A STUDY OF SOME ASPECTS OF NURSING CARE IN NINE
PAEDIATRIC UNITS, WITH PARTICULAR REFERENCE TO
THE EMOTIONAL NEEDS OF CHILDREN.

A Thesis submitted as a requirement for
the degree of Doctor of Philosophy in
the University of Surrey.

by

P. J. HAWTHORN

This research was undertaken as part of a larger project designed to establish some means of assessing standards of nursing care. This particular study was confined to examination of 'quality care' in paediatric units.

An assumption was made that nursing care of satisfactory quality exists only when the emotional needs as well as the physical needs of the patient are considered and provision is made for their fulfilment.

A review of the literature concerning child care studies in paediatric hospitals makes it apparent that general theories of child care or findings from relevant studies are not always incorporated in nursing practices in hospitals.

The field work for the present study has been conducted in nine paediatric units. Modified activity sampling was used to find out how the nurses spent their time, and similar techniques were modified to observe and attempt to assess the child's emotional well-being during a seven day period. Nurses completed questionnaires designed to demonstrate their understanding and knowledge of the young patient's emotional needs, and semi-structured interviews were held with sisters in charge of the units and tutors of the training schools, in order to discover how much benefit the nurses were deriving from ward practice and from theory.

The results of these interviews and findings derived from the questionnaires are presented and discussed. A means of measuring the quality of care for children's emotional needs is described. Finally, conclusions are formulated, and subsequent recommendations to improve nursing practice are suggested.
These relate mainly to the need to find ways of increasing the nursing staff's understanding of the emotional needs of young children and discovering ways of meeting those needs. An experimental course, which might contribute to these ends, is outlined.

During the project it became clear that little objective knowledge of nurses' activities in children's wards was available. As already stated, part of the study comprised of a modified activity sampling of nurses' duties. The results showed that with proper management the nurses in the wards observed had time available to be able to care for the children's emotional needs. Taking the study as a whole it is clear that there is a strong case for teaching the nurses more of these emotional needs and for extension of parental attendance in children's wards.
Happiness is the only sanction of life:
where happiness fails, existence remains
a mad and lamentable experiment.

(George Santayana, Little Essays).

It is by studying little things that we
attain the great art of having as little
misery and as much happiness as possible.

(Boswell, Life of Dr. Johnson).
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ACKNOWLEDGEMENTS

Help with this research project has been given willingly by too many people to mention them individually.

I should like, however, to express my gratitude to my supervisor - Professor P. Davis of the University of Surrey - for his encouragement and continued interest in the project, and to Miss J.K. McFarlane, Director of Education at the Royal College of Nursing. Thanks are also due to Miss M. Simpson, Department of Health and Social Security.

Without the conscientious work of the study observers and the willing co-operation of the hospitals concerned, particularly the nursing staff, the patients and their parents, this survey would not have been possible.

Finally, the support and encouragement given by my colleagues and members of my family, have been invaluable.
SECTION 1.

Chapter 1. Background to the research.
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Chapter 1

Summary

This chapter describes the background to the study. The theoretical framework is given. Former attempts that have been made to define and measure the quality of nursing care are discussed. Current child care concepts are considered. Studies concerned with the care of children in hospital are summarized and the findings are stated and examined. A definition of high quality nursing care in the paediatric setting is accepted. Questions relating to paediatric nursing practices which have not been asked or adequately answered are listed.

Background to the Research

This research was carried out between October 1967 and September 1970 as part of a larger project designed to formulate methods of assessing the quality of nursing care.

The need to develop criteria for the assessment of quality of care was made evident by a Hospital Service inquiry into the development of nursing and midwifery staff (National Board for Prices and Incomes, (1968)(88)) when wide divergencies in the level of staffing in acute hospitals with seemingly similar work loads became apparent.

The enquiry made it clear that any formula for nursing staff designed to achieve more equitable staffing levels, should incorporate a defined standard of expected nursing service. Such a standard had not been identified.

Accordingly, a research project was sponsored by the Department of Health and Social Security in the Education Division of the Royal College of Nursing – to be known as 'The Study of Nursing Care'.
Each of the six nurses in the first group employed to work in the project, selected her own area of interest, and attempted to design a method of measuring the 'quality of care' within that area.

The study reported here was conducted in nine paediatric units.

Theoretical Considerations

The theoretical framework of this study, although depending mainly on current child care concepts, takes into account previous attempts to define and measure the quality of nursing care.

Review of Relevant Literature

'The nurse must maintain the highest standards of nursing care'.

(International Code of Nursing Ethics. July 1953)

It seems important to define 'nursing care' before discussing briefly what is meant by 'high standards of care'.

Florence Nightingale (1859) provided an early guide to what she called 'good nursing'.

'Good Nursing consists simply in observing little things which are common to all sick, and those which are particular to each sick individual' (p. 130)

Reiter and Kakosh (1963) accepted the following definition of the function of Nursing Care, which is quoted in full:

'Nursing is one of the services for the care of the sick, for the prevention of illness, and for the promotion of health, which is carried on under medical authority. Its distinctive function is to give close and individual service to the patient, performing for him what he can not do for himself, giving supportive care, physical and emotional, to bring him through dependence to self directive activity, toward his own health. Professional nursing is always patient-centred, either
through service given directly, or through
instruction given to the patient and his
family, or through co-ordination of
services given the patient or his family
during the period of nursing care. It is
based on an understanding of the total
therapeutic plan and the concept of
preventive medicine and community health
and on the physical, emotional and
intellectual state and capacity of the
individual and his family'

(p. 7)

It is this definition which is accepted for the purpose of
this study.

This quotation was discussed by Finer (1952)(30) when
writing of the 'Non Measurability of quality of Nursing Care'. He
remarked on the number of words of degree which appeared in it
(e.g. close and individualized service, supportive care, understanding
of total plan). He suggested that although each may have imaginable
minima and maxima, they did not possess numerical precision permitting
either an indisputable comparison with another, or the making of one
stereotyped standard common to all practitioners. He stated that:

'We are in the realm of considerable
ambiguity and subjective judgement'

(p. 119)

However, most sociological research might be said to suffer
from the same difficulties that Finer outlined - but ways of
overcoming these inherent difficulties are being continually explored.

The following paragraphs are taken from an address by Reiter
(quoted by Reiter and Kakosh (1963)(102)) when discussing the function
of nursing service in 1954 - it seemed particularly relevant when
searching for some basis of examining quality of care in a paediatric
setting:-

'At its best, nursing is to fulfil the role
of mother substitute. Psychologically this
has tremendous importance. At its best, it
is skill to nurture and promote growth. Its
uniqueness lies in these services which the patient received earlier in life from the mother—bathing, feeding, toileting, dressing, providing warmth and rest and ease and trust throughout the night. It is these services, distinctly motherly, that neither the doctor, nor the social worker, nor the dietitian, nor any of the allied health provisions give, that are distinctly motherly and unique to nursing. Without this, the giving of medicine or tests or treatments, are purely technical functions and the charting of these only a record of orders carried out'.

(p. 28)

Reiter continued by suggesting that the 'professional characteristics' of nursing practice were dependent on the use of judgement, which were to include understanding of the patient, his physical, mental and emotional, spiritual and social capacity to understand his own illness and purpose of treatment.

A recently published study of the literature concerning criteria of quality for nursing (McFarlane) (1972)(64) discussed the many problems that are apparent in developing any measure of quality care.

As previously stated, no attempt has been made to establish a measure of the quality of nursing care in this country, although several studies have been reported from America and Canada.

These studies can be categorized in many ways, although common to all of them is the arbitrary establishment of criteria prior to the main study.

Some studies remained 'theoretically oriented' when panels of experts deliberated for long periods on the establishment of such criteria (Reiter & Kacosh (1963)(102) Campion (1966)(13), attempting to define their combined subjective views in objective language. These reports tended to be somewhat verbose, and consequently difficult to evaluate. They defined the criteria of quality of nursing care,
checked them under rather restricted, and often experimental, conditions, and recommended certain 'tools' for hospital practice. Not infrequently, these 'tools' consisted of detailed check-lists designed to reveal the standard of care in the wards. These 'tools' failed to achieve wider acceptance.

Some of the criteria of quality of nursing care, based on professional experience, were discussed by such experts as Jensen (1960)(49) Quint (1962)(99) Abdellah and Levine (1965)(3) and Lambertsen (1965)(55) and (1966)(56).

Other attempts were made to assess criteria by measuring the efficiency of the nurse performance or her skill at completing a technical task, or the manner in which she utilized 'underlying scientific concepts' in her work (Fisher (1957)(31) Tate (1962)(126) and (1964)(127) Ellsworth et al (1962)(26) Edgcombe (1966)(25) National League of Nursing (1966)(89) Madier (1964)(86)). Measurement of the effectiveness of care, as opposed to performance, was also attempted. Doctors and/or patients were asked to help in the assessment of some particular ministration (Abdellah and Levine (1957)(2) Ellsworth et al (1962)(26) and Howland and McDowell(l964)(45)).

Even in those cases where the criteria of quality of nursing care were selected, and their adequacy accepted by the initiators of the study, no reports appear to have been published confirming the effectiveness of these criteria outside the institute of their origin, although manuals for general use have been published (Fisher (1957)(31) Ellsworth et al (1962)(26) Tate (1962)(126) Edgcombe (1966)(25)).

It would thus appear that these isolated attempts to establish workable criteria did not achieve a sufficiently wide measure of recognition for them to provide the necessary stimulus for further research.
An additional drawback common to these earlier studies, derives from their 'American orientation'. It is evident that the criteria of quality of nursing care found to be satisfactory under American or Canadian conditions, may not be either acceptable or relevant in this country. For instance, the training and the job allocation of nursing staff intended to be deployed in multi-bedded rooms (indeed, up to 20 or more beds per room, as shown in the sketch plan on page 56) would introduce variables which are far from common in both the U.S.A. and Canada.

Although no known study of the quality of nursing care, as such, has been undertaken in this country, several studies and reports have been carried out which have highlighted areas of nursing care requiring further improvement and expansion, (Barnes (1961)(8) McGhee (1961)(65) Norton et al (1962)(92) Robb (1963)(106) Cartwright (1964)(14) Cohengl (1964)(17) Revans (1964)(103) Ley and Spelman (1967)(60)).

In some studies, patients' satisfaction with the nursing services and patients' views and suggestions were noted (Haywood et al (1951)(38) Hugh-Jones et al (1964)(44) Raphael (1965)(100) Dudgeon and Davidson (1965)(23)). It is apparent, however, that none of these studies has succeeded in establishing objective measures or criteria for the quality of nursing care.

It appeared from the lack of previous studies, that for the purposes of the present research, arbitrary criteria of the components of high standard of nursing care might be selected.

Following the acceptance of Reiter and Kakosh's (1963)(102) definition of the function of nursing care, it was therefore decided that a high standard of nursing care must include consideration of the patient's emotional needs, and these needs are examined in the subsequent sections of this chapter.
Child care theories

'the prolonged deprivation of the young child of maternal care may have grave and far reaching effects on his character and so on the whole of his future life'.

John Bowlby (1951)(9) (p. 7)

Freud (1902) knew of the importance of the mother child relationship, but because he had stressed the sexual aspects of this relationship, his views had not been wholly acceptable. Suttie (1935) developed Freud's original theories, and, although he did not use the term maternal deprivation, in his conclusions he stated the principles of his whole theory, from which the following can be extracted:

"The infant must be re-adapted during development to an independent responsible-adult role. The renunciation or repression of the various wishes constituting infantile dependency can be effected thoroughly only by the loved object (mother) herself, and not by external interference. The mother's will and capacity to enforce the renunciation will vary - disturbances of this maternal function are the causes of 'fixations', 'repressions', 'depressions', 'jealousies' and 'antagonisms' which in turn are the root cause of mental illness'.

(Chapter 1)

Bowlby's monograph (1951) examined the evidence already available concerning maternal deprivation, and reached the conclusion that

'what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment'.

(p. 11)

He derived his evidence from many previous studies which were categorized into three main types: Direct studies of children in
institutions, hospitals and foster homes; Retrospective studies - case histories of the childhood experience of adolescent and adults who developed psychological illness; Follow-up studies of children who suffered deprivation in their early years.

Because many of the studies were conducted on small populations and there were difficulties in isolating particular factors of childhood experience, Bowlby was dependent on the numbers of different types of study reaching similar conclusions to support this theory. Sometimes, by the inclusion of slender evidence, he invited much criticism - he himself admitted that the evidence used was neither systematic nor statistically controlled. Nevertheless, there was widespread support for the methods Bowlby suggested to avoid or lessen the incidence of maternal deprivation.

His critics contributed to a further publication by the World Health Organisation (Deprivation of Maternal Care, W.H.O.) (1962) (132). The writers did not question the importance of Bowlby's contribution, but thought that his statements were accepted so uncritically and so completely, that attention was diverted from other considerations which might require equal attention.

Prugh and Harlow (1962)(98) suggested that a child's response to separation was a complex process influenced by the child's previous experience of mothering, his age, his experience during separation, and the nature of important later events. His inborn or acquired biological capacities needed also to be considered.


'No clear connection was evident between separation from the mother and a particular pattern of disturbed behaviour, neither delinquency nor incapacity for affectionate relationships was significantly more frequent in the separated children'. (p. 83)
This study can be criticized in that the sample was of children entering a reception centre, who may in any case, have had 'below average' experience of mothering. Rowntree matched 277 children living in households in which one parent was no longer present - either dead, divorced, estranged, or temporarily absent - with children from more stable homes, and found that children from the 'broken homes' did not suffer from grosser forms of emotional disturbance - apart from a rather higher incidence of bed-wetting at four years old, which affected only the better-off families.

Douglas and Blomfield (1958)(22) found that in a sample of 4,668 legitimate children 52% of them had been separated from their mother at some stage between birth and the age of six. Those separated for more than a month were 'matched' with unseparated ones and from this analysis the authors concluded that:

'separation did not affect children adversely in any way if they remained at home. Among the children sent away from home, more nightmares and bad habits, such as thumbsucking were manifest'.

(p. 149)

Woolton continued that more of the separated children also attended Child Guidance and Speech Therapy clinics, but the differences were small. Woolton further suggested that Bowlby had confused the consequence of the separation from the mother with those of providing children with the substitute of bleak institutional care. Mead (1954)(71) observed that cross cultural studies had suggested that adjustment was most facilitated if the child were cared for by many warm friendly people.

Ainsworth (1962)(5) replied to the critics on Bowlby's behalf, and answered their arguments skilfully, nevertheless conceding that Bowlby's statements did need clarification and some modification. She concluded:
'An examination of the evidence should leave no doubt that maternal deprivation in infancy and early childhood indeed has an adverse effect on development, both during the deprivation experience and for a longer or shorter time after deprivation is relieved, or that severe deprivation experience can lead in some cases to grave effects that resist reversal'.

(p. 142)

Bowlby's 1951 monograph led to a proliferation of research to find the variables which might be important in the mother-child separation theory.

A sample of 'separated' children may generally be subdivided into two groups in accordance with the causes of separation: It may either be due to family circumstances or to the child's illness leading to hospitalization.

It would appear that the majority of research workers tend to concentrate on either the one or the other of the two groups of separated children. It is the results of research relating to children in hospital that are relevant in the context of this report.

Literature and studies concerning children in hospital

Edelston (1943)(24) somewhat tentatively suggested following his own study of 42 cases referred to a child guidance clinic that the theory that nervous and behavioural disorders in childhood might arise because the physical illness in some way lowered the child's vitality and disturbed the mental balance making for neurosis was incorrect. He hypothesized that:

'The symptoms and behaviour of most hospitalized children could be seen to be defences against the separation anxiety or the resuscitation of old conflict by it'.

(p. 93)

Jessner (1952)(50) found in a sample of 143 children
undergoing tonsillectomy or adenoidectomy that the main causes of anxiety were separation from parents, exposure to strange surroundings, fear of the anaesthetic and fears of injections. 20% suffered 'severe reactions' - but there was a greater incidence of 'disturbed children' (so rated pre-operatively by a psychiatrist) amongst the group suffering 'severe reactions'. Jessner reached the conclusion that the operation was not likely to be a harmful experience except in those cases in which at least some neurotic traits pre-existed.

Faust et al's study (1952)(29) was an ambitious attempt to measure the effectiveness of changes in hospital procedures by noting the children's reactions. 140 children were divided into two equal groups. Those in the experimental group were prepared for their period in hospital by a meeting with a psychiatrist prior to admission. A parent was allowed to remain in hospital throughout their child's stay. Some procedures such as the giving of enemas were discontinued, and the method of induction of anaesthesia was altered. The effects of these changes were so favourable that the methods were used for later members of the control group thus confusing the results.

17 of the control group displayed residual behavioural difficulties after three months, whilst no members of the experimental group did so (p < 0.05). The authors concluded that the benefit was due to preparation for hospitalization by the psychiatrist - no mention was made in the study that the presence of a parent throughout the child's stay in the hospital may have been helpful in any way.

Prugh's study (1953)(97) again investigated the differences between children cared for in control and experimental conditions - there were 50 children in each group matched (as far as possible) for age, sex and diagnosis. The experimental group were allowed daily visiting, early ambulation, and were given a special play
programme. They were given psychological preparation for, and support during potentially emotionally traumatic procedures. The parents were allowed to help in the care of their children, and the admission procedure was 'improved'. The control group was allowed the usual amount of visiting (two hours per week), and the parents were not allowed to assist in their care. The overall results were described as statistically significant - only 68% of the experimental group displaying moderate or severe reactions compared with 92% in the 'control' group. - (p < 0.05).

The younger children manifested more "severe" reactions, but Prugh was unable to find a significant correlation between parental visiting and the child's adaptation, as he had hoped, and considered the results "inconclusive".

Meanwhile Spence (1947)(121) deplored the habit of treating children as miniature adults, he had admitted mothers with children for some considerable time. He had found that not only was the rate of infection lowered, but also that the child's 'well-being' was improved. Moncrieff (1952)(82) advocated one hour's visiting daily, since he felt that the visit might become aimless if it were to be prolonged; he suggested that the benefits of admitting the mother to hospital with her child were unproven.

Howells and Layng (1955)(42) in a retrospective study comparing the number of times and length of separation from parents that a group of 37 neurotic children and 37 control children had experienced were unable to find significant differences in their results.

Illingworth and Holt (1955)(45) studied the behaviour of 181 children by noting their reactions during their stay in hospital particularly during and after visiting sessions. They concluded that
daily visiting was important, and suggested that ideally the younger child needed his mother to be admitted with him. They also stressed the need for medical students and nurses to be taught deeper understanding of the child's needs. Robertson's film (1953)(107) was available at this time, demonstrating the effect of hospitalization for a two year old girl. Unfortunately many doubted the validity of his interpretation of the child's behaviour, and the film met with some scepticism. The English translation of the study by Yippo et al (1956)(133) read somewhat unsatisfactorily. The conclusion that hospitalization had only 'exceptionally a negative effect on the child' was difficult to follow. The results of the survey should be treated with caution as they were dependent in part on postal communication and were collated from a low rate of response, for some questions it appeared from the text that the response rate was as low as 25%.

Vaughan's study (1957)(129) was inconclusive, the children who received opportunities to 'discuss' their fears and worries being generally 'more disturbed' (as assessed by the Ward Sister) than their counterparts in the same hospital. No real differences however were noted following their discharge. The sample was small (40) and there were many variables.

Whilst these studies were continuing, a committee under the chairmanship of Sir Harry Platt was appointed in 1956 by the Central Health Service Council:—

'To make a special survey of then arrangements for the welfare of ill children - as distinct from their medical and nursing treatment - and to make suggestions which could be passed on to the Hospital Authorities'.

Robertson was invited to give evidence on behalf of the Tavistock Clinic and the Tavistock Institute of Human Relations;
much of this evidence was subsequently published in book form (1958) (109). In this he stated that hospitalization was inevitably an unhappy experience for a young child. Since the child normally was intensely attached to his mother, separation from her usually caused the child to react with shock and anxiety. After an initial noisy period, the child fretted and became withdrawn - a condition often misguidedly referred to as 'settling-in'. If the child remained in hospital for a long period he passed from the withdrawn phase into a third phase where he appeared to be bright and happy. Robertson had undertaken several case studies describing such reactions, and believed that this bright and happy reaction was a superficial facade - the child becoming determined not to become 'involved' with other people in order that the painful experience of loving and being separated could not be repeated. Longitudinal studies cited by Bowlby (1951)(9) had shown that children who had experienced long periods of hospitalization from an early age may have found permanent difficulty in establishing meaningful personal relationships. However for most children the stay in hospital was comparatively short and it was unlikely that they reached the 'bright and happy' stage, but merely showed grief and became withdrawn. They were often anxious and difficult on their return home: sometimes this behaviour only lasted for a week or two, sometimes for months.

Robertson believed that during the early fifties there had been attempts to improve the care of young children: because there was uncertainty about the problem, the changes had been introduced on an 'ad hoc' or empirical basis, and whilst some hospitals gave great consideration to the children's emotional needs, others did not. He had therefore published his evidence to explain why the importance of the child's mental well-being in hospital should be
considered as 'equal to that of the principle of asepsis'.

At the same time as the book was published, Robertson re­leased a second film. This was made in order to demonstrate the advantages for the child (1958)(108) being admitted to hospital together with his mother. Although the film concentrated on one child and his reactions, several more mothers accompanying their children were shown in the film. Nevertheless, critics have felt that the child's behaviour was filmed to fit the commentary, which again was subjective. The film would probably be accepted readily by those who had already accepted the psycho-analyst's concern with the emotional effect of hospitalization on the young child, but would largely be discounted by those unconvinced of these theories.

The Platt Report, (The Welfare of Children in Hospital) was published in 1959 (130). In this it was stated that:

"........the emotional needs of a child in hospital required constant consideration ........
The new approach to the care of children 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 had been made during twenty years or so" (p.3)

The advisability of admitting mothers with their young children was agreed and recommended. Unrestricted visiting was recommended for all parents, with the proviso that it did not mean that parents were to be in the ward all the time, but that their visiting could be arranged to fit in with other family commitments.

It seemed that following the publication of the Platt Report, little further literature concerning this subject appeared for some time.

MacCarthy (1962)(62) published some data about his experience of admitting mothers with their children. He felt that for the scheme
to work, the paediatrician, sister and the staff nurse, must be 'absolutely positive' about it. He noted the beneficial effect it appeared to have on the young child. Although any mother could accompany her child, it was normally the younger ones who were accompanied, but he found that older ones with some special difficulties, for example backwardness, were able to benefit from the arrangement.

Riley et al (1962)(105) described the experience of admitting the mother with her child, and concluded that 'none doubted the value of the (Mother and Child) Unit'.

Mahaffy (1965)(69) studied further the question of whether or not the child benefited from his mother's presence. One of the reasons given for the re-examination of the problem was that the staff appeared not to recognise or have time for the child's emotional needs.

He did not attempt to measure the psychological effects of tonsillectomy or of the hospital experience. He wished to see whether the children would benefit if they were allowed to have their parents with them throughout their stay in hospital, the parents being helped and supported by the nurses to care for their child's needs. Mahaffy hypothesized that the reduction in distress could be measured by a lower systolic blood pressure, lower pulse rate, and lower temperature. The child would cry and vomit less, he would take more fluids more easily, would pass urine sooner after operation. 43 children were randomly selected and placed in the 'control' or 'experimental' groups. The results were all stated to be statistically 'highly significant', (p < 0.01) the 'experimental' or 'with mother' group showing the results anticipated by Mahaffy.
Fagin (1966)(28) asked the mothers of 60 children aged between 18 months and 3-years to describe selected areas of behaviour pre and post operatively, as she wished to assess the quantity, direction and behavioral area of change, to see if there were differences between the two groups. 30 children were assigned to each group. In only one group were children admitted to hospital with their mothers. After both one week, and one month at home the groups were said to differ significantly ($p<0.01$) in the way the child reacted to a brief separation from the mother following discharge from hospital; his emotional dependencies, his 'finickiness' with food; and finally his urine control.

The differences in the amount of resistance expressed by the child to going to bed were statistically significant after one week ($p<0.01$). By the end of one month, differences between sleep behaviour and the child's manner of eating were reduced - ($p<0.02$).

Unexpectedly, the experimental group had actually progressed in some areas - for example in urine control - which emphasized that the presence of the mother allowed progress to continue, rather than to remain static or to regress.

Fagin felt that the selection of the sample may have limited its value: the illnesses were different and therefore the amount that the parent could do for the child was varied. Nevertheless, her findings confirmed earlier results that indicated that the young child's emotional behaviour is less disturbed when he is admitted to hospital accompanied by his mother.

The remaining studies restricted their samples to children undergoing tonsillectomy and adenoidectomy. This is the most frequent cause of hospitalization for the young child in Western society and often the only cause that presents a large enough sample
to eliminate other variable factors such as age. The usual period of hospitalization of from two to eight days is sufficient to allow for detailed observation.

Schulman et al (1967) (118) wanted to observe how children were influenced by their mothers attending them during anaesthetic induction: they wished to see whether the mothers themselves became upset, critical, interfering, or anxiety-provoking and also whether the physicians found their presence 'uncomfortable'.

Their sample was confined to 32 children between the ages of two and six years, divided into two groups matched for age and sex.

Although no mother who was asked, declined to accompany her child, only the 16 children in the experimental group were allowed to have their mothers with them. The children were admitted to hospital immediately prior to operation.

The children were 'scored' on a basis which ranged from: 'happy or contented' (score 1), to 'screamed full blast' (score 7). Normally the mothers left the child after 15 minutes (described as the pre-threat phase). 'Threat phase' was from the time the mother normally left until the anaesthetic induction began; and the 'impact phase' was described as lasting until the induction reached the point of surgical anaesthesia. The 'experimental group' mothers stayed until induction had reached the point of surgical anaesthesia.

All families were sent a questionnaire six days post-operatively. There were 28 items rated on a five-point scale: e.g. 'does your child make a fuss about going to bed'? - much less (score 1): less (score 2), the same (score 3), more (score 4), much more (score 5).

The mother's anxiety at the induction had been rated as: severe, moderate or low.
The results were analysed in detail: the differences in behaviour of the children of the two groups 'approached significance' in the threat stage, and were 'significant' in the impact stage. (Differences were measured by the different scores achieved). The authors reported a significant difference in the behaviour of the children at different ages, but unfortunately did not clarify this statement (the sample was confined to children aged two to six years). The parents' occupational grouping, the mothers' anxieties during the induction of the anaesthetic, and the sex of the child were described as 'not significantly different'.

Brain and Maclay (1968)(10) considered that there had been a lack of systematic study in assessing the value of admitting the mother with her young child. Their sample was limited to children under six years of age, undergoing tonsillectomy and/or adenoidectomy whose mothers had previously agreed to accompany them if there were a bed available. The groups were randomly selected: 101 children with their mothers formed the experimental group: the 96 children in the control group were only allowed limited visiting. All children were admitted for three days, the groups alternating week by week. The same staff cared for both groups of children in the same ward.

All the children's homes were visited one month prior to the child's hospitalization: a full medical-social history was taken, and an assessment made of the mother's emotional state, her relationship with her child, her marital adjustment, and the home background. Relevant information was obtained from the general practitioner. Two ward sisters kept records of the children's behaviour in hospital, emotional reactions to the induction of anaesthesia were recorded by the anaesthetist. Repeat visits to
the home were made after discharge - two weeks, and six months post-operatively. Adjustment in hospital was defined as:
satisfactory, limited, or unsatisfactory - when for example the child reacted with pains, or by complete denial and withdrawal. 76.2% of the experimental group compared with 41.7% of the control group made a satisfactory adjustment. An unsatisfactory adjustment was made by only 3% in the experimental group, compared with 13.6% in the control group. This was a highly significant difference ($p < 0.01$).

There was a significant difference in the post-operative complications the children suffered (i.e. haemorrhage or infection within ten days): 11% of the experimental group and 23% of the control group were involved ($p < 0.05$). The authors concluded that the incidence of disturbance due to hospitalization varied inversely with increasing age; children who were emotionally disturbed prior to admission were likely to show further disturbance; the more anxious a mother was to accompany her child into hospital, the more likely was the emotional disturbance if the child were admitted alone. They suggested that the success of any medical unit depended largely on the attitudes of the staff, and on the selection and training of nurses for work in mother and child units. The staff helping in the experiment were unanimous in that they did not like the mothers coming in with their children.

Pill's study (1967)(96) was part of a larger project (1970)(123). Her part of the study was designed to find the factors inhibiting parents from visiting their children and from living in, and to examine the way in which introduction of mothers into the wards affected the doctor-child, mother-child relationships as well as reacting on the whole structure of inter-personal relationships.
in the hospital. As the psychiatrist was using the same sample of children to assess the extent and nature of any relationship between emotional disturbance and separation from the mother, the social relations of the child in the ward were also studied in detail. The findings will be discussed later.

An interesting study undertaken recently by Branstetter (1969)(11) sought to distinguish between the state of anxiety caused by maternal separation and that caused by the lack of 'mothering care'. Children undergoing hospitalization aged between 14 and 36 months were divided into three groups for the purpose of the study. In the first group the children were admitted into the hospital together with their mothers, in the second they were cared for during most of their waking hours by a 'mother surrogate', and the third group of children were given the usual paediatric unit care. There were 'clear behavioural differences' (p<0.05) between the groups: the first two groups showed much less disturbed behaviour than the group given routine care. Branstetter concluded that the child could cope with maternal separation if he were given the opportunity to establish a relationship with a constant caretaker. Her findings are corroborated by those of Robertson who demonstrated by the use of films 1968(111) 1969(113) that a young child separated from his parent and cared for in the foster-parents' home was less affected by the change than a child who was cared for in a residential or institutional setting 1968(112).

**Discussion of the literature and research findings:**

It seems appropriate to examine one of the principal difficulties found in conducting research into the effects of
hospitalization on children — that is: the number of variable factors which can never be controlled.

Jehu (1966) categorized five groups of such factors. Those which are hereditary (genetic predispositions), and those operating before separation (he included here factors operating in utero, and social factors), the other three categories he described were those operating at, during, and after separation.

Many of the factors can never be controlled, but those that deviate from the norm in obvious ways can be eliminated, and as the provision of measurement of variables improves, the better becomes the control of the factor. For example: it is relatively easy to know that a child is being physically ill-treated and neglected — it is more difficult to recognise that the parents' relationship with the child is distorted when the outward appearance is satisfactory. Nevertheless the method of measurement the psychiatrist employs is continually being improved, and in recent studies, the psychiatrist spent considerable time in preliminary interviews in an effort to assess the child's personality factors more accurately, prior to the experience of hospitalization.

The 'control' group had often been carefully matched to the 'experimental' group in an effort to cancel out children's individual differences. Thus in Brain and Maclay's study we learn that there were no significant differences between the two groups with respect to the following variables:

- Family and background.
- Age on admission to hospital.
- Sex.
- Parental ages.
- Social class.
- Number of siblings.
- Birth rank.
- Emotional state of the child before admission.
- Previous hospital admissions.
Marital adjustment of parents.
Emotional state of mother.
Mother-child relationship.
Attitude of mother towards staying in hospital with child.
Type of operation being performed.

This study contained the largest number of children (197) of any research done, and because of this, the variable factors were less likely to be different between the two groups.

Having carefully controlled many variables to ascertain that the experimental and control groups were as well matched as possible, many of the research workers confused the findings by having introduced 'programmes' which contained a multiplicity of factors: for example in Prugh's study (1953)(97) not only were the children in the experimental group allowed to have their mothers with them, but the nurses were especially trained to deal with their emotional difficulties, special play programmes were arranged, and anaesthetists met and explained the procedures to them. In Faust's study, (1952)(29) a social worker prepared all the children in the experimental group for their hospitalization: She commented that none of the children had remained in the 'disturbed' group post-operatively: the implication being apparently that this was because of their preparation. However, these children were also accompanied by their mothers and this may have had some influence on the results.

It is because of the number of variables that no one study has appeared to offer sufficiently controlled findings to state conclusively:

(a) The young child suffers emotional trauma because of hospital admission and separation from his mother.
(b) The effects of this can persist for some months or even longer.
(c) The young child benefits from the presence of his mother when he is in hospital.
Of the pre 1959 studies: Edelston (1943)(24) makes no observations about the younger child's hospital experience. Analysis of his figures shows that it was the older child who had previous problems, or pre-neurotic traits or else the child who had been admitted to hospital under the age of five years who suffered from hospitalization.

Jessner (1952)(50) in his studies concluded that tonsillectomy and adenoidectomy was not likely to be harmful experience 'except in those cases where at least some neurotic traits pre-exist'. The number of children under five years was only 32 out of a total sample of 145. Jessner found that anxiety about hospitalization and separation was greatest in the young child: the effect of pre-operative hospitalization on those under four years old was 'dubious'. He felt that if the mother stayed with her child, although she could give comforting assurance against the fear of illness, the child might feel her anxiety.

Faust (1952)(29) concluded that children who had previously suffered emotional trauma, reacted less well to the experience of hospitalization. The younger children showed more but milder adverse behavioural changes. The case-worker in her report of the study found that it was observed that for most children under four no amount of love and understanding would make up for the absence of the mother.

In Prugh's (1953)(97) report we learn that the child of three years of age or under was the most susceptible to the circumstances surrounding hospital care.

Illingworth and Holt (1955)(45) felt that the younger child ideally needed his mother to be admitted with him.

Ylppo (1956)(133) did not appear to support the conclusions found in these other studies. His team of workers concluded that
hospitalization only exceptionally had a negative influence on the child - though earlier in the study it had been stated that 'the oldest child exhibited the smallest differences (that is of behaviour) whereas the behaviour of the youngest had frequently changed. He found it more difficult to evaluate the effect of the hospital experience with the younger age group, and fewer parents of younger children made comments concerning their behaviour.

Vaughan (1957)(129) made few conclusive remarks about his findings. His study of 40 children included only four under the age of four years, all of whom appeared considerably disturbed when reviewed after a period of six months. Older children appeared to have benefited from the explanations they had received.

The four studies carried out after the Platt Report are of interest.

Although they all describe their purpose as showing that the young child in hospital benefits from his mother's presence, they have an underlying theme in common, that this hypothesis had already been demonstrated but not accepted. These studies seem to be attempts to prove that it was so, in a manner convincing to the sceptics. For example, Mahaffy stated at the beginning of his study that the staff appeared not to recognise or have time for the child's emotional needs, this being particularly true when the unit became busy.

Fagin in her conclusions remarked that it was interesting to note that some of the floors that permitted mothers to room-in on the semi-private floors, had restricted visiting on the wards. It appeared that theories of child development applied only to those who were acquainted with the theories and could afford to carry them out.
Schulman was anxious to find whether physicians performing the procedures felt 'uncomfortable' when the mothers were present, but he did not answer this question.

Having concluded their study Brain and McClay remarked that the success of any medical unit depended largely on the attitudes of the staff and the selection and training of nurses for work in mother and child units. The staff helping in their experiment had not liked the mothers coming in with their children.

These last four studies support the three original assumptions that:

a) The young child suffers emotional trauma because of hospital admission and separation from his mother.

b) The effects of this can persist for some months or even longer.

c) The young child benefits from the presence of his mother when he is in hospital.

The eleven studies were undertaken by people from different backgrounds including psycho-analysts, psychiatrists, paediatricians, social workers and nurses. While their methods have varied and each is subject to some criticisms, their findings would appear to substantiate Bowlby's statement that the young child benefits from the presence of his mother whilst in hospital.

Formation of the Problem

It seems from examination of literature that care of the 'whole' person, that is his physical and emotional well-being, is essential if a high standard of nursing care is to be achieved. Child care theories have found that young children are best cared for by their mother, or failing her, a mother substitute. Hospital studies have demonstrated that there can be long term ill effects
resulting from a child's stay in hospital which can be avoided if his mother is allowed either to accompany him or in the case of the older child to visit him, as is needed.

Recent studies, however, have suggested that these theories are not practised in hospitals, as they are seemingly not accepted by the staff.

Pill in her study, (1967)(96) recorded the amount of contact the nursing staff had with each child she observed. Eleven children between the ages of four and five years were observed on two wards on a time sampling basis. That is five minutes out of 25 were recorded in detail of five second intervals. This sampling was carried out between seven a.m. and eight p.m. at night.

Pill found that the amount of nursing contact with each child varied from 12 minutes to 42 minutes per day. The average amount of time being 28 minutes a day. It was further suggested that most of the contact arose from the need to feed the children or perform other routine tasks. That is it was not apparent that time was spent with fulfilment of emotional needs. Pill continued that:-

"One of the interesting things to emerge from this study was the small amount of time that the nurses devoted to entertaining the children. It was apparent that they did not regard this as part of their job .... It was clear that the nurses did not perceive it as their task to spend time with the children after they had finished the rest of their work."

"The amount of technical nursing that they were called upon to do in a ward catering largely for tonsillectomies was limited. The basic nursing which formed the greater part of the nurse's work did not occupy all day. Yet any time over was not spent with the children."

She was very critical of the nurses' attitudes to 'free visiting' which was introduced on one ward during the study and suggested interesting sociological theory as to why the nurses found it difficult to tolerate free visiting. The way 'free visiting' was
gradually 'phased out' was well described but it is somewhat
depressing if these attitudes towards free visiting were typical of
those of many nurses.

It was largely as a result of the findings of Pill's report
that the form of this present study evolved. It seemed important to
know whether her findings could be described as typical of childrens'
experience in hospitals. Other questions became important. If, as
Pill suggested, the amount of nurse-patient interaction is so low,
what happens the rest of the time, both in the case of the nurses
and of the patients? Was the amount of interaction she observed
so low because the nurses knew the particular child was observed?
Do the patients need more interaction with the nurses or are they
content to be without it and able to amuse themselves? Do nurses
resent the presence of parents and discourage visiting?

It was with the purpose of answering these questions that
the methodology of the project was designed.
Chapter 2

Summary

A brief resume of some of the findings of Pill's study is given. This is followed by a discussion of different methods of observing the work of nursing staff used in previous surveys. Modified activity sampling is described in some detail as it is the method selected for use. Other classifications of coding nursing activities are given, and the reasons for ways of grouping and coding these activities in this study are explained. The method of observing the children is described and the details of items included in the coding systems are expounded.

Development of the Research Method for Observation:

As discussed at the end of the first chapter, Pill (1967)(96) had concluded in her study that the nursing time spent with the children was inadequate, in that they were sometimes miserable and their emotional needs ignored.

In one ward nine % and in the other five % of crying episodes were said to be ignored. This occurred particularly when only the nurses were in the ward and the child was one who had been crying before.

The nursing staffs' attitudes towards 'free visiting' which was reintroduced on one ward during Pill's study appeared to be somewhat negative. A graphic account of their reactions to the more frequent presence of visitors was given. If the supposition that high standards of nursing care, or as Reiter said, 'the professional characteristics of nursing practice' are dependent on the use of judgement based on the understanding of the physical, mental and emotional needs of the patient, these negative attitudes are an
Further research to substantiate or repudiate such conclusions seemed important. Pill's method of observation was to study one child throughout his stay - his activities being observed the whole time, but five minutes of every twenty-five were recorded in detail. Observations were made of eleven children. The findings of the study were based on their experiences in hospital and the general background observations made during their stay. Criticism of this method of observing, and the conclusions derived from it can be made. Observing one child for the whole period may lessen the objectivity of the attentions paid to his needs, in that the needs of the total patient population have to be considered and the time apportioned appropriately.

For example, where the choice lies between comforting a miserable four year old and preparing a bed and equipment for an acutely ill emergency admission expected immediately, the nurse will be directed to the latter activity, which to the observer watching the continuing distress of 'her' four year old may seem a misguided use of time, particularly when the 'acute emergency' does not arrive for three hours!

It was to avoid this possible bias that it was decided to seek a method of observation which could be applied to the total population of the ward, whereby both nurses and children could be observed simultaneously.

Methods of observing the nurses' working day

Abdellah and Levine (1954) discussed four different approaches that could be adopted in studying the work of nursing personnel.

The first method suggested was that of one observer shadowing one nurse continuously. Whilst this might give a full account of the
way that the nurse spent her time, the possibility that her routine might be altered because of the presence of the observer could not be overlooked. This method was considered to be an expensive one. Alternatively the staff might be asked to keep a detailed diary of how they spent their time. This became difficult during the busier parts of the day and either long gaps would occur in the records or the nurse relied on recall, which would often be selective and subjective and thus the record might not be sufficiently reliable.

Neither of these methods appeared to lend themselves for use in this particular study, as the former method became impracticable when a team of observers would be required to follow the team of nurses, and the latter too disruptive if all nurses were to stop to keep account of their work.

Clearly neither method would give a quick overall impression of how every nurse was occupied at the same moment in time.

Abdullah and Levine discussed a third method. This was used by the team reporting a job analysis 'The Work of Nurses in Hospital Wards' (1953)(93).

This team was asked to carry out a complete job analysis of the work of the nurse in order to obtain data to attempt to answer the fundamental question 'What is the proper task of a nurse?' A method had to be devised which would

'take note of the constant interruptions and the variations which circumstances require as to ascertain the pattern of the work itself'.

(p.13)

A completely objective approach was also needed. A unit of measure - 'time taken' was decided upon in order that comparison could be made between tasks. The technique that was chosen was a detailed minute by minute observation of the ward staff. It was
necessary to have more than one observer at a time - because of the ward layout and the size of the population being observed.

Limitations of this method were pointed out by the team themselves.

As the ward was "zoned" and the observer was responsible for the personnel within his area, difficulties arose when staff moved from one zone to another.

When there were private rooms the nursing activity was not observed in detail.

This method was also used by the team appointed by Leeds Regional Hospital Board (1963)(57). One of the advantages of the use of this method is that the length of time taken for any one particular task, e.g. bed making, may be established.

The fourth method was work or activity sampling. This method seemed more suitable and was investigated further.

Activity Sampling

Activity Sampling is a more recent development of work study which was largely developed by three Americans, Taylor, Gilbreth, and Bedaux (1956)(46). Techniques such as Activity Sampling were developed and used more frequently during the fifties (1959)(18). Activity Sampling is the name given to the process of collecting information about machine or human activity by making a large number of instantaneous observations of the subject instead of by continuous timing.

There are three advantages of activity sampling in preference to continuous observation. It is difficult, when using continuous timing, to observe and record the activities of more than one or two people accurately, while writing down one can miss an important detail.
The fact that 'snap observations' may be taken on a large number of machines or people means that results are obtained which represent the situation in global terms much more closely than continuous studies on a relatively small number of machines or persons. Perhaps more importantly it is not necessary to use observers who are fully trained in time study. Any intelligent person is able to make 'snap' observations provided they have been shown how to distinguish the various states of activity or inactivity.

Modified Activity Sampling is a further development of Activity Sampling which has recently been developed for use in fields other than industry. Here some interpretation of Activity becomes necessary. It is not sufficient to record that a nurse is 'walking', the walking is part of an activity of, for example, serving a meal when she is walking to carry the tray to the patient. In this way the observer is called upon to interpret the immediate activity of the worker into a meaningful category.

The number of observations which must be taken is controlled by the limits of error that can be permitted in the results, and the degree of certainty required that the true value lies between these limits. A 95% certainty or level of confidence is satisfactory for most situations and it was decided that, as this had been accepted as adequate for Adams and Mollwraith's study (1963) it would suffice for the present study.

The number of observations which must be made in order to be 95% confident that the results of the study will be within \( \pm L \% \) of the actual value is given by the formula:

\[
N = \frac{4P(100-P)}{L^2}
\]

Where \( P \) is the proportion of the total duration of the study
which is taken up by the activity concerned expressed as a percentage and \( L \) represents the upper and lower limit on either side of \( P \) between which it is desired that the results of the study should fall. This formula is taken from Currie (1959)(18).

The necessary number of observations needed to be made, is based on the percentage of time the major activity is likely to occupy.

The duration of the study in which the calculated number of observations should be made is controlled by the variability to which the various activities are liable.

At the beginning of the study none of these values were known and an arbitrary decision had to be made about the number of observations to be made over what period. In deciding this, studies using similar methods were considered.

For the investigation 'The Work of Nurses in Hospital Wards', (1953)(93) it was decided that 24-hour coverage for a period of seven days was necessary. A 'settling-in' period of twenty four hours was also needed. The author contended that the weekly period was in order to cover routines of theatre and 'admitting days'.

In 1955 after preliminary observation preparatory to a study of The Work of Mental Nurses (1955)(70) it was arranged to visit each ward for a period of five days - later reduced to three days because 'every day was remarkably similar'.

Adams and Mollwraith (1963)(4) found two or three days of observation followed by two or three days of analysis to be satisfactory.

Observations prior to the start of the present study indicated that there was a weekly routine. On surgical wards, admission and theatre days followed this seven day cycle. Auxiliary services such as school were only available during the weekdays.
and it was important to include the weekend as there were less activities arranged to occupy the children. The pattern of visiting was also thought to be different on Saturdays and Sundays.

It was therefore decided that for the pilot study a whole week of observation plus an initial settling in day would be allowed. In order to reduce the number of observers, the period of observation was limited from 7.30 a.m. to 8 p.m. It was agreed that two observers would be engaged to undertake 'shifts' of observation in rotation with the author.

Method of Observing Children

Appraisal of the literature concerned with observation of children was somewhat unrewarding, it seemed that most methods were complex and often highly technical, and in any case designed primarily to observe only an individual child. (Bales (1950)(7), Cameron (1957)(12) and Freud (1953)(34)).

Thompson (1960)(127) suggested that the scientific study of children's groups had been a 'relatively neglected area' of research during the previous ten years. He discussed methods that had been used to observe adults and considered their adaptation for observing children. He agreed that the composition of the group was usually predetermined, but thought that if the sample of groups was well selected it should be possible to generalize concerning the findings. In view of the sparsity of methods of observing groups of children it seemed feasible to adapt activity sampling methods and devise some method of coding, so that it was possible for one observer to be responsible for coding the nurses activities and the children's well-being.
Literature revealed that efforts had been made by the 1930's to code nursing activities. Johns and Pfefferkorn (1934) had itemized lists of nursing activities - that of the hospital nurse contained 250 items.

Goddard (1953) itemized the components of nursing care in the following way:-

<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
</tr>
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<tbody>
<tr>
<td>Basic nursing</td>
<td>23</td>
</tr>
<tr>
<td>Technical nursing</td>
<td>28</td>
</tr>
<tr>
<td>Administration &amp; Organization</td>
<td>17</td>
</tr>
<tr>
<td>Domestic duties</td>
<td>8</td>
</tr>
</tbody>
</table>

i.e. total of 76 activities

He considered that the essential characteristic of basic care was that it was universal i.e. common to all patients.

'It is the care required in the interests of the comfort and well being of the patient for the maintenance of health and the prevention of infection, irrespective of the disease from which he is suffering'.

He continued by sub-dividing basic nursing into four main components: daily hygiene, comfort in bed, feeding the patient and elimination of body waste. He also suggested that

'besides these tasks there are others, the objects of which are less specific and which are perhaps related to the social needs of the patient'.

(p.29)

'Technical nursing' included all the nursing tasks concerning the specific requirements of treatment of the patient's particular illness.

Again this was discussed under four headings: noting the treatment, preparing the patient for technical procedures, giving the
patient general nursing care, e.g. observation during post operative care, and finally carrying out or assisting with carrying out of technical procedures on a patient.

'Ward Organization' was concerned with:— Maintaining contact with the other departments of the hospital, internal organization of the ward — including allocation of work, and clerical work. Errands to other wards were included in this category.

A final category of 'domestic duties' was included — domestic work in a hospital ward was considered to be fundamentally the same as that which any housewife or domestic worker in other settings was engaged upon. The different types of domestic work were not coded separately. An appendix of three items (official meal-break, time spent with job analysis team and unaccounted time) was included.

In the Leeds Regional Hospital Board Study (1963)(57) the four categories of nursing (basic, treatment, administration, and domestic) remained but the number of activities had increased to 127. A miscellaneous category of six items was included.

Adams and McIlwraith (1963)(4) listed activities under nine headings:—

Basic
Technical
Dietary work — non technical and technical
Domestic
Clerical
Teaching
Human relations
Absence from ward unit
Unproductive

Although Goddard's studies had each included two paediatric units, these had been subjected to the same classifications as the adult wards, and as the present study was confined entirely to children's wards, it seemed sensible to modify the code to suit paediatric requirements.
'Basic care' was re-defined as the care that a 'good' mother would give her child should he be ill at home. It seems self-evident that any justification for removing a child from home because of illness is because either home circumstances are inadequate, or the child requires care which is not possible at home.

By the use of this definition several of the items included in the basic nursing category of the Bradford survey had to be re-allocated, e.g. work involved during the admission procedure, or care of pressure areas.

Technical nursing care became defined as any procedure which merited nursing staff's attention as opposed to that of the 'good' parent or domestic. Cleansing the mouth of an ill patient, or admission procedure became technical care.

'Domestic work' contained categories which would appear to be more suitably carried out by domestic staff. This survey was to be entirely restricted to nursing staff and therefore any activity classified as domestic work was only recorded when it was done by nurses. It was important that distinction should be made where possible between direct and indirect nursing care of the patient, because it was hoped to estimate the proportion of time that the nurse spent with the patient.

It was decided to economize on the number of categories used in order to make it easier for the observers.

A copy of the coding and instructions issued to the observers is included at Appendix I. Appendix 2 contains a copy of the sheet used by the observers to code activities (this will be discussed later in the text). However it can be seen that a brief note of each category was included for reference. Where possible mnemonics were employed in order to make it easier for the observers to learn the
appropriate code letter for each category of task.

Categories which, because they were reduced in number, and were used more widely, were separated where possible into direct and indirect care. Thus whilst category 'B' included bathing in bed or bathroom, washing, combing hair, tying hair ribbons or teeth cleaning, unless the nurse was actually observed with the patient, the code used was 'H' i.e. preparing or clearing away after basic nursing procedure. Again distinction had to be made between clearing away the items used for a procedure, and 'domestic cleaning'. For example, on one ward where the coding list was originally planned, one nurse was expected to scrub all washing bowls once a week, hence these weekly cleaning activities were coded in the 'domestic' category.

One further important difference occurred when deciding the categories for this survey. The previous work studies had included a category in the basic nursing section to include nurses' personal contact with patients, and care and attention to the friends and relatives of patients.

On paediatric units where the Ministry of Health support a policy of unrestricted visiting and where (as previously discussed) the child's needs for personal contact are so great, it seemed that these two activities should be regarded separately from 'basic nursing'. Thus direct contact with a child could be for basic, technical nursing reasons, or social reasons.

'Social contact' was defined to include any contact made with a child which was not necessary to cater for his basic or technical nursing requirements. This included playing, reading or talking to the patient and giving the baby an extra cuddle after the feed had been finished (and the necessary winding!)

It had originally been hoped to restrict 'off the ward'
codes to two: 'off the ward for meal times' and 'off the ward for any other reason'. However it became clear that sub-divisions in the latter code would be required. This was because it often happened that a nurse officially on duty in the ward was 'lent' to another ward for an hour or two, and it seemed necessary to distinguish between this type of absence and that of the nurse who had gone on an errand - to the laboratory or X-ray departments. The children were often accompanied by a nurse when they went to other departments - X-ray or physiotherapy. This was coded 'N.P.' If the children were taken for walks or to church the nurses' absences were marked 'N.S.' and 'N.O.' and in the analysis considered together with code 'S'.

Coding of the Children's Activities

The method of coding the children's activities was largely arrived at by 'trial and error' methods during a long period of informal observation which took place in paediatric units before the survey began.

It had been noticed that one of the wards visited had been particularly short of furniture, e.g. chairs and toys. The children had appeared very bored and spent most of the afternoon sitting or lying on their beds in spite of the fact that they were officially allowed to be out of bed the whole time. Coding for the children, therefore, commenced with defining whether the child was in or on the bed (1), sitting in a chair (2) or standing up (3). Later another category was added, being held or sitting on a person's knee (4).

Obviously this information on its own was of very limited value, as some children might be playing quite happily whilst on the bed. Therefore in addition the children who were asleep were categorized as 'a' and it was simple to note those who were distressed 'd'. It was more difficult to decide which of the children were happy
and those who, whilst not overtly distressed could in no way be described as contented 'c'.

Jacob (1951)(47) in her description of behaviours or moods defined 'freedom from tension' as the state existing when the following characteristics were present:- constructive play alone or with others, talking contentedly, singing, showing lively interest in the surroundings, relaxing followed by sleeping. These characteristics were marked as 'c'.

Greater difficulty arose when observers were called upon to make an instantaneous observation about some behaviour. Whilst Jacob listed 'tension states' as crying, fidgeting, daydreaming, head rocking, destructive play, disorganized play, general disorganization and thumb sucking, the degree of distress suffered appeared very different between the young child who was crying, and the older child who was participating in disorganized play. Definitions of destructive play and general disorganization were not given and without these one would be reluctant to employ the terms.

Thus it was decided that a 'middle' term was needed and 'b' was added signifying that the child was bored, apathetic or listless. As the observer glanced at the child it was possible to use one of the four numbers and the four letters signifying mood.

Using the nurse coding it was possible to know whether or not the nurse was involved in direct patient care, but the patient that she was with, was not identified. However, when the nurse was observed with a child, her identifying number was written in the record of the child's observations.

Whether or not the child's parent was present, was also noted. This would show how frequently visiting occurred and at what times. Finally whether or not the child was occupied with ancillary members
of staff, other children, or their visitors was charted. The chart used is shown in the appendix (2). It will be remembered that mnemonics were used where it was possible to do so. Consequently two letters each had two meanings in the childrens' code. 'c' could mean either that the child was 'contented', or that he was in contact with another child. 'd' was used to denote that the child was 'distressed' or that a doctor was with him. However as the child's 'mood' was always noted immediately after his mobility it was easy to know what was meant. Similarly an asterisk placed in the column marked 'Ill' on the chart was not confused with an asterisk placed by each observation when the child's parent was visiting. Having decided on the method of observation and the coding system, questionnaires were designed and schedules for the interviews with the sister in charge were arranged. Plans for the pilot study were then complete.
Chapter 3

Summary

This chapter is concerned with the description of the preliminary stages of the survey and of the pilot study. The reasons for selecting the two wards for the pilot study are given, followed by a brief description. A discussion of the training of the observers is followed by an account of the progress of the pilot study.

Preliminary analysis of some of the results are given. The results of the observations of two of the children are displayed as 'profiles'. Factors considered in deciding the scope of the main study are presented. Finally the selection of further units to be included in the survey is discussed.

Pilot Study Preliminaries

The proposed methodology was discussed with a work study consultant, and it was agreed that the arrangements seemed satisfactory. The observations were to be made six times an hour, at random pre-selected intervals of not less than five minutes apart, for a period of eight days - 7.30 a.m. until 8.0 p.m. The results obtained on the first day would be discarded. Any adjustment in the duration of the study, or the necessary number of observations, would be made after the pilot study was completed.

In order to reduce the number of variables involved, it was considered advisable to conduct the pilot study in two wards of the same hospital. A paediatric hospital, on the outskirts of London, agreed to offer its facilities for the purpose. (See the following page for a sketch plan of the two wards involved.)

Although one ward was a 'mixed' medical ward, and the other a girl's surgical ward, by chance at the time of the survey, they
SKETCH PLAN OF THE TWO WARDS
USED IN THE PILOT STUDY

WARD A

NOTE:
BEDS ARE SHOWN THUS:
The number shown is that
used for identification purposes
during the survey.

WARD C

VERANDAH

DRESSING ROOM
TREATMENTS

SISTER'S
OFFICE

KITCHEN

VERANDAH

DRESSING ROOM
TREATMENTS

SISTER'S
OFFICE

KITCHEN
were both admitting boys and girls with medical and surgical conditions. The wards were staffed in the main by student nurses training for registration as Sick Children's Nurses, although students were seconded for paediatric experience from both general hospitals and hospitals preparing nurses to care for subnormal patients.

At the outset of the study, only a limited explanation of the purpose of the survey was given to the staff concerned, as it was thought that further clarification might cause the nurses to change their pattern of work behaviour.

It was explained that no attempt had been made to look at paediatric nursing as a separate entity from adult nursing. It was hoped that by visiting different wards, both in paediatric hospitals and general hospitals where the nurses were training for different parts of the register, and facilities for the paediatric patients were variable, some useful assessment and comparison of the care given might be made.

It was promised that after the eight day survey had finished, and all the staff had completed their questionnaires, the purpose of the study would be explained to them in more detail, and their queries would be answered as fully as possible.

An explanatory letter was prepared for distribution to all the staff, older children, and all parents. Again, this was not intended to give full explanation of the survey, but to inform the participants that it was being undertaken by a bona fide organization, and to assure them that although a written account of the results of the survey would be made, no person would be identifiable, and information contributed by those concerned, would not be passed on to the hospital authorities. Finally, it was intended to emphasize that the observer would not be participating in any way, either in the ward routine, or with the care of the children.
Observer Reliability

It is considered that the training of observers is one of the most important phases of preparing a study, as however well developed the observation schedule is, it needs to be used accurately. Madge (1965)(67), Moser (1958)(85) and Stacey (1969)(122).

Many authors have discussed methods of checking the reliability of observers in using the coding, the more they are called upon to use inference in their judgment, the greater their disagreement is likely to be. This has been shown by Bales (1950)(7).

The four observers who were to take part in the pilot study were all trained nurses. They spent an afternoon in the pre-pilot hospital, using the codings which had been explained in detail to them earlier in the day. During the practice they experienced little difficulty in using the coding of the nurses' activities, but found that of the children's activities more confusing.

Although the observers knew more of the study than the participants, in order that there should be as little bias as possible, they were not told of the theories that were being put to the test, or of the author's views of child care, and they were advised to code the child's mood as 'contented' if they were in any doubt about the interpretation.

The results of the observations were checked immediately for completeness of detail - for example in the case of a child 'being held' (coded '4') the details regarding the person holding him were also entered, by the use of the appropriate code. (See Appendix 1 for full details of all coding.)

It did not seem feasible to check the observers coding more systemically, as this would have required that at least two people observed at the same time. Both observers would have to note each
nurse's activity and that of each child at exactly the same moment before accuracy could be reliably established, which was not a necessary condition of the method being used.

Thompson (1960) discussed the difficulty of establishing complete agreement of coding between the observers. He considered that this was of less importance than the validity of the measure used:

'It is a matter of relative unimportance whether observers agree with respect to the number of units of behaviour assigned to a specific individual if the score with which the investigator is concerned is the number of units in each category made by the group as a whole'.

(p. 839)

Pilot Study

The observation sheets were designed to contain all the observations made during one hour of the survey. The randomly selected times were all entered on to the sheets prior to the start of the study.

On the day immediately before the study commenced, the necessary details of the participants were collected, numbers were allocated to each of the staff and children, and relevant personal details were added to the observation sheet. The nurses' name, hours of duty and code number were inserted. Her code number only appeared in the 'nurse no.' column if she was scheduled to be on duty during the particular hour concerned.

The child's sex and age were given. The column headed 'Ill' was marked with an asterisk if the child were considered to have special nursing needs, either because he was ill or particularly handicapped. The column headed 'state' was marked 'bed' 'chair' or 'up' which indicated the allowed degree of mobility, and finally the child's identifying number was given. (A completed observation sheet is given in Appendix 2.)
The 'number badges' were issued on the first day, and corresponded to the bed numbers which were also marked in sequence. One difficulty which had not been foreseen, was the frequency with which the bed order was changed. In practice this meant that each child could have several different numbers, and also, that as one child was discharged and another admitted, the number was used again. At the end of the survey, it was necessary to alter the numbering on the charts, so that all the observations made of any particular child were allocated to his own unique number.

The 'settling in' day (Day No. 1) proved to be of great value. The observers were able to learn the coding system and become familiar with the numbers allocated to the nurses and children. They all found that the first few 'rounds' of observations took a long time to complete, but by the end of their first day's session, they were often completed in less than two minutes. (The observers were not told that the first day was a practice session until after they had finished their 'shift'). They were accompanied by the author for the first few observations and the initial sheets were examined for faults in recording or obvious errors immediately after completion. An 'anecdotal' sheet was provided, so that any questions of coding, changes in numbering, or comments on the ward, could be written down. Appendix 3 shows a typical anecdotal sheet. The survey continued without difficulty for the eight days. The staff, patients and their visitors, appeared to become accustomed to the presence of an observer, who had little time to spare during her four hour period of work.

At the end of the eight days when all the observations were made, the nurses completed their questionnaires. These were self-administered and took about 20-25 minutes to complete. This was usually done whilst the nurse was on duty. A copy of the questionnaire
issued to nurses completing their general training is shown in Appendix 4. A modified version of the questionnaire was completed by the nurses who were either training for the sick children's register, or working on a children's unit by choice. The differences are given in 'Appendix 5'.

The interview schedule containing the questions which were asked of the sister in charge, is shown in Appendix 6. This took longer and the interview was always conducted by the author.

The pilot study continued on the second ward (Ward C) one week after that on the first ward (Ward A) had been completed, and again no difficulties were encountered.

Preliminary analysis and discussion of the results of the Pilot Study

The analysis of the nurses' activities on the two wards was completed by hand. The results showed that there were few differences between the nurses' activities that were not accounted for by the slightly different structure of the patient population, for example – there were more young patients who had undergone surgery on Ward C and the nurses spent more time doing dressings and more time feeding the patients, than their counterparts on Ward A.

These initial results were seen by the work study consultant who had been advising on the activity sampling methods. He thought that they seemed 'satisfactory'. However, it was not considered that either the length of time, or number of observations, could be reduced for the main study.

Analysis of the observations of the children in total was not carried out at this stage, as meaningful ways of doing this had not been clarified. However, the results for each of the children under the age of six years, were examined in detail. Should a child be in hospital for the whole of the period of the study, there would
be 525 observations made of him. These could be arranged in sequence to show a 'profile' of the child's observed emotional level throughout his stay. The number of times that a nurse, doctor or visitor was with him could be shown, and perhaps more importantly, the presence of his parent.

The results of drawing these 'profiles' were of great interest. Ward C although described as an 'acute surgical ward' numbered several young children amongst the population who had frequent experience of being admitted to hospital, often for considerable periods of time. When their 'profiles' were compared with those of the young children who had never been in hospital before, considerable differences emerged.

Two 'profiles' are shown on the following page. These profiles are those of 'Jane' and 'Mary'. Jane, aged four years seven months, had never been in hospital previously and showed great distress when her mother or father were not present. Mary, aged two years ten months, had many previous periods of hospitalization. She was only observed to be distressed on three occasions throughout the seven day period.

Robertson (1958)(109) had observed young children's behaviour in hospital and described the ways in which the periods of maternal separation and/or hospitalization affected it. (Given in Chapter 1.) The 'profiles' seemed to demonstrate his theories clearly.

The results were of particular interest for several reasons. Firstly, it seemed that behaviour patterns that had previously only been described by those already versed in child psychology could be demonstrated by another method of observation. Secondly, the usefulness of the method of observation was confirmed in that it has produced meaningful results, and perhaps equally importantly, because
different observers were contributing to the production of the 'profiles', it seems to indicate that their judgments were consistent. (It must be remembered that the observers were not trained to interpret children's behaviour, or necessarily knowledgeable of the child care theories that have been discussed in Chapter 1.)

The total study was expected to be completed within two years. (October 1967 - October 1969.) The field work for the pilot study was not finished until the end of August 1968, and little attempt had been made to analyze the observations of the children. The main study was planned for the period December 1968 - to March 1969. It was only after completion of the pilot study on Wards A and C that two difficulties were foreseen. It became apparent that hand counting of results when more wards were included in the study, would become unrealistic.

Table 1 shows the numbers involved in the pilot study.

<p>| Table 1: Number of observations in pilot study |
|-----------------|--------|--------|--------|</p>
<table>
<thead>
<tr>
<th>Ward</th>
<th>Nurses</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2,430</td>
<td>7,361</td>
<td>9,791</td>
</tr>
<tr>
<td>C</td>
<td>2,812</td>
<td>7,199</td>
<td>10,011</td>
</tr>
<tr>
<td>Total</td>
<td>5,242</td>
<td>14,560</td>
<td>19,802</td>
</tr>
</tbody>
</table>

Another consideration which had not been made, was of the effect of the season.

The pilot surveys on Wards A and C had been completed during the latter end of June and July 1968. Both the ward sisters had continually commented on the difference in their work load during the summer months. There were allegedly fewer children, and the number of children admitted with upper respiratory tract infections, often needing intensive nursing care (because of oxygen therapy) was
greatly reduced. Furthermore, the children were not confined to the ward because of poor weather and were able to use the extensive grounds available to them. It seemed that if the regimes in different types of units were to be more accurately compared, any further surveys to be completed should not be done during the winter months.

A further survey was therefore arranged immediately for September 1968 with the intention of completing field work, if the study were not to continue after the two years.

Ward B was one ward of a large paediatric unit forming part of a general teaching hospital near Central London. The methods used followed those of the pilot study.

Whilst the study on this ward was continuing, the progress made during the year was discussed with the steering committee, which had been appointed to guide all studies forming part of 'The Study of Nursing Care'. The original period of two years was extended to three, and it was suggested that six further wards might be included. It was agreed that analysis should be completed by the use of a computer.

Although it had been accepted without question from the sisters of A and C wards that the work load during the summer months was different and lighter than during the winter months, it was possible to verify this by examining the records of admissions to Ward B during previous years.

The total number of admissions for each month was found and the numbers of those suffering with the following diagnoses were considered separately:--

- upper respiratory infection
- tonsillitis
- bronchospasms
- pneumonia
- laryngeal strider
- croup
- bronchitis
- chest infection
- broncho-pneumonia
Table 2 gives the details of the numbers involved. Statistical tests showed that both the numbers of total admissions, and those admitted with respiratory tract infections, did vary during the summer and winter months. In fact, the seasonal variations in the number of admissions were such that the probability of their occurring 'by chance' was less than 5% ($p < 0.05$).

Differences between the types of illness diagnosed during summer, as compared with those diagnosed in winter were also noted and commented on by Robinson (1969)(115).

| Table 2: Total number of admissions and those with respiratory tract infections (R.T.I.) during 'Winter' and 'Summer' to Ward B. |
|---|---|---|---|---|
| Month | 1966 - 67 | | 1967 - 68 | |
| | Total | R.T.I. | Total | R.T.I. |
| October | 31 | 13 | 41 | 12 |
| November | 35 | 12 | 40 | 17 |
| December | 30 | 8 | 41 | 19 |
| January | 30 | 9 | 43 | 10 |
| February | 35 | 13 | 35 | 10 |
| March | 36 | 13 | | |
| 'Winter' | 197 | 67 | 240 | 85 |
| April | 20 | 2 | 41 | 8 |
| May | 23 | 5 | 35 | 8 |
| June | 33 | 1 | 26 | 5 |
| July | 26 | 6 | 37 | 6 |
| August | 33 | 6 | 31 | 8 |
| September | 32 | 13 | 30 | 4 |
| 'Summer' | 167 | 33 | 200 | 39 |

Selection of the Hospitals for study

With the decision to enlarge the scope of the study, no further work was undertaken to analyse the results of surveys on Wards A, B and C.

The changes in the methods and coding had been so limited that the results could be adjusted to make them directly comparable with those of the main study. For example, Code I had been amended
to 'I' and 'II' as it did not differentiate clearly between direct and indirect care. The sheets from A, B and C were amended so that in observations where 'I' had been used (giving of medicines and injections), where the nurse's number did not appear in the child's observation, 'I' was altered to 'II'.

The pilot study for reasons stated previously, was conducted in a large paediatric hospital on two wards, referred to in this study as wards A and C.

When it was agreed to complete a survey on a third ward before the winter, selection was limited to a hospital where personnel were known to be agreeable to research, and would be willing to allow research to commence almost immediately.

As selection of all three wards was deliberate, it seemed sensible to choose the remaining six hospitals for specific reasons rather than use a 'random sample' of paediatric units.

The study had to remain 'London based' as the observers were, generally senior nurses undergoing courses at the Royal College of Nursing, and surveys were restricted to their holiday periods. In order that two surveys might be going on at the same time, it was essential that hospitals in question should be within travelling distance of each other.

The paediatric units to be included for selection were therefore restricted to hospitals situated within a twenty mile radius of London, and the following criteria for selection were initially enumerated:–

1) All units in the survey should be approved by the General Nursing Council as training units for nurses - this would mean that in the main they were dependent on student or pupil nurses for staffing purposes.
2) Paediatric units in general hospitals should be more highly represented than paediatric hospital units, as only approximately 33% of children are cared for in these latter hospitals. (Ministry of Health (1967)(80).)

3) Regional Board Hospitals should be well represented. In the London area 75% of available paediatric beds are in such hospitals. (Department of Health and Social Security (1969)(19).)

4) One long term paediatric unit should be included, as these children's needs are different, and the nursing routine might reflect these differing needs. It was particularly important to include a long stay unit, in order to test the validity of the initial findings concerning the children's 'profiles'.

(The younger children with long term experience of hospitalization in a unit of this type, should exhibit different 'profiles' from the young child undergoing his first hospital experience.)

5) Ideally, hospitals with very differing policies concerning parents visiting, should be included in this sample.

6) One unit at least, should offer structural play facilities for its patients - that is the ward should not be dependent on voluntary workers for this service.

7) Units practising 'case' assignment, rather than 'task' assignment, should be included.

8) Although it was recognized that as many as 18% of the children were nursed either in adult units or in small annexes attached to adult wards, (Ministry of Health (1967)(80)) the sample would not include this sector of the population, because:

   1) It was against advised policy (Department of Health and Social Security) (1969)(19)

   2) The numbers of children in any one unit would be so few, that no real comparison would be possible.
The most difficult units to locate, were those with admitted restrictive visiting policies. Enquiry of all the Metropolitan Regional Board Nursing Officers was abortive - units known for their restrictive visiting policy did not meet other criteria e.g., being within easy travelling distance of London. It also did not seem wholly ethically justifiable to include a ward which, by the definition of 'high standard care' discussed in previous chapters, could not be thought to exhibit these standards. It was, therefore, decided that visiting policy as a criterion of selection should be eliminated.

The Nursing Officers could not help in the search for a unit practising case-assignment - this is not a fact that is documented in any statistical return, and no one had personal knowledge of a hospital using this method of care.

A meeting with an ex student nurse, who remembered that case assignment had been practised when she was undergoing her paediatric experience, led to further enquiry, and the hospital was subsequently included in the sample.

The details of the nine paediatric units selected, are shown in table 3.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>A.</th>
<th>B.</th>
<th>C.</th>
<th>D.</th>
<th>E.</th>
<th>F.</th>
<th>G.</th>
<th>H.</th>
<th>J.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Governors</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Regional Hospital Board</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
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<tr>
<td>General Hospital</td>
<td></td>
<td>x</td>
<td>x</td>
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<td>x</td>
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<td>x</td>
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<td></td>
</tr>
<tr>
<td>Paediatric Hospital</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Hospital</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Long Stay Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time school/play</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Part time school/play</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of beds</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total = 225</td>
<td>20</td>
<td>17</td>
<td>20</td>
<td>33</td>
<td>40</td>
<td>30</td>
<td>25</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>
SECTION 2.

Chapter 4. Method of Analysis.
              Results of the modified Activity Sampling of the Nurses' Work.
              Grouping of Nursing Activities.
              Discussion of the Results.

Chapter 5. Results of the modified Activity Sampling conducted on the Children.

Chapter 6. Nurses Questionnaires.
              The Purpose of the Questionnaires.
              Results.
Chapter 4

Summary

Details of the four programs written for analysis of the observations of both the nurses and the children are given. Results of the modified activity sampling of the nurses work are presented. Results, where the greatest differences in utilization of nursing time occurred are discussed.

Analysis by computer

As mentioned previously, arrangements were made to process most of the data by computer. This involved the development of a convenient method of storing the data, together with compiling a suitable program.

Method of Storing Data

The information from the modified activity sampling survey was stored on punch cards. Each card, apart from general information, contained the coded results of one hours observation of one person either a nurse or a child. Examples of a 'nurse' card and a 'child' card are shown on the following page.

The programs were written in ALGOL language (1968)(32) with the help of the computer department staff. There were four programs in all.

Program 1

The output from this program was arranged to show the number of times each nurse has been observed on each of the eight days carrying out her various duties.

The output for each nurse was produced in numerical sequence - thus the breakdown of sisters' work pattern (Nurse 00) was displayed first.
SPECEHEN PUNCH CARDS (SEE CHAPTER 4)

Nurse Card

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child Card

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ward Code Letter

- A: Number of the hour
- B: Observation
- C: Special Nursing Needs
- D: Mobility
- E: Parent Present
- F: No Parent Present
- G: Social Interaction
- H: Left Blank

Ward Code Letter

- A: Number of the hour
- B: Observation
- C: Special Nursing Needs
- D: Mobility
- E: Parent Present
- F: No Parent Present
- G: Social Interaction
- H: Left Blank
On the left hand side of the output sheet a brief descriptive phrase ("declaration") of the activity together with its code was arranged in alphabetical order. The last two lines were marked 'total of activities' and 'adjusted total'. 'Total of activities' showed the addition of every observation made. The 'adjusted total' showed the addition of all codes except those denoting either the nurse's absence for a meal break (M) or because she had been called upon on a temporary basis to help on another ward (N.L.). For the purposes of analysis the adjusted total was always used.

At the head of each print-out the columns were numbered one to eight. These numbers were followed by columns headed 'total', 'mean' and finally 's.d.'. The activities observed each day were shown under the column headed with the appropriate day number. In the column marked 'total' the results obtained from Day 2 up to and including Day 8 were added. The figure shown under 'mean' was the average number of times the activity was observed on each of the days that the nurse had been on duty. (Day 1 again being excluded from this calculation). The standard deviation was also calculated, and shown in the column marked 's.d.'.

The final output sheet from Program 1 gave the total activities of the ward for the seven days, each nurse's contribution to the work load being totalled.

When the program was being developed it was considered (because of the experience gained from the pilot studies) that there would not be more than 20 different nurses on each ward, and this number was used as one of the array constraints in order to limit the amount of 'memory banks' the program would occupy. In fact, only wards A, B, C, F and J were staffed by less than 20 nurses over the eight day period. The reasons for the greater numbers of nursing
staff were several: on some wards the rota changed and nurses left the ward to be replaced by new members of staff on others the night duty shift did not finish until 8.0 a.m. and thus their contribution to the total work load had to be included. This was often made more complicated by the fact that the night staff changed from night to night.

Before starting the main fieldwork it was decided that unless a nurse worked for a minimum of ten hours, excluding meal breaks and 'being loaned' to another ward, she would not be required to complete a questionnaire - it was therefore not necessary to record her activities separately if it could be calculated that she would work for less than this time. For example, the work of different night nurses (who were occasionally on duty until after 7.30 a.m.) was attributed to Nurse number 19. If there were any doubt about the amount of time that a nurse was likely to be observed, she was given an individual number. After the survey was completed these observations (if less than 60) were often amalgamated with those of other nurses to comply with the constraint of 20 nurses per ward.

It was found necessary to revise the program for Ward G. where in spite of night nurses' numbers having been amalgamated as far as possible, the number of nurses completing ten or more hours was still as high as 30.

Program 2

The output from this program was arranged to group the various nursing activities together into related categories according to whether or not the care implied direct contact with the patient. Again, a brief descriptive phrase of the type of care was shown on the left hand side of the output sheet, and the amalgamated totals of the groupings were shown under the day number.
The summaries of observations were not only grouped together in absolute numbers, but the results obtained for each group were also expressed as percentages of the 'adjusted total'.

The only new column introduced into this program was headed 'W.S.'. It was based on the work study formula:

\[
W.S. = \pm \sqrt{\frac{4interveneprobability(100 - interveneprobability)}{N}}
\]

(from Currie (1959)(18)).

This formula was used to define the limits of the accuracy with which the results that were obtained during a survey using modified activity sampling techniques could be regarded. For this study the 'ninety five percent confidence limit' was accepted i.e. \( p < 0.05 \). In the formula \( N \) = the 'adjusted total' of observations made during the second day up to and including the eighth day. \( P \) = the percentage figure entered in the column headed 'mean'.

For example: The mean value for the percentage of nurses' time spent on Direct Basic Care on Ward A over the period of survey = 9.67%. The value of W.S. corresponding to this result is 1.20. Hence, in order to comply with the 95% confidence limits, the true percentage mean for this activity would lie between \( 9.67 \pm 1.20 = 10.87\% \) and \( 9.67 - 1.20 = 8.47\% \). (See table 4, page 80.)

Program 3

The output of Program 3 was designed to show the results of each day's observations on each child.

For each ward there were nine sheets of output. The sheets one to eight showed the results of the observations on that day number, whilst on the ninth sheet, the total results of day 2 up to and including day 8 were given.
Each of the 30 columns was headed by a brief description of the category which had been included in the analysis. Under this, each column was numbered from one to thirty. Every child was allocated his own unique number for the survey and the line immediately below the numbering of the column shows the analysis of the observations made of child No.1. If the child were not present on that particular day - because he had not been admitted or had already been discharged, the line recorded a zero count. The array constraint of the number of children was declared for each program as the number of children observed on each ward varied from 20 to 60. Immediately following the analysis of the last child's observations the total number of observations in each category was shown. This was followed by the average number of observations of each child in each category.

Finally, categories were expressed as percentages of the total number of observations and the means of observations were also expressed in this way.

Program 4

This was very similar to Program 3 but the observations of the children were grouped for comparison into various categories.

These included age groupings - groupings by sex and grouping by age and judgment of having 'special nursing needs'.

Again the program gave the output for each day and the total for day 2 up to and including day 8. The actual numbers were grouped and the table re-presented giving figures in all columns expressed as a percentage of the total number of observations made.

Results of the modified activity sampling of the nurses' work

The results obtained from the pilot study are considered together with those of the main study. The observers were working
between 7.30 a.m. and 8.0 p.m. for eight days, and the first day's results were not included in the analysis. With the exception of Ward D where one observer missed her four hour period on duty, 87\(\frac{1}{2}\) hours of 'day time' duty on each ward were available for analysis.

Ward D's results were considered in two ways. Firstly, it was possible to calculate how many observations had been 'missed' by checking the 'duty book' and verifying who had been present during the period. This made it possible to calculate results using the 87\(\frac{1}{2}\) hour period as 100%, thus bringing the basis of calculations into line with other wards. (Note that the missed observations were estimated to be 124 or 4.12\% of the total). The second alternative was to ignore the four hours missed and use 85\(\frac{3}{4}\) hours as the basis of calculations. The basic figure used will be given in each table.

Grouping of Nursing Activities

45 Categories of nursing activity were used to classify nurses' work. (These are fully explained in Appendix 1.)

For convenience in analysing the results of the study, all these activities are sub-divided into the following main groups:-

- Basic Nursing Care - direct and indirect care.
- Technical Nursing Care - direct and indirect care.
- 'Extra' or professional care - direct and indirect care.
- Administrative and teaching.
- Errands and ward tidying.
- Domestic Tasks.
- Miscellaneous.

A further re-arrangement of these groupings was also made, to highlight the total amounts of both direct and the indirect nursing care.

The reason for grouping the amounts of all indirect and all direct care together, was because it was often difficult, when coding, to distinguish the correct coding to use for the contact. For example, a nurse might be bathing a child and playing at the same time thus the
extra attention might well be coded as direct basic care, rather than
direct 'extra care'.

The 45 nursing activities were grouped and coded as follows:-

1. **Basic Nursing Care.**

   A. Feeding a patient.
   B. Bathing or washing.
   C. Attending to toilet needs.  'Direct' nursing care.
   D. Making an occupied bed.
   E. 'Other' basic care.

   AA. Serving meals.
   AB. Preparing bottle feeds.
   GC. Potties and Bedpans.
   F. Making empty beds.
   H. Clearing or preparing basic equipment.

2. **Technical Nursing Care.**

   I. Giving medicines or injections.
   J. Recording temperature, blood or pulse rates.
   K. Other technical care with the patient.  'Direct' Nursing Care.
   AK. 'Tube' feeding.
   KK. Surgical dressing.
   NO. Taking patient to operating theatre.
   NP. Taking patient to another department.

   II. Preparation of medicines or injections.  'Indirect'
   KT. Technical care - not with the patient.  Nursing Care.
   L. Preparation of equipment for technical task.

3. **'Extra' Care.**

   S. Social Interaction.
   NS. Off the ward with a patient for social reasons.  'Direct'
   NC. Off the ward accompanying a patient to church.

   T. Talking to visitors.  'Indirect'

4. **Administration and Teaching duties.**

   NT. Off the ward for teaching purposes.  'Indirect'
   Ṣ. 'Exchanging information'.
   ṢṢ. 'Helping' with a task.
   F. 'Phone call.
   Q. Clerical Work.
   R. 'Rounds' with other members of the hospital staff.
   TT. Talking to the team.
5. **Tidying and Errands.**

   V. Tidying the ward and toys and arranging flowers.
   NM. Off the ward on a mission.

6. **Domestic Tasks.**

   X. Preparing meals.
   XX. Washing crockery.
   Y. 'Light' cleaning.
   YY. 'Heavy' cleaning.
   Z. Dealing with clean linen.
   ZZ. Dealing with dirty linen.

7. **Miscellaneous.**

   G. Washing hands.
   W. Walking.
   U. Unclassified.
   N. Off the ward - purpose not known.

   Not included in categories of 'direct' or 'indirect' nursing care.

The percentage breakdown of nursing activities in all the wards, is summarised in the tabulation shown on page 80.
Table 4. Percentage breakdown of Nursing and other Activities in the nine wards.

<table>
<thead>
<tr>
<th>Activities</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>J</th>
<th>Mean ± W.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Basic Nursing Care</td>
<td>9.7</td>
<td>14.0</td>
<td>21.2</td>
<td>24.1</td>
<td>21.1</td>
<td>18.9</td>
<td>19.2</td>
<td>9.1</td>
<td>18.6</td>
<td>17.3 ± 1.7</td>
</tr>
<tr>
<td>Direct Technical Nursing Care</td>
<td>6.3</td>
<td>9.5</td>
<td>8.2</td>
<td>7.7</td>
<td>6.3</td>
<td>6.4</td>
<td>9.2</td>
<td>7.9</td>
<td>10.4</td>
<td>8.0 ± 1.1</td>
</tr>
<tr>
<td>Direct Extra Nursing Care</td>
<td>16.9</td>
<td>17.6</td>
<td>8.4</td>
<td>6.2</td>
<td>6.3</td>
<td>11.5</td>
<td>5.9</td>
<td>15.8</td>
<td>15.0</td>
<td>11.5 ± 1.6</td>
</tr>
<tr>
<td>Total Direct Nursing Care</td>
<td>32.9</td>
<td>41.1</td>
<td>37.8</td>
<td>38.0</td>
<td>33.7</td>
<td>36.8</td>
<td>34.3</td>
<td>32.8</td>
<td>44.0</td>
<td>36.8 ± 2.2</td>
</tr>
<tr>
<td>Indirect Basic Nursing Care</td>
<td>14.4</td>
<td>6.9</td>
<td>10.5</td>
<td>18.4</td>
<td>17.9</td>
<td>16.3</td>
<td>15.1</td>
<td>9.1</td>
<td>10.9</td>
<td>13.3 ± 1.5</td>
</tr>
<tr>
<td>Indirect Technical Nursing Care</td>
<td>3.7</td>
<td>5.6</td>
<td>3.9</td>
<td>3.8</td>
<td>5.9</td>
<td>4.7</td>
<td>5.3</td>
<td>4.3</td>
<td>2.2</td>
<td>4.1 ± 1.4</td>
</tr>
<tr>
<td>Indirect Extra Nursing Care</td>
<td>3.0</td>
<td>1.4</td>
<td>2.8</td>
<td>2.7</td>
<td>2.5</td>
<td>2.2</td>
<td>2.7</td>
<td>5.6</td>
<td>1.8</td>
<td>2.2 ± 0.7</td>
</tr>
<tr>
<td>Administration and Teaching</td>
<td>20.3</td>
<td>24.3</td>
<td>19.4</td>
<td>25.8</td>
<td>18.3</td>
<td>26.5</td>
<td>27.3</td>
<td>21.8</td>
<td>23.0</td>
<td>19.3 ± 1.9</td>
</tr>
<tr>
<td>Total Indirect Nursing Care</td>
<td>41.4</td>
<td>36.2</td>
<td>36.6</td>
<td>50.7</td>
<td>49.0</td>
<td>41.5</td>
<td>49.6</td>
<td>46.3</td>
<td>36.7</td>
<td>37.6 ± 2.2</td>
</tr>
<tr>
<td>Tidying and Errands</td>
<td>4.0</td>
<td>2.8</td>
<td>4.9</td>
<td>3.8</td>
<td>3.3</td>
<td>6.1</td>
<td>2.9</td>
<td>3.8</td>
<td>2.4</td>
<td>3.8 ± 0.9</td>
</tr>
<tr>
<td>Domestic Tasks</td>
<td>8.7</td>
<td>6.1</td>
<td>10.2</td>
<td>2.9</td>
<td>6.1</td>
<td>3.7</td>
<td>5.1</td>
<td>9.7</td>
<td>7.1</td>
<td>6.6 ± 1.2</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>13.0</td>
<td>13.8</td>
<td>10.5</td>
<td>4.6</td>
<td>7.9</td>
<td>11.9</td>
<td>8.1</td>
<td>7.4</td>
<td>9.8</td>
<td>9.7 ± 1.4</td>
</tr>
<tr>
<td>Total Basic Nursing Care</td>
<td>24.1</td>
<td>20.9</td>
<td>31.6</td>
<td>42.5</td>
<td>39.0</td>
<td>35.2</td>
<td>34.3</td>
<td>18.2</td>
<td>29.4</td>
<td>30.6 ± 2.1</td>
</tr>
<tr>
<td>Total Technical Care</td>
<td>10.0</td>
<td>13.1</td>
<td>12.1</td>
<td>11.5</td>
<td>12.2</td>
<td>11.1</td>
<td>14.5</td>
<td>12.2</td>
<td>12.6</td>
<td>12.1 ± 1.5</td>
</tr>
<tr>
<td>Total Extra Care</td>
<td>20.0</td>
<td>19.0</td>
<td>11.1</td>
<td>8.9</td>
<td>8.7</td>
<td>36.7</td>
<td>8.6</td>
<td>21.4</td>
<td>16.9</td>
<td>14.2 ± 1.7</td>
</tr>
<tr>
<td>Domestic and Errands</td>
<td>12.7</td>
<td>8.9</td>
<td>15.1</td>
<td>6.7</td>
<td>9.4</td>
<td>9.8</td>
<td>8.0</td>
<td>13.4</td>
<td>9.4</td>
<td>10.4 ± 1.4</td>
</tr>
</tbody>
</table>

**Note:** 1 hour = 8 %
Table No. 5, presented on the following page, shows the total number of observations made of nurses on each ward, together with the numbers of different nurses who contributed to the work load during the period of the study. It should be remembered that this represents a slight under-estimate, since the work of two or more nurses could have been attributed to the same nurse's code number, as, for example, that of the 'relief nightnurse's'.

The last column in Table 5 gives the average number of observations made of each nurse.

Had each nurse completed 40 hours of day-duty during the seven-day period of the study, the average number of observations per nurse would have been 240, while the number of nurses observed would have been reduced to 106, or approximately, 12 nurses per ward during day duty hours. It will be seen from Table 5 that such regularity was not observed in practice. The main reasons for this were the holiday periods, sickness etc. among the staff, and the system of 'Internal night duty rotation' practiced in five of the nine wards studied. It was thus found impracticable to make meaningful comparisons between the activities of individual nurses.

It would seem appropriate to note at this stage that, from the patient's point of view, the appearance at different times of 18 or more nurses in his ward, presents quite a problem in familiarization. This problem must be particularly formidable in the case of a young child.

The Accuracy of Activity Sampling (Discussion)

The ninety-five per cent confidence limits were calculated for the grouped activities of nursing care for each ward, using the formula given on page 45:

$$N = \sqrt{\frac{4p(100-p)}{L^2}}$$
where \( N \) is the total number of observations and \( P \) is the occurrence of the specified group of activities expressed as a percentage of \( N \).

Using this formula, it can thus be stated with ninety-five per cent degree of confidence, that the direct basic care given on Ward A took up \( 9.7 \pm 1.7\% \) (or between 8.0\% and 11.4\%) of the total daily activities. To give an 'overall' estimation in the summary table for any group of activities observed in the wards, the largest variation in the confidence limits is given in the table in the last column.

**Table 5. Total number of observations made of nurses on each ward, and the average number of observations made of each.**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total observations of nurses</th>
<th>Number of different nurses on each ward</th>
<th>Average Number of observations per nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2,430</td>
<td>12</td>
<td>202.5</td>
</tr>
<tr>
<td>B</td>
<td>2,875</td>
<td>18</td>
<td>160.0</td>
</tr>
<tr>
<td>C</td>
<td>2,812</td>
<td>16</td>
<td>180.0</td>
</tr>
<tr>
<td>*D</td>
<td>3,069</td>
<td>21</td>
<td>147.5</td>
</tr>
<tr>
<td>E</td>
<td>2,564</td>
<td>20</td>
<td>128.2</td>
</tr>
<tr>
<td>F</td>
<td>2,650</td>
<td>13</td>
<td>203.8</td>
</tr>
<tr>
<td>G</td>
<td>3,367</td>
<td>30</td>
<td>112.2</td>
</tr>
<tr>
<td>H</td>
<td>3,736</td>
<td>19</td>
<td>198.5</td>
</tr>
<tr>
<td>J</td>
<td>1,968</td>
<td>14</td>
<td>140.6</td>
</tr>
<tr>
<td>Total</td>
<td>25,471</td>
<td>163</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>2,830</td>
<td>18.2</td>
<td>156.3</td>
</tr>
</tbody>
</table>

* Includes the estimated number of missed observations.


Discussion of the Results

It will be appreciated that there are many variables which have to be accepted in a survey of this type. For this reason, to compare the results obtained in one ward with those of another, is often meaningless. For example, it can be seen that the highest percentage of direct basic nursing care was given on Ward D. Ward D at the same time, had the largest proportion of babies under the age of ten months. As another illustration, Ward J had a strict post operative routine, which the nurses were conscientious in following; this is probably reflected in the comparatively high percentage of direct technical care revealed by the study and shown in Table 4.

The analysis shows that there are only three results which can be considered of 'statistical' significance - i.e. whose departure from the mean is at least 2.5 standard deviations.

The first of these relates to the above average amount of time the nurses on Ward H appeared to be spending in indirect extra care. It was on this ward that several parents 'lived-in' and cared for their own child, often under the supervision of the nurses.

At the same time, this was the ward with the highest percentage of visitors present, and the highest staffing ratio; (one nurse to 2.5 children). The other two wards enjoying comparable staffing ratios (Wards G and J both with a ratio of 1: 2.6) had 'low' visiting rates. Ward E had almost as high visiting rates as Ward H with the lowest number of nurses per patient (1: 5.9). Since talking to the visitors constitutes 'indirect extra nursing care' it would appear that the above-average percentage of this activity in the case of Ward H was due to the combined effect of some of the mothers 'living-in' with the children, and to the high staffing ratio in that ward.

The second result which differed significantly from others,
occurred on Ward F. The nursing staff here, spent more time tidying up or going on ward errands. (Again differing by 2.5 standard deviations from the mean.) Records show that the children on this ward tended to remain in hospital longer, and may have collected more belongings necessitating more tidying. However, 6.11% of time represented 27 nurse-hours over the duration of the study, and this time might perhaps have been spent more profitably in some other nursing activity.

Finally, the nursing staff on Ward D appeared to spend considerably less time doing 'miscellaneous tasks' — 21.3 nurse hours or 4.6% of the total time (a total of 83.5 hours observation was used as a basis for this calculation).

Included in 'miscellaneous' were four categories 'washing hands', 'walking', 'off the ward - purpose not known' and 'unclassified'. The first two, 'washing hands' and 'walking' were only categorized as such when they did not appear to be part of preparing or cleaning equipment, or part of a patient-centred task.

Grandjean (1969)(36) suggests that rest pauses form an indispensable physiological requirement for the preservation of work capacity. He differentiated four types of rest pauses, spontaneous, disguised, work conditioned and prescribed.

For the purpose of the present study, spontaneous pauses or periods of 'not working' were classified 'U' whilst disguised pauses were probably covered by 'washing hands' or 'walking'.

Grandjean gives a diagram in his text which shows that where there is not prescribed rest pause, the amount of time spent in spontaneous and disguised pauses, can be as high as 21.5% - while with prescribed rest pauses, this is lowered to 12.5%.

Results from wards A, B, C and F seem to bear this out.
If domestic tasks are considered 'secondary' work and combined with 'miscellaneous' to form 'disguised' pauses, then the nurses on Ward D (who spent less than half the time that their colleagues elsewhere did on such work, (combined-percentage of 7.5) had fewer opportunities to give themselves rest pauses. There was a low staffing ratio on this ward (one nurse to 4.3 patients), and an assumption might be made that the work load on Ward D could be considered to be too heavy.

The amount of direct nursing care given on all wards is fairly similar, averaging about 37%. The amount of time nurses spent with the children (direct extra care) varies considerably. On three wards the time is less than 9% or one hour per day, whilst on others 'extra' care occupies over two hours each day. (17.6% on Ward B). These figures are somewhat academic, in that they represent the total time the nurse spends giving direct nursing care in the ward, while what really matters, is the amount of attention and time received by the individual children.

The amount of time nurses spend doing 'domestic' work and errands, is of interest. It will be remembered that it was in this category that tasks more suited to a domestic staff were recorded— including preparing meals, cleaning dishes, light and heavy cleaning, and dealing with clean and soiled linen. It would appear that the nurses employed in paediatric hospitals do more of this type of work; (Wards A, C and H with 8.7%, 10.2% and 9.6% respectively). Nurses in these wards were seen more often preparing jellies and cutting break and butter than the staff of children's wards in general hospitals.

Two paediatric units were included in the Leeds study (1963)(57). Their method of categorizing the activities was different from that used in the present study, but they found that the staff
spent 11.5% of their time doing domestic work - a figure comparable, although slightly higher than the one found in the paediatric wards in the present study. (See above.)

'Personal contact' with the patient was considered as part of 'basic nursing' and occupied 4% of time.

The analysis is very difficult to follow, as there appear to be discrepancies within the tables, and further comparison was not carried out.
<table>
<thead>
<tr>
<th>Category</th>
<th>Number of observations</th>
<th>Percentage</th>
<th>Time in hours and minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Basic Nursing care</td>
<td>4,335</td>
<td>17.1</td>
<td>2 hours 8 minutes</td>
</tr>
<tr>
<td>Direct Technical Nursing care</td>
<td>2,025</td>
<td>8.0</td>
<td>1 hour</td>
</tr>
<tr>
<td>Direct 'extra' Nursing care</td>
<td>2,886</td>
<td>11.4</td>
<td>1 hour 26 minutes</td>
</tr>
<tr>
<td>Direct Nursing care</td>
<td>9,246</td>
<td>36.4</td>
<td>4 hours 34 minutes</td>
</tr>
<tr>
<td>Indirect Basic Nursing care</td>
<td>3,337</td>
<td>13.7</td>
<td>1 hour 38 minutes</td>
</tr>
<tr>
<td>Indirect Technical Nursing care</td>
<td>1,071</td>
<td>4.2</td>
<td>31 minutes</td>
</tr>
<tr>
<td>Indirect 'extra' Nursing care</td>
<td>729</td>
<td>2.9</td>
<td>22 minutes</td>
</tr>
<tr>
<td>Administration and errands</td>
<td>5,911</td>
<td>23.3</td>
<td>2 hours 55 minutes</td>
</tr>
<tr>
<td>Indirect Nursing care</td>
<td>11,048</td>
<td>43.5</td>
<td>5 hours 26 minutes</td>
</tr>
<tr>
<td>Tidying and errands</td>
<td>960</td>
<td>3.8</td>
<td>29 minutes</td>
</tr>
<tr>
<td>Domestic tasks</td>
<td>1,685</td>
<td>6.7</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>2,408</td>
<td>9.5</td>
<td>1 hour 11 minutes</td>
</tr>
<tr>
<td>Total Care</td>
<td>25,347</td>
<td>100.0</td>
<td>12 hours 30 minutes</td>
</tr>
<tr>
<td>Total Basic Nursing care</td>
<td>7,672</td>
<td>30.2</td>
<td>3 hours 46 minutes</td>
</tr>
<tr>
<td>Total Technical Nursing care</td>
<td>3,096</td>
<td>12.2</td>
<td>1 hour 31 minutes</td>
</tr>
<tr>
<td>Total 'Extra' Nursing care</td>
<td>3,615</td>
<td>14.3</td>
<td>1 hour 56 minutes</td>
</tr>
<tr>
<td>Domestic, Tidying and Errands</td>
<td>2,645</td>
<td>10.5</td>
<td>1 hour 19 minutes</td>
</tr>
</tbody>
</table>
Chapter 5

Summary

The results obtained from the modified activity sampling of the children are presented. The results were examined in 29 different categories. Each of these categories is given, and the figures obtained are shown. By using some of the results of activity sampling of the nurses, together with those of the children, staffing ratios can be calculated. These are demonstrated visually by the use of graphs. Bed occupancy rates are also shown. The amount of nursing contact that the children received is assessed. The number of different nurses participating in the care of each child is noted. Frequency of visitors and the significance this had for the children is given.

Results of the Modified Activity Sampling conducted on the children

Having examined the 'profiles' of the young children taking part in the pilot study, it was necessary to find a quantitative way of sorting or collating the data. All children were observed throughout the seven day period - although in many cases they were either admitted or discharged, or both, during this time, meaning that rather less than the possible 525 observations were made of each child in the survey.

Only one parent objected to his child being part of the survey, but after explanation agreed to his inclusion.

Many parents appeared pleased that interest was being shown in something which affected them and their children so vitally.

In this chapter, the twenty nine categories of observations will be explained, and some of the total results and findings obtained will be given and discussed. Table 7 on the following page gives a summary of the results.
<table>
<thead>
<tr>
<th>Ward Category</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D*</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>J</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Number of observations</td>
<td>7361</td>
<td>8568</td>
<td>7199</td>
<td>12769</td>
<td>15122</td>
<td>12956</td>
<td>9236</td>
<td>9520</td>
<td>5201</td>
<td>8.96</td>
</tr>
<tr>
<td>2. Special needs</td>
<td>10.7</td>
<td>16.5</td>
<td>6.3</td>
<td>6.0</td>
<td>5.8</td>
<td>9.9</td>
<td>10.3</td>
<td>6.5</td>
<td>14.0</td>
<td>58.85</td>
</tr>
<tr>
<td>3. Marked 'up'</td>
<td>78.3</td>
<td>67.3</td>
<td>75.0</td>
<td>36.0</td>
<td>56.8</td>
<td>21.7</td>
<td>55.1</td>
<td>67.4</td>
<td>56.1</td>
<td>14.0</td>
</tr>
<tr>
<td>4. Marked 'Chair'</td>
<td>2.3</td>
<td>6.1</td>
<td>7.9</td>
<td>7.2</td>
<td>0.2</td>
<td>11.7</td>
<td>0.2</td>
<td>6.2</td>
<td>10.7</td>
<td>5.56</td>
</tr>
<tr>
<td>5. Marked 'Bed'</td>
<td>19.4</td>
<td>26.6</td>
<td>17.1</td>
<td>56.8</td>
<td>43.0</td>
<td>66.6</td>
<td>44.7</td>
<td>26.4</td>
<td>33.2</td>
<td>40.56</td>
</tr>
<tr>
<td>6. Observed 'Up'</td>
<td>26.2</td>
<td>34.9</td>
<td>10.9</td>
<td>10.8</td>
<td>12.0</td>
<td>8.1</td>
<td>16.2</td>
<td>19.5</td>
<td>24.0</td>
<td>16.54</td>
</tr>
<tr>
<td>7. Observed Sitting</td>
<td>18.0</td>
<td>12.7</td>
<td>24.5</td>
<td>13.8</td>
<td>9.6</td>
<td>12.3</td>
<td>15.4</td>
<td>27.1</td>
<td>23.1</td>
<td>16.14</td>
</tr>
<tr>
<td>8. Observed in bed</td>
<td>36.8</td>
<td>40.7</td>
<td>50.8</td>
<td>63.5</td>
<td>67.8</td>
<td>59.9</td>
<td>45.6</td>
<td>37.8</td>
<td>48.4</td>
<td>52.67</td>
</tr>
<tr>
<td>9. Observed held</td>
<td>2.0</td>
<td>5.6</td>
<td>2.5</td>
<td>6.2</td>
<td>9.8</td>
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<td>8.8</td>
<td>8.2</td>
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<td>5.90</td>
</tr>
<tr>
<td>10. School</td>
<td>10.7</td>
<td>0.6</td>
<td>7.6</td>
<td>NIL</td>
<td>NIL</td>
<td>8.7</td>
<td>8.3</td>
<td>NIL</td>
<td>NIL</td>
<td>3.74</td>
</tr>
<tr>
<td>11. Social off Ward</td>
<td>4.1</td>
<td>4.6</td>
<td>1.8</td>
<td>0.4</td>
<td>0.1</td>
<td>5.0</td>
<td>3.3</td>
<td>6.4</td>
<td>0.2</td>
<td>2.78</td>
</tr>
<tr>
<td>12. Other Off Ward</td>
<td>2.1</td>
<td>0.7</td>
<td>1.8</td>
<td>1.0</td>
<td>0.7</td>
<td>3.7</td>
<td>2.4</td>
<td>1.1</td>
<td>0.5</td>
<td>1.60</td>
</tr>
<tr>
<td>13. Nursing Contact</td>
<td>11.3</td>
<td>16.4</td>
<td>14.8</td>
<td>8.7</td>
<td>5.9</td>
<td>7.9</td>
<td>12.3</td>
<td>13.0</td>
<td>18.4</td>
<td>10.98</td>
</tr>
<tr>
<td>14. Staff Contact</td>
<td>13.2</td>
<td>19.0</td>
<td>15.7</td>
<td>9.5</td>
<td>7.2</td>
<td>10.3</td>
<td>15.8</td>
<td>16.9</td>
<td>20.7</td>
<td>12.69</td>
</tr>
<tr>
<td>15. Diff. Nurses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>16. Visitors</td>
<td>16.5</td>
<td>28.3</td>
<td>15.5</td>
<td>17.5</td>
<td>34.2</td>
<td>19.7</td>
<td>17.8</td>
<td>33.1</td>
<td>15.5</td>
<td>23.10</td>
</tr>
<tr>
<td>17. Own Parents</td>
<td>15.7</td>
<td>24.6</td>
<td>13.9</td>
<td>16.0</td>
<td>28.0</td>
<td>14.8</td>
<td>16.2</td>
<td>30.1</td>
<td>12.7</td>
<td>19.90</td>
</tr>
<tr>
<td>18. Other Parents</td>
<td>0.8</td>
<td>3.7</td>
<td>1.6</td>
<td>1.4</td>
<td>6.2</td>
<td>4.9</td>
<td>1.6</td>
<td>3.0</td>
<td>2.8</td>
<td>3.20</td>
</tr>
<tr>
<td>20. Alone Awake</td>
<td>39.5</td>
<td>31.4</td>
<td>40.3</td>
<td>45.5</td>
<td>36.6</td>
<td>41.8</td>
<td>32.8</td>
<td>32.5</td>
<td>39.6</td>
<td>38.01</td>
</tr>
<tr>
<td>22. Excited</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
<td>0.2</td>
<td>0.2</td>
<td>0.8</td>
<td>-</td>
<td>-</td>
<td>0.15</td>
</tr>
<tr>
<td>23. Contented</td>
<td>64.7</td>
<td>72.8</td>
<td>66.6</td>
<td>51.5</td>
<td>68.0</td>
<td>69.4</td>
<td>59.9</td>
<td>70.5</td>
<td>68.0</td>
<td>65.30</td>
</tr>
<tr>
<td>24. Happy</td>
<td>64.7</td>
<td>72.8</td>
<td>66.6</td>
<td>51.8</td>
<td>68.0</td>
<td>69.6</td>
<td>59.9</td>
<td>71.3</td>
<td>68.0</td>
<td>65.50</td>
</tr>
<tr>
<td>25. Distressed</td>
<td>3.0</td>
<td>3.2</td>
<td>2.9</td>
<td>7.1</td>
<td>8.6</td>
<td>2.6</td>
<td>3.7</td>
<td>2.9</td>
<td>6.9</td>
<td>4.80</td>
</tr>
<tr>
<td>26. Apathetic</td>
<td>9.2</td>
<td>9.7</td>
<td>7.0</td>
<td>16.5</td>
<td>6.5</td>
<td>4.3</td>
<td>6.1</td>
<td>3.5</td>
<td>10.0</td>
<td>8.00</td>
</tr>
<tr>
<td>27. Miserable</td>
<td>12.2</td>
<td>12.9</td>
<td>9.9</td>
<td>23.6</td>
<td>15.1</td>
<td>6.8</td>
<td>9.8</td>
<td>6.4</td>
<td>10.9</td>
<td>12.80</td>
</tr>
<tr>
<td>28. Miserable Alone</td>
<td>8.7</td>
<td>9.4</td>
<td>8.1</td>
<td>18.6</td>
<td>11.8</td>
<td>5.1</td>
<td>7.4</td>
<td>4.0</td>
<td>12.1</td>
<td>9.70</td>
</tr>
<tr>
<td>29. Miserable with Parents</td>
<td>1.7</td>
<td>2.0</td>
<td>0.3</td>
<td>2.1</td>
<td>2.0</td>
<td>0.9</td>
<td>0.8</td>
<td>1.8</td>
<td>1.3</td>
<td>1.50</td>
</tr>
</tbody>
</table>

* Calculated using actual number of observations.
As already stated if a child were observed throughout the survey, it was possible to make 525 observations of him. Category 1 (see table 7) gave the total number of observations made either of the child, or the group of children. A total of 87,932 observations of children were made in all. The bed occupancy rate was calculated as follows: the number of observations that would be possible if every bed on the ward were occupied throughout the survey, was divided by the actual number of observations made on each ward during the survey.

It can be seen from Table 8 that ward J was somewhat under occupied throughout the period of the survey. Wards in paediatric hospitals had a 74% occupancy rate in a census of 1964 and 1965 (Ministry of Health) (1967) whilst paediatric wards in 'other hospitals' had an occupancy rate of 68% and 71% in the same census.

<table>
<thead>
<tr>
<th>Ward</th>
<th>No. of Beds</th>
<th>No. of observations if occupied 100%</th>
<th>Actual No. of Observations</th>
<th>% Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20</td>
<td>10,500</td>
<td>7,361</td>
<td>70.1</td>
</tr>
<tr>
<td>B</td>
<td>17</td>
<td>8,925</td>
<td>8,568</td>
<td>96.0</td>
</tr>
<tr>
<td>C</td>
<td>20</td>
<td>10,500</td>
<td>7,199</td>
<td>68.6</td>
</tr>
<tr>
<td>D*</td>
<td>33</td>
<td>17,325</td>
<td>12,769</td>
<td>73.7</td>
</tr>
<tr>
<td>E</td>
<td>40</td>
<td>21,000</td>
<td>15,120</td>
<td>72.0</td>
</tr>
<tr>
<td>F</td>
<td>30</td>
<td>15,750</td>
<td>12,956</td>
<td>82.3</td>
</tr>
<tr>
<td>G</td>
<td>25</td>
<td>13,125</td>
<td>9,238</td>
<td>70.4</td>
</tr>
<tr>
<td>H</td>
<td>20</td>
<td>10,500</td>
<td>9,520</td>
<td>90.7</td>
</tr>
<tr>
<td>J</td>
<td>20</td>
<td>10,500</td>
<td>5,201</td>
<td>49.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>225</strong></td>
<td><strong>118,125</strong></td>
<td><strong>87,932</strong></td>
<td><strong>74.44</strong></td>
</tr>
</tbody>
</table>

* Calculated using estimated figures for 87 1/2 hours of observation.
Recent figures (Department of Health and Social Security) (1970)(20) show that the average bed occupancy in paediatric departments of hospitals throughout England and Wales in 1969 was approximately 62%. This is considerably lower than the rate found during the present survey, the average rate being 74.4%.

Comparing the number of observations made of the children with the number made of the nurses, the effective staffing ratio during the survey can be estimated. This is shown in the following table.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total observations of Nurses</th>
<th>Total observations of Children</th>
<th>Nurse/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2,430</td>
<td>7,361</td>
<td>1:3</td>
</tr>
<tr>
<td>B</td>
<td>2,875</td>
<td>8,568</td>
<td>1:3</td>
</tr>
<tr>
<td>C</td>
<td>2,812</td>
<td>7,199</td>
<td>1:2.6</td>
</tr>
<tr>
<td>D*</td>
<td>3,069</td>
<td>12,769</td>
<td>1:4.3</td>
</tr>
<tr>
<td>E</td>
<td>2,564</td>
<td>15,122</td>
<td>1:5.9</td>
</tr>
<tr>
<td>F</td>
<td>2,650</td>
<td>12,956</td>
<td>1:4.9</td>
</tr>
<tr>
<td>G</td>
<td>3,367</td>
<td>9,238</td>
<td>1:2.7</td>
</tr>
<tr>
<td>H</td>
<td>3,736</td>
<td>9,520</td>
<td>1:2.5</td>
</tr>
<tr>
<td>J</td>
<td>1,968</td>
<td>5,201</td>
<td>1:2.6</td>
</tr>
<tr>
<td>Total</td>
<td>25,471</td>
<td>87,934</td>
<td>1:3</td>
</tr>
</tbody>
</table>

* Calculated using actual number of observations.

The staff/patient ratio can be conveniently represented by means of a graph showing the hourly fluctuation in the numbers of staff and patients present on the ward. The graphs on the next page illustrate these. Two wards were included to demonstrate the effects of 'high' and 'low' staffing rates.
Graphs showing the numbers of patients and nurses observed on wards J and E during each hour of 7-day survey from 7 AM till 8 PM.

Patients shown thus: 

Nurses shown thus: 

Ward J - capacity 20 beds

Ward E - capacity 37 beds
Table 10 shows the number of children observed during the week of the survey and the average number of observations made of each. It can be seen that the average number of observations was lowest in the paediatric wards of 'Regional Board General Hospitals', indicative of a greater turnover rate (Wards D, E and J). Ward J had a low occupancy rate, this accounting for the somewhat misleading ratio given in the table. D and E had high rates of admissions and discharges and the lowest nurse/patient ratio. Ward F, the long stay ward, had the highest average number of observations per child as might be expected.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of Beds</th>
<th>Number of Different Children</th>
<th>Average number of observations</th>
<th>'Turnover' Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>20</td>
<td>23</td>
<td>320.0</td>
<td>1:1.15</td>
</tr>
<tr>
<td>B</td>
<td>17</td>
<td>28</td>
<td>306.0</td>
<td>1:1.65</td>
</tr>
<tr>
<td>C</td>
<td>20</td>
<td>24</td>
<td>300.0</td>
<td>1:1.20</td>
</tr>
<tr>
<td>D*</td>
<td>33</td>
<td>49</td>
<td>260.6</td>
<td>1:1.49</td>
</tr>
<tr>
<td>E</td>
<td>40</td>
<td>59</td>
<td>256.1</td>
<td>1:1.47</td>
</tr>
<tr>
<td>F</td>
<td>30</td>
<td>34</td>
<td>381.1</td>
<td>1:1.13</td>
</tr>
<tr>
<td>G</td>
<td>25</td>
<td>34</td>
<td>271.7</td>
<td>1:1.36</td>
</tr>
<tr>
<td>H</td>
<td>20</td>
<td>36</td>
<td>264.4</td>
<td>1:1.18</td>
</tr>
<tr>
<td>J</td>
<td>20</td>
<td>20</td>
<td>260.1</td>
<td>1:1</td>
</tr>
<tr>
<td>Total</td>
<td>225</td>
<td>307</td>
<td>286.4</td>
<td>1:1.36</td>
</tr>
</tbody>
</table>

* Calculated using estimated figures for 87½ hours observations.
Category 2. 'Special Needs'. (Coded '†').

Children who were critically ill, recovering from the effects of an operation or anaesthetic, or who were mentally handicapped would be considered to have special nursing needs. The observer using her nursing experience decided whether or not the child's condition was such that extra nursing attention might be considered necessary. If this were so the information was coded and marked as the observation sheet. The numbers of such observations were shown in this second category. 9.0% of the observations were in this category, ranging from 5.8% (Ward E) to 16.5% (Ward B). When the amount of nursing attention was compared with that given to the rest of the children it was slightly increased to 15.2% from 10.1% (not statistically significant).

The category was also useful in that when assessing the children's emotional well-being it was important to know which of the children were particularly ill or handicapped so that if necessary they be considered separately.

Category 3. 'Marked 'Up''

Each day before the study began, the person in charge of the ward was asked to state the child's permitted mobility. If he were allowed up all day this was marked on the hourly chart. When the permitted mobility changed this was recorded. (See Appendix 2 for an example of the chart.)

Category 4. 'Marked 'Chair''

When a child was allowed to sit out of bed - as for example post-operatively, this was noted. On the long stay ward children were allowed to sit out of bed 11% of the time. As many suffered with orthopaedic conditions they were obviously not free to move about (category 3).
The percentage of time that children had to remain in bed during the day varied from as little as 17% of the time to as much as 67%. Again the long stay ward had the greater amount of observations marked 'bed'.

Category 6. 'Time 'Up' (Coded '3')

This category was used for counting all observations coded '3', that is the code denoting that the child was mobile at the moment of observation. The figures in the column are meaningless on their own, as other codes such as N.S. or N.P. were used if the child were absent at the time of observation, when he was probably mobile.

'S' - (Schooling Activities) may have also been used.

Category 7. 'Time Sitting' (Coded '2')

Obviously if a child were eating his meal his activity would be coded by a 2 - The number of observations in this category was similar to that in category 6, each observed about 16% of the time. Because most children were observed to be sitting out of bed at one time or another, it was not possible to know if those only permitted to sit in a chair by their bed were out of bed the maximum possible time.

Category 8. 'Time in bed' (Coded '1')

The reason for including these codings of degree of mobility has been given earlier - it will be remembered that prior to the study one of the wards visited had not had enough chairs to enable the children to sit out of bed, and there was little to occupy them if they had been up. It can be seen from table 7 that most children were observed to be in bed for a large part of the time. Approximately 3/5ths of all observations made on Wards D and E showed that the children were in bed. Whilst it is easy to conclude that this was because of
the lack of activities provided for them (discussed in later chapters) it must be remembered that in these two wards, the turnover rates were high, and the children may have been less accustomed to the hospital environment and therefore more reluctant to leave their beds.

**Category 9. 'Time being held' (Coded '4')**

This category shows the percentage of total time that children were being nursed. The total figures are not quite comparable: Wards A and C did not have any children present under the age of two years, whilst Ward D had a particularly large number of babies on the unit during the week of the survey. The children on the long stay ward were nursed marginally less time than the children on Wards A and C. Many of these small children were receiving orthopaedic treatment and were in plaster. They could not then in any case be held. It may be construed that these figures show the physical isolation of these 'long stay' children.

**Category 10. 'School' (Coded 'S')**

During the survey, when ever a child was participating in school activities all other coding was ignored and the entry was 'S'. Schooling facilities were available on four of the wards during the time of the survey from Monday to Friday. 11% of the observations made of children over the age of five years were in this category. This aspect of care is discussed in greater detail in chapter 10.

**Category 11. 'Social off the Ward' (Coded 'N.S.')**

Many of the children were allowed to spend a certain amount of time outside the wards, some went home for the day or afternoon, others went for walks in the hospital grounds. The hospital policies seemed to differ concerning these outings - on three of the wards (Regional Board General Hospitals) the amount of time spent outside the ward was very little, whilst children from Ward H were absent for 6.4% of the total time for which they were observed.
Children often left the wards for medical reasons, such as physiotherapy, X-ray, or to undergo an operation. Absences were noted more frequently in hospitals where it was the policy for the children to remain in recovery rooms outside the wards for some time after their operations.

Category 13. 'Nursing Contact'

In this column was shown the 'total nursing contact' that each child received. It will be remembered that whenever a nurse was with a patient at the time of observation, her number was entered in the appropriate child's coding. Sometimes two or more nurses were with the child at the same time but the computer program was so arranged that this was only counted as one nursing contact. The children were seen to be accompanied by at least one nurse in approximately 11% of the entries. In terms of time this meant that each child received an average of 75 minutes of nursing attention each day. It is of interest to note that the children observed in Pill's study enjoyed an average of 28 minutes nursing attention each day.

Tables 11a and 11b on the following page show how the time was divided between the children considered to have special nursing needs and those without.
Table 11a. Percentage of time for which children with special nursing needs were observed to have a nurse in attendance.

<table>
<thead>
<tr>
<th>Ward</th>
<th>&lt;10 months</th>
<th>&gt;10 months ≤ 2 years</th>
<th>&gt;2 years ≤ 5 years</th>
<th>&gt;5 years ≤ 7 years</th>
<th>7 years+</th>
<th>Nurse Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>-</td>
<td>-</td>
<td>14.7</td>
<td>7.9</td>
<td>9.5</td>
<td>73</td>
</tr>
<tr>
<td>B</td>
<td>22.0</td>
<td>-</td>
<td>16.9</td>
<td>16.4</td>
<td>12.7</td>
<td>209</td>
</tr>
<tr>
<td>C</td>
<td>-</td>
<td>-</td>
<td>19.3</td>
<td>-</td>
<td>8.7</td>
<td>71</td>
</tr>
<tr>
<td>D</td>
<td>33.3</td>
<td>13.3</td>
<td>7.0</td>
<td>-</td>
<td>13.9</td>
<td>103</td>
</tr>
<tr>
<td>E</td>
<td>11.1</td>
<td>-</td>
<td>8.3</td>
<td>-</td>
<td>3.3</td>
<td>63</td>
</tr>
<tr>
<td>F</td>
<td>-</td>
<td>-</td>
<td>23.2</td>
<td>10.0</td>
<td>9.0</td>
<td>191</td>
</tr>
<tr>
<td>G</td>
<td>5.6</td>
<td>55.6</td>
<td>22.7</td>
<td>16.7</td>
<td>20.9</td>
<td>209</td>
</tr>
<tr>
<td>H</td>
<td>-</td>
<td>-</td>
<td>16.6</td>
<td>15.2</td>
<td>20.0</td>
<td>105</td>
</tr>
<tr>
<td>J</td>
<td>-</td>
<td>16.7</td>
<td>-</td>
<td>21.4</td>
<td>31.5</td>
<td>172</td>
</tr>
<tr>
<td>Nurse Contact</td>
<td>37</td>
<td>37</td>
<td>427</td>
<td>190</td>
<td>505</td>
<td>1196</td>
</tr>
<tr>
<td>Total Observations</td>
<td>225</td>
<td>156</td>
<td>2566</td>
<td>1283</td>
<td>3652</td>
<td>7882</td>
</tr>
<tr>
<td>% Nurse Contact</td>
<td>16.44</td>
<td>23.72</td>
<td>16.64</td>
<td>14.81</td>
<td>13.83</td>
<td>15.17</td>
</tr>
</tbody>
</table>

Table 11b. Percentage of time for which children without special nursing needs were observed to have a nurse in attendance.

<table>
<thead>
<tr>
<th>Ward</th>
<th>&lt;10 months</th>
<th>&gt;10 months ≤ 2 years</th>
<th>&gt;2 years ≤ 5 years</th>
<th>&gt;5 years ≤ 7 years</th>
<th>7 years+</th>
<th>Nurse Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>-</td>
<td>23.7</td>
<td>22.2</td>
<td>11.7</td>
<td>6.7</td>
<td>756</td>
</tr>
<tr>
<td>B</td>
<td>24.0</td>
<td>17.6</td>
<td>12.4</td>
<td>15.5</td>
<td>18.5</td>
<td>1200</td>
</tr>
<tr>
<td>C</td>
<td>20.6</td>
<td>22.1</td>
<td>17.0</td>
<td>7.7</td>
<td>8.9</td>
<td>999</td>
</tr>
<tr>
<td>D</td>
<td>12.9</td>
<td>12.7</td>
<td>7.4</td>
<td>4.0</td>
<td>4.4</td>
<td>1008</td>
</tr>
<tr>
<td>E</td>
<td>11.8</td>
<td>9.3</td>
<td>4.6</td>
<td>2.7</td>
<td>2.3</td>
<td>824</td>
</tr>
<tr>
<td>F</td>
<td>-</td>
<td>7.9</td>
<td>7.6</td>
<td>7.8</td>
<td>6.1</td>
<td>829</td>
</tr>
<tr>
<td>G</td>
<td>18.3</td>
<td>27.0</td>
<td>13.4</td>
<td>5.4</td>
<td>3.0</td>
<td>927</td>
</tr>
<tr>
<td>H</td>
<td>16.5</td>
<td>13.3</td>
<td>17.1</td>
<td>14.2</td>
<td>8.7</td>
<td>1133</td>
</tr>
<tr>
<td>J</td>
<td>23.3</td>
<td>19.3</td>
<td>32.3</td>
<td>10.4</td>
<td>10.5</td>
<td>783</td>
</tr>
<tr>
<td>Nurse Contact</td>
<td>1590</td>
<td>1286</td>
<td>2455</td>
<td>1130</td>
<td>1998</td>
<td>8459</td>
</tr>
<tr>
<td>Total Observations</td>
<td>10090</td>
<td>9498</td>
<td>19507</td>
<td>13018</td>
<td>27918</td>
<td>83934</td>
</tr>
<tr>
<td>% Nurse Contact</td>
<td>15.76</td>
<td>13.54</td>
<td>12.57</td>
<td>8.68</td>
<td>7.16</td>
<td>10.08</td>
</tr>
</tbody>
</table>
It will be remembered that less than nine per cent of all children observed during the survey were considered to be in need of special nursing care. (The total number of observations made of each category is given on the last but one line of tables 11a and 11b.) It can be seen that there were very few babies under the age of two who were considered to have these special needs.

Statistical correlations have not been attempted because of the differences in the size of the two groups and because these differences were liable to subjective factors. However, it can be seen from reading the last lines of the two tables that in each age group more time was spent with the children noted to require such special nursing attention. The greater differences occurred between the older ill children and the older children.

From the results it can be seen that children over the age of seven years without special nursing needs received an average of 53.7 minutes of nursing attention.

Category 14. 'Staff Contact'

Apart from contact with the nursing staff, children were also observed in the company of doctors, school teachers, physiotherapists and other ancillary staff. In this category such contacts were added to those of the nurses, the average increase being 1.7%. In terms of time the average total staff contact amounted to an average of 87 minutes per day for every child.

Category 15. 'Total different nurses'

Figures in this category are excluded from table 7 as they were not meaningful. As has been previously stated whenever a nurse was with a child her number was noted. The program was arranged in such a way that everytime a different nurse's number appeared in the child's observation for the first time, the figure in this category
was increased by one. In this way it was possible to know the total number of different nurses participating in the care of each child.

Table 12 amplifies this aspect of the study. It shows the numbers of different nurses participating in the care of each child. Only the figures relating to children who were present throughout the whole survey are given.

Table 12. Numbers of nurses seen to have participated in the care of children present throughout the survey.

<table>
<thead>
<tr>
<th>Ward</th>
<th>No. of Children Observed 525 times</th>
<th>Average No. of nurses observed with each child</th>
<th>No. of nurses who completed a minimum of 10 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>6</td>
<td>9.5</td>
<td>10</td>
</tr>
<tr>
<td>B</td>
<td>10</td>
<td>15.3</td>
<td>15</td>
</tr>
<tr>
<td>C</td>
<td>6</td>
<td>12.7</td>
<td>12</td>
</tr>
<tr>
<td>D</td>
<td>11</td>
<td>9.1</td>
<td>11</td>
</tr>
<tr>
<td>E</td>
<td>10</td>
<td>10.7</td>
<td>13</td>
</tr>
<tr>
<td>F</td>
<td>17</td>
<td>9.5</td>
<td>13</td>
</tr>
<tr>
<td>G</td>
<td>6</td>
<td>15.8</td>
<td>15</td>
</tr>
<tr>
<td>H</td>
<td>9</td>
<td>13.2</td>
<td>17</td>
</tr>
<tr>
<td>J</td>
<td>6</td>
<td>11.7</td>
<td>10</td>
</tr>
</tbody>
</table>

It can be seen that each of these children came into contact with nearly all the nursing staff who were present on the ward. (Because only the numbers of nurses completing a minimum of 10 hours are used, the average number of nurses observed with each child is somewhat higher - this is because the children also met the 'relief' nurses who visited the ward.) Table 13, on the following page, shows the 'average' number of nurses caring for each child on every ward on each day of the survey.
The consistency of the figures for each day on all the wards indicates how widespread the practice of allowing different nurses to care for the children was found to be. This is discussed in Chapter 8.

Table 13. Ratios of different nurses attending children on different days.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Day 2</th>
<th>Day 3</th>
<th>Day 4</th>
<th>Day 5</th>
<th>Day 6</th>
<th>Day 7</th>
<th>Day 8</th>
<th>All Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2.9</td>
<td>2.2</td>
<td>2.9</td>
<td>3.4</td>
<td>3.5</td>
<td>3.2</td>
<td>4.4</td>
<td>7.2</td>
</tr>
<tr>
<td>B</td>
<td>5.8</td>
<td>5.4</td>
<td>3.9</td>
<td>4.9</td>
<td>5.8</td>
<td>3.8</td>
<td>3.3</td>
<td>10.0</td>
</tr>
<tr>
<td>C</td>
<td>3.6</td>
<td>3.6</td>
<td>4.6</td>
<td>3.9</td>
<td>4.1</td>
<td>4.9</td>
<td>2.9</td>
<td>8.6</td>
</tr>
<tr>
<td>D</td>
<td>3.7</td>
<td>3.3</td>
<td>3.0</td>
<td>2.6</td>
<td>2.1</td>
<td>2.6</td>
<td>3.1</td>
<td>7.2</td>
</tr>
<tr>
<td>E</td>
<td>1.5</td>
<td>2.3</td>
<td>1.9</td>
<td>2.1</td>
<td>2.2</td>
<td>2.3</td>
<td>2.2</td>
<td>5.5</td>
</tr>
<tr>
<td>F</td>
<td>2.7</td>
<td>3.2</td>
<td>3.7</td>
<td>2.7</td>
<td>2.5</td>
<td>3.7</td>
<td>3.3</td>
<td>8.0</td>
</tr>
<tr>
<td>G</td>
<td>3.1</td>
<td>3.1</td>
<td>3.0</td>
<td>3.4</td>
<td>3.8</td>
<td>3.6</td>
<td>2.7</td>
<td>8.7</td>
</tr>
<tr>
<td>H</td>
<td>4.4</td>
<td>4.0</td>
<td>4.0</td>
<td>2.7</td>
<td>2.7</td>
<td>5.3</td>
<td>4.5</td>
<td>8.8</td>
</tr>
<tr>
<td>J</td>
<td>3.9</td>
<td>5.3</td>
<td>4.8</td>
<td>3.4</td>
<td>4.6</td>
<td>4.7</td>
<td>3.5</td>
<td>7.4</td>
</tr>
</tbody>
</table>

Category 16. 'Total Visitors'

The number of times that either the child's own parent, or other childrens parents were observed to be with the child in question is denoted in this column. The 'other childrens' parents were included because on the ward where the study was originally planned, the contribution that they made to the children's well being appeared to be considerable. If the 'profiles' (page 63) are re-examined, it will be seen that for Jane, the symbol 'V' (which indicated that another child's parent was with her at the moment of observation) occurred on 14 occasions. Although not noted on the 'profile', Jane was 'being held' by the visitor for most of these 14 observations.
Category 17. 'Own Parents'. (Coded '*')

The number of times that the child's own parents were present was noted.

It is possible to demonstrate the visiting pattern on each ward by means of a graph showing the numbers of parents present each hour, in conjunction with the number of children. On the following page the graphs of Wards E and J (shown earlier in the Chapter) are repeated and the observations made of visitors (almost exclusively the children's parents) are added.

The graphs illustrate the difference between 'high' and 'low' visiting patterns. A far more liberal policy was adopted on Ward E than was allowed on Ward J. The 'popular' times for visiting - mid-morning or afternoon, show clearly in each graph. It is important to note that there was no indication from the method of coding used whether or not a child was being visited by both parents at the time of the observation. It was quite common for both parents to come in the evenings and at the weekends. In practice where there were many 'pairs of parents' the number of visitors could exceed the number of children.

Category 18. 'Other Parents'. (Coded 'V')

The observations made of other visitors are shown separately from those of the child's own parents. It can be seen from Table 7 that the amount of time the parents devote to other people's children varies from 0.8% (Ward A) to 6.1% (Ward E).

The children on Ward E spent almost twice as much time in bed as those on Ward A who were able to play in spacious ground and were, therefore, less likely to come into contact with other children's parents. However, the positive contribution the visitors made to the general well-being on Ward E was noted by the observers. On Ward F
Graphs showing the number of patients, nurses and visitors observed on Wards J and E during each hour of 7-day survey from 7:30 A.M. till 8 P.M.

Ward J — Capacity 20 Beds

Ward E — Capacity 37 Beds

Patients shown thus: ---
Nurses shown thus: ---
Visitors shown thus: ---
designated as a long stay ward, many children were visited less frequently, and the 4.7% of observed time that the children spent in the company of other children's parents was particularly important.

Category 19. 'Child Contact'. (Coded 'c')

Whenever a child was observed in the company of another child or children, his chart was marked with a symbol 'c' indicating 'child contact'. It will be seen from table 7 (page 89) that the average child contact at 13.5% was higher than the average nurse contact at 11.0%. The time children spent with each other, increased with age - so whilst the children aged ten months up to two years were only so occupied approximately 9.9% of the time, the eleven year old and over amused themselves with each other, 23% of the time, - that is nearly a quarter of the observation period.

Category 20. 'Alone awake'

The number of times a child was observed to be alone and awake was also recorded. This amounted to 36% of study time overall - again increasing with age, although only very slowly. The children aged from ten months to two years were alone approximately 30% of the time, and the eleven year old and over for 41% of the time. The amount of time spent alone is of interest when compared with the amount of time noted as 'miserable and alone' - (line 28, table 7). Children were observed on their own 36% of the time and 'miserable alone' 9.7% of the time. This means that approximately one quarter of the time (25.5%) that the children were on their own they were miserable. These figures will be discussed in more detail later in the text (Chapter 11).

Category 21. 'Asleep'. (Coded 'a')

Record was made of the number of times a child was observed to be asleep. On the average this occurred for 13% of the total number of observations. Those under ten months were found to be
asleep 40% of the time, whilst the older children slept for approximately
5% of the time.

Category 22. 'Excited'. (Coded 'e')

This category was an innovation introduced after one of the
observers completing the survey on Ward B stated that sometimes the
children exhibited real exuberance, and she felt that this was
inadequately coded as 'C'. Such occasions often arose at the
appearance of a parent. This coding was discussed with other observers
who had helped previously, and they agreed that it would be useful to
have an extra code. Consequently 'e' was introduced for the main
study as an indicator of exuberance or excitement.

Category 23. 'Contented'. (Coded 'c')

This category may have been used too freely as a result of the
directive to the observers to use it whenever they were in doubt as
to the child's state of contentment. Hence, children were noted to be
content for 65.3% of the time.

Category 24. 'Happy'

Here the codes 'c' 'contented' and 'e' 'excited' were merged.
In fact since 'e' was used on very few occasions the results were very
little different from those shown under category 23.

Category 25. 'Distressed'. (Coded 'd')

On the average, children were noted to be distressed for 4.8%
of the study time; that is for 36 minutes each day. It will be
remembered that this code was used only if the child were seen to be
crying or really upset.

Category 26. 'Apathetic'. (Coded 'b')

This code 'b' was used when a child did not appear contented
yet was not overtly upset. Although observers were asked not to use
this category if they were in any doubt about whether a child appeared
unhappy or not, it was used quite frequently. Eight per cent of such observations were recorded. In terms of time this meant that on an average a child was observed to be 'apathetic' for a period of one hour a day.

Category 27. 'Miserable'

The figures from categories 25 and 26 were added together into this category of 'miserable'.

Tables 14a and 14b show the figures in greater detail.

Table 14a. Percentage of time for which children with special nursing needs were observed to be miserable.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Age ≤10 months</th>
<th>&gt;10 months</th>
<th>&lt;2 years</th>
<th>&gt;2 years</th>
<th>&gt;5 years</th>
<th>&gt;7 years and more</th>
<th>% Misery</th>
<th>No. of Observations misery</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
<td>57.3</td>
<td>30.4</td>
<td>34.1</td>
<td>34.7</td>
<td>273</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>8.1</td>
<td>47.8</td>
<td>47.8</td>
<td>34.5</td>
<td>37.3</td>
<td>36.7</td>
<td>520</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>0</td>
<td>0</td>
<td>32.9</td>
<td>0</td>
<td>21.3</td>
<td>29.0</td>
<td>131</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>45.6</td>
<td>36.8</td>
<td>0</td>
<td>26.6</td>
<td>29.5</td>
<td>227</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>23.8</td>
<td>0</td>
<td>18.7</td>
<td>0</td>
<td>18.8</td>
<td>19.1</td>
<td>168</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>0</td>
<td>0</td>
<td>25.3</td>
<td>25.3</td>
<td>6.4</td>
<td>17.9</td>
<td>229</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>11.1</td>
<td>38.9</td>
<td>9.0</td>
<td>25.0</td>
<td>20.0</td>
<td>18.0</td>
<td>171</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>0</td>
<td>0</td>
<td>8.4</td>
<td>39.4</td>
<td>38.7</td>
<td>13.7</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>0</td>
<td>36.7</td>
<td>0</td>
<td>6.9</td>
<td>24.2</td>
<td>16.9</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>66</td>
<td>614</td>
<td>262</td>
<td>923</td>
<td>-24.0</td>
<td>1894</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>12.9</td>
<td>42.3</td>
<td>23.9</td>
<td>20.4</td>
<td>25.3</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 14b. **Percentage of time for which children who did not have special nursing needs were observed to be miserable.**

<table>
<thead>
<tr>
<th>Ward</th>
<th>Age ≤10 months</th>
<th>&gt;10 months ≤2 years</th>
<th>&gt;2 years ≤5 years</th>
<th>&gt;5 years ≤7 years</th>
<th>7 years and more</th>
<th>% Misery</th>
<th>No. of Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>0</td>
<td>19.6</td>
<td>15.1</td>
<td>8.9</td>
<td>6.9</td>
<td>9.4</td>
<td>621</td>
</tr>
<tr>
<td>B</td>
<td>6.6</td>
<td>9.4</td>
<td>11.7</td>
<td>7.2</td>
<td>8.1</td>
<td>8.2</td>
<td>587</td>
</tr>
<tr>
<td>C</td>
<td>5.9</td>
<td>17.9</td>
<td>11.4</td>
<td>0</td>
<td>3.2</td>
<td>8.6</td>
<td>581</td>
</tr>
<tr>
<td>D</td>
<td>12.7</td>
<td>27.0</td>
<td>23.0</td>
<td>17.9</td>
<td>31.9</td>
<td>23.2</td>
<td>2788</td>
</tr>
<tr>
<td>E</td>
<td>19.9</td>
<td>19.4</td>
<td>14.8</td>
<td>10.0</td>
<td>12.1</td>
<td>14.8</td>
<td>2113</td>
</tr>
<tr>
<td>F</td>
<td>0</td>
<td>8.9</td>
<td>5.3</td>
<td>6.2</td>
<td>4.0</td>
<td>5.7</td>
<td>655</td>
</tr>
<tr>
<td>G</td>
<td>8.4</td>
<td>11.5</td>
<td>11.5</td>
<td>8.7</td>
<td>5.7</td>
<td>8.9</td>
<td>735</td>
</tr>
<tr>
<td>H</td>
<td>9.5</td>
<td>5.6</td>
<td>2.3</td>
<td>4.2</td>
<td>6.5</td>
<td>5.9</td>
<td>525</td>
</tr>
<tr>
<td>J</td>
<td>21.1</td>
<td>35.6</td>
<td>21.7</td>
<td>18.2</td>
<td>11.1</td>
<td>17.6</td>
<td>788</td>
</tr>
<tr>
<td>Total</td>
<td>1361</td>
<td>1545</td>
<td>2620</td>
<td>1095</td>
<td>2772</td>
<td>11.8</td>
<td>9593</td>
</tr>
<tr>
<td>%</td>
<td>13.5</td>
<td>16.3</td>
<td>13.4</td>
<td>8.4</td>
<td>9.9</td>
<td>11.8</td>
<td></td>
</tr>
</tbody>
</table>

It can be seen that the children who were considered to have special nursing needs were miserable more frequently than the other children. The younger children were often more upset than the older children even when 'no special nursing needs' were considered necessary.

**Category 28. 'Miserable alone'**

Recorded in this category were the observations coded 'distressed' or 'bored' when the child was alone. When the results of this category (9.7%) are compared with category 20 - 'alone awake'(38.0%) it can be seen that the children were observed to be miserable for 25.5% of the time that they were alone.
Category 29. 'Miserable with parents'

This category is self-explanatory, and the time that children were with their parents and observed to be miserable was 1.5% of the total period of the study. If the effect of the parents presence was immaterial, one would expect to find less difference in the percentage of time that the children were observed to be 'alone and miserable', and 'miserable with their parents'. A test of significance ($\chi^2$) shows that the differences in the number of these observations is highly significant ($p<0.001$). That is, it is possible to say that the child benefitted from his parents presence, in that he was considerably less miserable than when he was left on his own in the hospital.

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage of total observed time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alone awake</td>
<td>38.0</td>
</tr>
<tr>
<td>Miserable alone</td>
<td>9.0</td>
</tr>
<tr>
<td>With own parents</td>
<td>19.9</td>
</tr>
<tr>
<td>Miserable with parents</td>
<td>1.5</td>
</tr>
</tbody>
</table>
In this chapter the questionnaires which were completed by nearly all the members of nursing staff covered by the survey are discussed. The purpose and format of them is outlined. The nurses' opinions concerning certain aspects of the nursing care of ill children were sought. This was done by including statements with which she had to agree or disagree. The method of scoring the results is given, followed by the ranking order of the preference for the various statements. The personal characteristics of the ten nurses with 'high' results are compared with those of the ten nurses with 'low' results.

The purpose of the nurses' questionnaires

All nursing staff directly covered by the survey were invited to complete a questionnaire. It was expected that, on the basis of these questionnaires and the results of the activity sampling, inferences could be made regarding the nurses' understanding of the emotional needs of children, especially children admitted to hospital and undergoing treatment.

Although the questionnaires met with very satisfactory response, it was decided subsequently that not all of the completed forms could properly serve the purposes of the survey. Three nursing auxiliaries had to be excused in view of their poor knowledge of English, and one student-nurse left the service during the survey. Of the total number of 163 members of nursing staff issued with the questionnaires only two failed to return these, which represents a response rate of approximately 97%. Of the remainder, 45 members of staff were noted by the study observers on less than 60 occasions.
which meant that their total time spent at work in the wards amounted to less than 10 hours, which, in turn, amounts to approximately 11% of the total of 87½ hours covered by the survey. In view of this, it was thought unlikely that any valid inferences could be made as to how these nurses' ideas affected their work pattern and, consequently, it was decided not to include these 45 questionnaires in the analysis of the results. Thus the total number of questionnaires found acceptable for the purposes of analysis was reduced to 116, which amounted to just over 71% of the nursing staff covered by the survey.

The distribution of respondents to these 116 questionnaires by their rank and ward is given on the following page.

The nurses questionnaire

The questionnaire was so designed that the nurses could complete it without assistance. They usually did so in 'ward time' taking from 20 to 25 minutes to answer all the questions.

It was made clear to each nurse that she need not fill out the questionnaire, in whole or in part, if she did not wish to do so. She was further told that her identity would remain confidential although her answer might be made use of in the final report on this survey.

Nearly all the nurses appeared to enjoy taking part in the survey and seemed pleased to be of help. This was evident from the fact that many of them contributed additional thoughtful comments at the end of their questionnaires.

The first part of the questionnaires (numbers 1 to 26 inclusive) yielded useful information about the personal and professional characteristics of the respondents and gave indications of the teaching they had received in the care of children in hospital.
Table 15.
Respondents to questionnaire by ward and rank

<table>
<thead>
<tr>
<th>Rank</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>J</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sister in Charge</td>
<td>1*</td>
<td>1*</td>
<td>1°</td>
<td>1</td>
<td>1</td>
<td>1*</td>
<td>1*</td>
<td>1</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Other Sister or Staff Nurse</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Post registration nurses</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>General training</td>
<td></td>
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<td></td>
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<td></td>
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<td>3</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>2nd. year</td>
<td>4</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>3rd. year</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Orthopaedic Certificate</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Combined Training</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>1st. year</td>
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<td></td>
<td>7</td>
<td>7</td>
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<tr>
<td>3rd. year</td>
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<td></td>
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<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
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<td>Paediatric training</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1st. year</td>
<td>3</td>
<td></td>
<td></td>
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<td></td>
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<td>3</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>2nd. year</td>
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<td>3</td>
</tr>
<tr>
<td>3rd. year</td>
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<td></td>
<td></td>
<td></td>
<td>3</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Pupil Nurses</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Senior enrolled nurse</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nursery Nurse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Cadets</td>
<td>1</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Nursing Auxiliaries</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Student nurse, Care of sub-normal</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>13</td>
<td>15</td>
<td>17</td>
<td>10</td>
<td>116</td>
</tr>
</tbody>
</table>

* denotes paediatrically trained sister
o questionnaire not completed.
The current chapter, however, is mainly concerned with the results derived from the analysis of the answers to be second part of the questionnaires.

This consisted of 35 statements, (numbers 27 to 61 inclusive), each statement accompanied by a five point 'Likert' type scale. The nurses were asked to mark the point on the scale opposite each statement which corresponded most closely to their own opinion of the correctness of the statement.

A copy of the nurses questionnaire can be found in the Appendix No. 4 and it will be seen that the scale ranged from 'strongly agree' through 'agree', 'don't know' and 'disagree' to 'strongly disagree'.

Although it was explained to the nurses that there were no 'right' or 'wrong' answers, some of the answers, in the author's opinion, were indicative of a greater understanding of children's emotional needs and such answers were coded '1', 'don't know's as '2' and the answers thought to show less understanding were coded '3'. (The answers considered to show 'more understanding' are shown in the questionnaire contained in the appendix.)

In the coding, it was decided not to distinguish between 'strongly agreeing' and 'agreeing' or 'strongly disagreeing' and 'disagree'. The main reason for including these alternatives was the psychological one of offering 'in between' answers other than 'don't know'.

The decisions about 'more' or 'less' understanding, were based on child care theories, and previous research findings. For example, several studies (Fagin (1966)(28), Mahaffy (1965)(69), Brain and Maclay (1968)(10) have shown that there is less distress post operatively and a less eventful recovery, if the mother is able to
stay with her child. Thus, disagreement with the following statement:

'paediatric patients do not benefit from having their parent present immediately after operation (i.e. immediately means when still recovering from the effect of the anaesthetic)

would be coded '1' indicating greater understanding of children's emotional needs.

However, not all the statements were as well demonstrated as this and the reply denoting 'more understanding' might be queried.

Statements numbers 40, 54, 56, 57 and 59 (see page 287) were disregarded in the analysis since the answers to them were of narrow application, particular to the ward concerned. They are of interest, however and are discussed in other contexts in the report.

Statements numbers 27, 28, 29 and 30 were also disregarded in the final scoring, as they were included for a different purpose which is considered later in this chapter. The final number of statements included in the analysis was 26.

Analysis of the Statements

The analysis was carried out in the following manner. The codes '1', '2' or '3' had been allocated, as described, to each statement. If these were then regarded as 'scores' each nurse's total score could be calculated.

The nurse with the lowest total score would be considered to have the greatest understanding of children's emotional needs. With this system of scoring the 'ideal' score would be 26 (100% understanding) while the worst possible one would be 78.

From the individual nurses' scores, ward averages were derived for the purposes of comparison. The ward with the lowest average score being staffed by nurses with the greater understanding of children's emotional needs.
Alternatively, the 'total' score for each statement could be calculated by adding the 'codes' returned by all 116 nurses whose questionnaires were accepted for the purposes of analysis. Thus a total score of 116 would indicate that all the nurses are in agreement with the author's idea of proper understanding of the children's emotional needs. Conversely a score of 348 would indicate a total disagreement.

In addition to this analysis, the personal characteristics of the ten nurses gaining low total scores were compared with the characteristics of the ten nurses returning high scores.

Finally, all scores were re-calculated, weighing the responses differently to see if this affected the results. In the re-calculation it was considered that a 'don't know' response, which could be construed to indicate an 'open mind', was preferable to an answer thought to show lack of understanding and a hardened opinion. Therefore, code '3' was scored as five, while codes '1' and '2' remained unchanged.

Results

In spite of the wider scatter, this modified weighing of the answers made no material differences to the total results.

Table 16 shows the statements which are listed in the order in which they were ranked (see left of the statements) and the percentage 'agreement' with the author, or 'percentage concordance' shown on the right.
<table>
<thead>
<tr>
<th>Ranking Order</th>
<th>'Concordance'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement</td>
<td>Using '3'</td>
</tr>
<tr>
<td><strong>Actual Figure</strong></td>
<td>%</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
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<tr>
<td>8</td>
<td>8</td>
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<tr>
<td>9</td>
<td>10</td>
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<tr>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Ranking Order</td>
<td>Statement</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Using '3'</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Toddlers are less trouble than babies to care for. (disagree)</td>
</tr>
<tr>
<td>13</td>
<td>If I had a child, toddler or baby who was in hospital, I would wish to stay with him all the time if he were very ill. (agree)</td>
</tr>
<tr>
<td>13</td>
<td>Children only cry if they are spoilt at home. (disagree)</td>
</tr>
<tr>
<td>15</td>
<td>The mother who wants to live with her toddler is being unnecessarily fussy. (disagree)</td>
</tr>
<tr>
<td>16</td>
<td>The toddlers are 'easier to manage' if mothers are able to visit them everyday. (agree)</td>
</tr>
<tr>
<td>17</td>
<td>Toddlers are easier to look after than children. (disagree)</td>
</tr>
<tr>
<td>18</td>
<td>The mother can be a great comfort to her child both immediately before and after operation. (agree)</td>
</tr>
<tr>
<td>19</td>
<td>Toddlers usually 'settle down' very quickly in hospital if not visited at all. (disagree)</td>
</tr>
<tr>
<td>20</td>
<td>Paediatric patients do not benefit from having their parents present immediately before their operation. (i.e. immediately means until the child is either asleep because of pre-medication or anaethetised. (disagree)</td>
</tr>
<tr>
<td>21</td>
<td>Children are generally less upset in hospital than babies or toddlers. (agree)</td>
</tr>
<tr>
<td>Ranking Order</td>
<td>Using '3'</td>
</tr>
<tr>
<td>---------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>23</td>
<td>23</td>
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<tr>
<td>23</td>
<td>25</td>
</tr>
<tr>
<td>25</td>
<td>24</td>
</tr>
<tr>
<td>26</td>
<td>26</td>
</tr>
</tbody>
</table>

N.B. 100% concordance - 116

0% concordance - 348 (scoring '3' or 580 scoring '5')
Discussion of the Ranking Order of the 26 Statements

Pill (1967)(96), on the basis of her observations of nurses' activities suggested that nurses do not regard 'playing' as part of their job. The three statements concerned with 'play', i.e. statements which were ranked one, two and four, showed the greatest degree of concordance with the author's opinion that play is an important feature of the nurses' work on a paediatric ward.

Whilst nurses generally agreed that the young patient needs to be visited, (statements ranked three and five) and found it helpful if the mother visited every day to help look after her own child, (statements ranked six and nine) they were slightly less inclined to agree that it was necessary for her to stay overnight (statement ranked thirteen). The degree of concordance fell considerably when the child was not described as 'very ill' (see statement ranked 22).

In some instances replies to two or more different statements appear contradictory. For example there was 91.8% concordance with the statement ranked sixth - toddlers seem happier if their mothers are visiting, and yet the same nurses thought that a toddler settled down better if not visited at all (statement ranked 19, concordance 69.0%).

It may well be construed from these answers that as Robertson (1958)(109) suggests, the quiet 'apathy' which a toddler may show in hospital, is still being interpreted by the nurses as a sign of 'settling down' and not as an indication of rather more severe emotional trauma.

Statement 24 (ranked 21st) (that is children* are generally less upset in hospital than babies or toddlers) was agreed upon by nearly half the nurses. This may be because the older children are more likely to be able to communicate their feelings of homesickness

*Note. For definition of children, toddlers and babies see Appendix no. 4 page 282.
or fear to the nurses.

The statements ranked 20, 23, and 25/24 confirm the findings of Merrow and Johnson (1968)(75) suggesting that nurses do not consider children's parents are either willing, or indeed capable of assisting with the more technical aspects of caring for their own children.

Research workers (Fagin, Mahaffy, Brain and Maclay) have previously demonstrated the benefit of a mother remaining with her child both pre- and post-operatively, yet the statements concerned with these aspects of child care in hospitals show the lowest rates of concordance (see statements ranked 20, 23 and 25/24).

The nurses agreed that 'if the mother is there all the time you cannot get to know the patients properly' (statement 50 ranked 23/25). It is not surprising that if they consider their personal relationship with the child important and believe that the mother's presence affects this, they will be resistant to her continual presence on the ward.

Whether this personal relationship is possible is discussed in Chapter 8.

The statement with least concordance (ranked 26th) was that babies cry a lot more in hospital than they do at home. It is the only statement with which the disagreement was so great that one might consider it to be wrongly coded. When the ten questionnaires with the scores indicating the highest degree of concordance, are compared with the ten indicating least concordance, this statement is the one which is answered consistently by both groups as being untrue. The 'high concordance' group showing 31.8% concordance and 'low concordance' group 19.8%. There is evidence by Schaffer (1958)(117) to suggest that babies do cry less in hospital than at home. This statement was therefore discounted when calculating further results.
Ward Scores

The average ward scores for each statement are shown in detail in appendix number 7 (page 292).

The overall average ward scores were found by totalling all the scores of the respondents on each ward and finding the average score. Table 17 below shows the degree of concordance and ranking by overall average ward scores. On the whole, the average rate of concordance, varying from 82.4% (ranked first) to 82.4% (ranked ninth) is quite high. The range of 10.2% between these extremes is too narrow for these figures to be of much value in distinguishing between the individual wards.

Table 17. Ward score, (concordance rate and ranking order

<table>
<thead>
<tr>
<th>Ward</th>
<th>Ward score Using '3'</th>
<th>Ward score Using '5'</th>
<th>Concordance rate Using '3'</th>
<th>Concordance rate Using '5'</th>
<th>Ranking order</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>36.1</td>
<td>45.1</td>
<td>77.8%</td>
<td>79.9%</td>
<td>4</td>
</tr>
<tr>
<td>B</td>
<td>38.1</td>
<td>47.1</td>
<td>73.6%</td>
<td>77.9%</td>
<td>6</td>
</tr>
<tr>
<td>C</td>
<td>36.7</td>
<td>45.2</td>
<td>76.6%</td>
<td>79.6%</td>
<td>5</td>
</tr>
<tr>
<td>D</td>
<td>38.6</td>
<td>50.5</td>
<td>72.8%</td>
<td>74.5%</td>
<td>7</td>
</tr>
<tr>
<td>E</td>
<td>34.0</td>
<td>41.5</td>
<td>82.0%</td>
<td>83.5%</td>
<td>2</td>
</tr>
<tr>
<td>F</td>
<td>38.6</td>
<td>51.4</td>
<td>72.6%</td>
<td>73.6%</td>
<td>8</td>
</tr>
<tr>
<td>G</td>
<td>33.8</td>
<td>41.0</td>
<td>82.4%</td>
<td>84.0%</td>
<td>1</td>
</tr>
<tr>
<td>H</td>
<td>35.2</td>
<td>43.9</td>
<td>79.6%</td>
<td>81.1%</td>
<td>3</td>
</tr>
<tr>
<td>J</td>
<td>39.0</td>
<td>51.7</td>
<td>72.0%</td>
<td>73.3%</td>
<td>9</td>
</tr>
<tr>
<td>Average</td>
<td>36.5</td>
<td>46.1</td>
<td>77.0%</td>
<td>78.9%</td>
<td>-</td>
</tr>
</tbody>
</table>

Ward Scores of Individual Statements

Although the sample of wards was too small (nine wards only) to place much reliance on simple statistical tests of significance, there were seven statements where the average ward score differed by more than two standard deviations from the mean, when the '5' scoring method was used:— (only three statements were so different when the '3' scoring was used).
Table 18.

Statements in which one ward's results differed by more than two standard deviations from the mean of all wards

(Using '5' scoring)

<table>
<thead>
<tr>
<th>Ward</th>
<th>More Concordance than other wards</th>
<th>Less Concordance than other wards</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>(82.5%) (mean 50.6%)</td>
<td></td>
<td>Most mothers would be frightened if they were expected to stay with their child immediately after operation even if the nurse were within call. (disagree)</td>
</tr>
<tr>
<td>C</td>
<td>(98.0%) (mean 80.4%)</td>
<td></td>
<td>Toddlers are easier to look after than children. (disagree)</td>
</tr>
<tr>
<td>D*</td>
<td></td>
<td>(72.5%) (mean 94.6%)</td>
<td>The patients do not need the nurses to play with them. (disagree)</td>
</tr>
<tr>
<td>F*</td>
<td></td>
<td>(8.5%) (mean 47.6%)</td>
<td>If the mother is there all the time you cannot get to know the patient properly. (disagree)</td>
</tr>
<tr>
<td>F*</td>
<td></td>
<td>(69.25%) (mean 88.6%)</td>
<td>Children usually 'settle down' very quickly in hospital if not visited at all. (disagree)</td>
</tr>
<tr>
<td>H</td>
<td></td>
<td>(51.5%) (mean 81.0%)</td>
<td>Toddlers are easier to manage if mothers visit them everyday. (agree)</td>
</tr>
<tr>
<td>J</td>
<td></td>
<td>(37.5%) (mean 65.8%)</td>
<td>Paediatric patients do not benefit from having their parents present immediately before their operation, i.e. immediately means until the child is either asleep because of pre-medication or anaesthetized. (disagree)</td>
</tr>
</tbody>
</table>

* difference in excess of two standard deviations remains when '3' scoring used.
With a small sample interpretation of why the members of the nursing staff on some wards responded so differently from their colleagues on other wards cannot be easy.

For example, there was one seriously ill child on Ward A during the survey whose parents were encouraged to remain throughout the post-operative period. The nurses' replies to the questionnaire were, in this case, undoubtedly conditioned by the ward practice. On the other hand, the staff of Ward H shared surprisingly low 'concordance' in their response to the following statement:

'toddlers are easier to manage if mothers visit them every day.'

This result seemed very difficult to understand, particularly when one bears in mind that this ward was the only one of the sample where parents were encouraged to stay with their children overnight and the nurses had in the main agreed that this was desirable. It seems possible that this statement was misunderstood, the nurses disagreeing because they thought that the parents should stay throughout hospitalization, and not just visit every day.

Perhaps the two statements in which Ward F shared low concordance with the author illustrate how the nurses accept the 'status quo'. Children on that ward often had long experience of hospitalization and were long distances from their homes and had 'to settle down when not visited'.

The influence of ward practice is also evident on Ward J. On this ward parents were not encouraged to visit preoperatively and were always asked to leave immediately prior to the administration of the premedication.
Further analysis of the Questionnaires

It had been expected that a comparison of a nurses' questionnaires and the activity sampling of her work would be meaningful. Because of the wide scatter of different categories of nurses (see table 15 page 111) and the difference in the times of the hours which they worked this was omitted. It was decided to examine and compare the ten questionnaires showing the highest concordance rate with the ten questionnaires with the lowest concordance rates. See table 19 on the following page.

Analysis of the Personal Characteristics of the Two Groups

When the personal characteristics of the 'high' concordance group (H.C.) were compared with those of the 'low' concordance group (L.C.) there were very few factors which would appear to distinguish between them. Five wards were equally represented in each group. Two wards had nurses whose questionnaires appeared in the 'L.C.' group only, and two Ward G nurses were included in the 'H.C.' group. There were three members of nursing staff from paediatric hospitals in both groups. The 'country of origin' of seventy per cent of the total sample was given as Britain. When the 'H.C.' and 'L.C.' groups were compared, there were eight who originated in Britain in the 'H.C.' group and four in the 'L.C.' group.

There were five registered and four student nurses in the 'H.C.' group and one enrolled nurse and eight student nurses in the 'L.C.' group. The total proportion of registered nurses in the sample was approximately 30%. It would appear that experience may bring understanding.

In the total sample of 116 nursing staff whose questionnaires were included in the analysis there were 45 without elder brothers and sisters. Both sub groups contained four nurses without elder siblings.
Table 19 shows the 11 statements to which the two groups of ten nurses responded to most differently.

Table 19. Greatest differences in statements by the two groups

<table>
<thead>
<tr>
<th>Statement</th>
<th>'High' Total Concordance Group</th>
<th>'Low' Total Concordance Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Toddlers only cry in hospital if they are spoilt at home (disagree)</td>
<td>90%</td>
<td>55%</td>
</tr>
<tr>
<td>2. Children only cry in hospital if they are spoilt at home. (disagree)</td>
<td>100%</td>
<td>35%</td>
</tr>
<tr>
<td>3. Toddlers usually 'settle down' very quickly in hospital if not visited at all. (disagree)</td>
<td>100%</td>
<td>55%</td>
</tr>
<tr>
<td>4. Toddlers are 'easier to manage' if their mothers stay away altogether. (disagree)</td>
<td>100%</td>
<td>45%</td>
</tr>
<tr>
<td>5. Most mothers get in the nurse's way. (disagree)</td>
<td>100%</td>
<td>40%</td>
</tr>
<tr>
<td>6. Paediatric patients do not benefit from having their parents present immediately after their operation. (i.e. immediately means when still recovering from the effects of anaesthetic. (disagree)</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td>7. Paediatric patients do not benefit from having their parents present immediately before their operation. (i.e. immediately means until the child is either asleep because of pre-medication or anaesthetized. (disagree)</td>
<td>90%</td>
<td>35%</td>
</tr>
<tr>
<td>8. If the mother is there all the time you cannot get to know the patient properly. (disagree)</td>
<td>100%</td>
<td>10%</td>
</tr>
<tr>
<td>9. The mother who wants to live in with her toddler is being unnecessarily fussy. (disagree)</td>
<td>100%</td>
<td>45%</td>
</tr>
<tr>
<td>10. Most mothers would be frightened if they were expected to stay with the child immediately after the operation, even if the nurse were within call. (disagree)</td>
<td>100%</td>
<td>55%</td>
</tr>
<tr>
<td>11. The mother can be a great comfort to her child both immediately before and after the operation. (agree)</td>
<td>95%</td>
<td>45%</td>
</tr>
</tbody>
</table>
There were 32 of the 116 (28%) without younger siblings. In the subgroups there was 1 in the 'H.C.' group and 6 in the 'L.C.' group, who were without younger siblings. In the whole sample there were only six nurses who did not have any siblings, and of these six, two were found in the 'L.C.' group.

It seems reasonable to infer that the high proportion of nurses in the 'L.C.' sub group without young brothers or sisters may indicate that understanding of the young child's needs is to some extent learnt at home.

Comparison of the results of the modified activity sampling of the individual nurses from the two groups, proved unrewarding. The difference in the seniority by rank of the two groups made any direct comparison of their work unprofitable. Similarly, the scatter of the twelve student nurses between the first, second and third years, made any conclusion speculative. Therefore this part of the analysis was not continued.

The statements numbered 27 to 30 have not yet been discussed.

**Statement 27.**
I prefer looking after adults in hospital rather than paediatric patients. (disagree = 1).

**Statement 28.**
I prefer surgical paediatric nursing to medical paediatric nursing. (disagree = 1).

**Statement 29.**
I prefer looking after toddlers rather than babies. (agree = 1).

**Statement 30.**
I prefer looking after children rather than babies. (agree = 1).
Statement 28 was included because a study by Meyer and Hoffman (1964)(76) suggested that nurses could be divided into two categories; 'ministering angels' and 'technical colleague' oriented nurses. In their study, a 'spot check' showed that the nurse on paediatric wards who fitted the 'ministering angel' category rather than that of the 'technical colleague' were observed more frequently with patients. Statistically significant differences were said to be found in the behaviour between the two groups. One of the most discriminating factors between the groups, was the technically oriented nurses preference for surgical nursing.

Statements 29 and 30 were included because it was thought that nurses preferring to nurse toddlers and children, might be more sympathetic towards their needs. The results are shown in Table 20.
Table 20.

Responses to Statements 27-30

<table>
<thead>
<tr>
<th>Statement</th>
<th>'H.C.' Group (Total = 10)</th>
<th>'L.C.' Group (Total = 10)</th>
<th>All (Total = 116)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27. Prefer nursing adults to children. (disagree = 1)</td>
<td>7 2 1</td>
<td>2 7 1</td>
<td>52 42 22</td>
</tr>
<tr>
<td>28. Prefer surgical to medical. (disagree = 1)</td>
<td>6 2 2</td>
<td>2 2 6</td>
<td>50 42 24</td>
</tr>
<tr>
<td>29. Prefer looking after toddlers rather than babies. (agree = 1)</td>
<td>4 1 5</td>
<td>4 1 5</td>
<td>33 25 58</td>
</tr>
<tr>
<td>30. Prefer looking after children rather than babies. (agree = 1)</td>
<td>3 2 5</td>
<td>1 1 8</td>
<td>27 28 61</td>
</tr>
</tbody>
</table>

The results show that the nurses who prefer nursing children, to nursing adults, have in theory, more understanding of the children's needs (statement 27). The nurses in the 'H.C.' group generally preferred Medical nursing to Surgical. The numbers of nurses in the two sub-groups preferring to nurse babies, corresponded closely to the number in the total sample. Less than 25% of all nurses (27 out of 116) preferred nursing the toddlers or children. Although the analysis of the questionnaires proved to be of considerable interest, due to the scatter of the respondents by rank, (see table 15) and the comparatively short time during which each was observed, the conclusions derived from it proved less useful than expected.
SECTION 3.

Chapter 7. Interviews with the Ward sisters
Design of Wards and Nursing Organization.

Chapter 8. Reception

Chapter 9. The Child as an In patient

Chapter 10. Other aspects of In patient care
Education and Play
Safety Measures
Toilet needs
Chapter 7

Summary

An introduction to section 3 (which deals almost entirely with the interview schedules completed with the ward sisters) is given. The importance of the 'Platt Report' to the study is discussed, as the questions in the sisters schedule were based on the recommendations of this report. Each question is presented and is followed by the relevant paragraph from the 'Platt Report'. The 'stated policy', and 'observed practice' are outlined, and where necessary discussion follows. The nine questions in this chapter relate to the design of the ward (three) and the nursing organization (six).

Introduction

The 'Platt Report' (1959) played an important part in design of this study. Indeed, any study aiming to establish the degree of the nurses' understanding of children's emotional needs, and how nursing itself, as a profession was organised to meet these needs would be incomplete without reference to this report.

The committee which compiled it, worked under the chairmanship of Sir Harry Platt. The committee was appointed on June 12th 1956, and 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 the hospital authorities'.

(Paragraph 1)

The committee published its report in 1959 and made many recommendations. Whilst it was recognised that:-

'The paramount duty of a hospital is to diagnose the patient's ailment and to secure the appropriate treatment'

(Paragraph 9)
the committee went on to say that:-

"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 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 experience."

(Paragraph 10)

The report contained many recommendations which if adopted could greatly improve the methods of caring for children in hospitals.

Since the main premise of this study is similar, i.e., that high quality nursing care is inseparable from consideration of the patient's emotional well-being, part of the study was devoted to establishing the extent of adoption of the Platt report recommendations into the ward practices.

A separate interview schedule based almost entirely on these recommendations was designed with this aim in view (See Appendix No. 6). At the end of the period of modified activity sampling the author interviewed the ward sisters and this questionnaire was completed by the author.

Since it became evident during the pilot study that stated ward policy was not always adhered to, the study observers were also asked to answer the same questionnaire. Where they had not observed a particular practice, such as the admission of a patient, they were asked to state 'not observed'. It will be appreciated that all these answers lacked the objectiveness and accuracy of the more formal activity sampling method of observation.

It is perhaps an appropriate time to mention that, without exception, the observers found the experience of participating in the
survey very worthwhile - not only did they begin to appreciate research methods, and the value of research, but as senior nurses they became convinced of the value of being able to 'stand back' from the responsibility of caring for patients and observe the strengths and weaknesses of the nursing practices of which they would have otherwise been completely unaware.

Sisters' questionnaire. Results and Discussion.

In the rest of this section (chapters 7 - 10) each question asked of the ward sisters is given. It is followed by the appropriate recommendation given in the 'Platt Report'. 'Stated policy' is followed by an account of the observed practice. Where appropriate, results of the modified activity sampling of the nurses and the children are incorporated. The results from the nurses' questionnaires, and their opinions are also included. 'Anecdotal' material from the observers notes is presented.

Design of Wards

Question 1. Which categories of patients are nursed in cubicles?

Question 2. If children are in cubicles (unless isolated because of infection or serious illness), are they allowed to play with other children in the ward?

'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.'

(Paragraph 35)

Stated Policy

One ward did not have cubicles, although it was possible to partition off two small 'quist' areas from the main ward. The other
wards had varying numbers of cubicles, and all sisters were agreed that babies under the age of one year, children with infectious diseases, older children requiring privacy and very seriously ill children were nursed in the cubicles.

On one ward 'medical cases' were admitted to cubicles until diagnosis was established. Ward sisters agreed that children in cubicles were allowed to play with other patients if they so wished, and were medically fit to do so.

Observed Practice

The use of the cubicles was one of the many questions that required the observers to use their nursing experience when answering the sister's questionnaire. It was difficult to understand why many of the children were nursed in cubicles, as they did not appear to fit into any of the categories mentioned by the sisters, and it could rarely be said that it was because the ward beds were full. The observers views of the use of cubicles often differed from that of the sisters. It was found in many cases that the decision was not made by the sister, but, in her absence by the nurse in charge and, once a child was 'placed', he often seemed to stay there until a more general re-allocation of beds was undertaken.

In the ward where children with medical conditions, as opposed to surgical ones, were often in the cubicles, one observer remarked:-

'I did not see any playing with other children. Most of the time that I was on duty, I observed one little girl, who was nursed in a cubicle, standing at the end of the corridor watching the other children'.

(Ward E)

(this child had been declared free from infection before the survey started, but was not discharged until the fourth day).
Discussion

Quite often children were admitted into the cubicles temporarily when for instance their diagnosis was not made, or when they arrived after the other children had been settled. Observers agreed that this was inevitable, but found that, once admitted into the cubicles, children tended to be left in them for much longer than their illnesses warranted.

Conversely, some of the children might have been more comfortable if they had been nursed in cubicles. For example, teenage girls or children who had undergone major surgery immediately after their return to the unit from the recovery ward and ill emergency admissions.

A typical example was Anthony aged eight years three months, of him the observer wrote:--

'11.15 a.m. Emergency admission? cellulitis. T.104. Obviously in severe pain admitted to a bed half way down the ward, yet an empty cubicle was available'.

(Ward J)

One child was transferred from the ward into a cubicle and the observer wrote:--

'Sammy, four years 11 months is now? mumps. Now that Sammy has been moved to the cubicle he is much happier, he can see the medical secretary through the glass, also he is looked after by the cubicle nurses. He got fed, the first time I have seen this for him'.

(Ward D)

(One or two nurses were allocated to the cubicles each day, and were entirely responsible for the occupants' care.)

Sometimes, where children were isolated for specific medical reasons, the nurses found it difficult to keep the child in his
cubicle and away from other children. The difficulty in this instance seemed to be leaving on his own the child who was up and dressed, who was considerably distraught and was crying and banging on the door. Alexis was 2 years 11 months old.

1.35 p.m. nurse takes toys into doorway, plays (ungowned) with him with ward teddy!

1.45 p.m. Alexis screaming - various members of staff coaxing him - he is very distressed.

1.50 p.m. Nurse with Alexis - screaming, very distressed, does not want to stay in bed (rest time) and the nurse is trying to see he has a rest.

3.55 p.m. Parents left - two nurses stay in the cubicle with child screaming - one of them trying hard to quieten the child in her arms (ungowned) without success.

4.47 p.m. Nurse tries to comfort Alexis by playing with him through the cubicle glass.

5.26 p.m. Although supposed to be barrier nursed in the cubicle Alexis is playing and mixing with other children - 'much happier.'

(Ward J)

Again, after this child had been found to be free from infection, he was not moved into the ward, but left in his cubicle until the following day.

Question 3 Is there a separate playroom for the children? If not, do you consider it desirable?

'Children who are in bed need a view and facilities for outside play, whether on a balcony or playground. All children's wards need a playroom, 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 other play'.

(Paragraph 35)

'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'.

(Paragraph 101)

Stated Policy

Four of the nine wards did not have playrooms, on two of
these wards the sisters would have liked them, one of them thought that plans to build a playroom were 'in the pipeline'. The other two ward sisters without playrooms commented that they had adequate space in their wards, and they thought playrooms would leave the bedfast children isolated, particularly the 'well' children with orthopaedic conditions.

**Observed Practice**

The observers considered that three of the five playrooms were misused. One was only opened when the playleader was present (nine hours during 87 3/4 hours of observation). This playroom was well equipped, but the toys were not available unless the room was opened. As access to the balcony was through the playroom, this was not used either. The other two playrooms were used by children when accompanied by their parents, or at meal times, when 'up' children had their food served to them there.

The toys and books were neatly arrayed in one, whilst the other offered a very large blackboard (for which parents seemed to supply the necessary chalk) and a collection of broken toys.

The two which were well used had very good supplies of toys, but perhaps more significantly, were used by the teachers on one ward and the playleader on the other. The children liked to be where 'something was happening' and unless an adult was organizing 'play' or activity in the playroom, they seemed to be happier where the nurses were.

Two wards were without facilities to play outside, although the children on one ward were taken for walks round the seemingly endless open corridors of the hospital as often as the weather permitted. These walks were very popular with children of all ages.
Discussion

Three of the wards without playrooms had ample playing space, two having definite play areas. Provided the more ill children could be cared for away from the bustle and noise, these 'open' facilities seemed to make the ward a happier, albeit noisier, place. The bed fast children were better integrated into the school communal group activities such as singing.

While visiting the different wards, one was very much aware that the child confined to bed in a ward when his companions had gone to the playroom, was often isolated for long periods, particularly if he did not require nursing attention. Comment must be made about the imaginative way that the beds of the bedfast children on the orthopaedic ward (Ward F) were continuously moved, so that they could be with the other children, for example, to join different sections of the percussion bands.

One of the sisters (Ward F) without a playroom did not want one for the children, but thought it would be better to have a room with facilities for visiting parents to be with their children.

The varying use made of outdoor facilities was of interest - the advantages of the children being dressed in day clothes became apparent, since they could go out and play as they might at home. As the children tended to soil their clothes, there was probably greater reluctance to let them 'play out' when the supply of clothes and linen was more limited.

Finally, the babies in the paediatric hospital units were more likely to be outside in their prams, than those on the units in general hospitals.

The Platt Report comments that 'the sick child derives a stimulus to get better from seeing others play'. This seems to make
the inference that illness is 'self perpetuated' and that children enjoy being ill and unless they are jolted out of this, they will remain so. This may be true of a small minority, but for the most part, children, unless they are too ill or too young to want other than their parents' company, enjoy being gregarious, and it is for this reason they should not be prevented from playing with the more active children.

**Nursing Organization**

**Question 4** What are your qualifications?

"The keystone of the nursing organization is the sister in charge of the ward .......... She should be a Registered Sick Children's Nurse as well as S.R.N."

(Paragraph 37)

Seven of the sisters in charge of the units were Registered Sick Children's Nurses, six of whom were also State Registered Nurses. It should be noted that only one sister was trained later than 1959. Several of the sisters had attended management courses, but none had had an opportunity by the time of the survey to attend refresher courses specifically relating to paediatric nursing. Two of the sisters however had attended related courses in their own time, and of their own initiative. One was attending a course in child psychology one evening per week.

**Question 5** Are children under eighteen months looked after by a 'special nurse' or a special group of nurses (case assignment)?

**Question 6** Are the children between the ages of eighteen months and five years looked after by a 'special' nurse of 'anyone on duty'?

**Question 7** Does the child get the same nurse looking after him where possible?

"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.'

(Paragraph 38)

'Children under five 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.'

(Paragraph 65)

Stated Policy

Five sisters did not attempt to nurse by case assignment.

Two ward sisters said that their nursery nurses were usually with the younger children, thus providing some continuity of care. One sister allocated two nurses to care for the babies on a daily basis.

The remaining ward was selected for inclusion in the sample because it was known that the ward sister endeavoured to maintain this method of giving nursing care. When she was asked about the use of case assignment her reply was as follows:-

'Theoretically all the children are case-assigned. If possible the two nursery nurses feed and play with the younger ones - if they are very ill their care is assigned to a senior nurse - but as you can see with the nurses' sickness and one thing and another, case assignment goes by the board'.

(Ward G)

Four sisters (all paediatrically trained) discussed their reasons for not introducing case assignment - for them it can be seen it was very definite policy not to adopt this method of nursing care: -

'No. I do not use case assignment. The child then depends on the nurse too much - therefore I deliberately rotate the staff so that the children are used to everybody.'

(Ward A)
'No not here. If they (the patients) get attached to one nurse their day off creates additional difficulties. I often get their favourite nurse to carry out special treatments. Mum doesn't have quite so much trouble on the child's return home if we don't use case assignment.' (Ward B)

'No case assignment - well only if it's a very ill child e.g. just after they've had repair of cleft palate, and anyway everyone has their favourite child and they are very good at sharing the awful ones.' (Ward C)

'Nurses take turns to gain necessary experience.' (Ward J)

**Observed Practice**

Observers on two different wards noted that the care of the babies was usually allocated on a daily basis. On the unit known to use case assignment all three observers commented that case assignment was practised 'more or less', one observer writing:

'Each nurse had three children, regardless of age, allocated to her care. If nurse was busy with one of her charges often the other two were ignored, as nurses kept rigidly to their own three children.' (Ward G)

This was in fact quite noticeable, for example if the nurse were feeding one of the babies and 'her' toddler then wanted a potty, he had on occasion to wait until she finished feeding the baby.

On four wards which were structurally divided into two areas, nurses were allocated to one part of the ward or the other, but this was often only done on a daily basis so that many different nurses cared for each child during each week. On one ward the two nursery nurses were always assigned the nursing care of the children under the age of five years and only in their off-duty did the other ward nurses relieve them. On the days when more staff were available, student nurses would help with the younger children.
'Belinda (2 years ten months of age, with a long history of hospitalization) was settled down for the night by one nurse, who tidied away all her toys. Belinda started to cry as soon as the nurse disappeared. Another nurse came to her almost immediately, got her toys out and told her that she might sit up and play. Within five minutes a third nurse appeared, removed the toys again and Belinda was firmly told to go to sleep'.

(Ward C)

The numbers of nurses who were in contact with each child was noted on the observation sheet and subsequently counted by the computer. Tables 13 and 14 in Chapter 5, have demonstrated the number of different nurses who participated in the care of each child. The average number of contacts that the nurse had with the children was observed to be approximately 12 per day and these were rarely with the same child. Jacobs (1951) (47) investigating the few number of contacts each nurse had with each child in her survey suggested that:-

'In conditions where the majority of personnel saw the child entrusted to their care less than five times a day it was impossible for them to acquire an understanding of the child as an individual, of his behaviour pattern and of his responses to his illness and hospitalization. Nor could they have derived that personal satisfaction from their work which comes only with the development of a feeling relationship between the adult and the child'.

Discussion

The need for a mother substitute in the absence of the mother has been discussed in Chapter 1. The sisters' comments concerning the use of case assignment, show that the principles behind case assignment are not well understood, if indeed they are understood at all. Until the reasons for trying to introduce case assignment are not only understood at an intellectual level but also an emotional level, attempts to practise this method of nursing care will not meet with success. It is clear that the senior nursing
staff will have to be encouraged to appreciate the very real need
to reduce the number of nurses with whom each child is in contact. It is
only when this basic condition is complied with that different
methods of care can be tried. Various reasons for not practising
case assignment that have been suggested in the past were reiterated
during the survey. Four of these reasons are discussed here.

**Shortage of Staff**

It has to be recognized that for the present time the shortage
of staff is likely to be 'chronic' and the total nursing staff numbers
will remain fairly static.

It can be seen from the results obtained from the modified
activity sampling that between 6.7% and 13.4% of nurses' time was
being spent doing jobs that could be done by the ward orderlies or
domestic staff. As a first stage there seems no reason why the student
nurse training for the general register should not be allocated
throughout her stay on the ward to a particular part of it. For
example, on a Nightingale type ward she might be allocated to either
the left or right side team. This had been described by Sharpe
(1950)(120).

Whilst this could be criticised because it would limit her
experience of nursing many different types of paediatric conditions,
the reason for including the eight week period of paediatric
nursing is principally to accustom her to caring for babies and
children. There have been suggestions more recently that some of her
experience might in the future best be gained by caring for healthy
children outside the hospital setting.

It should not be too difficult for a sister to allocate her
staff so that at least one member of each team is always on duty.
As each team should normally include junior and senior nursing
students (seniority being in terms of service on the unit, as is customary in operating theatre hierarchical structure) it should be possible for the unit to function without detriment to efficiency.

Change of Staff

Staff changes can create difficulties at ward level. Responsibility of staff allocation to the paediatric unit generally rests with senior nursing officer who usually has overall responsibility for staffing the whole hospital. All student nurses are required to complete a minimum of eight weeks paediatric nursing. Many sisters complained however that student nurses came for two or three weeks and were then re-allocated to another unit, only to return later in their training. Ideally, at least from the sisters' and the patients' point of view, the student nurse should complete her paediatric training in one uninterrupted period of eight weeks.

Another difficulty for the ward sister is the irregularity of the staff change over, it is almost impossible for her to both ensure continuity of nursing care for the children, and to work out a plan for teaching the nurses when the duration of their period of allocation to the ward is not known and when the frequency of change is unpredictable. Fortunately the increasingly stringent requirements of the General Nursing Council concerning training programmes are demanding better planning of allocation and hospitals are beginning to plan staff-changes more methodically.

The average length of stay for each child is comparatively short and the majority should then be little affected by the constantly changing staff.

The problem of caring for the 'long stay' patient is rather different. The pattern of care has changed to allow more children who would normally have been cared for, continuously in hospital,
to be discharged (where home circumstances permit) and later return to the hospital for the specific treatment, e.g. an operation, change of plaster, blood transfusion. This means that children who remain in hospital for two or three months at a time, are likely to meet different nurses during each period of hospitalization. They may in fact return to a ward where perhaps the ward sister is the only member of the nursing staff known to them. It seems important to increase the number of permanent members of nursing staff in this type of ward.

For the younger long stay patient, care by permanent staff is essential for their healthy emotional development. It is difficult, if not impossible, to find any other adequate solution. With the older children, however, it might be worthwhile to have them allocated to a particular nurse, for although she is only on duty for part of the time, such things as washing hair, escorting to other departments etc. could generally be arranged to co-incide with her time on duty. She could possibly provide the extra mothering, at times when she is not busy with general ward routine. In this way each child would be assured of getting a certain amount of regular individual attention from a person whom he has come to associate with the ward.

Emotional involvement of staff with the patient

Without doubt case assignment is more demanding of the nurses than job allocation. Thorner (1955)(128) suggested that a nurse cannot allow herself to become emotionally involved without paying the penalty in terms of psychological strain. Menzies (1967)(74) has discussed this at length. She suggests that splitting up the nurse patient relationship is one of the ways the 'system' (i.e. that of hospital nursing) functions to avoid undue anxiety of the nursing staff.
Where one is concerned with the whole care of a patient rather than with the specific routines of care, (e.g. bed bathing, temperature taking), further involvement is inevitable. This is particularly so when nursing a distressed child who is difficult to comfort, and even worse when the child happens to be deformed, or is known to have short life expectancy.

Student nurses are young, but they are people who voluntarily chose to care for others. If, in addition to their own enthusiasm, they are offered and given the support, guidance and encouragement they require from more senior members of staff, case assignment should be a very satisfactory method of nursing. Menzies noted that little attempt was made by senior staff to help the student nurses to confront their anxieties. This was borne out by one of the observers in the present study who wrote:-

'The nurses looked very strained all day following John's death (a nine year old boy who had received a head injury) yet at no time have they been given an opportunity to express their feelings. 'It's awful' one nurse said, 'I know it's all wrong to show that you care when you are a nurse, but it's awful'."

(Ward D)

Difficulties of allocating the children

There is apparently, no uniform or standardized procedure in planning paediatric experience for those student nurses who are training for the general register or for pupil nurses.

Some hospitals send the nurses straight from the preliminary training school to the paediatric units, whilst others prefer that their nurses do not have any paediatric experience in their first year of training. Many of the nurses covered by the study had completed the full course of paediatric lectures (16 of the 47 nurses training in general hospitals stated this in the questionnaires) but others had received 'some':- varying from one lecture
to 'a lot' (remaining 31 nurses).

Ward sisters who have to deal with nurses lacking theoretical foundation in paediatrics, have to practice case assignment with great care. In the course of the present study it was found that there were some children on every unit who did not make heavy demands on either medical or a technical knowledge of the nursing staff. Those children could have been allocated to the more junior members of the nursing staff under the supervision of the ward sister.

Question 8

Does Sister feel that the ward was adequately staffed during the week of the survey?

'Whatever method of nursing is used, a higher ratio of nurses to patients will be needed than in most adult wards'.

(Paragraph 38)

Stated Policy

Six ward sisters considered themselves 'well-staffed' (A, B, C, F, H and J). One sister thought that the overall staffing level had been adequate, but that too many relief nurses had been required to maintain the appropriate level (G). One ward had been poorly staffed at the beginning of the survey, but was adequately staffed during the latter period (E). Only one sister complained that she was short of staff, but agreed that she had had as many nurses as usual during the week of observation. (D). None of the sisters thought that the work-load had been unusually heavy during the week of the survey, indeed many of them felt that they had been particularly slack during this period.

Observed Practice

In the main the observers' and the ward sisters' judgement concerning staffing levels was similar. The observers agreed that
six of the nine wards had adequate nursing staff (as the sisters had stated). On the ward with too many relief nurses one observer commented:

'I felt that the staff could manage the quiet routine but not the emergencies or additional work caused by shortage of numbers made up with reliefs'.

(Ward G)

Observers thought that E was understaffed but they disagreed about the level of staffing on the remaining ward (D) - two regarding it as adequately staffed, and one not sure.

Activity Sampling Results

The staffing ratio was calculated by counting the number of nurse observations and comparing them with the number of children's observations.

Obviously there are wide fluctuations in these numbers, for example on Ward H (working an overlapping shift system) the number of nurses on duty at 3.15 p.m. was extremely high. On one day there were 14 nurses to be marked in during this overlap period, but at other times, for example the nurses' supper time, there might only be one or two nurses on duty.

The overall average staffing ratio was shown in Table 9 in Chapter 5. Wards D and E (the general hospital paediatric wards) had the lowest ratio of nursing staff together with Ward F the longstay ward (1 : 4.3, 1 : 5.9 and 1 : 4.9 respectively). The shortage of staff on the longstay ward was not so evident, as there were ancillary staff (teachers) present and the work load did not appear to be quite so heavy.

Discussion

The ideal staff-patient ratio appears at present to be largely
a theoretical concept. Abdellah and Levine (1965)(3) describe and
discuss studies attempting to measure the relationship between nurse
staffing and patient welfare. Giving the findings of their own
study, they drew the conclusion that no matter how much nursing care
the hospital had available, there would still be some that felt that
certain aspects of nursing care were omitted. Certainly the better
staffed wards during the present survey would have welcomed one or
two more nurses to share their work load with the same enthusiasm as
their counterparts in the other wards.

The staffing needs of the ward are usually calculated on the
nurse/bed ratio. The bed occupancy varied considerably (from 49.5% to
96.0%) during the survey. Had occupancy been higher on some wards the
staffing ratio would have been much lower, for example on Ward E it
would have fallen from one nurse to approximately six patients to
one nurse to eight patients. Some of the hospitals had a team of
nurses who were not allocated to a specific ward, but were sent where
the need was greatest. This made it possible for the staffing ratio
to be maintained but resulted in a greater number of nurses with whom
each child came into contact (for example as happened on Ward G).
It would seem that for the benefit of both the nurses and the patients
better use should be made of the available beds so that the nurse/bed
and the nurse/patient ratio are as close as possible. From this it
would follow that the number of staff allocated to the ward is adequate
even with 100% bed occupancy.

Ways of attracting long term part time staff (to work early
morning and/or late afternoon) need to be explored. Ward F had
several voluntary workers who visited to read stories and play games.
The children enjoyed these visits, and nurses were able to give more
individual attention to those who required it.
In conclusion it seems that a ratio of one nurse to three patients (the average staffing pattern found in this survey) is a reasonable minimum for estimating the nursing staff requirements of a paediatric unit. The two 'acute' wards, D and E, whose nurse/patient ratios were below this were considered by the ward sisters and most of the observers to be understaffed. Ward F, where the ratio was also below the average, did not seem so noticeably shortstaffed, because there was excellent ancillary staff on the ward. Although high staffing rates do not necessarily increase the standard of nursing care, it is unlikely that the 'extra' or professional care can be given when there are acute staffing difficulties.
Chapter 8

Summary

The method of discussing the results of each of questions asked of the sisters is continued. - The question is given followed by the Platt Report paragraph. The stated policy and observed practice follow. Sometimes results obtained from the nurses questionnaires and/or the modified activity sampling of both nurses and children are included. 18 questions under the general title of 'Reception' are discussed.

Reception

Question 10 Where does the main admission procedure take place?

'There should be the least possible delay between entering the hospital and reaching the ward and if he (the patient) is immediately welcomed there by the nursing staff and occupied, there is a better chance that he will settle easily and quickly'.

'The main admission procedure should take place in the ward where the child will be nursed - the amount of information asked of parents before reaching the ward should be kept to the minimum'.

'A playroom is a good place for the child to be welcomed---where there is no frightening medical equipment'.

(Paragraphs 54 and 55)

Stated Policy

Most sisters agreed that the admission procedures on paediatric wards differed little from those used on adult patients wards.

The children being admitted to the paediatric hospitals received their preliminary medical examination in the admission room in the out patient department. Otherwise, the sisters said that the admission procedure took place in the ward.
It was established in the course of the survey that most children experienced a certain amount of delay. The delay occurring between their arrival at the hospital (when the ward was notified) and their actual admission to the ward. One ward sister conceded that the practice as she described it - the child to be greeted and welcomed by a nurse was 'ideal', but unfortunately this could not happen every time! It was on this ward that an observer reported the following:

'New patient Mary on arriving was asked to wait in the area immediately outside the ward together with her father - after one hour the father went into the ward to say that he could not wait any longer - apparently they had been forgotten!' (Ward G)

No children were observed to be 'admitted' in the playroom, it was usually described as 'in the ward' or 'at the centre table' although one ward used a pleasantly furnished doctor's room for a preliminary interview.

Discussion

Contrary to the suggestion contained in the 'Platt Report', it would seem that there is no evidence available to date to show that the child reaching the ward 'with the least possible delay' settles more easily.

The practice of the child having his preliminary medical examination before he reaches the ward has distinct advantages. Children, who are found to have a current infection or who have recently been exposed to infection may have to have their operation or investigations postponed. The preliminary screening means that they do not then enter the ward unnecessarily. Whilst many sisters are prepared to allow parents to stay for the child's preliminary medical
examination, this often proved impracticable due to long delays between the child's arrival on the ward and the doctor's examination. This situation would not arise if the preliminary medical examination were required to be completed before the child was admitted to the ward.

'9.48 a.m. Three new admissions arrive with parents. Doctor is on the ward - cannot find any member of staff. Waits in office.

9.59 a.m. Dr. leaves the ward. Has not seen the new admissions.

10.24 a.m. Third admission awaiting bed. Dr. and staff/nurse are chatting in the office. No information or reassurance given to parents of new admission - in fact conversation is nil. Although new admission is very heartbroken no reassurance by members of staff - no introduction to other children. Father left stranded.

4.15 p.m. Three new admissions taken to E.N.T. Clinic to see the doctor for medical examination'.

(Ward J)

The 'Platt' Committee suggested that the playroom is a good place for the child to be welcomed into the hospital (a room free from frightening medical equipment). During the daytime, if the playroom is fulfilling its proper function one might expect to find it occupied by several children playing. A quieter atmosphere would be less overwhelming and more appropriate to welcome the child and his parents. For example the parents and children on Ward D were usually received in a very pleasantly furnished doctor's room.

Question 11 Who is responsible for admitting the child?

'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'.

(Paragraph 56)
Stated Policy

Only two ward sisters said that they delegated this task to senior nurses - the remainder said that 'any nurse available' would complete the admission procedures.

Observed Practice

The present study showed that admission of patients was largely a very hasty routine procedure, which was carried out by any available nurse in most cases.

Discussion

The amount of time, patience and kindness that a nurse could devote to a new patient depended very much on other tasks she had on hand. With the toddlers, it is difficult to know how the 'admission separation period' can be softened unless the parent is allowed to remain indefinitely and if a nurse in addition to her other duties, is made responsible for the admission of a new patient, it is obvious that she would tend to hurry through the admission routine in order to return to her other tasks. The quality of the reception was clearly related to the staffing ratio on the ward at that particular time.

One sister commented that she preferred every nurse to have had the experience of admitting new children. It should be remembered that if a junior nurse is given the task she is more likely to be able to stay longer with the child than either sister or her deputy.

It would seem that in most cases, it should be possible to ensure that the 'admitting nurse' is the one who will be on duty for at least four or five hours after the child's arrival. With 'planned admissions' it might be better to arrange the time of their arrival so as to enable this practice.
It is perhaps of interest to quote here abstracts from the study observations relating to the immediate post-admission period. Katherine was fully ambulant and remained dressed in her own clothes. She was aged 4 years 7 months and admitted for 'abdominal investigations':

<table>
<thead>
<tr>
<th>Time</th>
<th>Observation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.37 p.m.</td>
<td>1</td>
<td>Up, contented, accompanied by her parents.</td>
</tr>
<tr>
<td>12.43 p.m.</td>
<td>2</td>
<td>Sitting, contented accompanied by her parents. Sister and senior staff nurse with them.</td>
</tr>
<tr>
<td>12.48 p.m.</td>
<td>3</td>
<td>Distressed - sitting with parents who were preparing to leave.</td>
</tr>
<tr>
<td>1.03 p.m.</td>
<td>4</td>
<td>Sitting 'apathetic'.</td>
</tr>
<tr>
<td>1.08 p.m.</td>
<td>5</td>
<td>Up. Contented with Nurse 12.</td>
</tr>
<tr>
<td>1.17 p.m.</td>
<td>6</td>
<td>Up. Contented with Nurse 04.</td>
</tr>
<tr>
<td>1.35 p.m.</td>
<td>7</td>
<td>Sitting, distressed. Alone.</td>
</tr>
<tr>
<td>1.44 p.m.</td>
<td>8</td>
<td>Sitting, distressed. Alone.</td>
</tr>
<tr>
<td>1.59 p.m.</td>
<td>9</td>
<td>Up. With Nurse 12. Distressed.</td>
</tr>
<tr>
<td>2.08 p.m.</td>
<td>10</td>
<td>(Up. With Nurse 04 - taken for a walk in the hospital grounds. (Ward A))</td>
</tr>
<tr>
<td>2.15 p.m.</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>2.26 p.m.</td>
<td>12</td>
<td></td>
</tr>
</tbody>
</table>

During the next hour 5 observations charted Katherine as sitting alone apathetically. The 18th observation recorded her as taking part in school activities. It was only after this that she began to 'settle down' and joined in with the other children, although at bedtime (6.30 p.m. onwards) she was charted as apathetic unless accompanied by a member of the nursing staff, when she appeared more cheerful.

In the first three hours of admission Katherine had met at least four different nurses and attempts to comfort her had been made by two of them.

The hours following this admission are described because this was probably one of the most thoughtful admissions observed.
The nurse 04, a post registration nurse, tried very hard to comfort Katherine – the nurse's own difficulties in coping with the situation are possibly shown in that she was charted as 'unoccupied' i.e. withdrew, at both 1.35 p.m. and 1.44 p.m.

More typical is the following: Sandra (3 years 8 months) was admitted to find the cause of epileptic attacks:

'She has cried and been very distressed almost continually since admission just before 1 p.m., until 3 p.m. but was completely ignored though adequate staff were available'.

In fact observations of Sandra read:

<table>
<thead>
<tr>
<th>Time</th>
<th>Observation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.56 p.m.</td>
<td>1</td>
<td>In bed distressed. Mother present.</td>
</tr>
<tr>
<td>1.04 p.m.</td>
<td>2</td>
<td>&quot;</td>
</tr>
<tr>
<td>1.16 p.m.</td>
<td>3</td>
<td>In bed distressed - alone.</td>
</tr>
<tr>
<td>1.24 p.m.</td>
<td>4</td>
<td>&quot;</td>
</tr>
<tr>
<td>1.38 p.m.</td>
<td>5</td>
<td>Asleep.</td>
</tr>
<tr>
<td>1.52 p.m.</td>
<td>6</td>
<td>In bed distressed - alone.</td>
</tr>
<tr>
<td>1.57 p.m.</td>
<td>7</td>
<td>&quot;</td>
</tr>
<tr>
<td>2.08 p.m.</td>
<td>8</td>
<td>&quot;</td>
</tr>
<tr>
<td>2.14 p.m.</td>
<td>9</td>
<td>&quot;</td>
</tr>
<tr>
<td>2.22 p.m.</td>
<td>10</td>
<td>In bed distressed - doctor present.</td>
</tr>
<tr>
<td>2.31 p.m.</td>
<td>11</td>
<td>&quot;</td>
</tr>
<tr>
<td>2.44 p.m.</td>
<td>12</td>
<td>Held by Nurse 16.</td>
</tr>
<tr>
<td>2.58 p.m.</td>
<td>13</td>
<td>Held by Doctor.</td>
</tr>
<tr>
<td>3.06 p.m. onwards</td>
<td>14</td>
<td>Asleep or lying awake contented until visited. (Ward B)</td>
</tr>
</tbody>
</table>

**Question 12** Are the parents seen separately from the child?

**Question 13** Is the child shown round the ward on admission?

**Question 14** Is the child introduced to other children?

**Question 15** Are the parents asked the child's personal habits, his likes and dislikes, his pet name for lavatory etc.?
We recommend the practice — whereby after reaching the ward the Sister talks to parents whilst another member of the nursing staff shows 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.

(Paragraph 57)

Stated Policy

Only four sisters of the nine usually interviewed the parents separately, of these two stated that the child was shown round the ward and all four said that he was introduced to other children. One of the four sisters admitted that 'in theory' the child was shown round the ward but that in practice this was not always so, whilst another did not think that it was necessary to do this.

One of the sisters who neither met the parents nor introduced newly admitted children to the ward said that it was no use introducing young children to each other:— 'little ones are better if they go at their own pace'. Two of the remaining ward sisters varied their policies according to their assessment of the parents and child's needs.

Only one sister said that she did enquire into the children's personal habits.

Observed Policy

The admission procedure does not always lend itself to easy observation but on two wards where the sisters had stated that they saw parents separately, this was not noticed by any of the three observers. Similarly there were only four wards where one observer of the three saw a child shown round the ward.

'Parents of new admission anxious to talk with Sister but no time for this'.
The introductions to other children although observed more frequently (by at least one observer of the three, on six of the nine wards) did not always occur.

'Although Margaret (aged 6 years 1 month) admitted for routine tonsillectomy, heartbroken no reassurance given by the nurses no introduction to other children'.

(Ward J)

The observers were not usually present during the interviews held on the child's admission, and it was not possible to comment on whether or not his personal habits were discussed. However, the observers were impressed by a large notice mounted at the end of one of the cots on Ward F.

'Jennifer does NOT each fish.'

and on another ward -

'5.22 p.m. Tharia distressed at tea because one of the nurses made her eat tinned peaches provided' - the child told her mother of this - who then told the sister.
Later. Sister observed making a list of foods that the child likes'.

(Ward G)

Discussion

The Platt report specifically states that it was particularly important in the case of the 'younger child' that a member of the nursing staff showed him round, introduced him to other children and told him of the ward routine. 'The younger child' is a vague term but there is no evidence available to suggest that children much under the age of five years are able to assimilate this type of information in a meaningful way. What might be more helpful would be that a particular nurse was able to spend more time with the child in order to get to know him better. One ward sister commented that only the bigger ones benefitted from meeting other children.

The kindness of the older children to the younger child was
often observed and this could perhaps have been exploited to the benefit of both. The older convalescent child, whilst reasonably content, often appeared under occupied and might have 'helped' with the small child if this were to be allowed. An appropriate introduction to an older child on arrival to the ward could have been helpful.

'1.42 p.m. Richard said 'I want my mummy'. Thomas stopped, listened and said 'Your Mum will come soon, don't worry'.

(Ward B)

Another day -

'John (2 years one month old) very distressed for a long time. Paul (10 years three months) went to pick him up and played. Child stopped crying but nurse arrived and was cross, took child from him and put him in cot. John immediately started crying again and Paul was told to go away. Later Lewis (13 years four months) came to play with John, who was still crying'.

(Ward B)

Question 16 If a preliminary medical examination is part of the routine, are the parents allowed to stay to help?

Question 17 If admitted during the day time, is the child allowed to stay up? (if medically possible.)

Question 18 If he is admitted at bed time is the mother allowed to help?

'Where a preliminary medical examination is part of the routine admission procedure the mother should be allowed to help'.

'If children admitted to a ward during the day—— where possible—— they shall be allowed to stay up and not put to bed—— If the child is admitted at bed time we recommend that the mother should be allowed to stay and help'.

(Paragraphs 57 & 58)

Stated Policy

With one exception all sisters answered 'yes' to all three questions. On only one ward (medical) all children remained in bed until they were seen by the doctor on the unit.
Although all ward sisters agreed that parents were allowed to stay for the preliminary medical examination, on some wards the onus appeared to be on the parent to ask to stay for this. Moreover, on some of the wards there was long delay before the doctor arrived on the ward to examine the child and the parents had often gone home. For example in the account of Sandra's admission it was 1½ hours before the doctor arrived to see her.

The advantages of a medical examination before arrival on the ward are discussed earlier in the chapter.

Only three children were admitted at bed time, two of whom were on the same ward. One mother stayed to undress her child and the other left immediately. On the second ward the parents were still on the ward when observation finished at 8 p.m. The ward sister said, that if the child were admitted in the evening and appeared to be distressed, it was usual to administer a sedative.

Discussion

It appeared that if the parent decided to stay and attend to their child they would be allowed to do so. Whilst no parent would be refused permission to stay, it seemed that little or no encouragement was given to them to do so on many of the wards. The parents who were unfamiliar with hospital routines and Robinson (1968)(114) suggested that there were many, went home as soon as they could.

Question 19 Are children allowed to wear their own clothes in hospital during the day?

Question 20 Are children allowed to wear their own clothes at night time?

'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 is worth consideration.

(Paragraph 59)

Stated Policy

All the sisters stated that the older children could wear their own clothes if they wished although four of the sisters added that they did not accept responsibility for the safe keeping of clothes. Two of the sisters did not encourage toddlers to wear their own clothes for this reason. One sister said that she found it very difficult to persuade parents to bring day clothes for their children to wear in spite of the fact that they were not available on the ward.

Observed Practice

On two of the wards (D and E) most of the patients wore night clothes throughout their stay in hospital. One sister had stated that the children were allowed to wear their own clothes, whilst the other had said that she found it difficult to persuade the mothers to bring the children's clothes into the hospital.

Discussion

The paediatric hospital wards appeared to have plentiful supplies of good quality children's clothing, and it was obvious that the staff enjoyed finding pretty, well fitting clothes for the children to wear.

'Cleaner asked if she might wash Sharon's dressing gown as it was dirty. Nurse looked for a bright button to sew on it, to make the child look more attractive.'

(Ward E)

There appeared to be a general shortage of plastic pants, and because of this, many of the children had to have more frequent changes of clothes than might otherwise have been necessary.
'John's mother very angry as she had brought him three pairs of plastic pants and one pair had been mislaid, mother thought that Emmanuel was wearing them. Pants removed from Emmanuel, washed and returned to John's mother, who then looked much more relaxed.'

(Ward E)

'Ronald causing alarm with Jonathan's mother because spreading urine everywhere - no plastic pants.'

(Ward E)

One of the observations made the following comment about the children wearing their own day clothes:

'As most of the parents think the children should have new clothes when they go in (to hospital) including slippers - the clothes they are wearing are strange. I feel that they should be advised to have washed everyday clothes they feel comfortable in. The children feel strange in new clothes, particularly evident with Katharine, Helen and Margaret today'.

(Ward J)

The children on the two wards where day clothes were seldom worn went out least, although whether they would have been allowed to go out more frequently if they had day clothes is a matter of conjecture.

Question 21 Do you regard playing with the children as part of the nurse's duties?

Question 22 Do the nurses know this?

Question 23 Do they appear to play with the children?

'The keystone of the nursing organization 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 judgement and guidance'.

(Paragraph 37)

'The younger children's play can often be organized by student nurses ---'

(Paragraph 58)

'--- but student nurses --- can all help to entertain the children ---'

(Paragraph 99)
Stated Policy

All the sisters agreed that playing was part of the nurse's duties, although some sisters were less enthusiastic than others. This can be seen from their replies:

'Yes - but after the work is done'. (Ward D)
'Yes definitely - it's all part of hospitalization and treatment. Kids must be kept happy to be kept fit'. (Ward B)

Another sister agreed with this:-

'Yes, it must be incorporated into care'. (Ward J)

When sisters were asked if the nurses knew that play was part of their duties, one sister replied that she thought the teachers told them (Ward F) whilst another said:-

'I always tell them to be as friendly as possible'. (Ward E)

One suggested that the nurses 'knew in theory', the other sisters saying that 'of course' the nurses knew. Only one sister answered quite uncompromisingly 'No' in reply to 'do they appear to play with the children?' (Ward D)

Five thought that their nurses did so, whilst one replied:-

'they haven't got time - poor things'. (Ward G)

Two others made more thoughtful comments:-

'Some do - some don't, when they first come to the ward they find it very difficult, but the permanent staff are better'. (Ward B)

'They don't really play with the children because they just don't know how to'. (Ward E)

Observed Practice

'Playing with the patients' or 'social interaction' was one of the nursing activities which was categorized. Some nurses seemed to find it easier to play as part of their task (as indeed two ward sisters commented). The amount of 'social interaction' observed on each unit probably demonstrated the sister's attitude towards play
as part of the task of paediatric nursing

This is illustrated in the following table (21) where the lowest percentages of 'social interaction' were noted on the two wards where the nurses were too busy (G) and could only play after their work was completed (D).

Table 21. Number of observations of 'social interaction' expressed as a percentage of the total number of observations.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total observations of nurses</th>
<th>Social Interaction</th>
<th>%</th>
<th>Expressed as minutes per hour of nurses time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2,430</td>
<td>382</td>
<td>15.7</td>
<td>9.4</td>
</tr>
<tr>
<td>B</td>
<td>2,875</td>
<td>424</td>
<td>14.7</td>
<td>8.8</td>
</tr>
<tr>
<td>C</td>
<td>2,812</td>
<td>213</td>
<td>7.6</td>
<td>4.6</td>
</tr>
<tr>
<td>D</td>
<td>3,069</td>
<td>182</td>
<td>5.9</td>
<td>3.5</td>
</tr>
<tr>
<td>E</td>
<td>2,564</td>
<td>159</td>
<td>6.2</td>
<td>3.7</td>
</tr>
<tr>
<td>F</td>
<td>2,640</td>
<td>285</td>
<td>10.7</td>
<td>6.4</td>
</tr>
<tr>
<td>G</td>
<td>3,367</td>
<td>196</td>
<td>5.1</td>
<td>3.1</td>
</tr>
<tr>
<td>H</td>
<td>3,736</td>
<td>561</td>
<td>12.7</td>
<td>7.6</td>
</tr>
<tr>
<td>J</td>
<td>1,968</td>
<td>282</td>
<td>14.3</td>
<td>8.6</td>
</tr>
<tr>
<td>Total</td>
<td>25,471</td>
<td>2,684</td>
<td>10.5</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Discussion

Pill (1967)(96) in her thesis stated that:

'One of the interesting things to emerge from this study is the small amount of time that the nurses devote to entertaining the children. It is apparent that they do not regard this as part of their job ---

It is clear that the nurses do not perceive it as their task to spend time with the children after they have finished the rest of their work'.
Noble (1967)(91) said in her study:--

'It may be that the assumption is that the paediatric trained nurse will do this automatically but there was little evidence of this. Indeed the nurses were too busy to pay more than passing attention to the children'.

(P. 102)

It has been stated earlier that this study was intended in part to follow up Pill's findings. For this reason both in the nurses' and sisters' questionnaires special emphasis was given to questions relating to play with the children.

The nurses were asked to answer (i.e. agree or disagree) with the following statements:--

I enjoy playing with the patients.

The nurse's job should not include playing with the children.

I get opportunities to play with the patients on this ward.

The ward is too busy to allow the nurses time to play with the patients.

Sister does not like us to play with the patients.

The patients do not need the nurses to play with them.

Of the 108 nursing staff who answered these questions, (sisters' questionnaires excluded), 105 agreed that they enjoyed playing with the patients - only three nurses agreeing with the statement that playing was not part of their job.

All the nurses on wards A, B, C and H agreed that they got opportunities to play with the patients, whilst four nurses on D and three on E either did 'not know' or disagreed that they got such opportunities. One nurse on each of wards G and J expressed themselves similarly.

When asked to agree or disagree to the statement:--

'The ward is too busy to allow nurses time to play with the patient'.


all nurses on wards B and J disagreed, (social interaction 14.7% and 14.3%) whilst six nurses on G and six on E agreed that they were too busy. (Social interaction 6.2% and 5.1%). All the staff on wards A and B disagreed with the following statement:

'Sister does not like us to play with the patients'

It was on these two wards that the staff spent the largest proportion of their time playing with the children 15.7% and 14.7%.

There were five nurses working on ward F (where sister 'thought the teachers told the nurses') who either did not know (two) or agreed that sister did not like them to play with the patients (three), and four nurses on ward G who did not know whether or not the sister liked them to play with the children.

Six nurses training for the general register and one doing paediatric training did not consider that children needed to be played with. As one of them stated, -

'I'm sure that I shall enjoy my paediatric experience providing that the spare time in the afternoons can be spent on theoretical instruction and not incessant play with the children'.

In the questionnaire nurses were invited to make comment on any aspect of their work that seemed relevant to the questionnaire. Play was one of the topics which elicited a great deal of comment. For example eight nurses working on ward G commented on importance of play. This is particularly interesting in view of the fact that proportionately they spent less time playing with the children than their colleagues on any other ward:--

'Unfortunately there is often too little time spent playing with the children due to pressure of work. The little ones love stories read to them, especially at bed time. Often a little thing, such as a story read or a dolly admired or school work approved of, can form the basis of a bond of trust between nurse and child and is well worth the time spent'.
'Unfortunately, however, many days go by when there is little time to spend reading or playing with the children, as there are so many routine jobs to be done'.

From another ward where the nurses felt that they were too busy to play, a nurse commented:-

'Another handicap for successful paediatric nursing is definite shortage of nurses, which prevents nurses to play with children and get to know them better'.

(Ward E)

Three comments from wards where nurses were not sure whether or not sister liked them to play with children:-

'Being busy and having to work hard is quite acceptable when there is nothing to do at some particular period, we should be able to communicate freely with the patients'.

(Ward F)

'It would be much better if the nurses were given more time to play with the children, so that when a child comes into hospital all children would learn not to be afraid of nurses'.

(Ward D)

'No, we do not have any time whatsoever playing with them, if we do we are soon asked to do something else'.

(Ward D)

finally 'positive comments' from the nurses:-

'I soon became interested in the work and found that one need never be bored, because the children really appreciate when the nurse plays with them. If I have time, I like to amuse the children or even take them for walks if possible - in this way the nurse gets to know the patients and gain their confidence, which is very important, especially in nursing children'.

(Ward B)

'I think that it is very important for the nurses to play with the children, as if they are happy this will aid their recovery'.

(Ward B)

'This ward is sometimes very busy, but all the nurses get some time to study or read to the children or do whatever they please'.

(Ward J)

Noble suggested that nursing staff took more interest in the children's play on those wards where nursery teachers or play leaders were included in the staff. This study has shown that nurses
play more on wards where firstly, sister in charge makes it quite clear that playing with the children forms an important part of the nurse's job, and, secondly, the staffing ratio is such that the nurses have time to play with the children. Both these conditions were satisfied on wards A, B, H and J. The sisters in charge of these four wards at the time of the study were all Registered Sick Childrens' Nurses.

To summarize it would appear that the majority of nursing staff covered by in this study considered play to be part of their job, whilst a few were sometimes in doubt about sister's point of view, and others too busy with routine tasks to do this.

**Question 24**

Are the children allowed to bring their own toys into hospital?

**Question 25**

If a child sucks a 'dummy' or has some comforter - for example an old blanket - is he allowed to keep it with him?

'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 --- if a child has been used to some sort of 'comforter' it should always be allowed unless there are special medical reasons against it'.

(Paragraph 59)

'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'.

(Paragraph 105)

**Stated Policy**

All nine sisters said that children were allowed to bring their toys in with them, although two qualified their statement; one saying that she sometimes suggested that the more expensive or easily breakable toys should be left at home, and the other saying that she always warned the parents that the other children might take, damage, or destroy their child's belongings.
On all nine wards the children were said to be allowed to have dummies or comforters. One sister said that although she detested dummies she allowed them on her ward, another sister believing that a dummy could be a great comfort to a child admitted that she was at times guilty of introducing children to the habit.

**Observed Practice**

Observers on three wards felt that the children were not encouraged to have their own toys -

'probably too much responsibility if they get broken'. (Ward D)

'I only saw one child appear to have a special doll of her own'. (Ward E)

With regard to dummies and comforters, one observer when filling in the schedule replied:

'Yes they are allowed to have dummies, and allowed to drop on the floor and back to the mouth just like normal!' (Ward E)

On one ward the following comments were made:

'The staff had been told that Timothy liked to suck a teat and have a nappy to cuddle when he went to bed. Each meal time Timothy left the teat on his bed, took off and folded up his half nappy (sewn with ribbon so that it could hang around his neck) and sat on it'. (Ward J)

**Question 26** If a child has already been in hospital is he admitted to the same ward if he has the same type of illness?

**Question 27** If a child has already been in hospital is he admitted to the same ward if it is a different complaint?

'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'. (Paragraph 60)
Stated Policy

Of the eight hospitals used in the survey, three had only one paediatric unit, and thus re-admission to the same ward was automatic.

Five ward sisters were doubtful about a child being re-admitted to the same ward if he had a different illness, although most of them agreed that he was likely to be re-admitted to the same ward in the case of a reoccurrence of the same complaint.

Observed Practice

Several children suffering from congenital disorders (for example spina bifida) were re-admitted during the survey. Their medical records showed that some of them had experience of being admitted to several different wards. Children who had been on the ward before, greeted the sister as a friend, and settled down into the ward routine. Whether they were less anxious and apprehensive than the first comers of similar age was not established.

'Francis (eight years three months) re-admitted for another operation, greeted sister cheerfully and disappeared to go for a walk round the grounds with his parents, after first unpacking his belongings into the locker'.

(Ward F)
Chapter 9

Summary

The discussion of the questions asked of the nine ward sisters based on the Platt Report continues. 11 questions concerning 'the child as an In-patient' are given. These questions are amongst the most revealing of this section, in that the role of the parent during the child's period in hospital is discussed. Whether or not they can be admitted with the children and what they may do whilst there, is given.

The Child as an In-patient

Question 28 Are there facilities for admitting mothers with their children?

'An obvious way of preserving continuity between the child's hospital and home life is by admitting the mother with the child. If an infant is being breastfed 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'.

(Paragraph 68)

'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. We realise that it may not always be possible for the mother to leave her own home, but this for her to decide. There may be accommodation problems for the hospital, but those hospitals that do admit mothers have been able to find accommodation by simple adaptations. In fact when the need has been appreciated, the accommodation has been found'.

(Paragraph 70)

Stated Policy

Eight ward sisters responded positively to this question.

Yes, there were facilities for admitting the mother with her child.

The remaining sister explained that there was a 'mother's unit' which
had facilities for three mothers to stay within the hospital grounds.

**Observed Practice**

This question was perhaps phrased somewhat vaguely, and two ward sisters who answered positively were in fact referring to a mother's unit within the grounds of the hospital. Thus three wards did not offer accommodation for the parent within the unit. (It will be noted that during the time of the survey parents from two of the three wards were known to be using the accommodation provided away from the ward but within the hospital grounds.) One ward had a number of mothers accommodated with their children throughout the period of the survey, but on the remaining five wards only one mother was observed to stay overnight, and this was on one occasion only. The unit with several 'living-in' mothers also had 'hostel type' accommodation available for parents.

**Discussion**

The advantages of mothers staying with their young children during the period of hospitalization have been discussed in Chapter 1. That these advantages are widely recognised is the fact that accommodation for parents to live on the ward was officially available on six of the nine units considered in the survey. The remaining three wards had hostel accommodation available. One ward of the nine offered both types of accommodation. The separate hostel accommodation was of particular value to the parents of older children living farther away from the hospital. The parents using hostel accommodation were able to spend all day (apart from their own mealtimes) on the ward leaving for the hostel when their children were asleep.

Several studies including those of Meadows (1964)(72), MacCarthy (1964)(63). Rice (1965)(104), Riley (1965)(105) and Robinson (1969)(114) have been concerned with estimating the demand for living-in accommodation. This is particularly important in the planning and design of future paediatric units.
The committee responsible for producing the book 'Children in Hospital: Studies in Planning' (1963)(94) devoted a large part of their time to gathering and analysing professional opinion concerning this aspect of child care. They held general discussions, and invited paediatricians and paediatric nurses who were members of the British Paediatric Association to complete a postal questionnaire on the subject. 22% of the 505 nurses who responded had experience of admitting the mother with her child. 11% were in favour of admitting mothers with their children, a further 27% qualified this by restricting admission to mothers of 'young' children.

Meadows gives the numbers of mothers admitted with their children at Amersham Hospital - where the practice was encouraged. - 21% of the mothers elected to stay in the 18 month period 1956-7 (the total number of patients was 1,031). In Newcastle, figures were collected during a six-week period in 1959. 11% of children were accompanied - quoted by Riley.

In 1964 the then Ministry of Health (1964)(79) suggested that in all cases, four mother and child rooms should be provided on every 20 bedded unit, that is 20% of all paediatric accommodation should be so designed that mothers could stay with their children.

The Report on the Census of Children and Adolescents in Non-Psychiatric Wards of National Health Service Hospitals June 1964 March 1965 (1967)(80) found that 1.8% of children under the age of 2 years had their parents staying with them on the day of the census in 1965. 1.4% of children between the ages of two and four years were accompanied. A total of 227 of 22,350 included in the census were accompanied. 560 beds were available for parents in approximately 20% of all hospitals. The census of the previous year (1964) had shown that 1.2% of children were accompanied. These figures did not distinguish between 'living-in' and 'hostel' accommodation, nor show
what number of parents were with their children because of critical illness. There was evidence to show that living-in accommodation was not always used.

The committee of 'Children in Hospital: Studies in Planning' found that a much higher percentage of mothers stated that they would accompany their children into the hospital than were observed to do so in practice. Meadow, Rice and Robinson were posing hypothetical questions since the accommodation was not always available. Rice commenting on the results of her study, said that few mothers were offered overnight accommodation in the hospital at the time of her survey. She concluded that it was very difficult to estimate future demand with any degree of accuracy since it was dependent amongst others reasons on the following two factors; firstly the climate of opinion created by the press and such organisations as The National Association for the Welfare of Children in Hospital, and secondly on the successful presentation of the idea to the mothers by the hospital staff who would be expected to assure the mothers that not only were they needed by the child, but that they could also be useful in taking an active part in his care.

With the exception of one ward (ward II), the results found in the present survey concerning the numbers of mothers living in can only be described as 'poor'.

Question 29. Who decides whether or not a mother should be admitted with her child?

'We realise that it may not always be possible for the mother to leave her own home but this is for her to decide'.

(Paragraph 70)
Stated Policy

Right of the answers given to this question can only be described as 'evasive'. For example,

'If a mother so requests she is normally allowed to stay unless medically unsound for the child. I can suggest if I think the child is very ill or exceptionally unsettled' (referring to hostel accommodation). (Ward A)

'Sometimes the doctors, sometimes the nurses, if terminal illness, breast feeding problems, or emotional problems of parents with difficult kids - Parents are definitely not told routinely that there are beds'. (Ward B)

'Paediatrician or surgeon'. (Ward D)

'Officially the registrar gives permission, if the mother asks she's rarely refused'. (Ward F)

'Doctors in Out Patients can ask me and I can recommend, but I don't, because there is only accommodation for one I daren't mention it, in case I need it for a more seriously ill child and his mother'. (Ward G)

The one sister who had several mothers living-in, replied,

'Oh I ask them, I'd never turn a mother away, however many want to stay, and the consultant will always back me up'. (Ward H)

Observed Practice

As mentioned in discussion of the previous question, seven of the wards did not have any mothers living-in during the survey, although hostel accommodation was used by parents from three of the four units where it was available. The six mothers using hostel accommodation had requested accommodation themselves. Their children had all had previous experience of hospitalization.

The mothers could probably be fairly described as intelligent middle class women who, because of their children's disabilities, had made themselves knowledgeable of every aspect of their child's welfare.

Ward H did have such parents, but several other parents had stayed because sister had suggested it. (It should be noted that
parents who were on the ward throughout the survey, got to know the
observers, and all were asked informally who had suggested that they
should stay.)

Discussion

The Platt report makes an interesting observation:—

'In fact, when the need has been appreciated, the
accommodation has usually been found'.

The lack of facilities was considered important by the
ward sisters, and often mentioned as a reason why mothers couldn't
be invited to stay on the ward. It can only be stated that accommoda­
tion on Ward H was limited, two cubicles having been converted to take
an extra bed to accommodate the mothers. In the remaining cubicles
a divan bed was 'squashed' into the child's cubicle and there were
no other facilities. There was no sitting room in the ward, yet the
sister managed to make all the mothers feel welcome, and although they
admitted to boredom at times, they were able to give each other and
their children the necessary comfort and support.

Meadows (1969)(73) suggested that it was easy to talk mothers
into going into hospital with their children, but less easy to make
sure that their stay was happy. During his interviews with the
mothers, his impression was of their 'exquisite boredom' of being
cooped up for twenty four hours a day. As he pointed out they had no
meals to prepare, no shopping to do, no walks to the park, and no
housework. He described it as a totally false situation. The mothers
on Ward H were able to use any part of the unit they wished, and if
their children were well enough, were able to take them out. The
mothers were encouraged to go from the ward, for example, to get their
hair set, if the child's condition were satisfactory. It was made
quite clear to them that because they were living in, they were not
expected to remain in the unit the whole time. One of the units provided a sound-proofed room for a mother and her child, and one could well understand the sense of isolation this must have produced.

Meadows also discussed the nurses' attitudes. He found that without exception all nurses approached were in favour of resident mothers, quoting one sister as saying that no children's nurse would dare to say she wasn't in favour in 1966. However, his findings that 'half the nurses' (actual numbers not given) found it 'less rewarding' and 'more work' having mothers living-in, seemed inconsistent with the statement that they agreed with the principle.

Similar inconsistencies were apparent in the responses that the nurses gave in their questionnaires in the present survey.

Nurses Questionnaires

Deliberately scattered throughout the nurses' questionnaire there were five statements concerning 'living-in' mothers.

If I had a child, toddler or baby, I would wish to stay with him in hospital, regardless of how ill or well he were.

If the mother is there all the time, you cannot get to know the patient properly.

If I had a child, toddler or baby who was in hospital, I would wish to stay with him all the time, if he were very ill.

Most mothers get in the nurse's way.

The mother who wants to live in with her toddler is being unnecessarily fussy.

Only 38% (44) of the nursing staff agreed that they would wish to always remain with their child in hospital. 20.7% of the nurses were not sure. The proportion of paediatric nurses agreeing with this statement (36%) was similar to the nurses employed in general hospitals (39%). (36% (children's) and 39% (general)). However, 76.8% (89) of all nurses agreed that they would wish to stay
if their child were seriously ill. Just over half the nursing staff (51.8%) agreed that if the mother were there all the time one could not get to know the patient properly. 84.5% of the staff disagreed that most mothers got in the nurses' way.

The final statement of this group, that is 'the mother who wants to live in with her toddler is being unnecessarily fussy' was disagreed with by 73.3% of the nurses. Ward H was the only ward in which living-in was practised consistently and the answers given by the nursing staff on this unit in response to these five statements were interesting. These were the only nurses included in the survey who had continuous experience of nursing children whose parents 'lived-in' with them throughout their stay in hospital, there was 100% denial of the suggestion that the mother was either 'getting in the nurse's way' or 'being unnecessarily fussy'. Analysis of the answers given by student nurses confirmed that their attitudes were influenced by ward practice.

On one of the paediatric hospital units offering only hostel-type accommodation, some of the nurses contributed comments concerning the care of the sick child, three nurses suggested that paediatric trained nurses were more likely to take effective care of the emotional needs of the children. Yet these same nurses did not think that a mother should live-in with her child.

'I think it is very important that children must be nursed in paediatric hospitals and by trained paediatric nurses. I do not think this is appreciated at all by any one who has not had any experience in paediatrics. The emotional needs of a child are just as important as the physical needs'.

(Ward A)

'I do not think mothers should be encouraged to stay in the hospital with their child unless he is very ill, or they have travelled a considerable distance'.

(Ward C)
From a general ward a nurse concedes to the practice of living-in, at least in theory:

'I agree with mothers staying with their children, especially if the child cannot speak English'. (Ward E)

Yet another paediatrically trained staff nurse wrote,

'From experience of my own children, they need the certainty of daily visits. 'Constant presence' is not necessary'. (Ward F)

'Mother certainly can be an asset to children in hospital, but again the frequency of their visits and whether they stay with the child throughout his stay, depends largely on the child and the emotional state of the mother'. (Ward G)

'Ideally, there should be more encouragement given to mothers to stay with their children whilst in-patients, especially those under five years of age'. (Ward G)

Finally, three comments from the ward with living-in mothers:

'nursing by mothers excellent idea - exceptionally helpful'.

'Mothers staying in with their children are a tremendous help, especially if the child is not very ill. I think, from the nursing point of view, it is easier to nurse very ill children without the parents present. However, I realise it is a great comfort to the parents to 'live in', even if the child is too ill to realise'.

'I think that allowing parents to stay with their children in hospital is a great asset to paediatric nursing. One is able to get the whole family feeling of the child's illness and we are able to help the parents adapt themselves to help the child in his/her illness'.

Many articles discussing the experiences of personnel on wards where mothers are allowed to live in with their children have appeared, including the following, Frank (1952)(35), Morgan (1955)(84), Hartrich (1956)(37) Hohle (1957)(41) Pattock (1957)(95), MacCarthy (1957)(61), Cavitch (1959)(15) MacCarthy (1962)(62) Moran (1963)(83) Mahaffy (1964)(68), Aufhauser (1967)(6) and Moller (1968)(81). All of the authors have found that it is possible for nurses to adapt
themselves to a situation in which mothers remained on the ward for 24 hours a day.

Summary

On only one of the nine wards were mothers actively encouraged to live in. Although this policy was due to the initiative of the ward sister, the majority of the nurses on the ward were enthusiastic about the practice.

The present study shows that on the whole there is much ambiguity concerning who should be directly responsible for informing parents that living in accommodation is available. Because of this it seems that such information may be withheld from parents. It is primarily a nursing problem, in that the nursing staff are the ones who are directly affected by the constant presence of the parents. It seems logical that the giving of this information should be the responsibility of the senior nursing officer of the paediatric unit.

Question 30

What is the official policy with regard to visiting hours? What does sister think about the official visiting policy in the hospital at the present time?

Question 31

Are there any times when sister prefers the parents not to visit, although officially they may?

'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 —— we recognize that visiting should not interfere with the education or treatment of children in hospital —— 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' as we understand it, means that parents are allowed into the ward at any reasonable hour during the day. —— it does not mean that parents are in the ward all the time'.
On the whole, the responses to the above questions lacked conviction. It had been expected that ward sisters would give the official hospital policy, instead they confined themselves to their own interpretation of this policy. Thus both ward sisters who worked in the hospital used for the pilot study, replied that visiting was from 10 a.m. to 7 p.m., but the less ill school children were occupied between the hours of 9.30 a.m. and 3.30 p.m. and therefore they preferred that they should not be visited during those hours. At the same time, the hand-book given to parents, it stated that visiting 'at all times' was welcomed.

Three other units also recommended avoidance of school hours by visiting parents, while their 'official visiting times' according to the hand-book, were respectively: 10 a.m. - 6 p.m., 9.30 a.m. - 6.30 p.m. and 'any time' during the day.

The literature supplied from two further units stated that visiting arrangements were to be discussed with the ward sister. On one of the two remaining wards visiting was permitted daily from 7 a.m. to 7 p.m. and on the other from 10 a.m. to 12 m.d., and from 2 p.m. to 6 p.m.

When asked their opinions about the official policy concerning visiting most ward sisters said that they were satisfied with the arrangements. One sister thought that 'free' visiting had minor drawbacks but refused to discuss the matter further.

One of the sisters who could in effect dictate her own visiting policy ('in accordance with the requirements of the ward') thought that from her personal view the arrangement was 'fine'. She described her own ward as being open to visitors 24 hours a day, she pointed out that the terms of reference were so vague that the most restrictive visiting hours could be imposed, and she did not think that that was desirable.
All the sisters who had school teachers working on the ward, emphasised that they preferred parents to visit outside school hours, although they would be allowed to come during school hours if they wanted to. Another sister thought it important that the parents did not come during, or immediately after lunch, so that the children were able to rest.

'Visiting on the day of operation' is discussed separately.

Observed Policy

On only one ward did sister appear to impose restrictions of visiting. This she did by issuing a small typed note informing parents that visiting was for short periods between 1.30 p.m. and 6.30 p.m.

Discussion

Table 22 gives a summary of the visiting times on the different wards.

It seemed that no parent would be refused permission to visit his child outside the official times. In some units however the parents were clearly not encouraged to do so. Robinson (1968)(114) in his study showed that mothers who were themselves frightened of hospitals were the ones who seldom used all the permitted visiting time. At the same time they would complain that these visiting hours were inconvenient or too instricted in order to assuage their guilt feelings about not visiting.

In the current study both the numbers of visitors present at any time and the overall pattern of visiting were noted.
Table 22: Visiting Times

<table>
<thead>
<tr>
<th>Ward</th>
<th>'Official' policy</th>
<th>Sister's interpretation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>'as to the requirements of the ward.'</td>
<td>'twenty four hours a day'</td>
<td>No apparent restrictions.</td>
</tr>
<tr>
<td>A</td>
<td>'at all times'</td>
<td>10 am - 7 pm.</td>
<td>Unless child under five years of age or ill, it is preferred that parents visit outside school hours.</td>
</tr>
<tr>
<td>C</td>
<td>'at all times'</td>
<td>10 am - 7 pm.</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>'free visiting'</td>
<td>Any time during the day.</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>10 am - 6 pm.</td>
<td>Any time during the day.</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>7 am - 7 pm.</td>
<td>Any time during the day.</td>
<td>Preferably not after 'lights out'.</td>
</tr>
<tr>
<td>B</td>
<td>9.30 am - 6.30 pm.</td>
<td>Any time during the day.</td>
<td>Visiting much less restricted than official times suggest.</td>
</tr>
<tr>
<td>J</td>
<td>10 am - 12 m'day 2 pm - 6 pm.</td>
<td>Any time during the day.</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>'daily visiting as sister advises'</td>
<td>1.30 pm - 6.30 pm.</td>
<td>Few morning visitors seen.</td>
</tr>
</tbody>
</table>
Table 23 shows the details of observations.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total No. of child observations</th>
<th>Total times a parent was noted</th>
<th>Percentage of time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>7,361</td>
<td>1,153</td>
<td>15.7</td>
</tr>
<tr>
<td>B</td>
<td>8,568</td>
<td>2,105</td>
<td>24.6</td>
</tr>
<tr>
<td>C</td>
<td>7,199</td>
<td>1,003</td>
<td>13.9</td>
</tr>
<tr>
<td>D</td>
<td>12,769</td>
<td>2,046</td>
<td>16.0</td>
</tr>
<tr>
<td>E</td>
<td>15,111</td>
<td>4,234</td>
<td>28.0</td>
</tr>
<tr>
<td>F</td>
<td>12,956</td>
<td>1,912</td>
<td>14.8</td>
</tr>
<tr>
<td>G</td>
<td>9,238</td>
<td>1,498</td>
<td>16.2</td>
</tr>
<tr>
<td>H</td>
<td>9,520</td>
<td>2,865</td>
<td>30.1</td>
</tr>
<tr>
<td>J</td>
<td>5,201</td>
<td>658</td>
<td>12.7</td>
</tr>
<tr>
<td>Total</td>
<td>87,923</td>
<td>17,474</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

The percentage of time that visitors were seen is given. It should be noted that for the purposes of this study it was not necessary for the children to be with their parents, merely to know that they were there. On one occasion during the pilot study several parents were noted to be present in the ward, whilst all the children were playing outside in the hospital grounds!

The pattern of visiting is shown in two graphs in Chapter 5 page 103. The visiting patterns of ward E (highest ratio) and ward J (lowest ratio) are shown. When the graphs for all wards were compared, there was marked similarity of distribution: a small peak (about 11 am)
in the morning, and a larger one in the afternoon. There was
increased visiting during the weekend. Often there were more visitors
than children present - particularly in the evening when both mother
and father visited - their joint presence was marked in the same way
as that of a single visiting parent.

Nurses Questionnaires

Two statements were included in the nurses' questionnaires
which are relevant to visiting:

'The visiting arrangements on this ward are very satisfactory.'

'Paediatric patients do not really need their parents to
visit them at all when they are in hospital.'

It was interesting to see that the answers favouring the
'status quo' were given almost entirely by the student nurses (95.0%)
only three of them not agreeing that arrangements were satisfactory.
The three came from different wards and were training for the general
register. One first year nurse admitted when returning her
questionnaire that she found visitors 'embarrassing'.

Of the second statement five student nurses all from different
wards agreed that the patients did not really need their parents to
visit. (i.e. 7% of the nurses).

Discussion

The National Association for the Welfare of Children in
Hospital, published a report in October 1969 (87) giving the results
of their latest survey into visiting.

In spite of several circulars from the Department of Health
and Social Security (the latest being Hospital Memorandum (69) No. 4
(19)) which recommended the introduction of unrestricted visiting,
N.A.W.C.H. found in their survey that 'free visiting' (defined at a
'modest level' of a minimum of 45 hours per week e.g. 10 a.m. until
6 p.m. with one and a half hours for mid-day sleep) was limited to 57% of hospitals in the South West Metropolitan Region. This contrasted with the Department of Health and Social Security's own figures published in 1967, suggesting that 85% of hospitals were allowing unrestricted visiting to children. The discrepancy in the two estimates is almost certainly due to the different ways in which data was collected. In neither case were the estimates derived from full-time observation on the wards. Referring to Table 22 it can be seen that if the 'official policy' were to be quoted, there would be one hospital in the list which would not meet the N.A.W.C.H. minimum criteria (Ward J). Enquiry at ward level would show a different hospital as falling below the minimum criteria (Ward D). In fact, the wards selected for this survey had (with one exception) much better records of unrestricted visiting than might have been expected from either the surveys of the Department of Health and Social Security, or the National Association for the Welfare of Children in Hospital.

**Question 32** What is a mother who is admitted with her child allowed/encouraged to do?

**Question 33** What is a visiting parent allowed/encouraged to do?

- feed child
- wash child
- bath child
- put him to bed
- get him up
- dress child
- assist with nursing procedures
- undertake nursing procedures
- give medicine
- escort to other departments
- anything else.
Question 34  Are the parents allowed and/or encouraged to be present during medical treatment?

'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'.

(Paragraph 69)

'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, seeing to his toilet, and, on occasion, by holding and comforting him when medical treatment is given'.

(Paragraph 75)

Stated Policy

All nine ward sisters agreed that living-in mothers were allowed and encouraged to feed, wash, bath their child, or get him up and put him to bed. There was more doubt about assisting or undertaking nursing procedures, giving medicine or keeping fluid balance charts, although on the ward on which living-in mothers were observed, they were allowed to do all these things, and were responsible for urine testing if their child were diabetic.

The replies concerning the parents assisting with medical treatment were more cautious.

'It is a good idea, particularly during intravenous infusions'.

(Ward II)

Others were less enthusiastic:

'Certainly allowed, mostly encouraged but not for blood tests, lumbar punctures or dressings'.

(Ward A)

'Yes, if they are here - and, of course, 'sensible''.

(Ward B)

(Sister did not enlarge on what her idea of a 'sensible' parent was.)
'When available'.  (Ward D)

'Yes, but on the whole we do not think it a good idea, it doesn't help'.  (Ward F)

'If the parents want'.  (Ward G)

'allowed, but not encouraged'.  (Ward J)

Observed Practice

As no living-in mothers were seen on seven wards, the answers to the question of what they were allowed to do were irrelevant (using the most conservative estimates of demand for 'living-in', one would have expected to find such facilities being used on at least one night of the survey for one child, if any encouragement were given to the parents to remain).

To a greater or lesser degree visiting parents on all wards were observed undertaking the basic nursing tasks. On one ward the printed slip concerning visiting hours stated:—

'We would appreciate it if parents of younger children would visit at appropriate meal times in order to feed children when possible'.  (Ward D)

Only on ward H were parents allowed and encouraged to be present during medical or nursing procedures. (The observers' opinion in the case of this practice were unanimous.)

On three wards, observers did not see any parents present during their child's treatment. The following comments were made.

'Allowed, but not encouraged, if they are present they accompany their children to other departments - sometimes'.  (Ward D)

'Allowed is the optimum word, they can be there if they don't go home, and as they often don't know what is happening, they do. Not what you might call encouraged'.  (Ward E)

Probably the most pertinent comment was,

'I don't think parents were warned in advance so they could plan if they wished to be present'.  (Ward B)
Discussion

Whilst parents are allowed to undertake most of the 'basic' nursing tasks, there seems an overwhelming reluctance to allow parents to participate in tasks which might be described as technical nursing.

A study by Merrow and Johnson (1968)(75) was designed to determine the degree of accord between the views of the nursing staff and those of the mothers of hospitalized children, concerning the latter's role when visiting their children. A list of 30 items of care was prepared and both the nurses and the parents were invited to state which of the tasks the parents might undertake. Amongst the items for which parents' and nurses' views were described as 'statistically different' (p<0.05), that is items which nurses were unaware that parents were willing to perform, were the following:

- to restrain their children for painful procedures.
- to hold their child for physical examinations.
- to go with their child to X-ray.
- to remain with their child during painful procedures.
- to watch the rate of infusion of intravenous fluids.

The authors reached the conclusion that nurses disliked 'amateurs' 'interfering' in techniques which were thought to require some degree of training.

The sisters' and observers' comments in the present study would bear this out:-

'Suzanne's mother arrived - she was furious to learn that Suzanne was in X-ray for an intravenous pylogram and nobody had told her, so that she could be there'. (Ward B)

On Ward H where mothers were responsible for the keeping of fluid balance charts, and collecting specimens of urine, the arrangement seemed to work without difficulty. A ward sister not included in the survey, suggested to the author that many of those in charge of paediatric wards did not seem to appreciate that if
parents were to care for their children whilst in hospital, they would have to be helped and reassured about the unfamiliar constraints that illness produced. This meant that the senior nursing staff would have to learn to spend time with the parents, and not regard this activity as a 'waste of time' or a 'social nicety'.

If the records from modified activity sampling are compared, it can be seen from Table 24 that the staff of Ward H devoted as much as 5.5% of their time to the visitors.

Table 24: Percentage of time the nursing staff were observed to spend with the parents of the patients

<table>
<thead>
<tr>
<th>Ward</th>
<th>Sister No. of observations</th>
<th>%</th>
<th>All nursing staff No. of observations</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>39</td>
<td>1.6</td>
<td>74</td>
<td>3.14</td>
</tr>
<tr>
<td>B</td>
<td>3</td>
<td>0.1</td>
<td>40</td>
<td>1.4</td>
</tr>
<tr>
<td>C</td>
<td>11</td>
<td>0.4</td>
<td>78</td>
<td>2.8</td>
</tr>
<tr>
<td>D</td>
<td>31</td>
<td>1.0</td>
<td>80</td>
<td>2.6</td>
</tr>
<tr>
<td>E</td>
<td>18</td>
<td>0.7</td>
<td>64</td>
<td>2.4</td>
</tr>
<tr>
<td>F</td>
<td>22</td>
<td>0.8</td>
<td>58</td>
<td>2.2</td>
</tr>
<tr>
<td>G</td>
<td>15</td>
<td>0.4</td>
<td>91</td>
<td>2.7</td>
</tr>
<tr>
<td>H</td>
<td>21</td>
<td>0.6</td>
<td>208</td>
<td>5.5</td>
</tr>
<tr>
<td>J</td>
<td>2</td>
<td>0.1</td>
<td>36</td>
<td>1.8</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>0.7</td>
<td>729</td>
<td>2.8</td>
</tr>
</tbody>
</table>

The time spent 'per child' on Ward H was twice as much on other wards (2.2%). It was on this ward that parents carried out much of the nursing necessary for their own child.
Nurses Questionnaires

Only one statement specifically mentioned the help that mothers could give.

It is very helpful to the nurse if the mothers come every day to look after their own child, toddler or baby.

Although 89% of the nurses agreed that this was so, there were few comments at the end of the questionnaires referring to this:-

'Mother should be encouraged to help look after their own child as much as possible. This not only relieves nurses of work - which, of course, it does, but makes the mother feel that she is contributing towards the recovery of her child'. (Ward G)

'It is an advantage that parents can visit their children any time. It is good that parents can feed their own babies while in hospital unless babies are very ill'. (Ward J)

'I personally think that the mother is the most important person to a child, and she, the only person who can really care for her child'. (Ward J)

No nurse mentioned the comfort a mother could be to her child at times of stress. When the answers given to the questions regarding pre- and post-operative presence of mother are considered, there are indications that nurses nursing in this country might agree with their American counterparts in studies by Merrow and Johnson. (That is that parents don't wish to be with their child pre- and post-operatively.)

Question 35 Are patients allowed to stay with their child
    a) until he goes to theatre?
    b) immediately post-operatively?

Question 36 Are parents allowed to visit on the day of operation?

'We should like to see the restrictions lifted on visiting on operating days. If both 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'. (Paragraph 83)
'It may often be helpful if the mother is allowed to be present until the child goes to sleep ---'.  

(Paragraph 114)

'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-affects of anaesthesia on the child should have been explained to her'.

(Paragraph 115)

'Operations for removal of tonsils and adenoids --- The same visiting arrangements should apply as elsewhere --- 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'.

(Paragraph 125)

Stated Policy

On nine wards visiting on the day of operation was allowed. In two cases the ward sisters preferred that parents telephone before they visited after the operation to make sure it was convenient. All sisters said that parents could visit pre-operatively, although one did not like parents to stay after the pre-medication had been given.

Three of the wards were situated at a considerable distance from the operating theatres, so that children had to be collected by ambulance to go to the pre-operative unit. Parents were not allowed to accompany their children on that journey. Three wards allowed parents to accompany the children as far as the operating theatre suite, but they were not permitted to enter the anaesthetic room.

Post-operatively, children from five of the units usually remained overnight in the recovery suite. Visiting policies in the recovery suites are outside the scope of this study. Of the remaining four wards, parents were allowed to remain on two units to await the
return of their child from the operating theatre, whilst on the other
two, visiting on the day of the operation was restricted until the
evening. (The ward sisters in charge of these units stressed that
the children were heavily sedated and usually slept until the
following morning and therefore did not require their parents presence
at all.)

Observed Practice

It seemed that unless the parents themselves asked to visit
of the day of operation they would not be encouraged to do so. Not
many parents were observed to be with their children immediately
prior to operation, and the majority of parents were those whose
children were to undergo major surgery.

'8.15 am. Nine year old boy awaiting surgery,
looked longingly at Ray (twelve years old in the
next bed also awaiting surgery) whose father was
with him, and said that his dad would have come
with him, but he did not know it was allowed'.
(Ward E)

'Derek, six years one month (appendicitis) for
theatre - very distressed indeed, given pre-
medication - other children watching!'
(Ward J)

It should be stressed that on every ward covered by this
survey pre-medications were given to all children, and most of them
were deeply as asleep before they left for the theatre. On one ward,
where the mothers appeared to stay more often, the sister encouraged
them to cuddle their children following pre-medication, and often the
mother nursed him, sleeping soundly, until he went for surgery. It
was not possible to comment on the visiting policies where children
were cared for in the post-operative suites, but some of the children
were observed to return to the ward accompanied by their parents.

One mother, who was very upset, told the observer that she
had to insist on visiting her son (four years - three months) in the
recovery room before the nurse-in-charge had thought it advisable. Unfortunately, the child had had a very noisy recovery from his anaesthetic and she thought the nurse blamed her for it. The mother felt increasingly guilty about her insistence at visiting, as the child had subsequently had a post-operative haemorrhage, and suffered from wound infection. No effort was made by any member of staff to ease her feelings at all, indeed it seemed quite apparent that they all thought the complications were the mother's fault entirely!

Many of the children slept very soundly on return from the operating theatre, but it would seem that the nurses did not always seem to appreciate the parents desire to see their children after the operation.

Discussion

Schulman et al (1967)(118) found that the child benefitted from his parent's presence. It was easier to anaesthetize him, and he was less worried by the process. The mothers were able to give the child the necessary support and contrary to those conducting the research were not frightened by the induction procedure.

It appeared that in most cases parents were allowed to assume that they would not be needed until early evening, even though the operation may have been scheduled for the morning. One sister remarked:--

'If they are here, they are here, but I'm not going to tell them, am I?'

Nurses' Questionnaires

The following statements regarding the mother's presence pre- and post-operatively, were included in the nurse's questionnaires,
Paediatric patients do not benefit from having their parents present immediately before their operation. (i.e. 'immediately' means until the child is either asleep because of premedication, or is anaesthetized.)

Paediatric patients do not benefit from having their parents present immediately after their operation. (i.e. 'immediately' means when still recovering from the effects of anaesthetic.)

Most parents would be frightened if they were expected to stay with the child immediately after operation, even if the nurse was within call.

The mother can be a great comfort to her child, both immediately before and after the operation.

All 116 questionnaires were included in assessing the responses to these statements. Although 55.5% thought that the child benefitted from having his parent with him until he was anaesthetized, only 39.3% thought there was any benefit immediately post operatively, and yet 69% agreed that the mother could be a comfort to the child before and after the operation. A large proportion of nurses (63.5%) thought that the mother would be frightened to stay with their child immediately post operatively. It is not perhaps surprising that the relevant Platt report recommendations are not widely implemented whilst so many nurses do not believe that the parent's presence is of any benefit to the child, and that in any case they would be frightened if asked to stay.

**Question 37** Is there anywhere for other children to wait while parents are visiting?

**Question 38** Are brothers and sisters ever allowed to visit?

' 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'.

(Paragraph 87)
'Although on 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'.

(Paragraph 85)

Stated Policy

At the paediatric hospital used for the pilot study there were facilities in the hospital grounds including supervision of children at certain times during the day. Wards D and E were said to have adequate facilities for children to wait, but one room was a long way from the ward, and in neither was there any proper supervision for the visiting children.

Two ward sisters said that other children had to wait on the corridor leading to the wards. The remaining ward sisters (three) said that brothers and sisters were allowed to visit, so the need for such facilities did not arise.

When asked whether siblings could visit, two sisters said that this was allowed officially at the weekends. Two others stipulated 'only in special circumstances' if the child were 'long stay' (not defined) and on 'high days and holidays' only, if under the age of fourteen years. Other sisters allowed children in with their parents, but in one case, 'only if they behaved'.

Observed Practice

The decision to allow siblings to visit seemed to be sister's prerogative and only on three wards did there seem to be some stringency about this. Two wards of the H.M.C. hospitals and one of the units in the paediatric hospital used in the pilot study, were particularly strict about this. Otherwise, children were allowed to visit freely accompanied by their parents. This was not without its hazards for the nursing staff!
'Visiting child fainted 5.30 p.m. Staff coped very quietly and well. No fuss'. (Ward D)

'5.30 p.m. Mrs. Q. had great trouble with Richard's brother who has been disobedient during their visit, but finally exceeded himself and threw a small chair at her, and the rocking horse. She was torn between the two children'. (Ward J)

However, these were the exceptions, and the children generally 'fitted in' well. Often it was difficult for the observers to distinguish between them and the patients.

Discussion

The generally liberal policies in allowing siblings to visit appeared in many cases to be the consequence of the lack of adequate waiting facilities, rather than the belief that it was of benefit to the young patient. Only one sister mentioned the hazards of the introduction of infectious diseases, and it was on this ward that the local Guide Company visited on Sunday mornings to 'play' with the patients!

In general the sisters were very kind to the younger visitors, one or two feeding them if they were present at meal times. As one sister remarked:

'What can mum do - we want her here, if she can't park her baby she won't come so we must put up with the baby'. (Ward B)
Chapter 10

Summary

This chapter concludes the section discussing ward policies and the observed practices. 13 questions are asked. Three of these relate to the availability on the wards of ancillary staff - teachers, play leaders and nurses. Four more questions are concerned with the toy supplies and the use of television and radio. Safety measures and toilet needs are considered. Finally five questions about the welfare aspects of medical care are presented and discussed.

Other Aspects of In Patient Care, Education and Play

Question 39 Are there any members of staff to organise the children's leisure activities, e.g. teachers?

'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 reason to believe that the school makes an important contribution to the child's mental health'.

(Paragraph 91)


'Any child over the age of two may be put on the school roll and where there is a large enough group of these children, the educational authorities can provide nursery teachers in addition to teachers for the older children'.

(Paragraph 92)

Stated Policy

Six of the ward sisters stated that there were school teachers working on their wards, of these one was temporarily without
a teacher who was on holiday during the week of the survey. The three wards without teachers on their staff were the paediatric units in Regional Board General hospitals. Wards D, E and J.

**Observed Practice**

The hospital used for the pilot study (Wards A and C) had a well organised school. Although one teacher was allocated to each ward and maintained a general interest in each child's education, there were available 'specialist teachers' who visited the ward on request. This could arise for example if one of the older children needed tuition in French. In addition teachers with special responsibilities e.g. arts and craft, visited the wards once a week.

The children on the 'long-stay' unit also enjoyed excellent schooling facilities in many ways similar to those already mentioned. One unit employed two teachers who worked with the 'up' children in the playroom. On another ward the teacher was also responsible for children in other units not covered by the study. Since she attended a course for two days during the week of observation, her value was likely to have been under-estimated. It was noticeable, however, that she helped the children on an individual basis, usually the older ones, whom she then expected to work on their own until she returned to the unit.

**Discussion**

Whereas for the 'short-stay' child schooling in the hospital enables him to rejoin his own class without having lost ground, the long-stay child without opportunities of proper schooling in hospital may become seriously retarded in his educational development.

In the two wards observed during the pilot study (Wards A and C) the schooling facilities provided were similar. Any child over
the age of two years might attend school. From 9.15 a.m. until 3.30 p.m. (with meal breaks) it was the teachers responsibility to keep the children occupied. The sister on Ward A did not consider children under the age of five years ready for school. They remained in the 'toddler' section of the unit, and nurses were delegated to play with them.

In contrast, on Ward C, all children over two years were included in the school group leaving the nurses free to carry out their other tasks. The value of this system seemed to be questionable, since the young children were unable to benefit when the teacher was occupied with the other children up to the age of twelve years. These younger children often appeared to be very miserable. It was because of this, that it was decided for the purposes of this survey, that activities of children under school age (five years) during the period of observations were not to be coded 'S' (school), but the codes describing their whereabouts and mood were to be used.

One of the very real problems which was apparent on three of the units which had schooling facilities was the difficulty the nursing staff found in arranging their work. On all three wards the children were expected to be ready for school by 9.15 a.m. However on ward A the nurses rushed through their morning tasks with bath times often being reduced to an absolute minimum, and breakfast being served immediately each child was washed and dressed. Any technical nursing tasks were also completed as far as practicable by 9.15 a.m., at which time the nurses left the main ward and disturbed the children as little as possible whilst they received their schooling. Only in cases of real need, were the children withdrawn from the ward for their special treatments.
On Ward C, the sister did not attempt to have many of the children bathed, as, with the more time consuming nature of their treatments, it was hardly possible to complete them by 9.15 a.m. After 9.15 a.m. the nurses were left with the major dressings to do. While the nurses on Ward A who played with the younger children were occupied, many of the nurses on Ward C found that during the school period they were underoccupied and many of their allotted tasks were completed more slowly.

On the long stay unit (Ward F) nursing duties appeared to take undue priority over schooling, so that the children and the teachers were interrupted more frequently than was perhaps desirable from an educational point of view.

A compromise which might have helped to solve this dilemma of ward routine would be for the 'over fives' to be prepared for school, but the 'under fives' left until later, when a more leisurely nursing care could then be given. This would have meant that the nurses' work was more evenly distributed and schooling less interrupted.

The teaching staff in this long stay unit provided not only the stability of a daily routine, but more importantly being permanent members of staff often ensured the badly needed continuity of care. Although the observers did not make any written comment about the school on the long-stay ward, they were all very impressed by the teachers' devotion to their work, they were often observed to be on the ward in the early evenings talking to various children. The two teachers had a helper (a student) who was specifically responsible for the younger patients who joined in group activities whenever possible.

The fourth ward (Ward G) with good teaching arrangements was the only one of the four to have a separate playroom. The children who were well enough to go to the playroom did so. This meant that
the bed patients did not enjoy the communal activities which were available in the other three wards. Although it is not suggested that their needs were ignored, they appeared to derive less benefit from the teachers presence on the ward.

'The teacher set up a telephone system running from the playroom to the ward where the children were allowed to speak to each other'. (Ward G)

Activity Sampling

The importance of the part played by the school periods in the general ward routine is shown in the following table, the construction of which is self-explanatory.

Table 25: Estimated percentage of time in which the children over the age of five years were occupied by school activities

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total No. of observations of children over the age of 5 years</th>
<th>School observations</th>
<th>Percentage of total time</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5,506</td>
<td>686</td>
<td>12.5</td>
</tr>
<tr>
<td>B</td>
<td>5,916</td>
<td>52</td>
<td>0.9</td>
</tr>
<tr>
<td>C</td>
<td>2,716</td>
<td>444</td>
<td>16.3</td>
</tr>
<tr>
<td>D</td>
<td>4,617</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>E</td>
<td>6,372</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>F</td>
<td>8,598</td>
<td>1,022</td>
<td>12.1</td>
</tr>
<tr>
<td>G</td>
<td>4,128</td>
<td>502</td>
<td>12.2</td>
</tr>
<tr>
<td>H</td>
<td>4,860</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>J</td>
<td>3,157</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>45,870</td>
<td>2,708</td>
<td>5.9</td>
</tr>
<tr>
<td>Mean</td>
<td>5,096.7</td>
<td>300.9</td>
<td></td>
</tr>
</tbody>
</table>
Question 40  Are there any members of staff to organize the children's leisure activities e.g. play leaders?

'If occupational therapists were able to devote more time to this kind of work, they could not only organize play but instruct other helpers in this important aspect of child care'.

(Paragraph 40)

'----- 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 organized under skilled supervision it is particularly useful'.

(Paragraph 99)

Stated Policy

One ward had a full-time play leader whilst another had a student teacher whose function was to occupy the 'under fives'.

Of the regional board hospital wards, one had a group of voluntary play leaders who visited the ward for a few hours each week, whilst another had a Save the Children Fund play group leader provided on a part-time basis.

Observed Practice

The 'full-time' play leader (approximately 9 a.m.-5 p.m.) appeared to keep the 'up' patients well occupied. She provided activities for the 'bed' children but unless they were older they could not often sustain interest when left to amuse themselves. However, her contribution to the ward was very valuable. The voluntary play leaders provided amusement for the 'bed' children but were on the ward for a very limited time during the week of observations.

The ward with the 'Save the Children Fund' play group leader had been selected for this reason. The leader was on the
ward for two hours each afternoon, it was perhaps unfortunate that
the leader had one afternoon off during the week of observations,
and her presence was only observed for a short time.

Discussion

Noble (1967)(91) discusses at some length the importance of
play for the young child, quoting from many sources. In her introduction
she states:--

'The child at home and in the nursery school
demonstrates very clearly his need to express
his tensions, frustrations and dissatisfactions
in a physical manner through his play materials,
very often in an aggressive way. If the child
at home behaves in this way under emotional stress,
what can he substitute in hospital, when activity
is reduced to a minimum?
If hospitals are to undertake to care for the
whole child, physically, mentally and emotionally
they should surely provide suitable play facilities,
supervised by an understanding adult, as an integral
part of their treatment'.

(Chapter 1, p. 13)

Only two wards employed such people and one other ward
depended on voluntary help for two sessions a week. The play leaders
appeared to be younger and less experienced in providing occupation
for the children, when compared with the teachers. Bedfast children
on the ward did not benefit as much as the children who were able to
get up and join the others in the playroom. The voluntary helpers
who were in charge of the play on one ward, seemed to concentrate on
amusing the child in bed, but their presence seemed to contribute
more to the child's comfort than to his entertainment.

The part-time play leader had a well equipped playroom, but
unfortunately she was only available from 2 p.m.-4 p.m. The
children's tea was served during her time there, interrupting the
organized play, often to such an extent that children failed to return
to the playroom after the break. Two observers commented on this,
'Play lady each week day afternoon from 2 p.m.-4 p.m. but whole time not utilized because of tea at 3 p.m.'.

'Play leader two hours per day - but only Monday, Tuesday, Wednesday and Friday this week - but tea in this time therefore used at most one and half hours'.

Question 41 Are there any members of staff to organize the children's leisure activities e.g. Nursery nurses?

'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 five years of age'.

(Paragraph 39)

Stated Policy

Only three wards (Wards F, G and H) employed nursery nurses (one ward having two). Their function seemed to be rather vaguely defined with the umbrella term 'to look after the little ones'.

Observed Practice

The nursery nurses were included in the modified activity sampling exercise as they were considered to be very much a part of the nursing team. Of the four nursery nurses included in the study, the work patterns of three of them did not differ materially from the work patterns of the junior nurses. It is interesting to compare the way the four nurses spent their time - see table 26.
Table 26: Comparison of the work pattern of the four nursery nurses in the study

<table>
<thead>
<tr>
<th>Nursery Nurse</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Basic Nursing Care expressed as a % of total time</td>
<td>43.6</td>
<td>54.0</td>
<td>53.0</td>
<td>13.65</td>
</tr>
<tr>
<td>Total Technical Nursing Care (as a % of total time)</td>
<td>17.4</td>
<td>6.0</td>
<td>6.7</td>
<td>1.15</td>
</tr>
<tr>
<td>Total Extra Nursing Care (as a % of total time)</td>
<td>13.3</td>
<td>7.0</td>
<td>10.7</td>
<td>55.60</td>
</tr>
<tr>
<td>Total Domestic (as a % of total time)</td>
<td>5.7</td>
<td>20.5</td>
<td>12.7</td>
<td>15.75</td>
</tr>
<tr>
<td>Other</td>
<td>20.0</td>
<td>12.5</td>
<td>16.9</td>
<td>13.85</td>
</tr>
<tr>
<td>Total time</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.00</td>
</tr>
<tr>
<td>Total No. of observations</td>
<td>263</td>
<td>200</td>
<td>206</td>
<td>197</td>
</tr>
<tr>
<td>Extra Nursing Care in minutes per hour</td>
<td>8</td>
<td>4.2</td>
<td>6.4</td>
<td>33.4</td>
</tr>
</tbody>
</table>

N.B. Extra or professional nursing care is defined as that care which is not essential, the extra cuddle, playing with, talking to or comforting a child.

Discussion

There appeared to be some misuse of the nursery nurses special skills, the following comments concern the same nurse.

'The nursery nurse spent most of the afternoon 2-3.30 p.m. talking or playing with the younger children and babies, with very good response - laughter, smiles and playfulness'.

'Nursery nurse busy ironing baby clothes and children's clothes'.

(Ward F)

One of the four nursery nurses was not happy working within the hospital environment:

'I find working on the paediatric ward very nerve wrecking and cannot relax at all because I think I am so used to normal children'.

(Ward G)
One nursery nurse was very forthright in her comments:

'I feel that here several tasks e.g. ironing washing clothes etc. could easily be done by the domestic staff, leaving the trained (nursery) nurse more time for the job she has been employed for. Sometimes I feel I cannot give the child a quarter of the attention and understanding they need, as there are several jobs I know have to be done'.

(Ward F)

Certainly it is a waste of valuable training that jobs such as ironing or washing clothes should be given to a nursery nurse. On one ward the nursery nurse always made up the bottle feeds for all those on the ward requiring them, this accounted for nearly 7% of her time.

Noble found in her survey that nursery nurses employed for general child care duties did not spend very much of their time attending to the children's play needs. She was not sure whether this was because they had too much to do, or because they themselves were unaware of the children's need for play. Perhaps more thought needs to be given to why nursery nurses are to be employed on paediatric units. If their function is to include play, their time must not be allowed to be misused because of pressure of other, more routine duties.
Table 27: Location of employment of teachers and nursery nurses during the week of observations

<table>
<thead>
<tr>
<th>Ward</th>
<th>Full time Teacher</th>
<th>Part time Teacher</th>
<th>Full time play leader</th>
<th>Part time play leader</th>
<th>Nursery nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>G</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>H</td>
<td>*</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

* Teacher away on holiday.

Question 42 Is there a plentiful supply of toys readily available?

'Periods of unorganized play will not be constructively used unless children are provided with something which they are allowed to play with during their free times'.

(Paragraph 100)

'For younger children a variety of suitable toys is essential'.

(Paragraph 101)

Stated Policy

Five ward sisters agreed that they had plentiful supplies of toys, one thought that her supply was 'adequate'. One ward sister wanted more constructional toys, whilst the remaining two sisters thought they were generally short of toys.
Observed Practice

The observers agreed with the ward sisters' assessment of the adequacy of their toy supply. On one ward, however, the observers noted that although the toys were there, they were not used properly.

'Yes, but not put out or utilized'. (Ward D)

'Yes, but locked up and used only when the play lady present'. (Ward J)

Discussion

The toy supplies were particularly good on the units in paediatric hospitals, and on the wards which had teachers and play leaders. Many of the toys seen on the wards appeared to have been donated, and often were not the most suitable, being too easily broken. Two wards did not use the toys they had, the toys appeared neatly stacked and were not seen to be distributed to patients confined to bed.

A few comments were made by the observers concerning the children's play with toys.

'1.25 p.m. Children using the rocking horse on the corridor. Children outside on the balcony playing with the tricycles'. (Ward D)

'Richard and Edgar entirely on their own without toys or any activity after breakfast'. (Ward D)

'Small children not provided with any toys during the morning'. (Ward E)

'Individual children played with, but variety of occupation not initiate for the rest'. (Ward B)

'New child, David, not given anything to play with, bored stiff'. (Ward J)
'1.45 p.m. Children very noisy and excited after lunch (rest time) thoroughly bored - developed a running up and down the ward race - tempers got frayed - children upset and one or two shouting. 2.15 p.m. staff nurse deflated them all on her return from lunch, they returned to 'rest'. After this no attempt was made to give the children something interesting to do, after a while they started a running game round the beds, taking each others fruit - if only there were some decent toys'.

(Ward J)

In fact this last incident concerned a group of older children who were all approaching their day of discharge, and were full of energy for which there was no real outlet. On the wards which encouraged the children to go outside, all these children would have been free to do so earlier in the day and probably would have been more content to rest on their beds. Without interesting toys and any outlets for their energy, it was perhaps unrealistic to expect seven to twelve year olds to 'rest' during the middle of the day, even though they were convalescent.

Several wards in the survey, would have been very grateful if they had the help from their 'League of Friends' or other voluntary bodies, to raise money to provide appropriate toys for their young patients - as the Platt report suggests:-

'Voluntary organizations such as 'Leagues of Friends' can often help with the supply of these (toys) 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'.

(Paragraph 101)

Question 43 Is there a television set and/or radio available for the children?

Question 44 Are these situated so that the more ill patients are undisturbed?

'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.  

(Paragraph 101)

**Stated Policy**

Radio and television were available on all the wards covered by the survey. On seven wards the more ill patients were not near the television or radio, whilst one of the remaining two sisters suggested that children, in any case, were not 'aggravated' by noise.

**Observed Practice**

On one ward the television set was not working throughout the period of observation. On some wards the television sets were moved to the playroom so that the bedfast children were prevented from viewing. On occasion, the sets were moved nearer to them with the result that the 'up' children had to crowd round the bedfast children.

**Discussion**

Most of the observers commented on the indiscriminate use of television, once someone remembered to turn it on, it often remained on until bedtime. No one seemed to be interested to find out when the programmes began and turn the set on at the beginning, and, even more frustrating for some of the older children, an interesting programme might be turned off before it had finished.

Often the quality of the picture was poor and for many of the children located further away from the set, the programme was hardly audible due to the general activity on the ward.

The observers made several comments about ratio and television:
'Wireless playing continuously in the toddlers' ward, adding to the general cheerfulness'.

(Ward A)

on another ward an observer remarked:-

'No radio or television on today, the ward is very quiet'.

(Ward B)

'Alison would like to watch television, but it is in the next room (having been moved from the playroom), nobody watching it - yet she is the only patient at the moment who has to stay in bed'.

(Ward B)

'5 pm.-7 pm. T.V. is a very definite asset, children all very interested'.

(Ward D)

'Vernon wheeled in his bed to the playroom at supper time in order to look at T.V.'. (Ward D)

'5.15 pm. Dr. Who. Great inflex of children and parents around the T.V. set'.

(Ward E)

'Karen's father organized the T.V. set at 3 pm. - horse racing!
Some of the following programmes were not very suitable for children. They took little interest in them. Pop Eye sustained a far larger audience'.

(Ward E)

'Programme on telly about crystal and its properties. How to cut it etc. - kids aren't too impressed. Not being watched at all'.

(Ward E)

The daytime programmes for the younger children never appeared to be switched on. Television was obviously very popular but more consideration needs to be given to the size of screen and quality of the picture. This is particularly important when the set is situated in the main ward, where all the children should be able to see it properly.

Safety Measures -

Question 45  Do you use restrainers?
If so, on what occasions?
Who decides, and what are the deciding factors about whether or not a child is nursed in a cot or a bed?

'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'.

(Paragraph 104)

Stated Policy

Three ward sisters stated that they never used restrainers. On two units restrainers had to be ordered by the medical staff, and written instructions to that effect made on the patient's notes.

Two ward sisters said that they were rarely used, one could only remember one incident within the last four years of an exceptionally aggressive child being restrained. The other stressed that the restrainers were never used as a punishment for naughtiness or difficult behaviour. She suggested that they might be used very occasionally to restrain a child who had had a plaster applied and had to remain still until it was dry. On the eighth ward, restrainer jackets were used with the toddlers because 'the height of the cot rails and the width between the bars did not conform with Ministry regulations'. On the last ward, restrainer jackets were never used, 'only cot nets'.

On three wards the decision concerning whether or not a child
should sleep in a cot or a bed was dictated by hospital policy. All children below the age of five years were to be nursed in cots. On the remaining six wards the decision was left to the ward sisters who generally took into account the child's age, his physical well-being, and sleeping habits at home.

**Observed Practice**

On only two wards were restrainers seen to be used. An active two and a half year old boy with a 'gallows traction' was nursed in restrainers. A six year old girl with aggressive post epileptic behaviour was nursed in a cot covered by a net.

**Discussion**

Sometimes children were admitted when sister was off duty, often by the night staff. It seemed that the younger and less experienced staff were more likely to admit under five year olds to cots, and once a child was 'allocated' to either a cot or bed, he remained there unless a general redistribution of beds and cots became necessary because of the age of further new admissions. The use of a cot net was generally decided upon jointly by the medical and nursing staff. One observer wrote,

'Sarah managed to climb through the net that has been fixed over her cot. She screamed and fought as she tried to get out again. Visitors seemed horrified by the sight'.

(Ward E)

It should be noted that the ward was short of staff on several occasions. Possibly with more generous staffing it would have been more satisfactory to assign a 'special' nurse to attend to this child through the difficult phase of her illness.

Several sisters mentioned the difficulty of making the decision of 'cot or bed'. One sister remembered her own experience
of being nursed in a cot when she was admitted to hospital as a child of six. Because of this experience, she never admitted into a cot any child who was used to a bed at home. Another sister remarked that the conflict experienced with the three and four year olds between the safety and the legal consequences of disaster through adhering to the custom at home was 'nobody's business'. She felt that this was a conflict that would never be solved until she retired. It should be remembered that children's beds in hospital are generally much higher than their domestic counterpart, which adds to the ward sister's difficulty in making a decision.

Toilet Needs

Question 46  How are children in cubicles able to contact the nursing staff? e.g., for a bedpan.

Question 47  Are screens provided for children using bedpans, if they wish?

'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 this first few days, before they get to know the nursing staff ——— 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 need, and this causes very great discomfort and unhappiness'.

(Paragraph 107)

Stated Policy

In none of the nine units were the children in cubicles provided with any means of communication. One sister said that older children in cubicles were provided with a hand bell and one nurse was made responsible for their welfare. Two ward sisters
stated that they kept 'close watch' on all children, whilst two others stated that regular toilet rounds were done. On one ward a bedpan was left in the cubicle if necessary! As one sister frankly admitted:

'They shout or call, there are no electric bells and no nurse has special responsibility'.

(Ward B)

and one said:

'they yell and fortunately we are usually in the ward to hear them'.

(Ward E)

None of the wards was provided with curtains, but all had at least three or four screens. Of the nine ward sisters, seven stated that screens were used to ensure children's privacy. In the remaining two wards screens were provided 'if children wished' on one, while on the other, children's beds would be wheeled into the bathroom to ensure privacy, 'if the child asked'.

Observed Practice

Most children got up or were carried to the toilet. Those who used bedpans formed a very small group on most wards (the 'long stay' ward being an exception). No children in the cubicles were ever observed to be issued with bells.

Some of the observers' comments regarding 'means of communication' were quite revealing:

'no system at all, children seen 'holding themselves''

(Ward B)

'shout, if they are old enough'

(Ward D)

'shout and cry - then they don't get heard'

(Ward G)

'signal through the window - but not always noticed straight away'.

(Ward H)

Only on one ward did all observers agree that the older children were always provided with screens. On the other wards this was not observed to be a regular practice.
Discussion

The inadequacy of means of communication between the patients and the nursing staff was commented by the observers. They recorded several incidences when they had seen children trying to attract attention unsuccessfully:

'David, trying desperately to call a nurse unsuccessfully - one finally went to him, after about half an hour'. (Ward B)

'Mahid, having an attack of asthma extremely distressed, nurses completely oblivious'. (Ward D)

'Sharon crying for nurse for eight minutes wanting bedpan, finally given by a visitor'. (Ward E)

'Nicholas shouted and cried 'I want to go to the toilet'. Three nurses heard but finished what they were doing, five minutes or longer before one went to him, by which time he was really distressed'. (Ward E)

'Screen used to give a bottle to David'. (Ward J)

later, referring to the same child:

'Given a bottle during supper time, no screens used'.

It would appear that communication from a cubicle (and even within the ward) can be difficult, and in the nine wards covered by the survey, the means adopted were frequently insufficient. One sister suggested that electric bells would be misused, particularly by the younger children.

Many of the sisters - as well as two or three of the observers - obviously felt that placing screens round the bed when a child was using a potty or bedpan was a nicety, rather than a necessity, and inclusion of this question in the schedule caused much discussion. One sister thought it ridiculous, saying that they were 'only children'. She pointed out that the young ones never complained, then later she recalled how surprised she had been because one of the eight year old girls (confined to bed) had said she didn't like
When one considers that children from a fairly early age, are encouraged to whisper their request to go to the lavatory and are told 'to close the door', it seems a little odd that it is so freely and unquestioningly accepted that children in hospital do not require privacy in this way.

Cartwright (1964)(14) and Raphael (1962)(100), (1969)(101) have demonstrated that 'lack of privacy' is one of the complaints often made by adult patients, particularly during bedpan rounds. Two sisters in the survey considered that the fitting of ward curtains, to enable efficient screening of the children, would be an extravagance.

This topic was discussed with the Director of Education of a large group training hospital, who kindly checked the use of the curtains on the paediatric unit.

Some of the following uses were mentioned: to allow the smaller child to rest; to give privacy for nursing procedures, (for example a bedbath); to give privacy for toilet needs; to allow the pre and post operative children to remain undisturbed; to enable the older children to read in peace!: The more seriously ill patients could remain in the ward, but could quickly be 'isolated' without disturbance. Finally, the sister said that the little ones liked to play house!

One observer during the present survey remarked the quality of the screens:

'The screens are old wooden ones, and extremely heavy to carry, and it is not surprising that they are only used if the patient asks'.

Welfare aspects of medical treatment

Question 48 If a child is to undergo special treatment is he told by either the nursing staff or the medical staff what is to happen?
Question 49
Where are special treatments carried out, at the bedside or in a treatment room?

'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 to happen'.

'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 then do not have to take place in the presence of other children'.

(Paragraph 112)

Stated Policy

All ward sisters considered that it was the nurse's responsibility to explain to the children the nature of their treatment. Two thought that the onus lay with the senior staff, but the rest expected all the nurses to do this. One sister remarked:

'Yes I encourage the nurses to tell the children, and I really think that they do'.

On one ward older children were told beforehand, whilst the tiny ones were told by the nurse as she picked them up to carry them to the treatment room. Whenever practicable the child's favourite nurse was instructed to stay with him. One sister pointed out that the child was always accompanied by a nurse, however long his treatment took - even if this involved hours in another department. (e.g. special X-ray procedures) or even another hospital.

All wards had treatment rooms. Four sisters said that they were used 'as far as possible'. On another three wards they were said to be used in every case. As one sister remarked:
'treatment room always - it's over my dead body that those nurses will go into the ward to do things like that'.

(Ward C)

On the remaining two wards the sisters were less insistent about the use of the treatment rooms. One of them probably because it was physically not possible to move the beds into the treatment room, and the other feeling that if the child found it less stressful to remain in the ward, this should be taken into account. Thus he might be allowed to remain in the ward for a straightforward dressing, but not for a lumbar puncture.

**Observed Practice**

This aspect of ward practice was not easy for the observers to see. An observer could only comment if she had seen and/or heard a child receive an explanation, or conversely observed him being moved without receiving one. There was only one ward (H) on which all three observers agreed that the children were told about their forthcoming treatment. On four wards all observers merely marked the question 'not observed'. On a further ward a ten year old boy was observed to be approached by a hospital porter, unceremoniously 'dumped' on a trolley and wheeled off towards the door, where a nurse stopped the porter to speak about some other matter. As the trolley was wheeled past the observer, she asked the child where he was going and why? The boy did not know the answers to either question.

Another observer commented:

'Samantha (aged four years ten months) appendectomy. Samantha had sutures removed today - a very traumatic experience, as nobody had told her that she had had an operation (neither parents nor staff) let alone what having stitches out was like'.

(Ward E)

The quotation from the Platt report stating that 'children's anxieties may seem fanciful, but they are none the less real to the
child' was upheld by the following entry made by one of the observers:

"Yesterday, Dick (aged nine years) was having blood taken for an estimation of sedimentation rate (a regular procedure for him). He told the nurse that he hated having his blood taken away, to which the nurse replied that it was only the same as an ordinary injection. Dick replied, with some vigour, that it wasn't at all - an ordinary injection was putting something in to make you better - the other sort took away your body and:-- I might get weak and die, -- at which the nurse giggled and walked away".

(Ward A)

Discussion

The treatment rooms were used for nearly all treatments and procedures. On two wards blood transfusions were started there, and the child then moved back into the ward. On another ward the transfusions was observed to be started and continued in the ward.

In some wards the doors leading to the treatment room were too narrow, and as a result, because of this limitation bedfast children could not be moved there. Three comments concerning the use of treatment rooms were made by observers, all relating to different wards:

"Stephen (aged two years) taken off gallows traction. This was done in the ward without screens being placed round the bed. He was very distressed throughout, and wasn't helped by the audience of five, who clustered round the bed to watch".

(Ward D)

"Paddy and Susan watching Norman's padding, bandaging and tension weights being painstakingly redone by a medical student. Fortunately a nurse was with Norman, who seemed to benefit greatly from her presence - though not the other children's".

(Ward G)

"Paul - new ill admission earlier this morning - had blood taken for blood culture in front of six other children - two of them, Helen and Margaret, both new admissions, did not like watching at all and moved away. The nurse did not appear to give Paul any comfort - she was standing staring into
space — although she told him at the completion
he had been a good boy. The small bottle of blood
was very much in evidence and Paul looked distressed.
No screens were used'.

(Ward J)

Question 50 Are the children undergoing surgery separated
from the others pre-operatively?

Question 51 Are they separated post-operatively?

Question 52 Are children returned from the theatre unconscious,
semi-conscious, or conscious?

'——— 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'.

(Paragraph 113)

'Operations for removal of tonsils and adenoids
——— special care should be taken that children
awaiting operation do not see those returning from
the operating theatre'.

(Paragraph 125)

Stated Policy

On the three pavilion-type wards (Wards A, C and F) pre­
operative medication was usually given to the children after they
had left the ward. Post-operatively the children generally remained
on the recovery units at least overnight. Thus they were separated
both pre- and post-operatively.

On other wards pre-operative medication was given on the unit,
they remained in post-operative suites on some units only if they had
undergone major surgery. Children on three units might return to the
ward with the airway still in position.

Observed practice

The observers confirmed the information given by the ward
sisters.

Discussion

In Paragraph 113 of the Platt report reference is made to
children remaining in sight of other children whilst they were being
anaesthetized or recovering consciousness immediately after the anaesthetic.

In the current study children were not always separated by screens after premedication, but all left the ward before receiving their anaesthetic. Post-operatively, all the children with airways in position were in beds surrounded by screens and often screens were placed by the beds of the children who had returned without airways in position.

The following comments were made:

'Patients for theatre are given pre-med by night nurses, so that they are asleep by the time they leave for theatre'. (Ward D)

'Deborah taken to operating theatre by nurse, still hugging her teddy bear - which was returned later by theatre staff'. (Ward E)

Whilst the standard of care overall was good, there were one or two comments from the observers that showed some thoughtlessness.

'Theatre packs prepared at 5 pm. and left by the beds of the children who are for theatre tomorrow, children concerned to know what the packs are for, but they did not receive any explanation'. (Ward J)

'Tony aged five years, very upset about wearing a 'night gown' (i.e. theatre gown). Wanted to wear pyjamas, cried bitterly'. (Ward J)

It appeared quite unnecessary to leave theatre packs by the childrens' beds until they were needed, and it would have been in order to remove pyjamas after the pre-medication was given rather than allowing the child to get so upset.
SECTION 4

Analysis of answers to sisters questionnaires.
Validity of Check List.

Chapter 12. Educating the Nurse.
Method of observing practice.

Chapter 13. Criticisms, Results, Conclusions and Recommendations.

Bibliography.

Appendices.
Chapter 11

Summary

The information gained from the sisters and the observers relating to ward practice is summarised into table form (table 28). Using some of the questions based on the Platt report, a tool for assessing the quality of care in a paediatric unit is presented. The validity of this form is shown by ranking the nine ward scores with the results of the different categories found in the modified activity sampling of nurses and children. The statistical significance of the ranking order when compared with the amount of 'extra' nursing care given, and the percentage of misery observed, is calculated by using Spearman's co-efficient - the co-efficient of ranked correlation. The correlation is demonstrated visually by means of a graph.

Development of a tool for assessment of quality of nursing care

At the outset of this study it was anticipated that the answers given by the sisters relating to their ward practices (see sisters Interview Schedule Appendix 6) would form a basis for the development of a means of assessing the quantity of nursing care on paediatric wards. The questions in the schedule were designed to reveal the degree of compliance with the recommendations contained in the Platt Report on the nine paediatric wards. The study itself, involving seven days of continuous observations by trained observers, was designed to reveal how the nurses spent their time and how far the emotional well-being of children who were nursed on these wards were considered. If the answers to the sisters interview schedule could be shown to have a definite relation to the children's emotional
well-being, the schedule itself would then be accepted as a main
criterion of the quality of care.

However, it became apparent during the pilot study, that
there was a disparity between what the sisters stated as being the
'ward policy', and what appeared to be the ward practice. (The extent
of this has been discussed in the preceding four chapters of this
survey.)

Because of this disparity between policy and practice, it was
decided to ask the study observers to answer the same questions in
accordance with their own observations on the wards. The results
obtained are presented in Table 28. It will be seen that an answer
to each question for each ward was entered in one of five available
columns, ranging from 'always' (column 1) to 'never' (column 5) as
shown.

Answers given by the ward sisters (stated policy) were marked
with a symbol '1' and those given by the study observers (observed
practice) were marked '0'.

With few exceptions, the classification of all the answers
into the five categories shown in the table presented no difficulty.
For example, the question:--

'Is there a playroom for the children? If not, do you consider
it desirable?' could be answered for the first part 'Yes' (always)
or 'No' (never). Whether it was desirable or not, was marked according
to the ward sister's opinion, which again was very firmly stated.
(See Chapter 7.)

Other answers were not so straightforward. For example,
consider the following question:--

'Are the parents seen separately from the child at the time
of his admission?'
### Summary of the Results of Comparison Between the Stated Policy and the Observed Practice on the Nine Paediatric Wards

<table>
<thead>
<tr>
<th>Question (Abbreviated Form)</th>
<th>Always (1)</th>
<th>Usually (2)</th>
<th>Depends (3)</th>
<th>Not Often (4)</th>
<th>Never (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are children used in accordance with ward recommendations?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>2. Are operating procedures observed?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>3. If there is a separate playroom on the ward, is it used?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>4. Do you consider a separate playroom desirable?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>5. Is the division of charge responsible (for admitting the child) R &amp; C?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>6. If the child is admitted to the same ward he or she had before admission, is there a separate space for the child?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>7. Is there a different level of care for the child during the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>8. If there is a different level of care, is it used?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>9. How many nurses are present each day?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>10. Are these times when visitors are not allowed?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>11. Can a child keep his/her toys from home?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>12. Is the child admitted to the same ward?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>13. Is there a separate place for the child before the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>14. Are parents allowed to stay for the preliminary medical examination?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>15. Can the admission stay up, if well enough?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>16. Is the child admitted to the same ward he or she had before admission?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>17. Are parents allowed to wear their own bath clothes?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>18. Are children allowed to have their own toys?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>19. Can a child keep his/her personal habits?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>20. Are parents allowed to stay for the routine medical examination?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>21. Is there a different level of care for the child during the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>22. If there is a different level of care, is it used?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>23. How many nurses are present?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>24. Are these times when visitors are not allowed?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>25. Can a child keep his/her toys from home?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>26. Is the child admitted to the same ward he or she had before admission?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>27. Is there a separate place for the child before the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>28. Are parents allowed to stay for the routine medical examination?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>29. Can the admission stay up, if well enough?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>30. Is there a different level of care for the child during the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>31. If there is a different level of care, is it used?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>32. Are parents allowed to observe the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>33. Are the parents present immediately after the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>34. Are parents allowed to visit on the day of the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>35. Is there a separate place for the child to wait?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>36. Are children allowed to visit?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>37. Are these times when visitors are not allowed?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>38. Can a child keep his/her personal habits?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>39. Are parents allowed to observe the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>40. Are parents allowed to observe the operation?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>41. Are these times when visitors are not allowed?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>42. Can a child keep his/her personal habits?</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
</tbody>
</table>

**Key to Symbols:**
- **Stated Policy)**: A
- **Observed Practice**: B

**Summary:**
- **Always (A)**: Always observed
- **Usually (B)**: Usually observed
- **Depends (C)**: Depends on the situation
- **Not Often (D)**: Not often observed
- **Never (E)**: Never observed
Replies were categorized in the following way:-

<table>
<thead>
<tr>
<th>Ward</th>
<th>Comment</th>
<th>Considered to be:</th>
<th>Column No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward A</td>
<td>'Usually before they go.'</td>
<td>Usually</td>
<td>2</td>
</tr>
<tr>
<td>Ward B</td>
<td>'Not usually, in fact very unusual to.'</td>
<td>Not often</td>
<td>4</td>
</tr>
<tr>
<td>Ward C</td>
<td>'Sister or senior nurse tells them things with the child - but often sees them separately.'</td>
<td>Usually</td>
<td>2</td>
</tr>
<tr>
<td>Ward D</td>
<td>'Yes, in the Out Patients department and after admission of the child.'</td>
<td>Always</td>
<td>1</td>
</tr>
<tr>
<td>Ward E</td>
<td>'Nurses see parents, but not usually separately from the children.'</td>
<td>Not often</td>
<td>4</td>
</tr>
<tr>
<td>Ward F</td>
<td>'Senior nurse admitting the child sees the parents but not usually separately.'</td>
<td>Not often</td>
<td>4</td>
</tr>
<tr>
<td>Ward G</td>
<td>'Yes. It's difficult to, at times, but it is important.'</td>
<td>Usually</td>
<td>2</td>
</tr>
<tr>
<td>Ward H</td>
<td>'Sometimes if necessary, but I prefer to wait until the parents have settled before saying anything critical.'</td>
<td>Depends</td>
<td>3</td>
</tr>
<tr>
<td>Ward J</td>
<td>'Yes I see them.'</td>
<td>Always</td>
<td>1</td>
</tr>
</tbody>
</table>

In these examples the number following each of the comments indicates to which of the five columns the answer was designated. Columns 1 and 2 denoting 'always' and 'usually', show compliance with the Platt report recommendations, 'depends' or 'as necessary' were designated to column 3 and considered as 'neutral' comments. The remaining two columns show either significant (column 4) or total disregard (column 5) of the Platt report recommendations.
In table 28 whenever 'stated policy' and 'observed practice' are in accord, both symbols '1' and '0' are found within the same square. The smaller the number of such squares with both symbols found together, the greater is the disparity between the 'stated policy' and the 'observed practice'.

Some of the reasons for this disparity can be given here. Sometimes this was due to the sister giving too decisive an answer 'yes always' when 'usually' would have been more accurate. Sometimes the differences were due to the fact that nurses in charge of the ward during the sister's absence, were unaware of her policies and were left to make their own decisions.

As one nurse wrote when completing her questionnaire (later discounted because she did less than ten hours)

'I feel that paediatric experience is very valuable, but I would like to make the following observations:

Some paediatric experience should come fairly early in the nurse's training period. It is surely unfair for a 3rd year student nurse to be put immediately in charge of a paediatric ward when she had has no previous experience with children'.

(Ward B)

This girl was left 'in charge' during her first afternoon of being on the unit! It is not surprising if in such circumstances nursing time has to be spent getting to 'know' the ward. It is of interest to note in this context that the average percentage of time that the sister-in-charge of the ward was found to be present during the survey, was only 51% of the total time.

Occasionally the ward sister gave misleading information - sometimes unintentionally - as when discussing 'living in' mothers and confusing these with 'mothers living in hostel accommodation'.

In a few instances the answers were at such variance with the observed practice that it seemed that the sister herself must be aware that her reply was inaccurate.

For the purposes of comparison of analysis of the answers to the sisters schedule it became necessary to omit certain questions. These concerned characteristics of the various wards which were not comparable with those of others. Whilst it was practicable to compare various wards on the basis of whether or not there was a playroom available, it was not possible to compare the answers to the two questions:-

'If a child has already been in the hospital, is he admitted to the same ward if he has the same illness?'

'If a child has already been in the hospital is he admitted to the same ward if he has a different illness?'

Some of the wards were single units within general hospitals, and the child on readmission would inevitably be cared for on the same ward. Thus the list of 68 questions (52 main questions and 16 subsidiary ones) listed in table 28 was reduced to a list containing 50 questions shown in Table 29. The symbols 'x' on this table correspond to symbols '0' (observed practice) in table 29, while the stated policy, having been shown to be an unreliable indicator, is omitted.

Table 29 illustrates the different degrees of compliance with Platt report recommendations as seen by the study observers in the nine wards at the time of the survey.

Since the answers appearing in columns 1 and 2 both show high degree of compliance, the sum of marks in these two columns, for each ward, could, in theory, be accepted as a relative measure of the quality of nursing care on that ward.
<table>
<thead>
<tr>
<th>No.</th>
<th>QUESTION (ABREVIATED FORM)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>ALWAYS</strong> (1)</td>
<td>DAILY (2)</td>
<td>OCCASIONAL (3)</td>
<td>SOMETIMES (4)</td>
<td>NEVER (5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 29**

**SUMMARY OF OBSERVED PRACTICE ON THE NINE PEDIATRIC WARS**

(Used) *The summary was based on the practice observed from the birth of the infant to the first birthday or until the infant's 12th birthday, as shown in Table 2.9)*
(The marks in columns 3, 4 and 5 can obviously be ignored since they represent either doubtful acceptance, as in column 3, or a total rejection of Platt report recommendation as in column 5).

In its final shape the proposed 'gauge' or 'tool' for assessing the quality of nursing care on a paediatric unit is shown in Appendix 8 at the end of this thesis. It contains the same set of questions as Table 29, but is much more compact having been designed to be used for one ward only.

It will be seen that this 'Form for the Assessment of the Quality of Nursing Care in Paediatric Ward's is weighted heavily with questions relating to the parents' presence and/or their participation in their child's care during hospitalization. There are, in fact, 30 such questions out of a total of 50, i.e. 60% of the total. Consequently, this form is biased against those paediatric wards which either lack the 'living in' facilities, or do not utilise such facilities to the best advantage. Restrictive visiting policies, particularly those on operating days, will also have adverse effect on the combined score of the columns 1 and 2 of the form.

Since the relationship between the hospitalized child and his parent has been the central theme of this study, no apology is thought necessary for weighting this form so heavily in favour of this relationship. Other aspects of care appearing on this check list are given equal weighting, although opinions may vary whether such items as permitting the child to wear his own clothes and placing a screen around his bed during toileting are of equal merit. The upper portion of the diagram at the end of this chapter (see page 235) summarises graphically the results of assessment of the quality of nursing care shown in Table 29. The column at the right of the graph representing the ideal or maximum score of 50 marks (or 100% acceptance of Platt report recommendations) shows that 10 questions
(i.e. 20% of total) relate to 'Living in' mothers, 19 questions (38%) to visiting or 'in-hostel' mothers and the remaining 21 questions (42%) to nursing and ward facilities.

The completed checklist of 50 questions by itself is of little value unless it can be shown that significant correlation exists between a high combined score in columns 1 and 2 of the check list, and the emotional well-being of the children. The hypothesis can therefore be stated as being; the children's emotional needs are cared for more successfully where Platt report recommendations are more often incorporated into nursing practice.

The validity of the check list as an effective 'tool' for measuring the quality of nursing care would be established if the hypothesis can be proved.

Validity of the Check list

The two variables to be tested for the existence of a significant correlation are therefore:

1. The assessment of the quality of nursing care found on the nine wards. This can be expressed numerically as a sum of the number of markings in columns 1 and 2 of the check list relating to the wards (table 29).

2. The percentage of observations shown in category 28 in table 7 under the heading 'miserable alone' - this being accepted as showing a lack of emotional well-being.

The statistical test which was applied to test the validity of the check list items is that known as Spearman's coefficient, or the coefficient of ranked correlation. This method is frequently used because the calculation involved is simple for small samples. The first step is to rank each variable - find the difference between the ranking and square it. The squares of these differences are added
together ($\sum (d^2)$) and substituted in the formula:

$$Q = 1 - \frac{6 \sum (d^2)}{N(N^2-1)}$$

where $N =$ the number of pairs being ranked

If the value of $Q$ is equal to, or greater than $\pm 0.6$ then the result is statistically significant at the 5% level ($p \leq 0.05$).

The result of application of this test are shown in the following example:

<table>
<thead>
<tr>
<th>Ranking of assessment</th>
<th>Ranking of category 'miserable &amp; alone'</th>
<th>Difference in ranking</th>
<th>Difference in square of the difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward H</td>
<td>1</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Ward B</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Ward C</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Ward F</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Ward A</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Ward J</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Ward G</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Ward E</td>
<td>8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Ward D</td>
<td>9</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

$$\sum (d^2) = 198$$

$$Q = 1 - \frac{6 \times 198}{9 \times (81-1)} = 0.65$$

Since 0.65 exceeds 0.6, the result shows that there is a statistically significant negative correlation between the quality of nursing care, and the emotional state of child-patients described as 'miserable alone'. Thus the higher was the numerical expression of the quality of nursing care on a paediatric ward, the less was the amount of misery observed among the children on the ward when they were left on their own.

This negative correlation is illustrated in the diagram at the end of this chapter (page 235).
The Spearman's coefficient method was subsequently applied to test the degree of correlation between the numerical expression of the quality of nursing care and the following variables in Table 4 (page 80) and Table 7 (page 89).

The percentage of time that direct nursing care was observed to be given on each unit (see Table 4). The percentage of time that extra nursing care was observed to be given (see Table 4). The percentage of time children were observed to have a nurse present (Table 7, category 13).

The percentage of time that the children were observed to be miserable (Table 7, category 27).

The percentage of time that the children were observed to be accompanied by their parents (Table 7, category 17).

The percentage of time that the children not requiring special nursing attention were observed to be 'alone and miserable' (derived from figures not shown separately in Table 7).

In only three instances were the results of the test statistically significant. These were the comparison between quality of nursing care and the percentage of time that 'extra' nursing care was observed to be given (a positive correlation) \( (p < 0.05) \); the percentage of time that children were observed to be miserable (a negative correlation) \( (p < 0.05) \); the amount of time that the children not requiring special nursing attention were observed to be 'alone and miserable (p < 0.01) (a negative correlation.)

The results of these tests show that on those paediatric wards where the Platt report recommendations (listed on the form for assessment of quality of care) are followed the children are less likely to be found miserable whether they are on their own or not. The results also show that one will find a higher percentage of
nursing time spent giving 'extra' or 'professional' nursing care
where Platt recommendations meet with a greater degree of acceptance.
GRAPHICAL PRESENTATION OF:
1). RESULTS OF ASSESSMENT OF QUALITY OF NURSING CARE ON THE NINE WARDS, COMPARED WITH
2). PERCENTAGE OF TIME CHILDREN WERE OBSERVED TO BE "MISERABLE ALONE"

KEY TO 1). ABOVE

SCORES RELATING TO 'LIVING-IN MOTHERS'
SCORES RELATING TO 'HOSTEL' OR 'VISITING' MOTHERS
SCORES RELATING TO NURSING OR WARD FACILITIES

NOTE: THERE IS A SIGNIFICANT NEGATIVE CORRELATION BETWEEN 1) AND 2)
Chapter 12

Summary

This chapter summarizes the findings made concerning the student and pupil nurses' knowledge of children's emotional needs. The 'stated policy' is compared with 'observed practice' and with the answers given by the nurses in their questionnaires. Results of interviews with the tutors are incorporated.

Educating the Nurse

'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'.

(Paragraph 137)

'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'.

(Paragraph 138)

'All this requires special study and we trust that those responsible for nursing curricula with give all possible priority to the adoption 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'.

(Paragraph 139)
The eight nurse tutors were interviewed after all the observations on the wards had been completed. The purpose of the project was outlined to them, and they were asked to explain the content of the syllabus which concerned the young patients' emotional needs. Four tutors had only heard 'by chance' of the survey and had not been notified from 'matron's office', although in each hospital it had been stated that interviews with them would be helpful. Two tutors thought that the project was of little value and could not understand the necessity for their involvement, consequently their contribution to this survey was negligible. The remaining tutors were more forthcoming, although often rather apologetic about the inadequacy of their syllabus in this particular area.

The interviews were informal and often quite lengthy. Generally, information was given without prompting. The information which was specifically required is summarized in the following four questions.

(Other material from the interviews was not directly relevant.)

1. What is the content of the course with regard to teaching the nurse of the child's emotional needs?

2. Which relevant films (if any) are shown to the nurses?

3. Whose responsibility is it to teach the nurse about the children's emotional needs?

4. What is the ward sister's role as a teacher?

It became clear that little time was given to teaching the nurses of the children's emotional needs. The hospitals where nurses were training for the sick children's nurses register seeming to differ little from the others. 'Emotional care' was discussed in seminars 'if and when' the topic arose. One tutor said:

'Nurses gain an understanding from their own background, for example when they baby sit. When we have discussions they can suggest examples from the ward'.

(Wards A & C)
Three tutors replied that this aspect of care was not discussed:

'There just is not the time'. (Ward D)

'They do applied psychology and must use their imaginations'. (Ward F)

'None at all in the school - to be blunt'. (Ward J)

One tutor was able to produce a typed sheet giving the contents of the three seminars arranged for the nurses, one in each year of training. All seminars were led by the paediatrician, a child psychologist and a parent.

In the first year seminar the following aspects were discussed:

The Home and the Child.
Effects of Illness.
Hospitalisation.
Nurse/child relationships.
Nurse/parent relationships.
Parent/child relationships. (Ward D)

Only one of the six hospitals training nurses for the general register provided a week's 'paediatric block' for the nurses immediately before they went to work on the unit. 'Children's needs' were discussed, and it was admitted that occasionally the student nurses 'missed' this special period of training.

The most widely shown film was that by the Robertsons. 'A two year old goes to hospital' which was shown at four of the eight hospitals. 'To hospital with Mother', the sequel illustrating the difference it made to the child to be admitted with his mother, was not shown at all. Two tutors suggested that these films were too old, and they liked to show more recent films, although none dealt specifically with this aspect of care. The general consensus of opinion appeared to be that it was the ward sister's responsibility to teach the nurse of the child's emotional needs as the need occurred in the practical situation.
When asked the sister's role in teaching, the tutors generally agreed that this was an important aspect. 'She is the 'key figure' teaching by example' but four of the tutors thought she either had too much to do, or wasn't interested in teaching. Perhaps one of the more disturbing aspects of these interviews was the admission by four tutors that their relationship with the ward sisters concerned were rather unsatisfactory. They explained that after they did not visit the wards because the sister did not welcome their interference. Ironically, three of the four ward sisters concerned suggested that the tutors 'never visited the wards because they didn't know enough about paediatric nursing' (this information was volunteered when the sisters filled in the nurse's questionnaire).

Method of observing practice

The code 'O' covered any exchange of information between members of staff relating to their work. Thus, the giving and receiving of ward reports, allocation of work, conversations between nurses relating to work and more formal teaching sessions, would be categorized in this way. The application of this code involved the observer in making an independent decision: for example, she had to distinguish between two nurses discussing some aspect of their work and chatting. Perhaps surprisingly, none of the observers found it difficult to make these decisions. The use of this code also included any teaching that took place on the units. It was not possible to distinguish between straightforward instruction and report giving. It was considered, however, that all activities coded 'O' would be potential teaching and/or learning situations.

'N.T.' was used if the nurse was 'off the ward' for any reason concerning her training. This included taking examinations and both giving (one ward sister) and attending lectures.
It can be seen from table 30 following that trained staff spent a larger percentage of their time on every ward 'exchanging information' when compared to that of the nurses who were still undergoing training.

Table 30: Number and percentage of observations in Category 'O'.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Qualified Staff</th>
<th>Student Nurses Pupil Nurses</th>
<th>Total Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Observations</td>
<td>%</td>
<td>Actual</td>
</tr>
<tr>
<td>A</td>
<td>138</td>
<td>19.4</td>
<td>111</td>
</tr>
<tr>
<td>B</td>
<td>122</td>
<td>19.5</td>
<td>129</td>
</tr>
<tr>
<td>C</td>
<td>133</td>
<td>19.7</td>
<td>171</td>
</tr>
<tr>
<td>D</td>
<td>146</td>
<td>27.5</td>
<td>173</td>
</tr>
<tr>
<td>E</td>
<td>161</td>
<td>18.3</td>
<td>119</td>
</tr>
<tr>
<td>F</td>
<td>101</td>
<td>17.5</td>
<td>79</td>
</tr>
<tr>
<td>G</td>
<td>293</td>
<td>31.0</td>
<td>82</td>
</tr>
<tr>
<td>H</td>
<td>193</td>
<td>18.5</td>
<td>124</td>
</tr>
<tr>
<td>J</td>
<td>75</td>
<td>11.6</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>1,362</td>
<td>19.8</td>
<td>1,065</td>
</tr>
</tbody>
</table>

Table 31 summarizes the various reasons for which the code 'N.T.' was used. It should be noted that 'N.T.' was not used to cover the regular weekly study day or ½ day which were considered when staff were allocated to the ward. The absences shown in table 31 were often notified after the off-duty had been planned, or were 'once-only' occurrences such as being absent for a post-registration examination.
### Table 31: Reasons for coding 'N.T.' 'off ward' for teaching purposes.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of observations</th>
<th>Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Trained Staff</td>
</tr>
<tr>
<td>A</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B</td>
<td>105</td>
<td>8</td>
</tr>
<tr>
<td>C</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>G</td>
<td>31</td>
<td>25</td>
</tr>
<tr>
<td>H</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>J</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>172</td>
<td>57</td>
</tr>
</tbody>
</table>

**Appraisal of answers to nurses questionnaires**

The nurses’ replies to questions concerning training reflected their own views of the syllabus of their courses and because of this are highly subjective. In the following discussion it will be
remembered that the questionnaires of the nurses who were observed
less-than 60 occasions on the unit (that is completed less than ten
hours) were not considered in the analysis.

All nurses were asked:— During your training do you have:—

Study days
block i.e. continuous periods of at least
one week's duration.
to attend lectures in your 'own'time'.
to attend lectures in 'ward time'.

All student nurses were taught in 'blocks', whilst pupil
nurses had study days. At three hospitals study days were combined
with 'blocks'.

All but two of the 24 nurses training in paediatric hospitals,
and 37 of the 45 nurses training in general hospitals, stated that
they had been told about the emotional needs of hospitalized children.

Table 32: Nurses own estimation of her experience
with children before training.

<table>
<thead>
<tr>
<th>Ward</th>
<th>'Lots of experience'</th>
<th>'Little experience'</th>
<th>'No experience'</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1 3 1</td>
<td>3 1 3</td>
<td>2 2 2</td>
</tr>
<tr>
<td>B</td>
<td>3 2 4</td>
<td>6 5 3</td>
<td>1 3 3</td>
</tr>
<tr>
<td>C</td>
<td>0 2 1</td>
<td>5 5 5</td>
<td>5 3 4</td>
</tr>
<tr>
<td>D</td>
<td>5 3 3</td>
<td>2 3 3</td>
<td>2 3 3</td>
</tr>
<tr>
<td>E</td>
<td>6 6 4</td>
<td>2 3 3</td>
<td>1 0 2</td>
</tr>
<tr>
<td>F</td>
<td>1 0 0</td>
<td>3 4 5</td>
<td>1 1 0</td>
</tr>
<tr>
<td>G</td>
<td>3 2 0</td>
<td>3 2 3</td>
<td>1 3 4</td>
</tr>
<tr>
<td>H</td>
<td>2 3 2</td>
<td>6 2 6</td>
<td>0 3 0</td>
</tr>
<tr>
<td>J</td>
<td>0 1 1</td>
<td>3 4 3</td>
<td>2 0 1</td>
</tr>
</tbody>
</table>

Total | 21 22 16 | 33 29 34 | 15 18 19 |
Total % | 30.6 32 23.2 | 48 42 49 | 21.8 26.2 27.6 |

Training for sick childrens register:
12.5% 33.3% 16.7% 58% 53.3% 58% 29% 33.5% 25% |
Training for general register:
40% 31.2% 26.6% 42.5% 47% 44.5% 17.8% 22.2% 29%
Two further paediatric nurses (total 24), and 11 general student and pupil nurses (including the eight who replied in the negative to the previous question) stated that they had not received any guidance during their training regarding the behaviour of young children whilst separated from their parents.

To the question of whether or not prior to their training they had any experience of caring for children, toddlers or babies, the replies were as follows. 15 nurses (21.8%) in training stated that they had no experience of caring for children, 18 nurses (26.2%) had no experience of caring for toddlers, and 19 nurses (27.6%) had no experience of caring for babies.

Perhaps unexpectedly a smaller proportion of nurses training for the paediatric register had experience of caring for children (12.5%) and babies (16.7%) than those training for the general register (40% and 26.6%).

Table 33 shows who was responsible for teaching the nurses on the nine wards during the period covered by the survey.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of Nurses in Training</th>
<th>Sister and/or Staff Nurse</th>
<th>Clinical Instructor</th>
<th>Tutor</th>
<th>Doctors</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (teacher)</td>
</tr>
<tr>
<td>B</td>
<td>10</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1 (other nurse)</td>
</tr>
<tr>
<td>C</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1 (other nurse)</td>
</tr>
<tr>
<td>E</td>
<td>9</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>8</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1 (physiotherapist)</td>
</tr>
<tr>
<td>J</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>53</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>%</td>
<td>100</td>
<td>76.8</td>
<td>2.9</td>
<td>2.9</td>
<td>5.8</td>
<td>5.8</td>
</tr>
</tbody>
</table>
It will be noted that as many as 53 of the 69 nurses in training (i.e. 76.8%) said that they had been taught by either the sister or the staff nurse during the week of the survey. In this connection one of the student nurses remarked:

'It is difficult to know what is meant by 'teaching' as those in authority are very willing to inform a nurse of anything, if the nurse asks'.

(Ward C)

The nurses in training on one ward were very definite,

'we should also have to be given more information and be more instructed by ward sister. From my own experience I can say that this is a very bad attitude towards nurses. I haven't been even shown around the ward, nor was I told the ward routine'.

(Ward E)

'this ward is not organized as I would like - the nurses are not told the correct way to nurse young babies and have to pick this up from other nurses who were on the ward before'.

(Ward E)

Adverse comments of teaching were, with one exception, confined to the wards where the sister was not herself paediatrically trained. Two nurses commented favourably about the paediatric study block they had attended immediately prior to coming to the ward.

'A paediatric study week before paediatric experience, helped me to know how children will behave in hospital, and what to expect'.

(Ward G)

Discussion

At present student nurses and pupil nurses often form the greater proportion of staff who are responsible for giving nursing care to the patients on the wards. Thus the service needs of the patient and the training requirements of the student nurses are often in conflict. (See table 34.) This was clearly illustrated during the period of observation on G ward. 29 different nurses were observed to be giving patient care during the week - yet only 15 of them were observed on more than 60 occasions of a possible 525,
i.e. nearly 50% of the nurses on G ward were present on the ward for less than 10 hours each during the period of observation.

Table 34: Distribution of nurses in training and their contribution to the service needs.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Total staff in training</th>
<th>for R.S.C.N. and S.R.N.</th>
<th>R.S.C.N.</th>
<th>S.R.N.</th>
<th>E.N.</th>
<th>Other</th>
<th>% of total service needs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>6</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>65.25%</td>
</tr>
<tr>
<td>B</td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>56.0%</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>10</td>
<td>8</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>73.0%</td>
</tr>
<tr>
<td>D</td>
<td>9</td>
<td>9</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>65.25%</td>
</tr>
<tr>
<td>E</td>
<td>9</td>
<td>6</td>
<td>3</td>
<td></td>
<td>3</td>
<td>4.0%</td>
<td>58.75%</td>
</tr>
<tr>
<td>F</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>4.2%</td>
</tr>
<tr>
<td>G</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
<td>6</td>
<td>27.2%</td>
</tr>
<tr>
<td>H</td>
<td>8</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>35.0%</td>
</tr>
<tr>
<td>J</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td></td>
<td></td>
<td>6</td>
<td>43.5%</td>
</tr>
<tr>
<td>Total</td>
<td>69</td>
<td>13</td>
<td>8</td>
<td>35</td>
<td>7</td>
<td>6</td>
<td>50.75%*</td>
</tr>
</tbody>
</table>

* Individual nurses, for whom less than 60 observations were made, have been excluded from the survey – although their contribution is included in the 'total' column.

On no other ward is this more apparent than on the paediatric units. In the discussion of the theoretical concepts of child care (Chapter 1) it was suggested that the young child needs to form a close relationship with either his mother or mother substitute, in order to allow his emotional development to proceed without hindrance. Whilst this has generally been recognized and is reflected in the staffing policies of the children's services organized by local authorities, hospitals (if one can generalize from the nine units used in the survey) have either ignored this fundamental concept in planning their nursing policies, or become overwhelmed by the difficulties presented
by both staffing the ward adequately and providing the training facilities required by the General Nursing Council.

Consideration has been given to this matter in the revision of the syllabus for 1971, in which it was stated that:

'Careful consideration was given to the question of children's nursing in view of the difficulties in some areas of providing a minimum of eight weeks allocation to a children's ward. It was finally decided that all State Registered Nurses in general nursing should have had during their training some experience with this age group. The aim is to provide experience in the handling of children, normal development and recognition of abnormalities, an understanding of the right environment for the care of children in hospital and in the community, and the advice and kind of help needed by the parents. Greater use will have to be made, for training purposes, of paediatric clinics, child health clinics, home and other special visits, combined with some experience in a children's ward'.

The nurses' training needs in this paragraph take precedence over paediatric patients' needs. The syllabus for the nurse doing her paediatric nursing is obviously more comprehensive. More time is allocated to the teaching of the children's psychological development and adjustment, indeed the guide to the syllabus of the subjects for examination for the Certificate of the Nursing of Sick Children 1964 is quite specific in its reference to children's emotional needs.

'Throughout training, information relating to the psychological and physiological processes underlying anxiety, and the reason for certain behaviour, can be discussed again using the student nurse's own experience with children and parents as far as it practicable'.

MacQuire (1961)(66) in a review of literature relating to the recruitment and subsequent retention of student and pupil nurses, mentions five studies whose authors agreed that little formal teaching takes place in the ward situation.

Although this chapter summarizes the attempts made during the
study to appraise the amount and type of teaching carried out in paediatric units, this has not been the main object of the survey. Hence the results must be treated with some caution. Whilst all the observations which were coded as '0' were potentially teaching situations, it would be wrong to assume that this was always so. For instance, the tedious arguments between one of the ward sisters and the various student nurses concerning their minor misdemeanours in carrying out ward routine, were of necessity classified '0'. Thus conclusions based exclusively on the percentages of activities coded '0' may not necessarily be valid.

The ward with the lowest percentage of '0' was considered 'well organized' or 'having a pleasant routine' with 'time to study' by several of the student nurses, and formal teaching sessions were held.

A further difficulty that was encountered in measuring the teaching content was highlighted when one of the ward sisters apologized for the amount of time she appeared to be spending 'making empty beds' (7%, that is more than twice as much as two of her colleagues, while four sisters were never recorded as doing this). She explained that in her opinion it was a useful way of spending time with nurses who were new to the ward, and she could 'teach' them at the same time.

What seems apparent is that once a nurse has 'learnt' a procedure she tends to regard repetition as a necessary chore rather than an opportunity to develop skill. Thus the enjoyment with which a second year student nurse tackles the administering of a medicine round, often a new experience, is more likely to become a chore to the senior nurse. That most nurses enjoy their paediatric experience and appreciate the opportunity to learn new skills and to please the young patient, is apparent from the comments they made:-
The paediatric ward is good and I am getting good experience - I am gaining a lot.

(Ward B)

'Since I've begun here I have learnt a lot'.

(Ward E)

'I regard paediatric training as a vital part of my career and it is very interesting'.

(Ward J)

It seems unfortunate that only one general training hospital (Ward G) was able to combine the theory with the practice in caring for children by having the paediatric block arranged immediately prior to the practical experience.
Summary

In this concluding chapter of the thesis, comments are made concerning some of the weaknesses of the study. The main results are reiterated and the conclusions which follow are given. A plan for using the assessment form for teaching purposes is outlined, and finally the recommendation that senior paediatric nurses should be given the opportunity of learning of current child care theories is stated.

General Comment

It has been reported earlier in this study that research into the literature on quality of nursing care failed to reveal a universally accepted definition of it. For the purpose of this survey, the quotation from Reiter and Kakosh (1963)(102) on page 14 of this thesis was accepted. However, definition of nursing care is an academic concept which, to be of any practical utility, must be translated into the daily nursing routines of hospital care.

The specific object of this study has been to suggest a practical method of measuring and comparing the standard of quality of nursing care on paediatric units.

In this context the inclusion of the young child's emotional needs as an important component of high quality nursing care appeared well justified.

The paediatric units selected for this survey were such that they did not form a random sample. Wards A and C were chosen for the pilot study because they were similar wards in a large childrens' hospital. Consequently the number of variables were reduced (Hospital locality, official visiting policy, number of beds, the
ward lay-out, and many of the daily routines were the same). It was easier to establish the validity of the methods of observation in these circumstances.

Following the pilot study, wards were selected for specific reasons (these were discussed in Chapter 3). Unfortunately some of the variables chosen with the intention of emphasizing the differences between the paediatrics wards did not prove as effective as had been expected. For example, ward J was selected because there was a play leader provided. She was only observed to be on the unit for 10% of the total time of the survey.

In another case, the ward which was selected because it was designated as 'long stay' had only a small number of 'long stay' patients, and the 'turn over' rate was higher than that on one of the acute wards, during the week of the survey.

The ward on which nursing by 'case assignment' was attempted, appeared to be hit by an epidemic of minor illnesses amongst the nursing staff, and this was reflected in the high number of nurses involved in care of the children.

The methods used to study the work of the nurses (Modified activity sampling) have been used previously. However, the classification of activities was changed in this survey, so that direct comparison with the results of previous workers cannot be made.

These changes of classification are justified for several reasons.

Goddard in his study (1953)(93) adopted an arbitrary classification of nursing activities which were used mainly on adult wards and, as already explained, (Chapter 2) it seemed that the work on children's units had a different emphasis.

The methods of observing either patient populations or groups
of children for long periods were not found to be documented in a search of relevant literature. It was therefore decided to extend the modified activity sampling of nurses to the children. Means of coding their behaviour had therefore to be initiated. Undoubtedly, this method of observing a group of children and coding their behaviour will lend itself to further refinement. The category 'b' - 'apathetic, listless or bored' was almost certainly underused during the survey.

It will be remembered that the observers, all qualified nurses, were not trained in observation of children's moods and they had been told that if they were in doubt about the category 'b' they were to record the observation as 'c' (contented). Most observers found that they were using the 'b' category more frequently in the latter part of the study, as they became more familiar with the method of observing the children, and could more easily identify their moods.

It was not intended, when this study was originally planned, to discuss the results obtained from the interviews with the ward sisters in great detail. However, they proved of great interest and it was decided to present these results, together with relevant anecdotes, in order to enable the reader to appreciate how the various ward practices appeared to the onlookers (in this case the study observers).

One critical comment made of this report at a later stage in its preparation questioned the assumption that 'the state of misery' was necessarily an 'undesirable' emotional state in a child patient. Indeed, Robertson (1958)(107) has suggested that it is healthier and more natural for a young child to be miserable when separated from his parents for any length of time. He continued to say that the
overtly 'happy' gregarious toddler found in hospital is often the child who is reacting to a long separation from his parents. He is more likely to suffer the damaging effects of separation, than the child who displays his grief.

However, Franklin in her unpublished thesis (1970) reviewed much of the literature relating to anxiety, and has concluded that if energy is deflected by undue anxiety, the healing process may be delayed. Crying and the other distress symptoms observed in the children, are demonstrative of their anxiety and it therefore seems quite proper to use misery as a negative indicator of quality of nursing care. This was particularly so when the child was observed to be miserable and unaccompanied, without even the limited comfort that an adult other than his parent could offer.

Discussion of the results

Detailed account has already been given in the preceding chapters. The more interesting findings are summarized and restated here.

The results of the Modified Activity Sampling have shown how the nurse spends her time: about one third of it being occupied in giving direct nursing care, and the rest devoted to 'behind the scene' activity or indirect nursing care. It is easy to dismiss these results as being of little importance, but if nursing care is to be improved, it is necessary to see first how the time is spent, and then to make suggestions about how the time could be more usefully organized.

It can be seen from Table 4 (page 80) that the nursing staff on Ward H spent less time than their colleagues giving 'basic' nursing care, but more time giving 'extra' nursing care. This was because the basic care was given by the children's own parents. One
of the ways their additional time was utilized was in formal teaching sessions, when the ward sister was able to bring together the theory and practice of the children's diseases and the specific care that was needed.

Nurses working in paediatric hospitals spent more time than their counterparts in general hospitals, in the ward kitchens, where they prepared jellies and sandwiches for their young patients. Whether this is a proper use of nurses' time, it open to question. The nursing staff on Ward F appeared to spend an undue amount of their time 'tidying up'. The storing facilities available on all the wards in the survey were often inadequate for the children's needs, they were usually provided with smaller lockers than adults, yet were required to store day clothes and their toys, as well as toilet requisites. This was particularly noticeable on Ward F. Better individual storage space would undoubtably have meant the nurses had to spend less time tidying up.

One of the unexpected, but important results of this study, was to find the high number of nurses concerned in giving nursing care on any one ward. This was revealed by the modified activity sampling. This was further demonstrated in the analysis of the results obtained from observation of the children, when the number of different nurses concerned with the care of each child during the period was calculated. Ways of reducing the number of nurses sharing this care seem very necessary. Some suggestions of doing this have been fully discussed in Chapter 7.

On the whole, the percentage of time that the children were observed to be alone and awake was high, and the number of observations which were coded in the 'miserable' category was correspondingly high. It must be stressed that this category was almost certainly underestimated.
The children who were nursed in the paediatric wards of the General Regional Board Hospitals were found to be less happy and contented than the children cared for in other wards. The reasons for this high incidence of 'misery' have been suggested in Chapter 11, where it was shown that these three wards gained low scores on the assessment form.

Although wards D and E had low nurse/patient ratios and high turnover rates ward J had a high nurse/patient ratio and low turnover rate. Indicating that a high nurse/patient ratio is not enough to ensure a high standard of nursing care.

The main results obtained from the analysis of the nurses' questionnaires and the interviews with the ward sisters, demonstrated the tremendous interest all the participants had in their work, and their enthusiasm for caring for the children. At the same time, the study revealed a fundamental lack of knowledge among the nursing staffs of the children's emotional needs. It is difficult to see how student and pupil nurses could learn 'good' child care whilst those in charge of the wards were themselves quite often unaware of the basic principles of the subject. The study has shown that some of them, for example, did not know the reasons for the recommendation that parents should either be able to live in with their young children or be able to visit them at any time.

It is clear that nurses who are accustomed to nursing adult patients, find it bewildering when they are first allocated to a children's unit. Written instructions would be of great benefit. Indeed, whilst the system of staffing the wards remains unchanged and nurses are constantly moved, written instructions become a necessity. It is extremely difficult, if not impossible for a ward sister to ascertain that every nurse coming to her ward will comply with her methods of caring for the children. Even if the nurse had
all her paediatric lectures, she may know very little of children's welfare needs. The nurses who received one week of paediatric lectures immediately prior to their experience in the children's unit found this very helpful. It could be of great benefit if this arrangement were to become a standard practice.

The Form of Assessment of the Quality of Nursing Care

As previously discussed, this study was part of a project to find ways of identifying and measuring standards of nursing care. In this study it was postulated that high standards of nursing care in paediatric units could only be attained when the children's emotional needs as well as the other needs received adequate consideration. The observations of the nine wards have shown how nurses in paediatric units spend their time, and have also demonstrated that where children's emotional needs were attended to, the proportion of time that the children were seen to be miserable was lower.

In the course of this study a Form of Assessment of the Quality of Nursing Care on Paediatric Wards was evolved.

On this Form the various features of nursing care and the facilities available on the wards could be marked (see Appendix 8 for a specimen of the Form).

It was found that the higher the number of marks in the columns 1 and 2 of the Assessment Form, the more satisfactory was the state of emotional well-being observed amongst the children in the paediatric units concerned. This relationship was shown to be statistically significant.

In order to ensure objectivity in the assessment of the quality of nursing care, it is essential that this form (or check list) is completed by a trained observer unconnected with the paediatric unit concerned.
The Form of Assessment, being a new and comparatively untried tool, can only prove its worth when tested thoroughly in practical situations on paediatric wards. One of the ways this can be done is suggested here.

It will be remembered that all the observers taking part in the survey were qualified nurses. In nearly all cases they were taking or completing further courses to equip them for senior nursing posts. Initially many of them volunteered to help with the survey, considering this as a way of supplementing their income. Almost without exception, however, the observers found the work of great interest and became increasingly aware of the opportunity it offered to 'stand back from the ward situation', and in that way, see the different facets of the day to day routine that had not been apparent to them previously. The children's needs were seen clearly (perhaps for the first time) during the period of observation.

It is considered that an experimental course for paediatric ward staff should be attempted. The observational method described in the study of modified activity sampling, (see Appendices for charts) culminating in the completing of the assessment form, might usefully form a basis for such a course.

Eighteen paediatric ward sisters from different wards and hospitals should be the minimum number attending any one course.

The first day should include a fairly full 'briefing' session on coding of observations and a preliminary visit to a paediatric ward to try out the method of observation to be adopted. The members of the course should form three seminar groups, and one member of each group should be allocated to a different paediatric ward in the area, (the location of the course must be carefully selected, in order to have sufficient paediatric units available for study). Later in the day,
each 'team' of three nurses (one from each seminar group) should visit their allotted wards, familiarise themselves with its layout and organisation and make all the necessary preparations - inform the staff and parents, number and label the staff, children and beds etc.

During the following three days, members of the various teams should carry out observations for about three to four hours - rotating their periods of observation each day in accordance with a pre-determined timetable. During this time the remaining participants of the course would attend seminars on various aspects of child care.

At the end of the three day period, the three members of each team should complete a separate assessment form (see Appendix 8) and after discussion, prepare a final assessment form for their particular ward. The final results of the modified activity sampling for all the six wards could then be compared.

The three-day period of observation should provide sufficient material for discussion at seminars, and together with films and lectures, may provide the impetus needed for the implementation of necessary changes.

It is expected that those participating in such courses will have ample opportunity for informal interchange of ideas and experiences which may encourage them to re-examine critically the organisation and the daily routines in their own wards. It is important that the course participants have a further opportunity to meet together in order to evaluate the effects of the course. If they have been able to introduce changes in their wards, the difficulties and/or benefits that have ensued can be discussed.

Recommendations

It is usual at the end of a survey, to conclude with a list of recommendations. It is felt, however, that there is only one such
recommendation which deserves the greatest possible attention and from the adoption of which other improvements will automatically follow. This concerns the very urgent need for senior nursing staff in paediatric units to be given the opportunity of learning of the current child care theories and their application to modern nursing care. Until there is understanding and appreciation of these theories amongst the nursing staff, the need for changes in the existing ward routines will not be recognized and implementation is unlikely to occur.

In most hospitals the sisters-in-charge of paediatric wards are faced with a problem of instructing and teaching the student and pupil nurses assigned to them and at the same time providing a nursing service for the patients, using these same nurses as a major, if somewhat irregular, part of the staff available for this task. This problem has been the subject of several previous reports on nursing reviewed by MacGuire (1961). (66).

From experience gained in the course of the present survey the author feels that a considerable improvement in the quality of training could be achieved if the nurses undergoing general training were allowed to complete their eight weeks paediatric experience in one block. This, together with a minimum staff rotation period of one month would enable the sister-in-charge to organize the teaching and instruction more effectively than seems possible at present.
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APPENDIX NO. 1.

CONFIDENTIAL - for Data Collectors' Use

THE STUDY OF NURSING CARE

A. Key to Coding Nurses' Work

*A Feeding patients: this includes giving of all food and drink and bottle feeding.

AA Serving food in the ward; issuing cutlery, trays, collecting used crockery in the ward, giving out water glasses or extra fluids, serving food cut in the kitchen.

AB Making up bottle feeds.

*B Bathing in bed or bath, washing (not cleaning nappy region unless a bath). Hair combing or washing; teeth cleaning.

*C Preparing to change, changing a child's nappy - includes powdering or washing bottom. Giving of bedpan escorting to lavatory - with the patient.

CC Supervising; potty round; (cleaning up after 'accident' is cleaning, - if superficial 'Y' if mop and bucket used 'YY'); collecting and emptying urinal or bedpan. All toileting 'away' from the patient.

*D Making a bed when the patient is in it (if patient in a nearby chair, Code 'F'.) Making patient comfortable - straightening sheets, pillows, 'tucking down' for the evening.

*E Other basic care. Please specify on notes when this category is used what is actually happening, (with patient).

F Making or stripping unoccupied or empty bed: (some confusion has arisen on this one - if the patient is not in the bed when it is being made, categories 'F'.

G Washing or drying hands - applying hand cream.

H Preparing or cleaning basic equipment. This relates specifically to items used during a procedure or task e.g. clearing the trolley after a bed bath has been completed - it does NOT include the weekly task of clearing trolleys: (this is 'Y') and covers any part of the task that takes place away from the patient.

*I Injections or medicines. If two nurses are doing this together code both as 'I'.

II Distinguish from I - the part of the procedure in which the patient is not present e.g. writing in the drug book (do not confuse with Q).
**J** Checking, taking or recording body functions, T.P.R., B.P. etc. This includes post-operative special records; fluid balance charts, diabetic charts. (This category should only be used if the nurses are making immediate records of findings and not transcribing - Category 'Q' - when they are with the patient.)

**K** Other technical care - with the patient, pressures area: attending to intravenous fluids; assisting at lumbar punctures etc.

**KK** Surgical dressings - with the patient.

**KT** Technical tasks which are not with the patient - testing urines.

**AK** Tube feeding.

**L** Preparing or cleaning technical equipment; (distinguish between activities as Code 'H'.)

**M** Meal breaks. 'M' should be used when a nurse is at a meal in her off-duty i.e. if she is at tea for ½-hour before she comes back from her afternoon off.

**N** Originally covered all absences 'off the ward' only use alone if other N codes are not applicable.

**NC** With patients at Church.

**N.L.** Loaned to another ward.

**N.M.** Gone on a ward message or errand.

**NG** Gone to operating theatre with or for a patient - otherwise code N.M.

**NP** Gone with patient to another department - e.g. physiotherapy, path. lab.

**NS** Gone off the ward for 'social' reasons to take the child/children out for a walk, to visit another ward, to post a letter etc.

**NT** Off the ward for teaching purposes.

**Ø** Exchanging information. This category involves making a judgement. It includes giving and taking reports, allocating tasks, giving information about patients or any treatment. Formal instruction from Tutors, Ward Sisters, Doctors, etc.

**ØØ** Helping senior nursing staff: this is a 'loose' category please use sparingly. Includes the second nurse who is allocated to help another nurse and appears to be 'standing around' rather than taking part in the activity - again, if an informal teaching/learning session for second nurse, categorise 'Ø'.

**P** 'Phone - making or receiving calls - whether business or personal.
Q Clerical Work: Report writing, transcribing list of items i.e. T.P.R.'s from book to chart and vice versa. Ruling books out; making duty lists, checking groceries or ordering; writing medicine lists.

R Rounds with Doctors, Senior Nursing Staff or other professional staff.

*S Social interaction: talking, playing or giving any extra attention to the children - i.e. extra 'cuddle' after a feed. If a child is 'gaining from nurses' presence, Code 'S'.

e.g. helping to 'clean' cupboard when obviously enjoying each other's company rather than passive standing watching;

e.g. holding a child during procedure which could feasibly be done without nurse's presence (accompanying off ward 'N')
e.g. physiotherapy. Helping the Path. Lab. to get a haemoglobin is category 'E'.

T Talking to parents, or other visitors either information giving or social chat. Code 'S' if the child is the principal participant.

TT Talking to the Study Observers.

U 'Unclassified', i.e. not working.
(Please be careful to distinguish between 'U' and 'V' when using these two codes.)

V Tidying ward - beds - castor straightening - locker tops. Doing flowers, in wards or ante-room.

W Walking - again a 'loose' code: it is usually possible to code as part of another activity. Some nurses, however, appear to walk up and down when not busy.

X Preparing food in the kitchen - distinguish between this and 'AA' - preparing to serve meals. Would include boiling milk, making jellies, cutting sandwiches but not setting the trolley prior to serving meals (AA).

XX Clearing or washing dirty crockery in kitchen (includes cleaning food trolley).

Y Light cleaning - dusting, cleaning lockers, medicine cupboards or other week-end cleaning - not cleaning empty beds or lockers. (YY).

YY Heavy cleaning - floors, polishing, scrubbing empty beds, cleaning nappy buckets and bins.

Z Dealing with clean linen or clothing, tidying into cupboards, getting out - preparing for use, checking for use, checking for tears etc.
ZZ Dealing with dirty linen - this would not include putting nappy in a bin immediately after changing a baby but WOULD include emptying the day's dirty nappies into another container. Includes sluicing.

REMARKS:

Broadly, categories A to E are the sort of jobs a mother would do if her child were ill at home. I to L are jobs which require to be done by a nurse.

The last categories might be considered to be the type of tasks that do not really require a nurse to carry them out: the X, Y, Z are possibly more borderline than XX, YY and ZZ.

One of the aims of this survey is to attempt to differentiate between direct + indirect patient care.

The following codes should not be used unless the nurse is actually with the patient or patients. (These codes are all marked with an asterisk):

A, B, C, D, E, I, J, AK, K, KK, NC, NS, S.

In all these cases the nurse's number should be registered in the appropriate child's record.

NOTES:

Key to Coding Children's Activities

Each child has a code from the first and second group and possibly from the third.

GROUP A

1. Any child in bed is category 1, this includes on a bed, sitting or standing on the bed.

2. This category is sitting out of bed in a chair, either by the bed, at the table, or in a central 'sitting area'.

Sitting on a rocking horse or see-saw is the next category.

3. Standing, running around, crawling, - in any way mobile - in a wheelchair, providing it is used to get about rather than as a chair.

For a younger child, being in a pram counts as Cat. 1.

4. This category is used when the child is being held on someone's knee or being carried. It does NOT include being carried in a carry-cot or toddler's chair.

Inevitably this Coding (4) means that a Code from Group C is used.
GROUP B

This Group of five symbols is used in an attempt to assess the child's mood - you will not have time to spend deciphering this and must record your fleeting impression:

a) Asleep or very drowsy (as when 'tucked in' for the night and following premedication).

b) Probably the most difficult coding. This is used to describe a child who is apathetic, bored, listless, uninterested, 'standing around' day dreaming, staring into space, thumb sucking, etc.

He may also be a sick child who is too ill to care. Please, in this case make a note of his being very ill in the appropriate square marked 'State'.

c) Is used to describe the 'contented' child - the child who is playing with other children, playing constructively on his own, or who is humming or singing. If he is sitting on parent's knee thumbsucking, it becomes slightly more difficult to decide whether 'b' or 'c' is appropriate. 'b' the child might be described as 'under tension' and 'c' free from tension.

d) Distressed, crying, temper tantrums, grizzling, apprehensive. This would include the child who is obviously frightened by other activities occurring in the ward.

e) This code was not used in the pilot study but it was felt that often children who had been marked 'contented' most of the day showed such marked pleasure at their parents visits that a different coding might be more appropriate.

This code will probably not be needed frequently but should be easily recognised.

GROUP C

This group refers to the other people who affect the child. If there is anyone with the child, his presence is coded as follows:-

* The appropriate columns is starred if the child's visitors are on the unit - regardless of whether or not they are actually with him (provided the child is aware that his parents or parent substitute) is within calling distance (thus parents speaking to sister after they have waved goodbye do not count). 'Living in' parents only count if on the unit.

v Frequently the parents of one child will include another in their visit.

c Use if child is playing with other children or another child.

d Use if doctor is present.
OTHER CODES

N  'Off the Ward'. This code has again been extended as follows:-
NC  Gone to church.
NH  Gone home for the afternoon (or day).
NP  Gone to operating theatre.
NP  Gone to another department for medical purposes.
NS  Off the ward for social reasons.
S  Some wards have schooling. For all children over 5 years who are having school lessons, ignore all previous codes and Code 'S'.
p  Use if play lady present, but use other coding also.
t  Use if the teacher is with the child.

GENERAL NOTES

1. During your observation period it is hoped that you will prepare the data sheets for the next person. As the 3.30 pm - 8.00 pm shift tends to be the quietest it is also the best time to prepare the diagnosis list for the following day.

2. Any admissions or discharges should be noted on both the diagnosis and (anecdotal) sheet.

3. The beds are frequently moved - it is easier if the number of both the bed and the child are changed after the 6th observation, but please note this on the anecdotal sheet and the diagnosis list and alter accordingly.

4. Letters of explanation are available for any member of staff or visitor who requests them. When there is a new admission please ensure that parents are given a letter of explanation as soon as practicable. (Children may keep their badges if they so wish on discharge!!).
5. If you are asked for details of the survey by all means let people see your form but avoid discussing further details and refer them to me - I will be visiting the ward quite frequently.

6. Any interesting 'happenings' and any difficulties in the coding system should be noted down.

Finally, when using the forms please try and be careful about legibility. Difficulty has been experienced in charting 'U' and 'V'. Can you make sure that you cross the 0's Ø and 'top and tail' the I - I. This is necessary for the computer punchers in order to distinguish between the letters 0 and I and numbers zero and one.
# Study of Nursing Care (Paediatric)

## Observer

<table>
<thead>
<tr>
<th>Code: D 086</th>
</tr>
</thead>
</table>

### A: Feeding Patient
- Off Ward
- Gone to church
- Gone home for day

### AA: Serving Meals
- Loaned to another ward

### B: Bathing or washing
- Gone to Theatre with patient
- Gone to other dept.

### C: Changing Nappies
- Off ward (social)

### CC: Making occupied bed
- Feeding patient

### D: Making occupied bed
- Serving heals
- Bulbing or washing

### E: Making empty bed
- Changing mappies
- Potties or beclpans

### F: Other basic care
- Making occupied bed
- Washing hands
- Prep/clear basic equipment

### G: Technical care with patients
- Injections medicines gen.
- Injections medicines c pot.
- Injections medicines gen.

### H: Technical care general
- Technical care general

### I: Preparing clear equipment
- Prep/clear technical equipment

### J: Preparing clear equipment
- Tidy ward, toys, flowers

### K: Other visitor present
- Walking

### L: Other member of staff present
- Phone

### M: Doctor present
- Clerical Work

### N: Nurse present
- Rounding: doctor, matron
- Social interaction

### O: School teacher
- Helping senior nurse

### P: Playleader
- Talking to visitors

### Q: Other visitor present
- Talking to team

### R: Tidy ward, toys, flowers
- Walking

### S: Unclassified
- Other visitor present

### T: Tidy ward, toys, flowers
- Walking

### U: Other visitor present
- Other member of staff present

### V: Other visitor present
- Doctor present

### W: Nurse no if present

## Nurse Code

<table>
<thead>
<tr>
<th>Nurse Code</th>
<th>Nurse No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 Sister Dear</td>
<td>2 4</td>
</tr>
<tr>
<td>01 Sister Nat.</td>
<td>5 15</td>
</tr>
<tr>
<td>02 N. Brown</td>
<td>5 15</td>
</tr>
<tr>
<td>03 N. Smith</td>
<td>5 15</td>
</tr>
<tr>
<td>04 N. Jones</td>
<td>10 15</td>
</tr>
<tr>
<td>05 N. Taylor</td>
<td>2 4</td>
</tr>
<tr>
<td>06 N. Tom</td>
<td>10 15</td>
</tr>
<tr>
<td>07 N. Dick</td>
<td>5 15</td>
</tr>
<tr>
<td>08 N. Harry D. o.</td>
<td></td>
</tr>
<tr>
<td>09 N. Last</td>
<td>5 15</td>
</tr>
</tbody>
</table>

## Bed No.

<table>
<thead>
<tr>
<th>Sex</th>
<th>Age</th>
<th>Ill</th>
<th>State</th>
<th>Bed No.</th>
<th>1st Obs.</th>
<th>2nd Obs.</th>
<th>3rd Obs.</th>
<th>4th Obs.</th>
<th>5th Obs.</th>
<th>6th Obs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>4 1</td>
<td>Bed 01</td>
<td>1c 19 1c 10</td>
<td>1c 10</td>
<td>1c 1a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>2 7</td>
<td>Bed 02</td>
<td>1d 12 1d 1d</td>
<td>1d 1d</td>
<td>1d 1d</td>
<td></td>
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<tr>
<td>M</td>
<td>8 5</td>
<td>UP 04</td>
<td>2c 2c 2c 2c</td>
<td>3c 3c</td>
<td>3c</td>
<td></td>
<td></td>
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<tr>
<td>F</td>
<td>7 10</td>
<td>Bed 05</td>
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<td>1b</td>
<td>1d 1a</td>
<td></td>
<td></td>
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<tr>
<td>M</td>
<td>7 11</td>
<td>Bed 06</td>
<td>1b 1c 1c 1c</td>
<td>1c</td>
<td>1c</td>
<td>1c 05</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>8 4</td>
<td>Bed 07</td>
<td>2c 2c 2c</td>
<td>3c 2c 2c</td>
<td></td>
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<td>M</td>
<td>118</td>
<td>UP 08</td>
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<td>3c 2c 2c</td>
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<tr>
<td>F</td>
<td>7 4</td>
<td>UP 09</td>
<td>2c 2c 2c 2c</td>
<td>2c 2c 2c</td>
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<tr>
<td>M</td>
<td>106</td>
<td>UP 10</td>
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<td>2c 3c 1c</td>
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<tr>
<td>F</td>
<td>9 9</td>
<td>Chair 11</td>
<td>2c 2c 2c 2c</td>
<td>2c 2c 2c</td>
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<td>M</td>
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<td>1d 1d</td>
<td>1d 1d</td>
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</tbody>
</table>
APPENDIX NO. 3

STUDY OF NURSING CARE (PAEDIATRIC)

ANECIDOTAL MATERIAL

WARD II  DAY 7  HOURS 11.30 am. - 3.30 pm.

Birthday party for JOHN SMITH (06) being prepared from 2 pm., hence the 'e's code!

John himself has gone to the zoo with his mother; will be coming back in time for tea though.

07 MARY WHITE discharged 2.15 pm.

ANN JONES (05) changed to 07 on 3.30 onwards charts.

MICHAEL (01) sick and nurse (08) mopping up? How do I code this (I've put E) (at 2.58).

TOM BROWN New admission at 11.45 am. No. 10.

Head injury to stay in bed on taking pulse.

Aged 3 years, 3 months.

The Birthday Party has meant that all the children have been helping in the kitchen - not much help some of them!

CHRISTINE still crying for her mother.
# Royal College of Nursing

## Study of Nursing Care (Paediatric)

Please read the questions carefully. There are no right or wrong answers, just reply the way you yourself believe to be correct. The information is confidential to those organising the project. It will in no circumstances be disclosed to any other members of staff of this hospital. Any material used later will not identify either you or the hospital by name.

Please use BLOCK letters throughout!

<table>
<thead>
<tr>
<th>1. Please circle whether Mr. Mrs. or Miss</th>
<th>4. i ii iii</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Country of Origin</td>
<td>5. i ii iii</td>
</tr>
<tr>
<td>3. Date of birth</td>
<td>6. i ii iii</td>
</tr>
</tbody>
</table>

Please read this question carefully and tick only one category.

4a. Are you a Registered Sick Children's Nurse and a State Registered Nurse?

<p>| Are you a Registered Sick Children's Nurse? | ii |
| Are you a State Registered Nurse training to become a Sick Children's Nurse? | iii |
| Are you a State Registered Nurse who chose to work on a children's unit? | iv |
| Are you a State Registered Nurse who was just 'sent' to the children's unit? | v |
| Are you an Enrolled Nurse who chose to work on a children's unit? | vi |
| Are you an Enrolled Nurse who was 'sent' to the children's unit? | vii |
| Are you training for any part of the register or for the roll? | viii |</p>
<table>
<thead>
<tr>
<th>if no categories above are suitable please tick the last box but state your job.</th>
<th>ix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>i</td>
</tr>
<tr>
<td>No</td>
<td>ii</td>
</tr>
<tr>
<td>Are you training for registration as a General Nurse?</td>
<td>i</td>
</tr>
<tr>
<td>Are you training for joint registration as an R.S.C.N. &amp; S.R.N.?</td>
<td>ii</td>
</tr>
<tr>
<td>Are you training for any part of the Register?</td>
<td>iii</td>
</tr>
<tr>
<td>Are you training to become an Enrolled Nurse?</td>
<td>iv</td>
</tr>
<tr>
<td>Are you completing a ‘paediatric’ certificate course?</td>
<td>v</td>
</tr>
<tr>
<td>5b. Are you in the first year of training?</td>
<td>10.</td>
</tr>
<tr>
<td>Are you in the second year of training?</td>
<td>i</td>
</tr>
<tr>
<td>Are you in the third year of training?</td>
<td>ii</td>
</tr>
<tr>
<td>1. Type of School:</td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td>i</td>
</tr>
<tr>
<td>Direct Grant</td>
<td>ii</td>
</tr>
<tr>
<td>Grammar</td>
<td>iii</td>
</tr>
<tr>
<td>Private</td>
<td>iv</td>
</tr>
<tr>
<td>Public</td>
<td>v</td>
</tr>
<tr>
<td>Secondary Modern</td>
<td>vi</td>
</tr>
<tr>
<td>Technical</td>
<td>vii</td>
</tr>
<tr>
<td>Other</td>
<td>viii</td>
</tr>
<tr>
<td>Boarding</td>
<td>ix</td>
</tr>
<tr>
<td>2. Please state age on leaving school:--</td>
<td></td>
</tr>
<tr>
<td>3. Please list details of certificates or diplomas obtained at school, or since school:</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Options</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 7. Father's occupation/or last job. (Please be as precise as possible, e.g. if an engineer state type of engineer) mother's occupation | a) before marriage   
   b) at present.                                                               |
| 8. Please tick through the appropriate reply.                          |   
   Did you live with both parents until you left school?                     |
|                                                                        | Yes                                                                 |
|                                                                        | No                                                                  |
|                                                                        | Those replying NO to the last question, please state with whom you lived (e.g.) mother, aunt, grandmother, foster parent. |
| 9a. Have you any brothers or sisters older than yourself?               | No. 1 2 3 or more                                                   |
| 9b. Have you any brothers or sisters younger than yourself?             | No. 1 2 3 or more                                                   |
| 10* When you started your training did you know that you would have to spend some time working on children's units? | Yes   
   No   
   Do not remember                                                               |
| 11* Did you anticipate that you would like working in the children's ward? | Yes   
   No   
   Did not think about it                                                     |
| 12* How much time have you spent on children's wards altogether.         | two weeks or less    
   More than two weeks but less than six weeks    
   Six weeks or more                                                            |
13. Apart from working on the wards with children have you had any other experience of looking after babies under the age of 18 months?
   - Yes, a lot to do with children
   - Yes, but only a little
   - No, not at all.

14. Apart from working on the wards with children have you had any other experience of looking after children aged 18 months to 5 years.
   - Yes, a lot to do with children
   - Yes, but only a little
   - No, not at all.

15. Have you previously had much to do with children between the ages of 5 and 12 years?
   - Yes, a lot to do with children
   - Yes, but only a little
   - No, not at all.

16. How long have you worked on this particular ward?
   - Seven days or less
   - More than seven days but less than 3 weeks
   - Less than 6 weeks, but more than 3 weeks
   - More than 6 weeks, but less than 6 months
   - Six months or more.

17. Are you enjoying working on this ward?
   - Yes
   - No
   - Indifferent
   - If no, please state why not.

18. Have you enjoyed previous children's wards that you worked on?
   - No
   - Yes
   - Indifferent
   - No experience on other wards

19. Have you had any information given to you during your training about the emotional needs of children in hospital?
   - Yes
   - No
   - Don't know
20. On the whole, do the children on the ward over five years of age behave the way you expect them to?

- Yes
- No
- Don't know

If you have answered "No" please state in what way behaviour differed from that which you expected.

21. On the whole do the children under the age of five years on this ward behave the way you expect them to?

- Yes
- No
- Don't know

If you have answered "No", please state in what way behaviour differed from that which you expected.

22. During your training do/did you have:

<table>
<thead>
<tr>
<th>Study days</th>
<th>Yes</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>ii</td>
</tr>
</tbody>
</table>

"Block" i.e. continuous periods of at least 1 week's duration

<table>
<thead>
<tr>
<th>Yes</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>ii</td>
</tr>
</tbody>
</table>

To attend lectures in your own time

<table>
<thead>
<tr>
<th>Yes</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>ii</td>
</tr>
</tbody>
</table>

To attend lectures in "ward" time

<table>
<thead>
<tr>
<th>Yes</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>ii</td>
</tr>
</tbody>
</table>

Other - please state

<table>
<thead>
<tr>
<th>Yes</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>ii</td>
</tr>
</tbody>
</table>

23. Did you have any lectures or teaching before you started work on a paediatric unit concerning how paediatric patients might be expected to behave when they are away from home?

- Yes
- No
- Cannot remember
24. Have you received all your paediatric lectures?

<table>
<thead>
<tr>
<th></th>
<th>35.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>i</td>
</tr>
<tr>
<td>No</td>
<td>ii</td>
</tr>
<tr>
<td>Don't know</td>
<td>iii</td>
</tr>
</tbody>
</table>

25. Do you get any teaching on this ward from:-

<table>
<thead>
<tr>
<th></th>
<th>36.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Sister-in-Charge and/or Staff Nurse Yes</td>
<td>i</td>
</tr>
<tr>
<td>No</td>
<td>ii</td>
</tr>
<tr>
<td>b) Clinical Instructor Yes</td>
<td>37.</td>
</tr>
<tr>
<td>No</td>
<td>i</td>
</tr>
<tr>
<td>c) Sister Tutor Yes</td>
<td>38.</td>
</tr>
<tr>
<td>No</td>
<td>i</td>
</tr>
<tr>
<td>d) Doctors Yes</td>
<td>39.</td>
</tr>
<tr>
<td>No</td>
<td>ii</td>
</tr>
<tr>
<td>e) Other (please state who) Yes</td>
<td>40.</td>
</tr>
<tr>
<td>No</td>
<td>i</td>
</tr>
</tbody>
</table>

26a. During the last seven days, have you had any such teaching?

<table>
<thead>
<tr>
<th></th>
<th>41.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Sister-in-Charge and/or Staff Nurse Yes</td>
<td>i</td>
</tr>
<tr>
<td>No</td>
<td>ii</td>
</tr>
<tr>
<td>b) Clinical Instructor Yes</td>
<td>42.</td>
</tr>
<tr>
<td>No</td>
<td>i</td>
</tr>
<tr>
<td>c) Sister Tutor Yes</td>
<td>43.</td>
</tr>
<tr>
<td>No</td>
<td>i</td>
</tr>
<tr>
<td>d) Doctors Yes</td>
<td>44.</td>
</tr>
<tr>
<td>No</td>
<td>ii</td>
</tr>
<tr>
<td>e) Other (please state who) Yes</td>
<td>45.</td>
</tr>
<tr>
<td>No</td>
<td>i</td>
</tr>
</tbody>
</table>

26b. I think that working on a children's ward is a valuable part of my training.

<table>
<thead>
<tr>
<th></th>
<th>46.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>iv</td>
</tr>
<tr>
<td>Not sure</td>
<td>v</td>
</tr>
<tr>
<td>No</td>
<td>vi</td>
</tr>
</tbody>
</table>
Paediatric Patients* are referred to in the following statements as children, toddlers and babies.

Children are those of the age of 5 years, or more.

Toddlers are those of 18 months of age, up to, but not including, 5 years.

Babies are those less than 18 months of age.

Please read the statements carefully. Will you mark the ANSWER which most nearly expresses what you think.

27. I prefer looking after adults rather than paediatric patients.

<table>
<thead>
<tr>
<th>strongly agree</th>
<th>don't agree</th>
<th>know</th>
<th>strongly disagree</th>
<th>agree</th>
<th>disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

28. I prefer surgical paediatric nursing to medical paediatric nursing.

<table>
<thead>
<tr>
<th>strongly agree</th>
<th>don't agree</th>
<th>know</th>
<th>strongly disagree</th>
<th>agree</th>
<th>disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

29. I prefer looking after toddlers rather than babies.

<table>
<thead>
<tr>
<th>strongly disagree</th>
<th>don't agree</th>
<th>know</th>
<th>strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

30. I prefer looking after children rather than babies.

<table>
<thead>
<tr>
<th>strongly agree</th>
<th>don't agree</th>
<th>know</th>
<th>strongly disagree</th>
<th>agree</th>
<th>disagree</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

31. If I had a child, toddler or baby, I would wish to stay with him in hospital, regardless of how ill or well he were.

<table>
<thead>
<tr>
<th>strongly disagree</th>
<th>don't agree</th>
<th>know</th>
<th>strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: The dotted boxes as shown on pages 282-286 and the corresponding codes (circled) did not appear on the original Nurses Questionnaires. They are used here merely to show which answers, in the author's opinion, reveal a higher degree of awareness or understanding of children's emotional needs.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 32. | Toddlers are easier to look after than children.  
      | strongly agree | don't agree | strongly disagree | 
      | disagree | strongly disagree | agree | don't agree | strongly disagree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 33. | The toddlers are easier to manage if mothers are able to visit them every day.  
      | strongly agree | don't agree | strongly disagree | 
      | disagree | strongly disagree | agree | don't agree | strongly disagree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 34. | Children are generally less upset in hospital than babies or toddlers.  
      | strongly disagree | don't agree | strongly disagree | 
      | disagree | agree | strongly agree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 35. | Babies cry a lot more in hospital than they do at home.  
      | strongly agree | don't agree | strongly disagree | 
      | disagree | strongly disagree | agree | don't agree | strongly disagree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 36. | Toddlers only cry in hospital if they are spoilt at home.  
      | strongly disagree | don't agree | strongly agree | 
      | disagree | agree | strongly disagree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 37. | Children only cry in hospital if they are spoilt at home.  
      | strongly disagree | don't agree | strongly agree | 
      | disagree | agree | strongly disagree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 38. | Toddlers usually 'settle down' very quickly in hospital if not visited at all.  
      | strongly disagree | don't agree | strongly agree | 
      | disagree | agree | strongly disagree | know | disagree | strongly disagree |
|   |   | i | ii | iii |
| 39. | Children usually 'settle down' very quickly in hospital if not visited.  
<pre><code>  | strongly agree | don't agree | strongly disagree | 
  | disagree | strongly disagree | agree | don't agree | strongly disagree | know | disagree | strongly disagree |
</code></pre>
<p>|   |   | i | ii | iii |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
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<tr>
<td>41. Paediatric patients do not really need their parents to visit them</td>
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<td>60. at all when they are in hospital.</td>
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<td>42. Toddlers are easier to manage if their mothers stay away</td>
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<td>61. altogether.</td>
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<td>43. Toddlers are less trouble than babies to care for.</td>
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<td>44. It is very helpful to the nurse if the mothers come every day to</td>
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<td>63. look after their own child, toddler or baby.</td>
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<td>45. I enjoy playing with the patients.</td>
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<td>46. The toddlers seem happier if their mothers are visiting, and are</td>
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<td>65. with them.</td>
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<td>47. Most mothers get in the nurses' way.</td>
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<td>48. Paediatric patients do not benefit from having their parents</td>
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<td>67. present immediately after their operation (i.e. immediately</td>
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<td>67. means when still recovering from the effects of anaesthetic.</td>
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<td>don't strongly disagree know</td>
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<tr>
<td>49.</td>
<td>Paediatric patients do not benefit from having their parents present immediately before their operation. *(i.e. immediately means until the child is either asleep because of premedication or anaethetised).</td>
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<td>strongly disagree</td>
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<td>50.</td>
<td>If the mother is there all the time you cannot get to know the patients properly.</td>
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<td>strongly disagree</td>
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<td>51.</td>
<td>The nurse's job should not include playing with the patients.</td>
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<td>52.</td>
<td>The mother who wants to live in with her toddler is being unnecessarily fussy.</td>
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<td>strongly disagree</td>
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<td>53.</td>
<td>Most mothers would be frightened if they were expected to stay with the child immediately after operation, even if the nurse was within call.</td>
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<td>55.</td>
<td>I get very bored with the routine on this ward.</td>
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<td>strongly disagree</td>
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<td>58.</td>
<td>The mother can be a great comfort to her child both immediately before and after the operation.</td>
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<td>strongly agree</td>
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</table>
60. The patients do not need the nurses to play with them.

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<th>strongly agree</th>
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61. If I had a child, toddler or baby who was in hospital, I would wish to stay with him all the time if he were very ill.

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<tr>
<th>strongly disagree</th>
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Thank you for answering all these questions. You will realise that I have been trying to find out how student and pupil nurses enjoy their paediatric experience, and what opinions are held about ways of caring for the patients. I would be very grateful if you would write any additional comments below, and continue on the back if necessary.
Appendum

The following statements were included in the questionnaire but not used to find ward scores or individual scores:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Responses</th>
<th>59.</th>
<th>54.</th>
<th>56.</th>
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<tr>
<td>40. The visiting arrangements on this ward are very satisfactory.</td>
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<td>54. There is less to do on a paediatric ward than on a general ward.</td>
<td>strongly disagree</td>
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<td>56. I get opportunities to play with the patients on this ward.</td>
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<td>57. The ward is too busy to allow the nurses time to play with the patients.</td>
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<td>59. Sister does not like us to play with the patients.</td>
<td>strongly disagree</td>
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APPENDIX NO. 5

Alternative Questions asked of nurses working on paediatric units by choice:-

Questions:-

10. Have you ever nursed adult patients?
    Yes
    No

11. Did you enjoy looking after adults?
    Yes
    No
    Not applicable

12. Did you prefer looking after adults rather than children?
    Yes
    No
    Like both
    Not applicable
APPENDIX NO. 6

Ren THE STUDY OF NURSING CARE

QUESTIONS TO ASK SISTER IN CHARGE OF UNIT

1. Which categories of patient are nursed in cubicles?

2. If children are in cubicles (unless isolated because of infection, or serious illness), are they allowed to play with other children in the ward?

3. Is there a playroom for the children?

4. Do you consider that a playroom is desirable?

5. What are your qualifications?

6. Are children under 18 months looked after by a special nurse or a special group of nurses (case assignment)?

7. Are the children between 18-months and 5 years looked after by a special nurse, or anyone on duty?

8. Does the child get the same nurse looking after him where possible?

9. Is the ward adequately staffed at the present moment?

10. Where does the main admission procedure take place?

11. Who is responsible for admitting the child?

12. Are the parents seen separately from the child.

13. Is the child shown round the ward on admission?

14. Is the child introduced to other children?

15. Are the parents asked the child's personal habits, his likes and dislikes, pet name for lavatory?

16. If a preliminary medical examination is part of the routine, is the parent allowed to stay and help?

17. If a daytime admission, is the child allowed to stay up (if not admitted from bed)?

18. If he is admitted at bedtime, is the mother allowed to help?

19. Are children allowed to wear their own clothes in hospital during the daytime?

20. Are children allowed to wear their own night-clothes.

21. Is playing with the children regarded as part of the nurse's duties?

22. Do the nurses know this?

23. Do they generally appear to play with the children?

24. Is the child allowed to bring his own toys into hospital with him?

25. If he sucks a 'dummy' or has some other comforter, e.g. 'old blanket', is he allowed to keep it with him?
26. If a child has already been in hospital, is he admitted to the same ward if he has the same illness?

27. If he has a different illness?

28. Are there facilities for admitting mothers with their child?

29. Who decides whether or not a mother should be admitted with her child?

30. What is the official policy with regard to visiting hours? What do you think about the official visiting policy?

31. Are there times when it is preferred that parents do not visit even though officially they can?

32. What is a mother who is admitted with her child allowed to do?
   a) feed him
   b) wash him
   c) bath him
   d) put him to bed
   e) get him up
   f) assist with nursing procedures
   g) undertake nursing procedures
   h) give medicine
   i) keep fluid balance record anything else.

33* What is a visiting parent allowed/encouraged to do?
   a) feed him
   b) wash him
   c) bath him
   d) put him to bed
   e) get him up
   f) dress him
   g) assist with nursing procedures
   h) undertake nursing procedures
   i) give medicine
   j) escort to other departments.

34. Are the parents allowed and/or encouraged to be present during medical treatment?

35. Operating day - are parents allowed to stay with their child
   a) immediately pre-operatively?
   b) immediately post-operatively?

36. Are parents allowed to visit on the day of operation?

37. Is there anywhere for other children to wait while parents are visiting?

38. Are siblings ever allowed into the ward?
   a) younger
   b) older

39. Is there anybody to organise the children's leisure activities - teacher?

40. playlady?

41. nursery nurse?

42. Is there a plentiful supply of toys readily available?

43. Is there a TV/wireless available?

44. Are these situated so that the more ill patients are undisturbed?

45. Do you use restrainers?
   If so, on what occasions?
   Who decides, and what are the deciding factors about whether or not a child is nursed in a cot or a bed?

46. How are children in cubicles able to contact the nursing staff, e.g. for bedpan?

47. Are screens provided for children using bedpans if they wish?
48. If a child is undergoing special treatment, is he told by nursing staff or medical staff what is to happen?

49. Where are special treatments carried out: in treatment room elsewhere?

50. Are the children separated from the others pre-operatively?

51. Are they separated post-operatively?

52. Are children returned from the theatre, unconscious (with airway in situ) semi-conscious, or conscious.
## Form for the Assessment of the Quality of Nursing Care in Paediatric Wards

**Key to Rating**
1. *Always*  
2. *Usually*  
3. *Depends*  
4. *Not Often*  
5. *Never*

### Total Markings in Each Column

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>1</th>
<th>2</th>
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<th>4</th>
<th>5</th>
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<tr>
<td>Are cubicles used in accordance with the &quot;Play Recommendations?&quot;</td>
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<td>Are case assessment practised (0 to 18 months of age)?</td>
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<td>(From 19 months to five years of age)?</td>
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<td>Are the children allowed to wear their own clothes?</td>
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<tr>
<td>Are children encouraged to wear their own clothes?</td>
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<td>Are children allowed to have their own toys?</td>
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<td>Are the children allowed to have their own toys?</td>
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<td>Can a child keep 'comporter' or 'dummy'?</td>
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<td>Do nurses play with the children?</td>
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<td>Are the nurses allowed to play with the children?</td>
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<tr>
<td>Can a child use his 'comporter' or 'dummy'?</td>
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<td>Is there a nursery nurse on the ward who is available?</td>
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<td>Are parents allowed to visit on admission?</td>
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<td>Are parents allowed to visit on admission?</td>
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<td>Is the mother allowed to help if the child is admitted at night?</td>
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<td>Is a parent allowed to help if the child is admitted at night?</td>
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<td>Are siblings allowed to visit?</td>
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<td>Are siblings allowed to visit?</td>
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<td>Are parents allowed to stay until child goes to the operating theatre?</td>
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<td>Can parents be present immediately after the operation?</td>
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<td>Are parents allowed to visit on the day of the operation?</td>
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<td>Are parents allowed to stay until child goes to the operating theatre?</td>
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<td>Is there a nursery nurse on the ward who is occupied with welfare activities?</td>
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<tr>
<td>Is there a plentiful supply of toys readily available?</td>
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<tr>
<td>Are restraints used? (e.g. if answer is 'never' mark column 1)</td>
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<tr>
<td>Are children in cubicles able to contact the nursing staff?</td>
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<tr>
<td>Are siblings provided for children during toileting?</td>
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<tr>
<td>Is the child told beforehand of the nature of nursing procedures?</td>
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<tr>
<td>Is there a treatment room available, is it used?</td>
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</tbody>
</table>

**Total Markings in Columns 1 + 2 Combined**