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MINISTRY OF HEALTH

CENTRAL HEALTH SERVICES COUNCIL

The
Welfare of Children
in Hospital

Report of the Committee



LONDON

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1959

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* Sir Harry Platt ceased to be a member of the Council when he relinquished the Presidency of the Royal College of Surgeons on 11th July, 1957.

† Miss Raven ceased to be a member of the Council and the Committee on being appointed Deputy Chief Nursing Officer to the Ministry of Health, but she continued to attend meetings as an observer on behalf of the Department.

COPY OF LETTER FROM THE CHAIRMAN OF THE
COMMITTEE TO THE CHAIRMAN OF THE CENTRAL
HEALTH SERVICES COUNCIL

11, Lorne Street,
Manchester, 13.

28th October, 1958.

Dear Lord Cohen,

With this letter I send you the report of the Committee on the Welfare of Children in Hospital which the Central Health Services Council appointed on 12th June, 1956.

The Committee have found the subject of absorbing interest and we are only sorry that its ramifications have proved too wide to permit us to report sooner. It is clear that interest in the subject among parents and hospitals has been growing steadily since we were appointed and we believe that a movement towards a new concept of child care in hospitals is already well advanced. We trust that the results of our enquiry may be of some value in consolidating this progress and encouraging further advance.

We should like to record our appreciation of the services of Mr. R. G. Lavelle and Mrs. J. M. Craig, who successively acted as our Secretaries and dealt ably and skilfully with the assembling of material for us to study and the recording of our proceedings. We are also grateful to Mr. A. R. W. Bavin, the Secretary of the Council, for his help in the later stages of the drafting of our report.

Yours sincerely,
(Sgd.) HARRY PLATT,
Chairman

The Lord Cohen of Birkenhead, J.P., M.D., D.Sc., LL.D., F.R.C.P.,
Chairman,

Central Health Services Council,
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I. GENERAL

INTRODUCTION

1. We were appointed at a meeting of the Central Health Services Council held on 12th June, 1956, and were given the following terms of reference:

“To make a special study of 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”.

2. We met 20 times to consider written and oral evidence and for discussion. We invited evidence from a large number of organisations and we wish to thank those named in the Appendix for the evidence they submitted.

3. Our inquiry had already been preceded by a number of studies by the Central Health Services Council of particular aspects of child care in hospital. The Council had on several previous occasions considered the question of visits to children in hospital and their advice had been the subject of three memoranda which were issued to hospital authorities between 1949 and 1956, asking hospital authorities to allow daily visiting for children in all hospitals. They also published a report in 1953 on the Reception and Welfare of In-Patients in Hospital which included among its recommendations suggestions about visiting hours for children and the help that might be given to parents in preparing the child for admission. We have taken note of all this work for its bearing upon our study.

4. Public interest in the question of children in hospital is considerable, as has been shewn by the large amount of evidence we received from organisations representing the views of parents. During the course of our enquiry the British Broadcasting Corporation broadcast two series of programmes which drew a large volume of correspondence from parents and others and we are grateful to the Corporation for making this correspondence available to us. The work of such organisations as the Central Council for Health Education and the Tavistock Institute for Human Relations has done much to inform public opinion.

5. Although the routine statistics of patients admitted to National Health Service hospitals do not show children separately, it is possible to form some idea of the numbers affected from the 1951 census figures, and from the sample analysis of in-patients undertaken by the Ministry of Health and the General Register Office. On census night there were in hospital in England and Wales 36,856 children between the ages of 4 weeks and 14 years, 20,621 of them boys and 16,235 girls. This represents 0·387 per cent. of the child population (0–15 years). Figures obtained from the sample analysis of in-patients in 1955 suggest that some 685,000 children under 15 were admitted to non-mental hospitals in that year, compared with a total of 3·5 million for persons of all ages.

THE CENTRAL PROBLEM

6. During the past 50 years or so profound changes have taken place in the lives of children, at home and at school. The child of today is better housed, better clothed and better nourished than at any time in our history. His individuality is recognised and appreciated both at home and in school and there is a growing readiness to understand and care for his emotional needs. Parents are adopting a much more liberal and sensitive attitude than in the past, and since 1948 they have had available to them a wide range of domiciliary health services, including the services of a family doctor.

7. Along with this increased awareness of the child's needs there have been changes in the relation of the hospital to the community and in patterns of medical treatment which are relevant to the child's welfare in hospital. When most of our hospitals were built, the purpose of hospital care was primarily to permit the nursing of sick people many or most of whom had a background of poverty, bad housing and often malnutrition, while children of better off families were nursed at home or in private nursing homes. Today ten years of a National Health Service have widened the hospitals' sphere to cover the whole community, and have removed financial barriers to general medical care and specialist advice in the home. Hence new attitudes to patients of all ages are demanded.

8. In addition, recent advances in medicine and surgery have made possible a new approach to the care of the sick child. These advances, along with the social effects of the National Health Service, have made it possible to treat more children at home ; and there is today an increasing awareness that even when children have to go to hospital they do not necessarily have to be confined to bed. This implies that more thought has to be given to the welfare and occupation of ambulant children in hospital.

9. The view has been expressed, rightly or wrongly, that the child who has to be admitted to hospital finds himself in an environment which is unnecessarily different from that to which he is accustomed at home. The surroundings are strange and may be uninviting, discipline is said to be more severe, and his parents may have to be separated from him at a time when he is subjected to painful and distressing experiences. We accept that there is some substance in these opinions, and that some hospitals are more successful than others in lessening the upheaval of a child's life which admission entails. But in fairness to those responsible for the management of hospitals it is essential that a sense of proportion be maintained in assessing the criticisms that have been made ; and it would certainly be wrong to assume that medical and nursing staffs in hospitals are generally unsympathetic. It must be remembered that the paramount duty of a hospital is to diagnose the patient's ailment and to secure the appropriate treatment. This sometimes requires unpleasant and even painful procedures, which cause distress not only to the patient and his relatives, but to the medical and nursing staffs whose duty it is to perform them. Furthermore, it should not be forgotten that most of our hospitals were built over 50 years ago and that their planning included little or no provision for amenities and services that are now regarded as desirable—perhaps even essential—for the welfare of patients. In many hospitals the existing shortcomings have been partly overcome by skilful and

ingenious devices, and by a more modern approach to the problems under consideration. But much remains to be done.

10. We are unanimous in our opinion that the emotional needs of a child in hospital require constant consideration. Changes of environment and separation from familiar people are upsetting, and frequently lead to emotional disturbances which vary in degree and may sometimes last well into adult life. The Curtis Report⁽¹⁾ dealt with, among other things, the difficulties arising in the lives of deprived children, and it emphasised the part played by unfamiliarity and separation. The child in hospital, particularly when separated completely from his parents, encounters conditions similar to those of the deprived child, with the added risk of painful and frightening experiences.

11. We recognise that the training of medical students and nurses must concentrate on the physical aspects of illness but we think it takes too little account of the child's emotional and mental needs. Until this defect is corrected there will be delay in recognising that hospital rituals and discipline, when maintained too strictly, may cause lasting harm, undermining the child's self-confidence, his established habits and his capacity to develop and mature.

12. In general the responsibility for bringing up and looking after children rests on the parents. So long as a child is educated and not neglected or physically ill-treated, the absolute authority of the parents will not be challenged. Improved living conditions make it easier for parents in this generation to give their children a more satisfactory home life, with adequate care and affection. The training that they give their children is appropriate to the social setting of the family and varies, therefore, from family to family. Hospitals, on the other hand, still tend to impose a uniform routine regardless of the child's home background. The disciplines of hospital life ought to recognise the authority of parents and respect their methods of handling their children; otherwise the two modes of management may clash, presenting the child with a serious contradiction which can disrupt his training and make him feel insecure. The younger the child the more susceptible he is to confusion of this sort. Young children develop best in familiar surroundings where they learn easily through constant repetition. The hospital should, so far as is possible, avoid breaking this process of growth and learning and should realise that even a short stay in strange surroundings may seem interminable to a very young child. The new approach to the care of children in hospital should be based on a mutual understanding between hospital staffs and parents, and an insight on the part of hospital staffs into the great advances in child care which have been made during the past 20 years or so. Their attitudes to parents should take into account the general rise in the standard of living and the influence of health education on the mind of the public. For it must be remembered that the school education of many mothers has included at least elementary physiology, nutrition and hygiene; and in some cases—for example, those who have had nursing training—their knowledge reaches a fairly advanced level.

13. Children in primary school today are given a greater chance than previously to learn along the lines of their own choice and to follow their

⁽¹⁾ Report of the Care of Children Committee (Cmd. 6922) H.M.S.O., 1946.

own types of development. Children's rates of learning vary ; their interests fluctuate. Post-war schools in Great Britain have been carefully designed to meet the individual needs of growing children, recognising that children need light, air, interesting things to look at, room for movement and scope for individual activities. Earlier generations believed in standard patterns of learning. The design and decoration of many of our hospitals inevitably reflect the social pattern of previous generations, and this cannot but make it more difficult for medical and nursing staff to adopt the modern attitude towards child care. We may expect new attitudes to be reflected in future hospital design and in the renovation of existing buildings but special care is needed to ensure that the obsolete design of the older hospitals does not influence the care of child patients in the wrong direction.

14. The effect of the separation of a child from his parents has received some prominence in the medical Press of late. This has been excellent in that it has drawn attention to adverse factors in hospital practice which had not previously received adequate consideration. There are, of course, forms of separation which do not seem to be inherently harmful. It is, for example, common practice in this country to send quite young children away to stay with relatives or even to place them in foster homes for periods of weeks or months if the mother is ill. In these cases the emotional security of the child is easily safe-guarded by frequent visits from the father or other familiar figures. Children of 5 experience the sharp break of attending school, but this is only disruptive when the home life or school are unsatisfactory. Admission to hospital appears to be potentially more detrimental than any other common form of separation because it so often involves an element of fear. Hospital staff, when concerned with the care of children, and in their dealings with parents, should take account of those factors in the child's life that are considered by a good Children's Officer when arranging for a temporary break because of a mother's illness. Hence the desirability of frequent visiting by parents ; for when a child is confused, afraid, and perhaps in pain it is especially difficult for a stranger to offer him the sort of reassurance and comfort that makes him feel secure. Thus parents should not be denied access to their children in hospital in the mistaken belief that reassurance to a frightened child can be sufficiently afforded by a succession of nurses, however sympathetic they may be, none of whom is allocated to the child for this special purpose.

15. The guiding principle which emerges for the care of children in hospital is that while the child must, of course, undergo the necessary investigations and treatment for the condition from which he is suffering, he should be subjected to the least possible disturbance of the routines to which he is accustomed. Every effort should be made by hospitals to preserve continuity with the home during the time the child is in hospital. At the same time it must be recognised that children are more vulnerable to new and potentially frightening experiences and become more easily confused in strange surroundings than do adults. The attention they require therefore varies in a number of ways from that given to adult hospital patients. It follows that :

- (1) Special attention should be paid to devising methods of management of the sick child which avoid admission to hospital.

- (2) If a child has to go into hospital, everything possible should be done to meet the special needs to which we have referred.

16. It is outside our terms of reference to offer a detailed study of alternative ways in which children can be treated without becoming hospital in-patients but we refer briefly to some possibilities in Section II below. The remainder of the report deals first with general matters of hospital organisation as they affect the welfare of children and then proceeds to a general discussion of the child's special needs in relation to preparation for admission, reception, in-patient care and discharge. Important as each of these different aspects is, in-patient care is the kernel of the problem in relation to our terms of reference. We have devoted a separate section of the report to the welfare aspect of medical treatment, another to types of care which present particular problems, and a final section to the training of staff concerned with the care of children. We have not made a special study of children in mental and mental deficiency hospitals: but we consider that the general approach that runs through our recommendations is applicable in those hospitals and that some of our detailed suggestions could be adopted in them with advantage. (For mental deficiency hospitals—but not now necessarily mental hospitals—our remarks about the special problems of long-stay patients are of course relevant.)

II. ALTERNATIVES TO IN-PATIENT TREATMENT

17. Although our terms of reference concern the welfare of children while in hospital, we think it right to refer briefly to alternative forms of care which may make it unnecessary for the child to be sent to hospital. Children, particularly very young children, should only be admitted to hospital when the medical treatment they require cannot be given in other ways without real disadvantage. This may seem obvious but it is a consideration which should always be in the minds of those responsible for the admission of children to hospital and evidence submitted to us suggests that it is still often overlooked.

HOME CARE

18. When the nature of the illness and home conditions permit, mothers should be encouraged to nurse a sick child at home, under the care of the family doctor and with assistance, where necessary, from the home nurse. Too few local authorities as yet provide special nursing services for home care of children and the extension of such schemes should be encouraged. If children are to be nursed at home it is important that the mother should not only have sufficient skilled nursing assistance when she requires it but also such domestic help as she needs. The instruction of mothers in the care of sick children is most important; we were interested to hear of classes in child nursing that had been held for mothers in one medical practice. These, it was claimed, resulted in a decrease in the number of admissions to hospital of children from the practice. The County Borough of Rotherham have pioneered a special home nursing scheme; St. Mary's Hospital, Paddington, run an experimental scheme with a team of consultant registrar and

nurses who visit children in their own homes ; the City of Birmingham and the Birmingham Children's Hospital have collaborated in a comparable scheme.

19. We regard it as essential that such schemes should be based on the closest co-operation between the family doctor and the local authority services with the help of the hospital and specialist services as necessary, and we trust that every encouragement will be given to the care of the sick child in his own home.

OUT-PATIENTS AND DAY-PATIENTS

20. Many children who attend hospital may require no more than a brief stay within the building. They either attend out-patient clinics or are admitted to hospital for a day only for some operation or investigation which allows them to be discharged home the same evening or next day.

21. Ideally the out-patient department to which children are sent should be in close proximity to the children's wards and separate from the adult out-patient department, where they may be exposed to unpleasant or, to a child, alarming sights and sounds. We realise that at present separate departments are rarely possible, but we recommend that in future more hospitals should have a separate children's out-patient department, or at least arrange for children to attend at special times when adults are not called. If for a special reason it is inevitable that children must attend the same clinics as adults, a separate room should be found for them to wait in.

22. Waiting time for children should be reduced to the minimum. Appointments systems for all out-patients have already been enjoined on hospital authorities and widely adopted, and with children it is specially important that the time of arrival should be close to the time when they see the doctor. It should at the least be possible to spread attendance times by half-hourly block appointments ; or short daily sessions to which children can come without appointment may sometimes be found the best method of avoiding waits. An appointment system should not of course operate in such a way as to prevent attention being given to an acutely ill child.

23. Children's out-patient departments should have adequate accommodation for mothers and babies as well as children and should include waiting-rooms, a canteen, space for perambulators and rooms where feeds can be prepared and babies fed. Attractive decorations and furnishings and a supply of suitable toys are also important. A playroom in which some form of play group can be organised—perhaps by voluntary helpers—is valuable, and large fixed toys like the Swedish cubes and tunnels can provide better entertainment than small toys for the very young. Suitable literature should be available for the older children. Comfortable seating for parents and for children of different sizes is important. Hospitals who want expert advice on decorations and furnishings can make use of the services of such bodies as the Council of Industrial Design.

24. To give adequate service the out-patient department needs to have the essential diagnostic services, particularly X-Ray and routine pathology, in close proximity and there should be extremely clear signposting as well as receptionist guides. Close liaison with the children's wards should be maintained. There should be in every children's out-patient department people

who are responsible for answering parents' enquiries, showing them where to go, and generally ensuring that they are looked after. These people may be either paid receptionists or voluntary workers; most hospitals are unable to recruit as many receptionists as they need and voluntary workers can usefully supplement the services of the regular staff. Such volunteers should be given some preliminary training in the organisation and lay-out of the hospital before they take up their duties.

25. Many of our observations about out-patient departments apply also to casualty departments, but as these departments also present additional problems in relation to children receiving in-patient treatment we deal with them separately under "Reception Arrangements" (paragraphs 61-63).

26. A small but apparently increasing number of hospitals admit child patients—mostly infants—for a day only, for surgical operations of a simple nature or special investigations. The surgical procedures undertaken include circumcision, antrum lavage and herniotomy; some are conducted under local anaesthesia. In some hospitals patients are kept overnight and discharged the following day.

27. The practice is no doubt based on the belief that the risk of cross infection in a very young infant outweighs the advantages of admission, but we would also commend it as one that conforms with the general principle stated in paragraph 15 (1) above. It should however be used with discrimination and should be subject to the following provisos:

- (a) The hospital doctors concerned should be satisfied that the treatment required can be given in this way without danger to the child;
- (b) It should be ascertained from the general practitioner that the home is suitable for follow-up treatment and that adequate medical and nursing supervision can be provided;
- (c) Separate accommodation should be available in the hospital;
- (d) Attention should be paid to the needs of waiting parents.

III. HOSPITAL ORGANISATION, DESIGN AND STAFFING

TYPES OF HOSPITAL ACCOMMODATION

28. At present children may be nursed in four kinds of accommodation:

- (1) In a children's hospital.
- (2) In a children's ward in a general or special purpose hospital.
- (3) In a children's unit in a special department, e.g. Ear, Nose and Throat or Eye department.
- (4) In an adult ward.

In any of these types of accommodation children may be nursed either in large undivided wards or in partially sub-divided wards or in wards with one bed only.

29. Evidence which we received from the Nuffield Foundation, Division for Architectural Studies, and which was based on a survey of fourteen hospital groups, suggested that varying proportions of children are admitted to adult wards. During four six-week recording periods in the hospitals surveyed 2,684 children aged 1 to 11 and 2,389 aged 12 to 16 were admitted to adult wards compared with 12,757 children admitted to children's wards. 56 per cent of the children aged 1 to 11 in adult wards were admitted for tonsil and adenoid operations or the correction of squint and, of the total of 2,684, 819 were admitted to beds specifically set aside for the use of children though not actually classified as children's beds. The proportion of children aged 1 to 11 admitted to adult wards to the total number admitted to children's wards varied widely between different hospitals.

30. The nursing of children in adult wards has been defended on the following grounds:

- (a) the child can then be under the care of a particular consultant or nursed by a particular team;
- (b) one child in a group of adults is quiet and appears to be both safely supervised and sometimes entertained by the adults;
- (c) the single child can be "mothered" by the Sister of the adult ward, who does not have to divide her attention among many children;
- (d) finally, it is argued that an infant may escape the bugbear of cross infection in a children's ward by being nursed in an adult ward.

31. Much evidence against the practice was offered to us and we do not find the above arguments convincing when they are weighed against the needs of children for special care and for the stimulus of other children. There is a growing feeling that an adult ward is no place in which to nurse sick children. They are all too likely to see sights and hear sounds which are an affront to them; their habits, whether of excretion or sleeping, work to a different time schedule; and the noise that is natural for many children to make can be very disturbing to an ill adult.

32. We strongly recommend, therefore, that children should not be nursed in adult wards, whether medical or surgical. This principle was supported in evidence by the Royal College of Physicians, the Royal College of Surgeons, the British Medical Association, the British Paediatric Association, the Royal Medico-Psychological Association and the Royal College of Nursing and should only be over-ruled for periods of highly specialised treatment which can at present only be given in an adult ward or for emergencies when no bed in a children's ward is available. Even then the child should be returned or transferred to the children's unit as soon as possible. In those hospitals where children are at present scattered through adult wards, they should be gathered into a children's unit available to any member of the medical staff.

33. Our remarks about children in adult wards apply also to adolescents; indeed in our view it is even more important that adolescents should not be in a position to overhear some of the conversation of an adult ward, e.g. a gynaecological ward. Ideally, adolescents need their own accommodation, but if the numbers admitted do not permit this it is better for them to be nursed with children than with adults.

34. It has been suggested to us that the aim should be to nurse all children in children's hospitals. There are, however, various considerations which make this proposal impracticable. It is not desirable that a child should be removed to a children's hospital which may be far from his home, thus making it difficult for his parents to visit him, when he could be nursed in a children's ward in the local hospital, which is in the charge of a children's specialist visiting from a neighbouring centre sufficiently frequently. The greater the distance from a main children's centre the less the likelihood that the child will be sent to it and the greater the need for the doctor rather than the patient to travel. Although it may be best for the child requiring some unusual form of treatment to be nursed where there are special facilities, if his needs are more simple he will undoubtedly be much happier in a children's ward near home. The majority of children admitted to hospital are suffering from common conditions which can be managed in small children's units and there is no reason why our recommendations concerning the welfare of the child should not be adopted in small units just as in large ones. It is very difficult to lay down rules about the minimum size of children's units, but we believe it should be possible to run children's wards with as few as eight to ten beds, and that this number would justify the appointment of a sick children's trained nurse.

DESIGN OF WARDS

35. We have not been able to make a detailed study of the design of children's wards. We understand that some aspects of this subject are at present being considered by the Nuffield Foundation, Division for Architectural Studies, and their findings will be published in due course. We have, however, had various views expressed to us and the following comments have some bearing on planning of future buildings:

- (1) Children, once they are beginning to talk, enjoy each other's company and they should, therefore, when medical considerations permit, be nursed in wards with other children and not in completely separate single bed wards. There will of course be certain exceptions, for example, the child seriously ill or suffering from infectious disease who has to be separated from the rest. Children who are in cubicles feel much less isolated when the glass in the partitions separating them reaches well below eye level so that they can easily see each other.
- (2) Children are often put in adjacent beds simply because they are under the care of the same consultant. As far as possible children of the same age group should be kept together within the ward, so that they can enjoy each other's company. Very young children should be grouped together so that they do not isolate the older ones from each other.
- (3) Children who are in bed need a view and facilities for outside play whether on a balcony or a playground. Inside the ward colour schemes and furnishings should be bright and cheerful and there should be a plentiful supply of toys and suitable games. We make further recommendations about toys in paragraph 101.

- (4) All children's wards need a play room, preferably visible to the children in bed. Noise can be cut off by glass screens but the sick child derives a stimulus to get better from seeing others play.
- (5) With the present tendency for children to be up and about to a greater degree than in the past, prevention of accidents must always be borne in mind in designing children's wards but it is important that measures to this end should not be allowed to make the accommodation look unfriendly and forbidding.
- (6) The design of the children's ward should be such as to permit nurses always to keep the patients under proper supervision.

MEDICAL STAFFING

36. Sick children in hospital come under the care of various members of the medical staff. Although the actual responsibility for care of individual children must often rest with consultants in other specialities, a children's physician should have a general concern with the care of all the children, not so much in the details of medical treatment as in the general management of the unit. This is obviously of special importance at the earlier ages. In addition, the rapid extension of the child guidance services means that a children's psychiatrist is available in many areas. He will not necessarily see all the children in hospital who show evidence of emotional disturbances but he can be helpful in discussing with other members of the hospital staff the handling of individual disturbed children and any general psychiatric problems arising in the ward.

NURSING ORGANISATION

37. The keystone of the nursing organisation is the sister in charge of the ward. She sets the whole tone of the ward atmosphere and the welfare of both children and parents depends greatly upon her judgment and guidance. She should be a Registered Sick Children's Nurse as well as S.R.N., and should have had experience as a staff nurse in a children's ward before being appointed as sister. Apart from her direct responsibilities for the care of the children in the ward she is in a key position to interpret the needs of children and their parents to other members of the hospital staff. For instance she can ensure that any medical auxiliaries who come into contact with the children are alive to the need for special care in dealing with children and for a different approach to children of different ages.

38. The child in hospital, particularly during the first few days, should be handled by as few people as possible. Children suffer from passing through too many different pairs of hands. For the child's own welfare, a method of nursing which gives him a sense of security through being nursed by a familiar person, as in patient or case-assignment, is preferable to other systems. Shortage of nursing staff makes this type of care difficult to arrange, but there is no doubt that it is the ideal to be aimed at. Whatever method of nursing is used, a higher ratio of nurses to patients will be needed in children's wards than in most adult wards.

39. Some hospitals have found it useful to have nursery nurses to occupy and help with the younger children, thus relieving the more highly trained nurses for skilled nursing duties. If nursery nurses are employed, they should be used to the fullest extent that their training and natural aptitude allows to assist in the various aspects of care of children under 5 years of age.

OCCUPATIONAL THERAPY

40. Occupational therapists are at present employed in some children's wards in general hospitals and in many long-stay hospitals, but they are usually fully occupied in giving treatment to individual patients and are unable to give time to group activities. Their preliminary training qualifies them to a certain extent to organise play and recreation and there is a post-graduate course for them in play therapy and play diagnosis. If occupational therapists were able to devote more time to this kind of work, they could not only organise play but instruct other helpers in this important aspect of child care.

SOCIAL WORK

41. The recovery of the sick child may be retarded by emotional disturbance which can be aroused by parents who are anxious, or social factors may have operated in producing the condition for which the child is being treated. The almoner therefore has an important part to play in relation to the care of children in hospital, for she is in a position to maintain contact with the parents and the home and also to provide a link with the social services of local authorities, voluntary organisations, etc. Almoners and other trained case workers are skilled in eliciting hidden factors which parents may be too diffident to discuss otherwise; they can also help in solving parents' financial problems. We trust that all hospitals admitting children will be alive to the value of the social worker's contribution.

42. Psychiatric social workers, when available, can be of assistance with children showing more obvious behaviour disorder. These workers are specially trained in handling emotional disturbances and have an important function not only in connection with the treatment of these disturbances but in advising on relationships between staff and parents and upon the control of group tensions where they exist.

IV. PREPARATION FOR ADMISSION

43. The risk that any child will be disturbed by hospital admission can be reduced by suitable preparation of both parents and children. In this section we discuss the kind of preparation that should be attempted, how it should be done and by whom.

GENERAL CONTACTS

44. Apart from the hospital's role in preparing a child for imminent admission, informal contacts between a hospital and the community do much to increase the confidence of parents and children in the hospital's ability to look after the children should they ever have to be admitted. These informal contacts can be fostered by various means, for example through such organisations as "Friends of the Hospital", who may collect money for hospital funds, visit patients in hospital and be associated with the hospitals in various other ways, such as the running of hospital libraries. Hospital staff may be reluctant to "advertise" the work of the hospital, but the desire to avoid publicity can do harm if it allows prejudice and inaccurate information about the hospital to circulate in the community.



It is helpful to have "open days" when hospital staff show round people who are anxious to know more about hospital life. We would also welcome more opportunities for members of the hospital staff to talk to Clubs and Societies about the work of the hospital. In all these ways it is possible for a spirit of co-operation and goodwill to be built up between hospital staff and the community, and so to lessen the strangeness of the surroundings should a child have to be admitted.

THE FAMILY DOCTOR

45. The child will normally have been referred to hospital by the family doctor, who has an important part to play in preparing the whole family for the experience. Many parents have anxieties and fears about hospital life and about their child's illness, and worry is very easily communicated to the child. The family doctor can do a great deal to help and reassure by explaining to the parents the reason for the child's admission, the kind of treatment he will be given in hospital and, if the parents have no knowledge of it, details of hospital routine. To enable him to fulfil these functions a knowledge of the local hospital is essential and the hospital should accord him all possible facilities for securing this and should welcome visits by him to children he has referred.

LOCAL AUTHORITY STAFF

46. The majority of mothers have attended local authority clinics with their children at some time in their lives. The staff of these clinics can help to foster the understanding of parents and children so that hospital admission is less alarming. Mention was made in the evidence submitted to us of the appointment by local health authorities of a health visitor to act as liaison officer with the hospital or to keep in touch with the almoner or ward sister. Such arrangements undoubtedly secure a smooth liaison between the hospital and local authority and make for a better understanding between parents and hospital staff.

HOSPITAL STAFF

47. When the child is referred to an out-patient department and it is decided then to admit him to hospital, the responsibility for explaining to the parents and child the need for, and the implications of admission will rest with the consultant or other senior member of the medical staff who makes the decision. We consider that this interview should be followed, if possible at the same visit, by a talk with another member of the hospital staff responsible for explaining the details of admission and answering questions. (We discuss this fully in the section on preparatory talks below.) We are convinced that time spent in this way makes for the happiness of the child later on, and would recommend that hospital staffs should pay special attention to this first stage in the child's admission to hospital.

LEAFLETS AND LETTERS

48. Several hospitals issue leaflets to parents of children who are to be admitted to hospital. Some hospitals have designed their own leaflets; others make use of a standard one such as is supplied by the Central Council for Health Education. The evidence given to us showed that leaflets were regarded as useful both by professional workers and by the lay public, although they are only one facet of preparation for admission.

49. In designing leaflets the following points should be borne in mind :

- (1) It should be clear whether the leaflet is intended for parents or children. If the latter, it should be realised that children of different ages have different requirements.
- (2) If admission is likely to be delayed for a long time, the information should be general, and limited to essentials. Too detailed instructions given months ahead can cause unnecessary anxiety.
- (3) The more detailed information given immediately before admission should be as personal as possible. For example, parents should always be addressed by name and the names of the doctor and the ward sister should be given if possible. Parents also need to know what their children should bring into hospital, and the arrangements for visiting and for dealing with enquiries about the child while he is in hospital.
- (4) Leaflets will only be read if proper attention is given to lay out and illustration. Parents are used to a very high standard in advertisements, and leaflets for children which may include strips of "hospital games" should come as near as possible to the standard set by contemporary children's publications.
- (5) The information contained in leaflets must be kept up to date.

PREPARATORY TALKS

50. While leaflets and letters can be very helpful in paving the way for admission we suggest that they cannot replace discussion with hospital staff. We have already referred to the need for an interview with some member of the hospital staff who can explain matters of detail and answer questions: when admission is on the same day as the interview with the consultant this second interview can, of course, take place in the ward ; but when as is more common a child is placed on the waiting list it should preferably be given by a senior nurse on the out-patient clinic staff. Whoever sees the parents should have some training in the conduct of an interview and it should be known to all the staff of the out-patient department that there is a particular person entrusted with this duty. Some parents like to visit the ward before their child is admitted and an opportunity to do this can best be provided at the stage when details of admission procedure are being explained. We doubt whether there is much to be gained by arranging for the child to pay an advance visit to the ward.

51. Another way of increasing parents' knowledge of the hospital which has been tried with success in some places is the holding of talks between the ward sister and a group of parents at some pre-arranged time.

PREPARATION OF THE CHILD

52. What we have said so far about preparation for admission relates chiefly to preparation of parents. This is because the confidence of the child depends on the degree of security he senses in his parents. The extent to which the child himself can be directly prepared depends on his age and emotional maturity ; the child under 4 probably needs to know only that he is going to hospital, that it is a nice place where people are made better, that the nurses will be kind and that mummy and daddy will be there at the beginning and then come back to visit him. The information given to older

children depends upon their interests—one child will want to know the exact nature of the treatment he is to have, another whether he will be allowed to see something special, another whether he can take his favourite book or toy. No child, whatever his age, should be threatened with being sent away to hospital as a punishment and on the other hand no child should be given the idea that going to hospital is a special sort of treat or holiday. It is likely that it will fall to the parents to provide such direct preparation of the child as is possible and they are in the best position to know what he needs.

V. RECEPTION

PLANNED ADMISSION

53. First impressions are particularly important to a child entering hospital, when he may be naturally fearful of strange surroundings and parting from his parents. All his contacts with members of the hospital staff, from the porter at the gate to the nurses in the ward, will create vivid impressions, and the need for careful and tactful handling at each stage cannot be over-emphasised. There should be the least possible delay between entering the hospital and reaching the ward and if he is immediately welcomed there by the nursing staff and occupied, there is a better chance that he will settle easily and quickly.

54. We suggest that the main admission procedure should take place in the ward where the child will be nursed and that the amount of information asked of parents before reaching the ward should be kept to the minimum.

55. The child will be very conscious of his surroundings and we believe that, whether the interview takes place in Sister's office or on some other part of the ward, there should be as little as possible in the surroundings to frighten him and much to reassure him. It has been suggested to us that a playroom is a good place for the child to be welcomed, where he can play with toys or look at books, and where there is no frightening medical equipment.

56. Wherever possible the Sister should welcome the child to the ward and if she cannot be there herself, she should delegate responsibility to a nurse of some seniority who will handle the situation tactfully and with understanding.

57. We commend the practice which is already adopted in some hospitals whereby after reaching the ward the Sister talks to parents while another member of the nursing staff shews the child round, introducing him to other children and telling him something about ward routine. This is particularly important in the case of the younger child. During her interview with the mother, the Sister should find out about the child's personal habits, his likes and dislikes, including for instance his name for the toilet, and any other essential private vocabulary. Where a preliminary medical examination is part of the routine admission procedure the mother should be allowed to help.

58. If children are admitted to a ward during the day, we would recommend that, where possible on medical grounds, they should be allowed to stay up and not put to bed. It helps to lessen the strangeness of new surroundings, if the child can play with other patients and learn his way about the ward; the younger children's play can often be organised by student nurses. If the child is admitted at bedtime we recommend that the mother should be allowed to stay and help with feeding and putting to bed. It is a comfort to both the mother and the child if she is able to stay with him for this short period and do for him all the things that he associates with home, such as tucking him up in bed and saying prayers.

59. Some children are very sensitive about the kind of clothes they may have to wear in hospital, and any clothing provided by the hospital should be as attractive and well fitting as possible. The experiment of allowing children to wear their own clothes in hospital, whether these are laundered by the hospital or are collected by visitors and taken home for laundering, is worth consideration. It is generally desirable to allow children to keep with them one or two personal possessions such as toys or books which they may have brought into hospital to provide some visible contact with home, once the parents have departed, even if it means that such toys must be abandoned on discharge. If a child has been used to some sort of "comforter" it should always be allowed unless there are special medical reasons against it.

RE-ADMISSION

60. Where a child is re-admitted to hospital for treatment, it is a great help if he can be nursed in the ward which he already knows, and we hope that hospital authorities will arrange for this to be done whenever possible.

EMERGENCY ADMISSIONS

61. A child may be admitted to hospital in an emergency either from home, for example with acute appendicitis, or from outside, for example following a street accident. Whatever the circumstances, the same principles apply as in planned admission, but because the child is usually more shocked and upset it will be even more important to reassure him. If the parents do not come with the child to hospital, they should be notified at once and when they are present, they should be given all possible help and support. They themselves may well be suffering from shock.

62. Special attention should be paid to the arrangements for receiving children in casualty departments whether they themselves are seriously injured or not. The routines of a busy casualty department provide quite unsuitable sights for children and separate accommodation screened from the rest of the department should be provided for them. Within this separate accommodation children who are seriously injured should in turn be screened off from children waiting for quite trivial services. Nurses with experience in handling children should be available. Figures collected by the World Health Organisation suggest that the number of children involved in accidents is high—in seven of twelve countries supplying figures for 1951-53 from 30 to 40 per cent of deaths in the age group 1-19 were due to accidents—and it seems likely that in all but the smaller centres separate casualty accommodation for them would be justifiable economically.

63. Much of what we have said about out-patient accommodation for children applies also to casualty departments, e.g., the need for canteen and other facilities to enable parents to wait in comfort. The capacity of the parents to keep the waiting child reassured depends to a large extent on the comfort and sustenance they themselves can obtain. Children should never be left unattended in casualty departments.

VI. THE CHILD AS IN-PATIENT

1. GENERAL

64. As we have said, we regard the welfare of the child as an in-patient as the central subject of our enquiry and we have thought it right to preface our remarks on this by some discussion of the differing needs of children of different ages. We suggest that for this purpose children may be divided into three groups, the under 5s, those aged 5-12, and adolescents.

65. Children under 5 need close emotional contact with familiar adults. They are best cared for by their own parents but failing this should be handled by as few people as possible. This is not only because the youngest members of the group are extremely susceptible to cross infection but because the effect of a multiplicity of people looking after them is to disrupt their development and learning. They need the stimulus of other children and opportunities for play and conversation to help them develop their powers of movement and speech. They also need a display of affection from people they can trust. Their understanding is unrelated to their superficial reactions and it is necessary for those who look after them to learn how to develop an insight into each individual child. Development among them is uneven, their activity is related to their mental age but their mental and emotional ages can be unrelated. Regression to infantile behaviour is common in the older members of the group and toilet training is extremely important. There is therefore much for the nurse to learn if she is to look after these young children properly and in a later section of our report we enlarge on the need for new methods of nurse training.

66. Children over 5 have started school. They are thus used to being controlled in a group and have encountered school discipline. They are always searching for information and need adults whom they can trust, who will not deceive them (even with the best of intentions), contradict themselves or display uncertainty in handling them. Those over 8 can accept adult explanations provided that these do not go beyond their obvious interest. They can amuse themselves playing with the younger children and can use reading and writing material. All children in the group still need close contact with their parents but some have begun to understand the meaning of time.

67. The requirements of adolescents differ from those of adults and children. They dislike being treated as children but are prepared to play with children as long as they have separate accommodation in which they can carry on their own special interest. In this age group failure to provide adequate educational facilities can be critical. We have already discussed

the needs of adolescents in terms of hospital organisation in paragraph 33 and we discuss education in more detail in section VI. 4.

2. THE ADMISSION OF MOTHER AND CHILD

68. An obvious way of preserving continuity between the child's hospital and home life is by admitting the mother with the child and this is done in a few hospitals in this country where young children are concerned. One of the earliest hospitals to institute the practice was the Babies' Hospital, Newcastle-upon-Tyne, where the late Sir James Spence admitted mothers with their babies so that they could continue to care for them. In one hospital in New Zealand mothers were allowed into hospital with their children as an experiment to deal with the problem of cross-infection and as a result cross-infection was considerably reduced⁽¹⁾. If an infant is being breast-fed there is a special reason for admitting the mother; and it should be remembered that bottle feeding and other forms of care should not be too sharply interrupted with children under two.

69. 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, and that what the mother learns about the handling of her sick child can be of value to her if he falls ill again at home. Fear that the mother may get in the way of nurses and doctors and prove a hindrance to the child's recovery has not been realised: on the contrary nursing of the child has been made easier and although some medical or surgical procedures may have to take place in the mother's absence it seems in general to be of value to the doctor to have the mother nearby. It is of course of the essence of the practice that the mother should help in looking after the child including feeding, washing, keeping him entertained and putting him to bed and getting him up; as well as comforting him during painful or unfamiliar medical and nursing procedures.

70. We think there is much to be said for extension of the practice, more particularly where children under five are concerned, and that it is particularly valuable for the mother to be able to stay in hospital with her child during the first day or two, and thus to obviate the harm of a sharp separation and demonstrate mutual trust between parent and hospital staff. We realise that it may not always be possible for the mother to leave her own home, but this is for her to decide. There may be accommodation problems for the hospital but those hospitals that do admit mothers have been able to find the accommodation by simple adaptations. Expensive new buildings should not be necessary, particularly in view of the declining demand for hospital accommodation for children. In fact when the need has been appreciated the accommodation has usually been found. The correspondence received by the B.B.C. makes it clear that the practice is gaining in popularity with parents. In the undergraduate teaching hospitals the presence of the mother might well call for a modified technique in teaching, but one of the most valuable lessons for students is how to deal with a child's relatives. We look to these hospitals to give a lead in the matter, bearing in mind their responsibility for training the doctors of the future.

(¹) H. P. Pickerill, *Lancet*, February 28th and April, 10th, 1954.

3. VISITING ARRANGEMENTS

General

71. When a child is in hospital he is in danger of losing contact with the outside world, which has been up to that time the background of his development. If he is not kept in touch with the life that is familiar to him, he will suffer emotionally and mentally and his normal development will be retarded. It is vital that while he is in hospital he should be visited frequently so that he does not feel that hospital life is divorced from everything that he knows. The child "lives from day to day: he depends on the evidence of his senses and his understanding of the situation is fragmentary at best. A loving mother who remains absent is a figure whom he is incapable of conceiving. . . . His roots in home are dying."⁽¹⁾

72. Restrictions on visiting probably stem from three main causes, the fear that visitors will introduce infections, the belief that it is better for children not to be visited, and the expectation that visiting will disrupt the even tenor of the ward routine. An investigation into cross-infection carried out on behalf of the British Paediatric Association however, revealed no connection between visiting and cross-infection⁽²⁾, and experience of frequent visiting has shown the fear of infection to be generally groundless⁽³⁾. Modern psychologists consider that children suffer far more from not being visited than from any temporary upset that a visit may cause, and the experience of the majority of hospitals is that frequent visiting can be assimilated into the life of the ward without serious difficulty.

73. It has been suggested to us that not all parents are able to take advantage of facilities for frequent visiting; for instance, mothers who have other children to look after, those who fear to see their children in pain or distress which they cannot relieve, or those who cannot afford frequent long distance journeys. We deal later with possible sources of financial aid for those who need it; for the rest we think that more parents, if the value of frequent visiting were properly explained to them, would welcome the maximum facilities for it, and in any event the reluctance of some to take advantage of such facilities is no reason for denying them to all.

74. The Ministry of Health, on the advice of the Central Health Services Council, has issued three circulars in the last ten years encouraging daily visiting of children and daily visiting is now the practice in most hospitals, though there are still some, particularly those for long stay cases and some isolation hospitals, that do not encourage it. The length of time allowed varies from half an hour to two hours a day, although it usually does not exceed one hour. Visitors are however seldom permitted on operating days, sometimes only parents may visit, and few hospitals allow visits by children under 14 years of age.

75. We consider it most desirable for the majority of children not only that they should be visited daily but that there should be as few restrictions on visiting as is consistent with the efficient running of the ward. The younger the child the more important is it that he should be visited frequently; with

(1) Anna Freud, *Lancet*, 28th November, 1953.

(2) Watkins, A. G. and Lewis-Faning, E., *B.M.J.*, 17th September, 1949.

(3) e.g. Moncrieff, A.A., *B.M.J.*, 5th January, 1952.

tiny children, who are in hospital for a long time and are not visited, the parents may find that the child who returns home is a stranger to them and this may lead to serious domestic difficulties. The importance of frequent visits diminishes to a variable extent according to the age, emotional maturity, past history and home background of the child, but it is now generally agreed that it is much better for a child to be visited daily, even if he is upset at the end of visiting time, than to have no visitors and become quiet and withdrawn. In any event, upsets on parting can be minimised by sensible stage management. We suggest that the attitude of some hospitals to visiting needs to be thought out afresh and based on a different understanding of the part visitors play in the life of the patient; in particular there must be appreciation of the help that the mother can give to her sick child, by feeding him, washing him, playing with him and seeing to his toilet, and, on occasion by holding and comforting him when medical treatment is given. We recognise that visiting should not interfere with the education or treatment of children in hospital and we accept that visitors should not be in a room in which surgical dressings are actually being applied, for fear of spreading staphylococcal infection—but there are several times in the daily routine of any ward when visitors could be allowed, and we consider that the time has come to move away from the idea of strictly limited visiting hours, even when these occur daily, towards what is commonly described as unrestricted visiting.

Unrestricted Visiting by Parents

76. "Unrestricted visiting" as we understand it, means that parents are allowed into the ward at any reasonable hour during the day. The precise time at which visiting hours may begin and end must vary with local conditions, and in any case the Ward Sister will be able to tell parents at which times of day it is inconvenient to have them in the ward. Unrestricted visiting does not mean that parents are in the ward all the time. It does mean that they can arrange their visits to fit in with their other family commitments. Hospitals which have tried the experiment of unrestricted visiting find that some parents want to spend a large part of the day in the ward, but many will come in for a few minutes at a time, perhaps two or three times a day.

77. Several arguments have been put to us for and against unrestricted visiting, the practice of which is not as yet widespread, and we should like to mention these briefly. The arguments in favour of the practice may be summarised as follows:

- (1) Children are very much happier, particularly the younger ones. For the young child even daily visiting is not frequent enough when it means that he only sees his mother for a limited period each day.
- (2) There is much less tension in the ward, because there is no anticipation of a set visiting hour and a feeling of anti-climax once it is over.
- (3) Mothers with other children at home are able to fit visits into the family routine as suits them. Similarly fathers who are at work all day can come in the evening.
- (4) Mothers who are helping to look after their children in the ward are noticeably much more relaxed and less apprehensive than when they come in for a limited visiting time. Relations between nursing staff and parents are more friendly and informal.

- (5) If the mother is able to undertake some of the routine care of the child, including keeping him occupied and entertained, the nurses have more time for work that they alone can do.

78. Arguments which are sometimes advanced against unrestricted visiting may be summarised as follows:

- (i) The presence of parents in the ward from early morning until late in the evening prevents the staff getting on with their duties and hinders ward rounds.
- (ii) The wards are said to be noisier and less tidy.
- (iii) The application of the practice to a teaching hospital might present special difficulties in relation to teaching ward rounds.
- (iv) The child who has no visitors will feel neglected.
- (v) The limitation of unrestricted visiting to parents may occasionally give rise to invidious distinctions.

79. We have considered all these arguments carefully and in our judgment the advantages of unrestricted visiting far outweigh the disadvantages. We attach particular importance to the argument that children are much happier when there is unrestricted visiting and we have received evidence that the normal life of a hospital can continue even though the wards are open to parents and that nurses can be helped rather than hindered by having mothers present to look after the child in many small ways. Indeed, the evidence submitted to us has convinced us that where the practice has been adopted, both in teaching and non-teaching hospitals, all the difficulties mentioned above have yielded to simple adjustments, including if necessary a change in the technique of ward teaching.

80. We hope therefore that all hospitals where children are treated will adopt the practice of unrestricted visiting, particularly for children below school age. Again, this applies perhaps with particular force to the teaching hospitals, in view of their responsibility for demonstrating to medical students the special needs of the child in hospital.

Settling In

81. The time when a child most needs to see his parents is during the first few days following admission. It is sometimes thought that if a child is only in hospital for a few days he does not need to be visited, or that a child should be left alone until he is "settled". The reverse is true; while his surroundings are new and strange he needs the support of someone he knows and trusts; once he has settled into hospital routine he is more secure and relies less on his parents. Parents should be particularly encouraged to visit as frequently as possible at the beginning of the child's stay in hospital and short-stay cases should be visited at least as frequently as children admitted for a longer period. We have already referred to the value of allowing the mother to stay with her child during the first few days in hospital. The hospitals that have done this for some time (which include infectious diseases hospitals) comment that the parents maintain satisfactory relationships with their children based on mutual trust and gradually visit less frequently so that the ward is not overcrowded with visitors.

Evening Visits

82. Parents should also be encouraged to visit in the evening, when they will have an opportunity to help in settling the child for the night. They may be able to give the child supper and look after his other needs. There are obvious advantages to both the parents and child in letting them spend some time together just before he goes to sleep. Moreover, the child's relationship with the father is of the greatest importance and evening visits allow the parent who works to maintain contact with the child without incurring financial loss or jeopardising the efficiency of the home.

Operating Days

83. We should like to see the restrictions lifted on visiting on operating days. If parents are properly prepared and are willing to help, they can be present both immediately before, and when the child is recovering from the anaesthetic. We return in paragraphs 114-15 to the part the parent can play in this.

Interviews with Medical and Nursing Staff

84. The difficulty parents have in getting enough authoritative information about the treatment, progress and after care of their children is a common and well-founded complaint, and there is we are sure a wide need for a more forthcoming attitude on the part of hospital authorities in this direction. We do not suggest that parents should be able to have an interview with the consultant or sister whenever they visit—indeed with unrestricted visiting this would manifestly be out of the question—but it is essential that there should be certain fixed times, known to the parents, at which they can get authoritative information at first hand. We have no doubt that complaints about importuning of medical and nursing staff by parents reflect failure to make proper organised arrangements to meet parents' legitimate needs.

Visitors other than Parents

85. Some hospitals allow no visitors other than parents or guardians; others admit adult visitors, but do not permit children under 14 to visit. The most important visitors from the child's point of view are his mother and father, and we suggest that unrestricted visiting by others than parents is not necessary to the child's welfare unless there is some other person *in loco parentis*; it should be possible, however, to have set visiting hours for other relatives and friends once or twice a week. Although an occasional visit from a brother or sister, or a young friend, may be much appreciated by the sick child, we realise that this entails risks of introducing infections that do not arise with visits by adults.

Children with No Visitors

86. We have had a good deal of evidence about the problem presented by children who have no visitors. The reasons for this may be economic, or the parents of children in problem families may visit less frequently or not at all. Also a single parent with a family may find visiting extremely difficult. In spite of this it was pointed out to us that social workers were able to persuade parents to visit children who had remained unvisited for months or even years on end, in spite of difficulties in the home, thus avoiding the need for the child to be "taken into care". It is the responsibility of

hospital staff to tell parents simply, avoiding any suggestion of blame, that visiting is part of the treatment which the child needs. There may however be difficulties which cannot be overcome in this way, as in a case where the mother, a widow, was herself in a long-stay hospital. It is generally agreed that some arrangements should be made for visiting by others in such cases. There are various ways in which this can be encouraged; mothers of other children in the ward are often very willing to entertain those without visitors; sometimes there are relatives or friends of the child living near the hospital; voluntary helpers may also assist in this way. It is important that there should be only one or two visitors allocated to each child, and that visiting should not be organised on a rota system. This may be a difficult recommendation to put into practice when the time that can be given by voluntary helpers is limited, but we believe that the benefit may be lost if a series of visitors, all unfamiliar, tries to comfort the child. It is particularly important with children under five that they should get to know one particular person and that the visitor should have some knowledge of the kind of occupation and entertainment the child needs.

Facilities for Visitors

87. At present too few hospitals have been able to provide amenities for visitors, e.g. canteens, or in the case of hospitals at a distance from towns, waiting rooms and we should like to see this deficiency made good. Such amenities are an integral part of a fully-developed hospital, but if more urgent demands on Exchequer funds make it difficult to fit them into official building programmes voluntary organisations such as Leagues of Friends may be able to help. Another amenity which is much appreciated is a playroom where mothers who cannot leave their other children at home may bring them to the hospital and leave them in the care of a member of the hospital staff or of voluntary helpers. We hope that as soon as possible all hospitals dealing with children will make every effort to provide these essential facilities.

Financial Aid

88. Some parents may incur considerable expense in visiting frequently, particularly when their children are in hospital for some time, or at some distance from home. These difficulties will increase with the increase in visiting that we confidently expect. There are already certain ways in which parents in need can receive financial aid. A survey, to which we have had access, carried out by the Institute of Almoners shows that the main source of financial help comes from Hospital Samaritan Funds, which may be partly derived from Endowment Funds and partly from voluntary contributions from the public. Other sources of help and the extent to which they are used, are as follows:

- (1) Local health authorities have certain powers to assist with grants, but it is probable that very few actually do so.
- (2) The National Assistance Board give grants to those who are already entitled to national assistance or who would be so entitled if the cost of travel were deducted from their resources.
- (3) The railway authorities give a concession to relatives of patients in long-stay hospitals, which entitles them to a return journey at reduced cost.

- (4) In the case of tuberculosis patients, tuberculosis after-care committees, which are often voluntary bodies acting as agents of local authorities, sometimes make available voluntary funds to relatives visiting patients in sanatoria.
- (5) Local education authorities may be willing to give financial assistance to enable parents who would otherwise be unable to do so to visit children who are receiving education in hospital.

89. The arrangements for distributing hospital Samaritan Funds vary from hospital to hospital, but the most common arrangement seems to be for regular grants from these funds to be at the disposal of the almoner. Parents are sometimes informed in the initial letter that is sent to them before the child is admitted that help may be available or they may be told by the Sister on admission. They should always be told at this early stage that the almoner or other social worker is available to discuss with them any difficulties of this kind. If good liaison is maintained between the Sister and the almoner, there should be no difficulty in referring any needy cases to her.

90. We hope that hospitals will make even more extensive use of Endowment and Samaritan Funds to assist relatives who find visiting a financial burden.

4. EDUCATION

91. "In general, there are two main reasons for educating children in hospital. First, an endeavour is made to ensure that they do not fall behind in their school work, and that they will be able to return to their normal places in the ordinary school. Secondly (and this applies particularly to the under fives) they are assisted to develop mentally in an orderly and harmonious manner. The child has been uprooted from his normal home environment. We have every reason to believe that the school makes an important contribution to the child's mental health."

92. This quotation from the "Health of the School Child"⁽¹⁾ seems to us to sum up the reasons why every opportunity should be taken to provide education for children in hospital, and in recent years there has been a growing realisation of the importance of this. For over a quarter of a century a number of long-stay hospitals have had recognised hospital schools attached to them. In addition since the passing of the Education Act, 1944, education authorities have had power to make arrangements for teachers to work in hospitals where there are groups of children of school age. Any child over the age of 2 may be put on the school roll and where there is a large enough group of these children, the education authorities can provide nursery teachers in addition to teachers for the older children. School hours are usually from 9.30 to 11.30 in the morning and again from 1.30 to 3.30 in the afternoon. In September 1956 the Ministry of Health and Ministry of Education sent memoranda to hospital and local education authorities drawing attention to the importance of education in hospitals and stressed the need for liaison between the two types of authority both in regard to the identification of need for education in hospital and to the provision to be made on discharge.⁽²⁾

(1) "The Health of the School Child" Report of the Chief Medical Officer, Ministry of Education, for 1954 and 1955, Chapter XV.

(2) Ministry of Health Memorandum H.M. (56)81 and Ministry of Education Circular 312.

93. We understand that in January 1957 there were 114 hospital schools, with 5,844 pupils and that in January 1958 there were 206 other hospitals in which arrangements had been made for teaching to be done. These latter arrangements covered 1,689 children. Thus the total number of children covered may not represent more than a quarter of the total number in hospital, and, even allowing for the fact that a proportion of the children are under two and a proportion not medically fit to receive it, it seems that there may still be a substantial number of short stay cases who would profit from education but are not receiving it. Those in adult wards are specially liable to be overlooked. Even with a short stay case a break in education may be positively harmful, and whenever a child is admitted, hospital authorities should consider whether he is likely to stay long enough and be fit enough to receive education. If so, and if no regular teaching arrangements already exist within the hospital, they should notify the local education authority so that they will have time to make ad hoc arrangements if possible.

94. Children should not be admitted to hospital when they are about to take important examinations unless they require urgent treatment. The hospital will not know that an examination is imminent unless the parents tell them and leaflets for parents should make it clear that it is for them to seek postponement of admission on this ground if necessary. Arrangements for children in long stay hospitals to take examinations from hospital should be encouraged.

95. Co-operation by the hospital staff with the teacher is essential. In particular the medical staff can help by saying when a child is well enough to receive instruction. Similarly, the teacher can plan the work better if she knows for approximately how long a child is likely to be in hospital. A particularly close liaison between sister and teacher is essential.

96. Teaching is much easier if children of the same age are in the same ward, or the same part of the ward. Older children who are doing lessons may be distracted if there are younger ones playing nearby. Beds can often be rearranged for teaching periods so that all the children being taught are together. There are bound to be some interruptions to teaching while the work of the ward is carried on, but there is considerable variation at present in the amount of disturbance caused in different hospitals. Whenever possible treatment and visiting should be so arranged as to avoid school hours.

97. An efficient hospital teacher needs a room in which she can prepare her work and ample storage space for books and equipment in the ward units, and it is incumbent upon the hospital authorities to see that satisfactory accommodation is provided. It should also be realised that children in bed may be given activities that are messy and untidy, such as modelling, cooking and even scientific experiments.

98. During school holidays various arrangements can be made for organised activities to take the place of school. Some education authorities engage staff especially for holiday periods, perhaps students or retired teachers. Others arrange for the teaching staff at the hospital to take only 3 weeks' holiday at a time, so that the breaks are shorter. It is important that children should be given organised activity outside the school term; hospitals should not hesitate to ask local education authorities for help to occupy children during holidays.

5. OTHER ASPECTS OF IN-PATIENT CARE

Recreation

99. Much of the evidence we have received has emphasised the need to give children in hospital plenty of occupation for their spare time. An unoccupied child is less likely to be happy than one with interesting things to do. Where play can be organised under skilled supervision it is particularly useful but student nurses, cadets and voluntary workers can all help to entertain the children.

100. Children's activities fall into two types, spontaneous and organised. Since all children's activities are necessarily restricted in hospital, it is essential that there should be a daily programme. This should include rest periods, and periods of unorganised play, but those in charge should realise that these will not be constructively used unless children are provided with something which they are allowed to play with during their free times. It is important to see that every child's needs are catered for in this way. The child who cannot participate in an activity feels doubly left out unless he is given special attention of some sort, even if that special attention is somebody offering him an alternative activity such as reading, listening or drawing. On the other hand, diversion need not depend on elaborate organisation: a child may be happier watching traffic or a mechanical polisher than taking part in a carefully devised game.

101. For younger children a variety of suitable toys is essential. Voluntary organisations such as Leagues of Friends can often help with the supply of these but the supply should be under the supervision of the hospital, who should ensure that skilled advice is obtained, e.g. from the nursery schools associations, on the suitability of the toys provided. Older children may take part in club activities such as Scouts and Guides. When children have particular hobbies such as gardening, painting and handicraft these should be respected and encouraged as far as possible. Wireless and television are becoming increasingly common in hospital wards and selected parts of the programmes can be a great boon to the children. We have already suggested that it is an advantage if there is a separate playroom where children who are up and about can go without disturbing more ill children.

102. These suggestions obviously apply with greatest force to long-stay hospitals, but they can and should be applied in varying degree to those hospitals where stay is normally short.

Discipline

103. Children vary in their response to the disciplinary techniques of adults and an orderly ward depends very much upon fairness, reasonable firmness and harmonious relationships between all the staff. It is well known that certain adults find it easier to maintain discipline with children than do others, and that approaches vary from individual to individual. Nevertheless the following general observations should be useful:

- (1) It is extremely difficult for anyone to maintain discipline with children if his or her requests and instructions are countermanded by someone else in higher authority.
- (2) Children who participate in an orderly and sensibly devised programme with sufficient diversion to avoid boredom will not present

a disciplinary problem. Conversely the child in an otherwise empty cot sitting and staring into space is a potential disciplinary problem.

- (3) The child who has violent tantrums and is not restrained, as many are, by the presence of other children presents a special problem. A patient attempt to get to the cause of the outburst is obviously better than severity, but on the other hand a child in a ward with acutely ill children cannot be allowed to disturb them, and in the extreme case a child in a tantrum may have to be removed to a side ward. This will only be successful if the removal is presented as a matter of ward administration and not as a punishment, and if the child is not shut in there alone but is accompanied by a sympathetic adult until he can recover, and the reasons for the outburst can be ascertained.
- (4) A great deal of this report deals with the relationships between hospital staff and parents. A good relationship with the parents of a child makes discipline simpler ; contradiction between parents and staff which the child perceives can give rise to acute problems of discipline even in adolescence. It is better to convert a parent to a point of view than to over-rule him. A contradiction between staff and parents can be the reason why the child is not visited and the source of much later disturbance.

Safety Measures

104. The safety of the child is obviously a prime consideration of hospital staff and it is understandable that hospital authorities, because they are legally responsible for the children during their stay in hospital, take precautions which would not be necessary at home. We wonder however whether there is sufficient appreciation of the harmful psychological effects of such things as restrainers and high sided cots on all but the very youngest children, and sufficient readiness to explore other ways of preventing accidents, notably by closer supervision. In our view restrainers should be necessary only in exceptional circumstances, and children who are accustomed to sleep in beds at home should be allowed to do the same when in hospital.

Personal Possessions

105. We have already suggested (paragraph 59) that children should be allowed to take personal possessions such as toys and books with them into hospital and preferably they should keep these beside them. The choice of what to bring must be the child's, and neither parent nor hospital should stop him bringing something he loves on the ground that it is not clean or respectable enough to take into hospital. Hospitals should provide lockers, boxes or bags for each child which he can reach easily. Even very young children need accessible storage space.

Food

106. Children's food should look attractive, should be served in suitable utensils, with implements of the right size and shape to eat it with, and should be chosen to suit the age of the child. Portions should be small with an opportunity to ask for more; mountainous helpings often daunt the uncertain appetite. For infants sieving is important but different constituents should not all be mashed together. It will not be conducive to a properly balanced

diet if the child eats food brought by his parents and the aim should be to see that the food he gets in hospital satisfies him. Although a mother can sometimes persuade her child to eat when no one else can it is also possible that the reverse may be true.

Toilet Training

107. Some parents complain that young children regress in their toilet training after a period in hospital. This may be due either to the emotional upset of separation, or to inadequate attention to the child's toilet needs while in hospital. Children are shy about making their needs known, particularly during the first few days before they get to know the nursing staff. Hospital staff can avoid some embarrassment for the child if they learn his private vocabulary for the toilet and his home routine. Whenever possible children should be allowed to get out of bed to go to the toilet, but if they are bedfast they must have some means of making known their need for a bedpan or bottle. We have heard of hospitals where children in cubicles have no means of communicating such needs and this causes very great discomfort and unhappiness. No hospital staff should treat toilet "accidents" as occasions for punishment or rebuke of the child.

Information about Children's Progress

108. We have already referred to the need for organised arrangements to supply visiting parents with information about a child's progress. If parents are unable to visit it is equally important that they should be able to get information by letter or telephone from a responsible and knowledgeable person, preferably the Ward Sister, so that they can get full and sympathetic answers to their questions. It is not enough for a parent to be given a formal "bulletin" by, for instance a telephone operator. Obviously sisters cannot come to the telephone at frequent intervals throughout the day but it should be possible to ensure that someone with direct knowledge of the child's condition is available to answer telephone enquiries from close relatives at certain prearranged times. If parents are able to speak to *medical* staff when they visit their children they are less likely to seek information by telephone during the intervals between visits.

Transfers

109. It is important to explain to the child, and to inform parents, when the child is to be moved from one ward to another, to another hospital or to a convalescent home. Children can become very worried lest their parents are not able to find them in their new surroundings and it should be made clear to them that their parents know what is happening. Indeed parents should be given the opportunity to accompany their children when the move takes place. If they cannot do so, a familiar member of the hospital staff should go with the child.

Spiritual Welfare

110. This part of the child's welfare should not be neglected while he is in hospital. We were impressed by the interest in it shown by several of the bodies who gave evidence to us. Daily prayers are an important part of life in a children's ward. Much of the evidence we received from parents showed that they appreciated arrangements made for evening prayers. Where parents are allowed to visit their children every evening, they may prefer to say

prayers privately with them, but this is not to say that there should not be an opportunity for the whole ward to take part in prayers. The Ward Sister is normally the most appropriate person to conduct prayers. In addition to ward prayers, hospitals should make arrangements for children to take part in Sunday School. Hospital chaplains and visiting clergy are always willing to visit children in hospital and parents should be told that the services of a Minister of any denomination are available. The main object in this, as in other aspects of the care of the child, should be to preserve as far as possible the thread of his experience and the certainty that his normal life will be resumed.

VII. WELFARE ASPECT OF MEDICAL TREATMENT

GENERAL

111. Although our terms of reference specifically exclude the medical and nursing treatment of children in hospital we do not interpret this as precluding us from commenting on the impact of various medical procedures on the child's general welfare. For example, we think it right to draw attention to the harmful effects of postponing an operation once it has been fixed, and to the importance of careful scrutiny of the need for any medical procedures that involve unpleasant experiences.

PREPARATION

112. 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. Children's anxieties may seem fanciful, but they are none the less real to the child, and an opportunity should be taken to talk to the child about his forthcoming treatment and, as far as is possible within the limits of his understanding, to explain to him what is involved. 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 has no terrors for an adult will have none for a child. A child may be more afraid of a white coat than a painful procedure, and darkness and solitude can seem more terrifying than an operation. 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. It should not be necessary to dwell on the painful aspects of treatment: a child should be warned if he is going to be hurt but the hurt can be exaggerated by an exaggerated warning, especially if this is given too long in advance. Blame for crying or for being afraid not only makes the child feel guilty and ashamed but can increase his degree of pain. Conversely, strong suggestion, approval and support can minimise pain. Where the child is to undergo an operation, it is a great help if he knows that he will have a familiar person with him, for example his mother or a nurse he knows, as long as he is conscious. One of the most upsetting experiences for the child is to be

removed, when he is already apprehensive, from the environment and people he knows. The special needs of the blind, the deaf and those with language difficulties should be carefully considered in this context.

TREATMENT AND RECOVERY ROOMS

113. We agree with the recommendations made to us that there should be treatment rooms separate from the wards available for children so that unpleasant procedures do not have to take place in the presence of other children. For the same reason we believe that children should not be within sight of other children when they are being anaesthetised or coming round after an operation.

PREMEDICATION

114. Premedication has been of the greatest value in lessening the alarming aspects of operations and we believe that it should always be given unless there are medical reasons for not doing so. It may often be helpful if the mother is allowed to be present until the child goes to sleep. Premedication should also be used much more widely for minor procedures taking place in the ward unit, e.g., lumbar puncture.

PRESENCE OF MOTHER DURING RECOVERY FROM ANAESTHESIA

115. The mother may also be present when the child is coming round from the anaesthetic, provided that she is not present at too early a stage. Whenever the mother is allowed to be present during recovery it is important that the probable after-effects of anaesthesia on the child should have been explained to her.

WARD ROUNDS

116. Children often absorb much more of what is said in their presence than adults realise and they are liable to misinterpret what they hear and to worry about it afterwards. For these reasons, we believe that any discussion during medical ward rounds should take place as far as possible out of earshot of the children, or if discussion takes place round the bed, exceptional discretion should be used in what is said or left unsaid in front of them.

VIII. SPECIAL GROUPS

1. LONG-STAY HOSPITALS

117. Most of our recommendations apply equally to acute hospitals, where children may be discharged after a few days, and to long-stay hospitals. There are, however, certain aspects of hospital care which need particular emphasis in long-stay patients, because of the particular problems created by prolonged separation from home and parents and the need for the child to become fully adjusted to the life of the hospital. We should therefore stress the following points:

- (a) Careful preparation of both parents and child is particularly necessary. Normally children are not admitted to long-stay hospitals in an emergency and there is therefore plenty of time to accustom the

family to the idea of the child's admission. For the parents, an interview with the member of the medical staff who will be in charge of treatment is essential. Parents must be sufficiently informed about the hospital's regulations and routines so that once their child has settled in their attitude will be much the same as it would be if the child was starting life at a boarding school. They need assurance that they will be notified of changes in their child's life and they should be asked to co-operate in the process of settling in.

- (b) During the settling in period, before the child becomes accustomed to his surroundings, the hospital should be prepared, where necessary, to provide accommodation for the mother so that she can stay for a night or two. This short stay will ensure a better understanding between the staff, child and parents and may be essential in children whose home are many miles away.
- (c) Visiting in long-stay hospitals presents more of a problem than in acute hospitals since many parents are unable, because of the distance of the hospital from the home or for financial reasons, to visit their children daily. In addition, many long-stay hospitals have school hours and are therefore restricted as to the times when they can welcome visitors. Although visiting should not be allowed to interfere with education, we see no reason why this principle should entail rigid adherence to set times for all visitors and we suggest that parents should be allowed to visit, by arrangement with the ward sister, at whatever times outside school hours suit them best. Once the child has settled in, regular visits can be less frequent. Our remarks about amenities for visitors (paragraph 87) are of particular relevance to long-stay hospitals, which are often at some distance from towns. If a child has no visitors he may be given a "foster home" close to the hospital where he can enjoy family life.
- (d) Education and organised recreation have been for some time an essential part of the life of the child in hospital for a long period, but we should like to emphasise the importance of ensuring that such children are kept happily occupied during school holidays and of providing a well run children's library. The hospital school will provide some books and help with the library staffing but it is for the hospital to see that a library is provided and fully stocked and to make suitable accommodation available for it.
- (e) As the time of discharge approaches the hospital should make contact with the family doctor, the local health and education authorities and all those who will be concerned with the child's after-care. In particular where a child is of school age, provision should be made for continuing education once he has returned home, his special educational requirements having been made known to the local education authority without delay.
- (f) After a long-stay in hospital readjustment to home life can be difficult. It will be less so if parents have been able to visit sufficiently frequently, and also if the child has been home for occasional visits during his stay in hospital. During visits parents should be instructed

in any special care the child will need after his return home. The child who has been kept well in touch with events at home will find readjustment less difficult. The almoner should be informed about parents who fail to visit their children in long-stay hospitals so that she can find out the difficulties and see if they can be overcome. Health visitors can prevent the parents losing touch and can also help in dealing with problems which may arise after discharge. Long-stay hospitals should have under continual review the possibility of children having periods at home before treatment is completed and should of course discharge them permanently as soon as it is medically justifiable to do so.

2. THE BLIND AND DEAF

118. Again our general recommendations for the care of sick children apply with particular force to the child who is blind or deaf. The needs of children with such handicaps include those of other ill children and some additional ones, and particular consideration should be shown to them in the following ways:

- (i) The hospital should maintain close contact with the home or school from which they are admitted. Such children need plenty of preparation because adjustment to new surroundings may be more difficult than for the normal child.
- (ii) These children need special materials and equipment to occupy themselves. They also need even more than do other children the companionship of adults they know.
- (iii) The education of the blind or deaf child in hospital need not present as great a problem as is sometimes supposed, since teachers without special qualifications can often, with the help of a school for the blind or deaf, give the child what he needs for the time he is in hospital. None the less, hospitals should ask local education authorities to do their best to provide specially qualified teachers, even though this may mean one teacher being attached to several hospitals.
- (iv) Parents should be kept as fully informed as possible of their child's progress while in hospital. Particular care and sympathy is needed from hospital staff in talking to parents of blind and deaf children and everything possible should be done to allay fears and misunderstandings about their child's handicap.
- (v) Occasionally children may become blind or deaf while in hospital. For example, a child may become deaf as a result of tuberculous meningitis. There is a danger that the special needs of such a child may be overlooked and there should be no delay in providing any necessary hearing aid and the services of a teacher of the deaf.

3. INFECTIOUS DISEASES HOSPITALS

119. The character of infectious diseases hospitals has changed immensely in recent years. Many of the old "isolation hospitals" were built at a distance from towns to house a large number of patients for indefinite periods of time. Immunisation, changes in incidence and severity and new methods of treatment have meant that the number of cases of infectious illness has fallen

considerably and that relatively more of them are nursed at home. "Isolation" hospitals are now being used for the treatment of a much wider range of children's ailments.

120. These changed circumstances should be reflected in the management of children admitted to infectious diseases hospitals. In particular, more attention needs to be devoted, on the lines we have suggested for hospitals generally, to the occupation and education of children in these hospitals; and our recommendations on admission of mothers and unrestricted visiting are intended to apply to infectious diseases hospitals as to others. It is still being argued in some districts that parents cannot be allowed to see their children because of the danger of spreading infection, but we have had evidence that in other districts hospitals have allowed unrestricted visiting and admission of mothers without any increase in the incidence of infection. We should like to see the restrictions on visiting in infectious disease hospitals lifted, so that the parents can have access and talk to the child save in exceptional cases where there is a real risk to the community. There may be a few occasions on which parents must be asked not to visit because of risk to contacts at home or at work but these should be exceptional particularly if visitors can be given protective clothing to wear when necessary. More harm than good is done, however, by allowing parents to see their children only through a glass partition; this seems to us an unimaginative restriction, particularly where very young children are concerned, and since we know of hospitals which are able to dispense with it we hope it will disappear altogether.

121. The change in the role of the infectious diseases hospital also demands that it should have a nucleus of nursing staff with special training in the care of children and that a children's physician should be associated with the children's medical care. This association should preferably take the form of provision in the children's physician's contract for regular sessions at the infectious diseases hospital.

4. OPERATIONS FOR REMOVAL OF TONSILS AND ADENOIDS

122. The care of children before and after operations for removal of tonsils and adenoids merits particular attention. It has been calculated that nearly one child in three has his tonsils out before the age of 13, and that nearly 200,000 operations for removal of tonsils and adenoids are performed each year in England and Wales—largely in the 5-8 age group. In fact this is the commonest reason for admission of children to hospital, and because these cases are usually dealt with in batches and are usually only in hospital for a short period, there may well be a tendency to consider that their problems are less important than those of longer stay children.

123. Preparation for admission should include carefully prepared leaflets so that, shortly before his admission to hospital, the mother is able to give the child a simple explanation of what is likely to happen to him. This important matter has frequently been neglected in the past. The mother should be encouraged to discuss any problem with the Ward Sister before the time of admission, and there are also obvious possibilities for group discussion.

124. It is inadvisable for these operations to be carried out in small units if there are inadequate facilities for the handling of children. There

should be a tonsils and adenoid unit separate from the other children's accommodation. In a large centre it will no doubt be possible to provide a ward, separate from the adult accommodation, in the main E.N.T. Department, but if this cannot be done the children should be nursed in a ward within the children's unit. Wherever they are nursed, the staff should be properly trained to give the specialised pre- and post-operative care which is so necessary for this type of case, and a larger nursing establishment may be needed than for ordinary children's nursing.

125. The same arrangements for admission, reception and welfare in the ward should apply to children admitted for tonsil and adenoid operations as for other children, and special care should be taken that children awaiting operation do not see those just returning from the operating theatre. The same visiting arrangements should apply as elsewhere. There is no evidence of any increased incidence of infection where this has been done. Parents should be allowed in as often as possible, including the day of operation, although it may be better for them not to see their children until they have fully recovered from the anaesthetic. On discharge a simple leaflet setting out the after-care necessary will be very helpful to most parents.

5. EYE OPERATIONS

126. These operations also account for a large number of hospital admissions of children and again all our general recommendations about preparation for admission, visiting, etc., apply. It is best for the children to be nursed in a separate children's unit: in big centres this may be also a specialist eye unit but elsewhere it will be a general children's ward.

127. To have his eyes bandaged, as commonly happens after for instance an operation for squint, is profoundly disturbing to a child. Some hospitals have found it possible to avoid bandaging children's eyes after squint operations and while it is not within our province to discuss the medical arguments for and against bandaging, we would express the earnest hope that bandaging will not be resorted to without the most careful weighing of its serious disadvantages for the emotional welfare of the child. Whenever bandaging is necessary, time must be devoted to the reassurance of the child and arrangements must be made for his occupation. These above all are cases in which the parents should be given every opportunity to play their part.

IX. DISCHARGE AND AFTER-CARE

128. Some of the criticisms we have heard of the treatment of children in hospital have been made because some children show evidence of psychological disturbance after discharge. A certain amount of such disturbance appears to be inevitable, and results from separation and fear at vulnerable ages: the impossibility of arriving at an exact quantitative assessment is shown by the wide variation in the estimates offered to us, which ranged from 20 per cent to 90 per cent. The disturbances which children show on discharge from hospital fall into four main groups:

1. Regression to earlier stages in child development.
2. Aggressive behaviour of various sorts.
3. Terrors, timidity and sleep disturbance.
4. Difficulties at school.

129. Regressive behaviour due to stress means a reversion to forms of behaviour which the child had previously grown out of. The commonest forms are loss of sphincter control, loss of speech and demands for cuddling, rocking or the feeding bottle long after infancy. Regressive behaviour may be patchy in its occurrence, and a child's behaviour can vary from hour to hour between that normal to a seven year old and that of a four year old.

130. Aggressive behaviour is the natural response to being hurt or the memory of being hurt. It is not possible for the child in hospital to be allowed to act out his aggression when he is hurt or frightened as he would in the playground or at home. Hence aggression is stored up and released at home.

131. Night terrors and sleep disturbance are the commonest reactions of the individual of any age to stress of any sort. In hospital the positive provisions of a night light and a nurse who is sympathetic recognise this. When the child goes home he can miss this provision and parents need to be warned to deal with the problem with understanding. The fear of doctors and of white coats can persist throughout a person's life, or the white coat and the nurse's uniform can equally stand for security and reassurance. Which of these happens to a child depends on a meticulous attention to the details of the life of the child in hospital.

132. Preparation for discharge can be almost as important for both parents and child as preparation for admission and parents should be given as long notice as possible. We do not agree with those who hold that children should never be told before the parents when they will be discharged: it may not always be possible to inform the parents first, and provided they are told at the first opportunity, there is no harm in the child knowing in advance. Telling the parents the date when the child will be sent home is only one step in the preparation for discharge. They should be told, by the doctor concerned or a senior member of the nursing staff, what treatment the child has received in hospital and how this may have to be followed up at home. Special instructions may have to be given about feeding habits, diet, medicine, appliances, reference to the family doctor or return visits to the hospital. Where the child has been given special treatment in hospital which is to be continued at home it may sometimes be desirable to admit the mother to hospital for a day or two before discharge to be shown what she will have to do once the child is at home. Written instructions should be given to mothers about such matters as the making up and timing of infants' feeds.

133. At the time of discharge the Ward Sister or a senior member of the nursing staff should be available to talk to parents who come to take the child home. Times of discharge vary greatly, but hospitals should try to choose times which suit parents as well as themselves. For example, where the hospital is at some distance from a town, discharge should be arranged to fit in with bus services.

134. The need to inform the family doctor promptly about discharge of his patients has been stressed in the report of the Committee on the Reception

and Welfare of In-patients (H.M.S.O. 1953) and what is said in paragraphs 84-5 of that report applies to children no less than to adults. While we appreciate that it is often impracticable for a full report to go to the family doctor for some days after the patient has been discharged it should be possible, e.g. by using a printed form with space for the insertion of the minimum essential information in manuscript, for a brief notification to be sent off as soon as discharge on a particular day is certain, with the promise of a detailed note as soon as possible thereafter. When there is need for continued treatment or nursing at home after discharge, there should be full consultation with the family doctor to find out whether the home conditions are suitable, and he should always be told what advice has been given to the parents.

135. Hospital staff may not be aware of the services provided by local authorities for ill children, and we understand that these are not always invoked as they should be. The local health authority provides guidance for the mothers of children under 5 under the supervision of the maternity and child welfare staff. It is important that a liaison be preserved so that the advice given by the hospital on discharge does not conflict with that given by the health visitor. The local education authority is also responsible for the provision of special education for handicapped children, and for the education of children who cannot attend school for long periods. Hence it is essential that the Medical Officer of Health (who is usually also the Principal School Medical Officer) should be notified as soon as possible of the discharge of any children needing any of these services. Otherwise time may be lost which can prove vital in for instance the care of a child who has lost one of its special senses. In this chain of communication the services of the almoner should be invoked and the part that can be played by the Ward Sister should not be overlooked. It goes without saying that all that is done to arrange for after-care should be with the knowledge of the family doctor.

136. For some children, follow-up visits to the out-patient department by appointment made at the time of discharge will be necessary for a period, but these should be reduced to the minimum by keeping the family doctor fully informed about after-treatment and making full use of his services. The family doctor is in the best position to call in the services of Health Visitors and Home Nurses, when needed, through the local health authority.

X. TRAINING OF STAFF

137. While the child is in hospital he is under the skilled care of medical, nursing and other staff. For a shorter or longer period the hospital is his home and whether he is happy there depends more on the staff looking after him than on any other single factor ; it is therefore very important that all who have to look after sick children should learn not only how to deal with the child's ailment but also how to meet his emotional and other needs.

138. The members of the staff who come most into contact with children in hospital are of course the nurses, and their proper training is of the utmost importance to the child's welfare. The nurse's real competence with

sick children comes not from text books but from the close personal contacts with patients. In nursing sick children the nurse needs to understand not only the diseases of children—and disease in children presents many special features not found in disease in adults—but also the factors that influence the development of the normal child, including his emotional reactions, his family circumstances and the importance of his other social relationships. As we have already indicated children's needs vary at different ages and the nurse must have an understanding of these differences.

139. All this requires special study and we trust that those responsible for nursing curricula will give all possible priority to the adaptation of training courses for the purpose. A few lectures are not enough: experience with well children in a nursery school or a residential or day nursery would be a great advantage where practicable and the nurse should be given some knowledge of the results of recent studies by educationalists of the normal child's needs and development.

140. The children's nurse needs to know all that she can learn about the functions and difficulties of parenthood and the significance of family life. It is not possible for this information to be acquired theoretically, though lectures from a social worker could be of value. More useful would be practical work with a home nurse assisting in the home care of children in the district surrounding the training school. In this way also, the nurse in training would get insight into the problems which the average mother surmounts. It was suggested to us in evidence by several bodies that nurses in training should be trained in the taking of essential social histories; and we agree that such activity can establish the necessary confidence between nurse, child and parent, and teach the nurse a particular approach to patients which the training may not afford at present. We have already drawn attention to the key position occupied by the ward sister. The special elements in a nurse's training which we have just outlined should be a feature of the refresher courses arranged for ward sisters.

141. Training of medical staff should also take more account of the emotional and social needs of children and their parents. Though the doctor's contacts with the child are less prolonged than those of the nurse he is a figure of great importance in the hospital ward and the way in which he handles both parents and children can be vital to their welfare. It is not enough that those specialising in children's medicine should receive special instruction in this aspect of the child's well-being: every practising doctor and particularly every family doctor must frequently find himself in situations where this knowledge is essential to the proper management of patients.

142. Children in hospital also come into contact with a number of staff other than medical and nursing staff, e.g., radiographers, physiotherapists and laboratory technicians. All these people are concerned with procedures which may be frightening or painful and during their training they should learn about the need for special care in dealing with children and that the approach to the child must differ at different ages. Complicated techniques can only be performed on a willing child, and the technician will therefore normally be alive to their immediate emotional effect; less obvious is the reaction of a child to a daily blood count—a pricked finger can assume greater importance, particularly if force is used, than a major operation. The

technician should be taught to explain that a prick will be felt, and to act rapidly, meanwhile talking about something which will interest the child.

143. Another group of staff who should receive special instruction about children in hospital are hospital teachers. These are in a slightly different category because they require training in the needs of the sick child in relation to education. We should like to see an extension of the existing arrangements for this kind of training.

XI. SUMMARY OF RECOMMENDATIONS

GENERAL

1. 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. (Paragraphs 6-14.)

ALTERNATIVES TO IN-PATIENT TREATMENT

2. Children should not be admitted to hospital if it can possibly be avoided (paragraph 17).

3. Special nursing facilities for looking after sick children at home should be extended (paragraphs 18-19).

4. There should be separate out-patient departments for children, with suitable facilities and staff. Waiting time should be kept to the minimum (paragraphs 20-24).

5. Some simple surgical operations can be undertaken at the hospital, subject to certain safeguards, without fully admitting the child (paragraphs 26-27).

HOSPITAL ORGANISATION, DESIGN AND STAFFING

6. Children and adolescents should not be nursed in adult wards (paragraphs 29-33).

7. Separate children's hospitals for all children are impracticable and for the general run of cases a small children's unit at the local hospital should suffice (paragraph 34).

8. Children should be nursed in company with other children of the same age group. They should have facilities for inside and outside play and colour schemes should be cheerful. Supervision and prevention of accidents are important (paragraph 35).

9. A children's physician should have a general concern with the care of all children in hospital (paragraph 36).

10. The Sister in charge of the ward should be R.S.C.N. as well as S.R.N. The child should be able to get to know his own nurse. Nursery nurses can help with children under 5 (paragraphs 37-39).

11. Social workers and occupational therapists have a valuable contribution to make (paragraphs 40-42).

PREPARATION FOR ADMISSION

12. The risk of disturbance to the child can be reduced by proper preparation. This can be achieved by the promotion of a better understanding of the hospital's place in the community, by explanations from the family doctor and local authority clinic staffs, and by suitable measures on the hospital's part in arranging admissions. These should include :

- (i) explanation of the reasons for admission by the doctor who makes the decision ;
- (ii) an interview with a suitably trained person to discuss details ;
- (iii) properly designed leaflets and letters.

Talks between the ward sister and groups of parents may also be useful. The information suitable to be given to the child himself depends on his age, but a period in hospital should never be threatened as a punishment, nor promised as a treat (paragraphs 43-52).

RECEPTION

13. First impressions are important. The main admission procedure should be in the ward and there should be the least possible delay in reaching it. Sister should welcome the child in reassuring surroundings and should find out from the parents about his idiosyncrasies (paragraphs 53-57).

14. Children admitted during the day should not be put to bed unless this is medically necessary. Where children are admitted at bedtime the parents should be allowed to help put them to bed (paragraph 58).

15. Clothes provided by the hospital should be attractive and well-fitting. The experiment of allowing children to wear their own clothes is worth considering ; and they should be allowed to keep a favourite toy (paragraph 59).

16. Re-admission should be to a familiar ward (paragraph 60).

17. Proper reception is specially important for emergencies. There should be separate accommodation for children in casualty departments and suitable amenities for waiting parents (paragraphs 61-63).

THE CHILD AS IN-PATIENT

General

18. The differing psychological needs of children of different ages are described (paragraphs 64-67).

Admission of Mothers

19. There is much to be said for admission of mothers along with their children, especially when the child is under five and during the first few days in hospital. This is of great benefit to the child and if the mother is allowed to play a full part in his care she can be a help rather than a hindrance to the hospital staff (paragraphs 68-70).

Visiting

20. A child in hospital must be visited frequently to preserve the continuity of his life, and the arguments formerly advanced against frequent visiting are no longer valid. Parents should be allowed to visit whenever they can, and to help as much as possible with the care of the child. (paragraphs 71-80).

21. Visiting is specially important in the first few days of the child's stay in hospital (paragraph 81).

22. Evening visits should be encouraged and visits on operating days allowed (paragraphs 82-83).

23. Parents should be able to get authoritative information about their child's progress when they visit (paragraph 84).

24. Visitors other than parents should be permitted at certain times (paragraph 85).

25. Special arrangements should be made for children whose parents cannot visit them (paragraph 86).

26. More amenities for visitors are needed (paragraph 87).

27. Parents in genuine need of financial assistance to enable them to visit frequently should be helped to get it (paragraphs 88-90).

Education

28. The provision of educational facilities is important, for shorter stay as well as long stay patients, and it is the hospital's responsibility to approach the local education authority for the purpose (paragraphs 91-93).

29. Children should not normally be admitted to hospital when they are about to take important examinations (paragraph 94).

30. Teaching requires the co-operation of the hospital staff, suitable arrangement of the ward and the provision of space for storage of equipment (paragraphs 95-97).

31. Organised activity outside school terms is important (paragraph 98).

Other Aspects of In-Patient Care

32. There should be an organised programme of recreation with suitable toys and other diversions (paragraphs 99-102).

33. Happy discipline depends not only on correct management but on harmonious relationships between all the staff, and between staff and parents. If there is sensibly organised diversion disciplinary problems will be reduced (paragraph 103).

34. Physical restraints should not be needlessly applied (paragraph 104).

35. Children should be able to keep the personal possession they treasure by their beds and all should have accessible storage space (paragraph 105).

36. Food should be attractively served and satisfying (paragraph 106).

37. Toilet needs should be adequately attended to. Private vocabularies should be learned and children allowed to get up to go to the toilet if at all possible (paragraph 107).

38. Parents should be able to get information about their children's progress from a knowledgeable and responsible person. They should be told if their child is to be transferred and should be given the opportunity to go with him (paragraphs 108-109).

39. Daily prayers, Sunday school and visits by clergy are important (paragraph 110).

MEDICAL TREATMENT

40. Unpleasant medical procedures should be kept to the minimum and carried out with tact and understanding of children's reactions (paragraphs 111-112).

41. There should be separate treatment rooms and children should not be within sight of other children when they are being anaesthetised or coming round after an operation (paragraph 113).

42. Premedication should normally be used before operations. It will help the child if the mother can be present until he goes to sleep and when he is coming round (paragraphs 114-115).

43. Exceptional discretion is needed in the discussion of children's cases during ward rounds (paragraph 116).

SPECIAL GROUPS

44. Most of our recommendations apply to long stay hospitals and we make some additional comments on preparation, settling in, visiting, education, recreation and discharge in relation to such hospitals. Children should not be kept in long stay hospitals for longer than their medical condition requires and should be allowed to go home for short periods while they are under treatment (paragraph 117).

45. Blind and deaf children and their parents have special needs, e.g. in relation to contact with the home, occupation, education and contact between hospital and parents. If a child becomes blind or deaf in hospital there should be no delay in providing the special services he needs (paragraph 118).

46. Isolation hospitals are being used for a wide range of children's ailments than formerly and this should be reflected in their staffing and management. In particular restrictions on visiting should be lifted (paragraphs 119-121).

47. Regard must be had to the welfare of the large numbers of children admitted for tonsil and adenoid operations notwithstanding the shortness of their stay. They should not be nursed with adults and our recommendations regarding admission, reception and in-patient care (including visiting) all apply equally to them (paragraphs 122-125).

48. Children admitted for eye operations should be nursed in a separate children's unit. Bandaging of children's eyes should not be lightly resorted to and if it is medically imperative should be accompanied by special arrangements for the reassurance and occupation of the child concerned (paragraphs 126-127).

DISCHARGE

49. Parents should be warned about behaviour problems that may arise after discharge and advised how to deal with them. They should also be told of their part in any treatment required after the child's discharge from hospital (paragraphs 128-131).

50. Discharge times should be chosen with due regard to parents' convenience and a senior nurse should be available to speak to the parents (paragraphs 132-133).

51. The family doctor should be told in advance when his patient is coming out of hospital and he should be provided with a full report as soon

as possible. There should be adequate liaison with the local health and education authorities about any after care or special educational requirements. Follow-up visits to the out-patient department should be reduced to the minimum (paragraphs 134-136).

TRAINING OF STAFF

52. Nurses need training not only in the special aspects of disease in children but in the factors that influence the development of the normal child. Part of this training should take the form of practical experience in the care of well children both in nursery schools, etc. and in their homes. The emotional needs of children in hospital should be stressed in refresher courses for Ward Sisters (paragraphs 138-140).

53. Doctors generally also require more training in the child's emotional needs (paragraph 141).

54. Ancillary hospital staff should be taught how to adjust their procedures to children's needs (paragraph 142).

55. Extension of the arrangements for training hospital teachers is required (paragraph 143).

(Signed) HARRY PLATT
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MARJORIE E. JOHN
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APPENDIX

LIST OF ORGANISATIONS AND INDIVIDUALS WHO GAVE EVIDENCE

1. ORGANISATIONS

Association of Children's Officers
Association of Hospital Administrators
Association of Hospital Matrons
Association of Occupational Therapists
Association of Psychiatric Social Workers
British Medical Association
British Orthopædic Association
British Paediatric Association
British Paediatric Nurses Association
Central Council for the Care of Cripples
Central Council for Health Education
College of General Practitioners
Institute of Almoners
Institute of Hospital Administrators
Ministry of Education
National Association for Maternal and Child Welfare
National Institute for the Deaf
National Federation of Women's Institutes
National Union of Townswomen's Guilds
Nuffield Foundation
Mothers Union
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal Medico-Psychological Association
Royal National Institute for the Blind
Society of Medical Officers of Health
Tavistock Institute for Human Relations
Women Public Health Officers' Association

2. INDIVIDUALS

Dr. Portia Holman, M.D., M.R.C.P., D.P.M (Ealing Child G
Centre)
Dr. Dermod MacCarthy, M.D., M.R.C.P. (Amersham)
Hospital)
Dr. Charlotte Naish, M.B., B.Ch., M.D. (Cumberland)
Miss Joan Woodward, M.A. (Psychiatric Social Worker, Burns
Birmingham Accident Hospital)