

STANDARD 4: Giving ‘child centred’ healthcare

‘Health care providers, organisations and individual health workers, share a responsibility to advocate for children and to reduce the fear, anxiety and suffering of children and families by ensuring that they provide ‘child centred’ care’.

*A child should not be separated from their parents, unless this is in their ‘best interests’
Article 9 of the UNCRC*

Excluding parents can add significantly to the worry of both child and carer. In contrast, involving them has been shown to reduce many potential stress factors, improve coping mechanisms and compliance, and reduce time spent in hospital

Supporting criteria

1. Healthcare that meets each individual child’s needs given by skilled and named health workers in partnership with children and carers:
2. Healthcare ideally given in areas separate from adult patients. These areas will have facilities and resources that are suitable for children of different developmental ages, their carers, breast feeding mothers and visitors:
3. Supportive care (general and psychosocial) for children and families:

Discussion

In some countries children are still separated from their parents and families when admitted to a hospital and in others, although mothers are allowed to stay with their children during the daytime, they are often unable to sleep near their child at night. In most, fathers have little if any access to their hospitalised baby or child, despite a lack of evidence to support the many reasons given for their exclusion given to us during the pilot project for the CFHI. It costs very little, or nothing, to allow families free access to their children in hospital and the benefits of this are far greater than any possible disadvantages. In countries where fathers have free access, concerns have not been realised.

If a young child with limited understanding is separated from a parent they feel abandoned. This feeling can cause intense suffering, similar to the suffering and grief felt by an adult when a loved person dies, and may have a permanent impact on future mental health. To avoid this emotional damage, care given at home and by familiar carers is always best whenever possible. When this is not possible and ‘inpatient’ care is in the ‘best interests’ of the child, emotional suffering can be minimized if a parent (or another carer familiar to the child chosen by the parents) is encouraged to remain with and support the child at all times, especially during procedures, If a child is asleep, unconscious or anaesthetised it is even more important that a parent/carer is there when they wake. An ill child needs the reassurance of their family’s love and care even more than they normally do. Best practice is also to enable other family members and close friends to visit frequently and freely, with restrictions only when this is in the child’s best interests.



‘Child Friendly’ hospital ward

Health workers need to always respect the parents' role as the main carers. This means helping parents/carers to care for their child as they would at home by working in partnership with parents/carers. This includes enabling the child to follow their familiar routines wherever possible.



Mother using her own mosquito net



Mother contributing to the special care of her premature baby

Elements of partnership include:

- Openness and honesty
- Respect and trust on the part of both
- Freedom to express oneself
- Sensitivity
- Commitment to sharing
- Understanding
- Mutual support
- Empowerment
- Flexibility
- Sharing, including rights and responsibilities
- Mutual accountability
- Agreeing to sometimes disagree
- Being challenging
- Accepting of each other's reality
- Sharing a vision
- Listening to each other
- Not being manipulative

A kind welcoming attitude that shows respect for the individual child and family costs nothing but can minimise anxiety and fear making healthcare and treatment easier.

Best practice is to centre healthcare for each individual child and family round the needs of the child, not round the needs of the health workers or the systems of care and includes giving healthcare that is appropriate for the child's age and level of understanding. This is best planned in partnership with the child, if old enough, and with their parents/carers. Daily individual care plans made in partnership with the child and their parents/carers are also more likely to ensure that the care planned really does meet the child's needs.

Healthcare that meets a child's needs is more likely when this care is given by health workers who only look after children, and by those who are skilled and familiar with children's differing needs. For example a neonate will need a very different type of care to a child or a young person, as will children of differing ages who have a physical or learning disability. Unskilled, unqualified or newly qualified or appointed health workers, benefit from initial supervision by more experienced and/or skilled staff, as do the children and families they care for.

Looking after ill children of differing ages is a challenging task. Skills, experience and 'Child Friendly' behaviours and attitudes are best gained by:

- Learning about children during initial training
- Attending specialised education/training programs about children's healthcare
- Obtaining a specialist children's professional qualification
- Receiving induction training when starting a new appointment or starting work in a different clinical area
- Regular education/training that continues after qualification or basic training (continuing professional development - CPD)
- Personal life and family experiences.

The anxiety of children can be further reduced if a child becomes familiar with their main health workers. This familiarity can be achieved by allocating the same health worker to a child whenever possible so that the number of different health workers each child sees is reduced (a patient allocation system). The use of this system can also help with the organisation of care and improve information sharing between health workers and families.

A simple reminder given to a child about their nurse for the day



Note: In some countries it might be more appropriate to use Nurse and surname

Research shows that a welcoming, stimulating, pleasant environment that provides opportunities to play and learn contributes to a faster recovery from illness, and faster catch up growth and development after a slowing or stopping due to illness. The minimum quality for a healthcare environment is one that is appropriate to the child's age and level of development and similar, or better, than found in the average family's home.

Such suitable environments are easier to provide when children are cared for in children's areas or wards with different specialties going to the children rather than children going to adult areas for specialist services. Many in-patient facilities do have separate areas for caring for children of different ages. It is best if this age separation is flexible and more concerned with developmental age than actual (chronological) age. If it is in the child's best interests to be cared for on an adult ward, it is important to ensure that the children are cared

for in a special area of the ward and that they have access to the same range of stimulating opportunities, environment and care as provided in children's wards.

To minimise fear, anxiety and suffering during investigations and treatments, best practice is for treatment areas, X-ray departments and other areas used by children also to have 'Child Friendly' environments, and be staffed by health workers with 'Child Friendly' behaviours and attitudes. Stairs, long corridors, waiting areas and treatment rooms can all be especially frightening for children. These can be made 'Child Friendly' at little cost by using local materials and resources thus reducing a child's fear, anxiety and distress.



'Child Friendly' laboratory corridor in Moldova

'Child Friendly' stairs, UK hospital



'Child Friendly' treatment room, UK



'Child friendly' play corner in a waiting area, UK

It is important that healthcare environments for children are easy for families to reach. Often children's wards are on the high floors of multi-storey buildings. Even if there is a lift, it is still difficult for parents to access these, especially if they are carrying their children, other children and/or other possessions. It is difficult to escape down many flights of stairs if the building needs evacuating, especially when carrying frightened children. It is important to provide access to and supervise outside play areas (especially beneficial to children recovering from illnesses).

Hospitals need to have suitable and adequate facilities for resident parents/carers including somewhere to sleep, preferably near the child (particularly if the child is breast fed or very young). For young children beds that provide enough room for both child and parent to sleep together can be beneficial. Best practice is to have a chair at the bedside for the parent/carer to sit on during the day, storage for their possessions, adequate washing and toileting areas, food and drink provision and a suitably furnished area for relaxation. Best practice is for these to be of the same standard as found in the average family home.



Mothers able to sleep opposite or next to their child/baby

It is also important to have private, suitably furnished areas for giving explanations and other sensitive information to parents/carers and for mothers to breastfeed, the latter with facilities for expressing breast milk. The support, care and understanding parents/carers and families need if their child dies is best provided by their familiar health workers in an environment that is as pleasant as possible. Best practice is always to advise parents/carers about all the facilities, and to provide written or pictorial instructions about their use.

Poverty is repeatedly shown to have a direct link with a child's health, educational achievement and emotional development. When a poor family is unable to meet their child's needs, the State has a duty to intervene by providing financial and other support. Health workers are ideally placed through their intimate knowledge of a family to identify poverty and other adverse psychosocial circumstances, and to support a family's response to their individual problems. Best practice is to identify any special difficulties or problems for the child and family by asking about these early, ideally in the initial history taking. Any special difficulties and problems need to be taken into account when planning care and supported as much as possible. This support includes referring a child and/or their family to a social welfare or similar service, if these exist.

To prevent additional anxiety, fear and suffering, it is particularly important to support the emotional needs of all ill children and their families.

Audit can include children and parent 'satisfaction surveys', looking at the number of children cared for in adult wards without access to the facilities available to children compared with the number cared for in separate children's areas

Finally health workers also need support if they are to cope with the considerable stresses imposed by giving this child centred care in partnership with parents. Access to support systems enable health workers to avoid the 'burn-out' that may lead to incapacity and/or deprive the health service of their skills and experience (*See also Section 5*).

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