helpful source of information for parents and siblings.

ADOLESCENTS

It is important to establish an appropriate environment for teenagers, even if a separate unit is not available. Patients should be encouraged to mix with each other and join in with group activities so that anxieties can be shared. Recreation in this setting can provide not only information but also a therapeutic and counselling role. The adolescent's need for privacy and independence should be considered at all times.

MULTICULTURAL AWARENESS

An awareness and understanding of cultural background is important for the play specialist because cultural factors may have an impact on parenting style, attitude to treatment and the suitability of play preparation methods. Ethnic minority patients and their families will feel excluded from play facilities if resources do not reflect a multicultural society. Play materials should positively represent a range of cultures. Play activities must be culturally relevant to promote feelings of inclusion and self-esteem.

PARENTAL INVOLVEMENT

It is important to involve parents in all aspects of play. This not only encourages a link between home and hospital but can help alleviate the stress and boredom felt by parents in this situation. Some parents need to be encouraged to take an active part in playing with their children while others may have poor skills in this area and will need to be shown how to maximise play activities.

THE HOSPITAL PLAY SPECIALIST

The play specialist needs to be aware of contributory factors in the child's behaviour such as age, emotional maturity, attention span and health status. The specialist should aim to provide the child with the means to increase self-esteem, make choices, understand the illness and the treatment and to cope with anxiety. She should not only provide play opportunities suitable for the environment but should have the skills to facilitate worthwhile play in an unusual setting.

It is essential that the play specialist works as part of the overall healthcare team and liaises closely with staff members. There must be consultation on treatment plans, procedures and diagnostic implications so that a play programme can be designed to suit the individual child. The specialist should also liaise with the family so that the hospital experience is seen, as far as possible, as part of normal life. Opportunities for play should become opportunities for learning. A play specialist should have particular skills of observation so that they can monitor a child's development, his ability to organise his own behaviour and his emotional state. Observations can then be passed on to the medical team to aid the diagnostic process.

With an increasing number of children with chronic illnesses being nursed at home by parents, there is a growing demand for specialist play skills in the community. Play specialists can visit children in their home environment either to prepare them for future hospital admission or to help them deal with their medical condition and the necessary treatment.

BIBLIOGRAPHY

1. Action for Sick Children, Involving Parents in Hospital Play, Keypoint 1, 1996
2. Action for Sick Children., Messy Play in Hospital, Keypoint 2, 1996
3. Action for Sick Children, The Value of Play in Hospital, Keypoint 14, 1996
4. Barnes P, Thirty Years of Play in Hospital, International Journal of Early Childhood, Vol 27, No 1, 1995, pp48-53
5. Barnes P, The Training of Hospital Play Specialists, The Journal of the National Association of Hospital Play Staff, Spring/Summer 1997, pp15-16
6. Barrow S, Play Therapy in the Radiology Department, Radiography Today, Vol.58, No. 656, January 1992, pp12-16
7. Belson P, A Plea for Play, Nursing Times, 1 July 1987, pp17-18
8. Binns F, Play Specialist, Nursery World, 5 March 1992, p11
9. Collier J and MacKinlay D, Play at Work: Play preparation guidelines for the multidisciplinary team, Child Health, October/November, 1993, pp123-125
10. Department of Health and Social Security, Report of the Expert Group on Play for Children in hospital, 1975
11. Doverty N, Therapeutic Use of Play, British Journal of Nursing, Vol 1, No 2, 1992, pp77-81
12. Fradd E, Learning about hospital, Nursing Times, 15 January 1986, pp28-30
13. Goldstein J, A Question of Play, Under Five Contact, June 1995, pp8-9
14. Goldstein J, Life Skills Through Play, Under Five Contact, September 1997, pp12-13
15. Goldstein J, See How They Play, Under Five Contact, June 1997, pp10-11
16. Griffith C, The Importance of Play to the Developing Child, Children in Hospital (New South Wales), December 1991, pp2-4
17. Hogg C, Quality Management for Children: Play in Hospitals, Play in Hospital Liaison Committee, 1990
18. Huddlestone A, Play - the powerful painkiller, Nursery World, 4 August 1994, pp22-23
19. Jesee P, Nurses, Children and Play, Issues in Comprehensive Pediatric Nursing, 15, 1992, pp261-269
20. Miller J, Multicultural Awareness and the Hospital Play Specialist, The Journal of the National Association of Hospital Play Staff, Spring/Summmer 1997, pp18-20
21. Peterson G, Let the Children Play, Nursing, Vol 3, No. 41, September 1989, pp22-24
22. Pringle K, Promoting Opportunities for Children's Play, Childfacts No. 7, National Children's Bureau, August 1997, p4
23. Randall P, Encouraging Children's Development Through Play, Professional Care of Mother and Child, April 1994, pp81-83
24. Save the Children, Hospital: A Deprived Environment for Children? The case for hospital playschemes, 1989
25. Smith A, Why Needle Play?, The Journal of the National Association of Hospital Play Staff, Autumn/Winter 1994, pp15-19
26. Thompson R, Documenting the Value of Play for Hospitalised Children: The challenge in playing the game, The ACCH Advocate, Vol 2, No. 1, 1995, pp11-19
27. Walker J, Play is Medicine too: A survey of play facilities in hospital, The Journal of the National Association of Hospital Play Staff, Autumn/Winter 1995, pp6-7
28. Weller B, Helping Sick Children Play, Balliere Tindall, 1980

CHAPTER FOUR

Preparation

Hospitalisation is a worrying and potentially traumatic experience for both child and parent. It may be the first time a child has been away from home and without the individual attention of his parents.The Committee on the Welfare of Children in Hospital (Platt Report, 1959) acknowledged the emotional and psychological impact of hospital admission on children and recommended that preparation of both parents and children should become more widespread. It laid down clear recommendations for admission procedures.

> 'Greater attention needs to be paid to the emotional and mental needs of the child in hospital, against the background of changes in attitudes towards children, in the hospital's place in the community, and in medical and surgical practice. The authority and responsibility of parents, the individuality of the child, and the importance of mitigating the effects of the break with home should all be more fully recognised'.
>
> Summary of Recommendations. The Welfare of Children in Hospital, 1959, p37

The report proposed that information be provided by the family doctor, by contact with the local hospital outpatient department and by written information.

THE PARENTAL ROLE

The Platt Report recognised the importance of informing parents so that they felt confident and were able to pass on this sense of security to their children. It also understood the relevance of giving the child sufficient and appropriate information. Many children are afraid of hospital because they know little about it or because their understanding is based on misconceptions. In general, children are afraid of separation from their family, potential pain and the unknown environment. Some younger children interpret a period of hospitalisation as a punishment for being naughty. Older children may contemplate death. The parental role in preparation is vital. The integrity of the child/parent relationship needs to be maintained at all times.

It is important for the parent to provide concise, clear and truthful information. A lack of information can lead to misconceptions and exaggerated fears, leading to negative reactions to treatment. Timing and level of information is dependent upon the age and maturity of the child. Very young children have limited recall and are likely to forget the information if told too prematurely. The reasons for admission should be explained. Although the main concern is to allay the child's fears, it is important to be truthful so that the bond of trust between child and parent remains. It is important to explain that there may be some pain. Avoiding the issue may create unnecessary fear. A small child is likely to find even minor procedures such as blood tests, worrying. Their anxiety should be recognised. It is important to explain the reasons for a particular procedure.

'It is never safe to assume that a child will be afraid of an experience that an adult regards as frightening, or conversely that an experience which as not terrors for an adult will have none for a child......In reassuring a frightened child it is necessary to try to deal with his fears and not with what the adult thinks he is likely to fear:'

The Welfare of Children in Hospital. (p.28)

A parent should take great care not to show anxiety because this will be picked up by the child, increasing his own fears. A child should be encouraged to express his feelings so that any misconceptions can be dealt with as soon as possible. If the child will have to stay in hospital overnight alone, it is important he is made aware of this and understands that the parent will be returning. A parent should be aware of the hospital's policy on parental visiting and overnight accommodation. The developments in family centred care have made it more acceptable for parents to stay with their children for the duration of their stay. However, there will be cases where it is not possible for the parent to stay because of the demands of looking after siblings at home.

Playing hospital games, reading books about going to hospital and drawing and painting are simple ways of introducing the ideas of hospitalisation and of working through the child's fears. A bag should be packed in advance including the child's favourite toy or comfort blanket, favourite cup, dummy or bottle and some books, toys, games and writing instruments.

THE ROLE OF THE HOSPITAL

In recent years, hospitals have become more imaginative in their methods of preparing children and parents. There is significant observational evidence to suggest that a well prepared parent and child suffer less stress during hospitalisation and are more co-operative with staff during their stay. However, it is difficult to quantify the impact of preparation because their are so many variables in the situation of the individual child to consider. These include emotional maturity, timing of the experience, previous experiences of ill-health and/or hospital, parental anxiety and experience of nursing care.

'The aim of all hospital staff is naturally to make treatment as little frightening as possible to children. This means spending time and care in explaining to children what is to happen to them; careful preparation at this stage is amply rewarded later.'

The Welfare of Children in Hospital (1959) p. 28

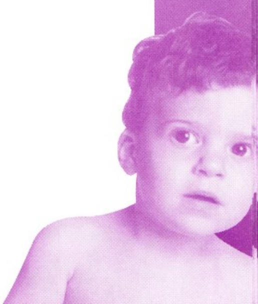
The cognitive processes of children must be taken into account when passing on information to children. Health staff are often guilty of using inappropriate language which children cannot understand. Explanations must be geared to the age and developmental level of the child.

WRITTEN INFORMATION

Many hospitals have produced their own booklets introducing children to the hospital or to a particular ward. The information focuses on admissions procedure, staff roles and likely medical procedures. Most booklets allow an element of individuality by allowing the child to add personal details about himself and his experiences and observations.

PRE-ADMISSION VISITS

Children are invited to visit the hospital before a planned admission to familiarise themselves with the environment and to meet hospital staff. If they are to undergo surgery, they may visit the operating theatre. Some hospitals organise Saturday clubs or happy hours for this purpose. Children are also encouraged to



dress up and engage in role play. The organisation and time costs involved may be one reason for the limited developments of such programmes.

WELL TEDDY CLINICS

Children are invited to bring their teddies along for a check-up. Focusing clinical activity on the teddy bear allows children to learn through play. Hospitals have introduced such clinics to create a positive image of the hospital within the community. Children are encouraged to use non-injurious equipment such as stethoscopes and bandages. Teddy bears may be given plaster casts.

AUDIO VISUAL INFORMATION

Films and videos are more appropriate for older children who are able to take in more information. Children and adolescents respond well to filmed information which focuses on a child of similar age to themselves undergoing the same or similar surgical procedures. Studies have shown decreased levels of anxiety rates amongst children undergoing the filmed modelling method of preparation.

HOSPITAL OR AMBULANCE CORNERS

For nurseries and pre-school groups it is quite simple to turn the usual home corner into a hospital corner. This can provide a useful feature for group work if an attending child is about to be hospitalised. Focusing on the event can make the child feel special and help him come to terms with the event with the support of his peer group. It also helps children who have not had any contact with hospitals to imagine a hospital experience. The designated area can be made into a hospital with beds, a reception area and simple appliances like bandages and stethoscopes, or can be a collection point for all hospital related toys and books.

POST DISCHARGE

Parents should be prepared for the possibility of a period of disruption when the child returns home. The child's behaviour may regress, he may develop new fears or he may be reluctant to leave his mother's side. This may have repercussions at playgroup or at school. Some children may be reluctant to give up the role of the ill child and may have to be reintroduced to the benefits of being well again. Patience and careful handling should ensure that any signs of distress are shortlived. Parents need to agree on a strategy for dealing with changes in behaviour and to be positive about long term recovery. The child has to come to terms with the fact that his parents cannot keep the outside world at bay and that painful or distressing things have happened to him. Deep insecurity may result in aggressive behaviour particularly if the child has experienced separation. The violence may be directed at other children or at parents. It is important for the parents to continue to talk to the child about his experience. This can be done in story form. With careful handling the child will eventually settle down into his normal routine.

BIBLIOGRAPHY

1. Action for Sick Children, Children and Pain, 1992

2. Action for Sick Children, Coming into Hospital, 1995 (Revised)

3. Action for Sick Children, Needles: Helping to take away the fear, 1994

4. Acharya S, Assessing the need for pre-admission visits, Paediatric Nursing, Vol 4, No 9, November 1992, pp20-23

5. Adams J et al, Reducing Fear in Hospital, Nursing Times, Vol 87, No 1, 2 January 1991, pp62-64

6. Bates T and Broome M, Preparation of Children for Hospitalisation and Surgery: A review of the literature, Journal of Pediatric Nursing, Vol 1, No 4, August 1986, pp230-239

7. Binns F, Saturdays At Booth Hall, Nursery World, 3 December 1992, pp18-19

8. Burton R, How to Bear the Pain: A Well Teddy Clinic as an Education Tool, Child Health, April/May 1994, pp251-254

9. Burton R, 'Me and My Teddy Bear...', Nursing Standard, Vol 5, No 38, 12 June 1991, pp20-21

10. Corke S, 'We Get Involved Here', Nursery World, 10 December 1992, pp20-21

11. Eiser C and Hanson L, Preparing Children for Hospital: a school-based intervention, The Professional Nurse, March 1989, pp297-28

12. Gaughan M and Sweeney E, Take Heart: Setting up a pre-admission day, Paediatric Nursing, Vol9, No 1, February 1997, pp2-23

13. Glasper A and Stradling P, Preparing Children for Admission, Paediatric Nursing, July 1989, pp18-20

14. Horne E, Preparing Children for Hospital, The Professional Nurse, June 1986, pp246-247

15. Lavery S, The A&E Team, Nursery World, 26 November 1992, pp14-15

16. Lynch M, Preparing Children for Day Surgery, Children's Health Care, 23 (2), 1994, pp75-85

17. Marriner J et al, A Children's Tour, Nursing Times, Vol 84, No 40, 5 October 1988, pp39-40

18. Popper B and Salett M, Preparing for a Child's Hospitalisation, Mothering, (USA), Summer, 1988, pp32-37

19. Price S, Preparing Children for Admission to Hospital, Nursing Times, Vol 7, No 9, 27 February 1991, pp46-49

20. Stone K, Preparing Your Child for Hospital: a parent's guide, Child Health, Vol 2, No 4, 1994/95, p165

21. Storer S, Call an Ambulance!, Child Education, July 1991, p16

22. Taylor D, Prepare for the Best, Nursing Times, Vol 87, No 31, 31 July 1991, pp64-66

23. Walker J, Symposium: Play Preparation ; A review of the important issues and materials and methods used to help prepare children for medical and surgical intervention in hospital World Pediatrics and Child Care, Vol 4, 1990, pp45-53

24. Walters T, The Saturday Club, Nursery World, 7 October 1993, pp10-11